Witness Name: Professor Sir Louis Appleby

Statement No: WITN0069001

Dated: 24th October 2025

THE NOTTINGHAM INQUIRY

WITNESS STATEMENT OF PROFESSOR SIR LOUIS APPLEBY

I, Professor James Louis John Appleby, will say as follows: -

INTRODUCTION

1. I am Director of the National Confidential Inquiry into Suicide and Safety in Mental Health, referred to here as the National Confidential Inquiry.
2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 26 August 2025 (the "**Request**").

BACKGROUND

3. I have been asked to describe the work of the National Confidential Inquiry, with particular reference to homicide.
4. I have been asked to set out when and why our homicide research was stopped and subsequently recommissioned.
5. I have been asked to comment on the effectiveness of individual homicide inquiries.

PERSONAL DETAILS

- Professor Sir Louis Appleby

6. Career and role

   a. *Qualifications*

   - 1980 M.B., Ch.B.; 1995 M.D.
   - 1983 M.R.C.P.; 1995 F.R.C.P.
   - 1986 M.R.C.Psych.; 1996 F.R.C.Psych.

   b. *Roles*

   - 1996-present Professor of Psychiatry, University of Manchester.
   - 1996-present Director, National Confidential Inquiry into Suicide and Safety in Mental Health, formerly the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.
   - 1996-present Honorary Consultant Psychiatrist in the NHS in Manchester, currently with Greater Manchester Mental Health NHS Foundation Trust.

   c. *Relevant appointments*

   - 2000-2010 National Director for Mental Health in England (Secondment to Dept of Health).
   - 2010-2014 National Director for Offender Health (Secondment to Dept of Health).
   - 2013-2019 Non-Executive Director, Care Quality Commission.

7. The National Confidential Inquiry into Suicide and Safety in Mental Health was established, as The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, at the University of Manchester in 1996 in response to public concern over the safety of mental health services, specifically over risks to

the public from community mental health care. Its objectives were to enhance monitoring and safety in mental health services, identify patterns and risk factors associated with suicide and homicide, and provide recommendations to improve clinical practice, service delivery, and patient and public safety.

8. For homicide, we undertook the systematic collection of clinical and offence-related data on all people convicted of a homicide offence in the UK. Primarily, we identified perpetrators who had prior contact with mental health services and in these cases clinical data were obtained from the relevant NHS Trust in England or the equivalent organisation in the other UK countries. Clinicians supervising the patient at the time of the homicide were asked to complete a comprehensive clinical questionnaire [WITN0069002]. Mental health histories were also compiled from pre-trial psychiatric assessments, including for those who were not patients. Additional data sources included: Home Office Homicide Index; the Police National Computer (via Greater Manchester Police); HM Court Service; UK police forces.

9. We produced a series of national reports and peer-reviewed research papers, disseminating our findings to practitioners, policy makers and academic audiences both in the UK and internationally. Learning resources for mental health staff were made available via our website, and findings were presented in formats suitable for patients and the general public.

10. In June 2018, the Independent Advisory Group (IAG) established by our commissioners the Healthcare Quality Improvement Partnership (HQIP) made the decision to discontinue comprehensive homicide data collection. IAG membership

includes funders from all four UK countries and individuals with subject expertise. This decision was based on their assessment of priorities in the context of a reduction in funding, a competing priority being the extension of our studies of suicide by mental health patients to groups of concern within the general population. Informal discussions also referenced: the growing maturity of NHS serious incident investigations in cases of patient homicide; concerns that regular publication of our homicide findings may inadvertently perpetuate stigma towards people with mental illness; and that the core learning from our homicide findings had by now been sufficiently achieved.

11. National Confidential Inquiry staff were not present when the final decision was made, so we cannot be sure which factors most influenced the decision.

12. Data collection did not cease entirely in 2018. We continued to record the number of homicides committed by individuals in contact with mental health services.

13. In 2025, NHS England recommissioned our research into patient homicide. This decision was prompted by heightened public and political concern regarding the safety of mental health services, following high-profile homicides involving individuals with known mental health histories, in particular the Nottingham tragedy.

14. The National Confidential Inquiry will re-establish prospective data collection on homicides by people with mental illness. We will also undertake retrospective data collection for patients and former patients convicted of homicide between March 2023 and April 2025. This initial phase of the study will focus exclusively on

homicides committed by individuals diagnosed with schizophrenia or other primary psychotic disorders.

Learning Analysis

15. Our last annual report featuring detailed homicide findings was published in 2017, covering the years 2005-15 [WITN0069003]. We were notified of 6,004 homicide convictions in the UK in that period. Data below refer to England:

- 11% of homicides were committed by mental health patients, an average of 58 per year.
- Most patient homicides were committed by men (85%).
- The median age of patients who committed homicide was 32 years (range 13-83).
- 73% of patients had a history of alcohol misuse and 78% a history of drug misuse.
- 49% of patients were either non-adherent to prescribed medication or had missed their final contact with services and were therefore not in receipt of planned treatment prior to the homicide; it was noted that this figure was falling.
- 6% of all those convicted of homicide had schizophrenia or a primary psychotic disorder, an average of 32 per year. Of these, 61% were patients, an average of 20 per year.
- 88% of patients with schizophrenia had a history of either alcohol or drug misuse.
- 59% of patients with schizophrenia were non-adherent with drug treatment in the month before the homicide or had missed their final appointment.

- The most common relationship between perpetrator and victim was acquaintance (46%), followed by family member (19%), spouse/partner (18%) and stranger (16%).

16. In the 2016 annual report [WITN0069004], we included a commentary on our findings over the previous 20 years, i.e., since the establishment of the National Confidential Inquiry in Manchester. We concluded that two interventions were crucial to the prevention of patient homicide:
    - Services for drug and alcohol misuse, and for "dual diagnosis", where severe mental illness and drug or alcohol misuse co-exist.
    - Services to maintain engagement with patients who are likely to lose contact.

17. In 2020, we extended these findings in an academic paper based on National Confidential Inquiry data [WITN0069005]. This was a comparison between two groups of male patients with schizophrenia, one group convicted of homicide, the other with no such conviction. The main findings were:
    - Almost all (94%) of those convicted of homicide had either a history of drug or alcohol misuse or were not in receipt of planned treatment.
    - Although these features were common in both groups, they were more common in those who committed homicide.
    - In the absence of these factors, homicide by patients with schizophrenia is rare; they should be a focus of prevention.

18. The National Confidential Inquiry previously conducted a thematic analysis of recommendations from NHS serious incident investigations into patient homicides

(often called "homicide inquiries") published between 2002 and 2009, and presented the findings in a series of reports, with our final report in 2010 [WITN0069006]. We have not assessed these investigations more recently. We have not carried out research into any other form of public inquiry.

19. Our conclusions in the report [WITN0069006], were critical of this form of homicide investigation as it then operated. For example, we concluded that:
    a. Recommendations lacked specificity, were vague and difficult for mental health trusts to implement or monitor.
    b. Investigation panels were often small, making it hard to ensure they contained the necessary breadth of expertise.
    c. The inquiry process took too long, even in uncomplicated cases.
    d. Reports often lacked an implementation plan with deadlines to ensure delivery.
    e. Recommendations were often repeated from one report to another, suggesting that the inquiry system was not leading to changes in care.

20. We were concerned that recommendations focused on routine aspects of care such as risk assessment, care planning and working with families, suggesting that in many incidents there had been gaps in basic care.

Recommendations

21. I have been asked to comment on how this Inquiry might prevent similar deaths. In my view this touches on a crucial question for mental health care, namely the balance of autonomy and risk, the need to combine respect for patients' decisions

about their care with the social responsibility expected of professionals on issues of patient and public safety.

22. Based on the findings from my research group above and on what I know about the Nottingham tragedy, the key areas for recommendations should be the maintenance of treatment in the community, the response of services to signs of risk or relapse, and the oversight of evidence-based safe care.

23. With respect to maintaining treatment in the community, I believe the Inquiry should offer unequivocal support to:
    - The Community Treatment Order (CTO), introduced in the 2007 Mental Health Act, which the new Mental Health Act supports despite opposition from some mental health leaders and parliamentarians (I should declare an interest: I was National Director for Mental Health and adviser to the Government in 2007). The evidence for improved outcomes from CTOs is equivocal but in part this reflects the problem of conducting clinical trials with high risk patients. Individual case histories are less equivocal, as in Nottingham.
    - Outreach teams (also referred to as assertive outreach) whose purpose is to ensure that care is delivered to patients who have a history of disengagement and treatment refusal, often associated with previous drug or alcohol misuse. Outreach teams were national policy in England in the 2000s, were subsequently discontinued in most areas, and are again a commitment in the recent 10 Year Health Plan.

24. The Inquiry should aim to strengthen the rights of patients' families to request assessment, acknowledging that they are often in the best position to identify deterioration and risk. Services might respond to this with concern about excessive demand but this has to be considered beside the high risk of not only violence but suicide and self-harm in mental health patients, and the benefit of providing reassurance to worried families, even when assessment leads to no further action. A period of piloting would be needed, and presumably a protocol to limit repeat requests. The Inquiry could consider:
    - A right for families to assessment for patients with a history of high risk, as exists for patients subject to Mental Health Act powers.
    - A right to a second opinion, equivalent to Martha's Rule in acute health care.

25. After a devastating incident there is often an immediate determination in mental health services to prevent further incidents above other priorities but over time this tends to subside. I believe that in the merged DHSC/NHS England, a new national oversight body is needed to ensure that evidence-based and safety-critical mental health interventions are implemented, maintained and monitored.

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: Oct 24, 2025

Index to Witness Statement of Professor Sir Louis Appleby

No.	Inquiry URN	Document Description
1	WITN0069002	The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Homicide Questionnaire
2	WITN0069003	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2017
3	WITN0069004	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Making Mental Health Care Safer Annual Report and 20-year Review
4	WITN0069005	Homicide by men diagnosed with schizophrenia: national case-control study
5	WITN0069006	The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Independent investigations after homicide by people receiving mental health care (2010)