

THE NOTTINGHAM INQUIRY

SUPPLEMENTARY WITNESS STATEMENT OF PROFESSOR LOUIS APPLEBY

Personal details

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

1. I am Professor of Psychiatry at the University of Manchester. My qualifications and relevant experience are presented in my previous witness statement [WITN0069001].

Introductory remarks

2. I am Director of the (re-named) National Confidential Inquiry into Suicide, Homicide and Safety in Mental Health, referred to here as the National Confidential Inquiry (NCI). This supplementary statement is made in addition to my previous statement [WITN0069001] and the oral evidence I have given to the Inquiry [INQT0000101]. I am grateful for the opportunity to set out a factual account of the work of the NCI previously and in future, addressing references to our work in witness testimony to the Inquiry.
3. This witness statement is made to assist the Nottingham Inquiry (the “Inquiry”) with the matters set out in the Rule 9 Request number 2 dated 8 June 2026 (the “Request”).

BACKGROUND

4. I have been asked to provide further detail as regards to the methodology and breadth of NCI’s data collection.
5. I have been asked to provide further data and learning, particularly with regards the issue of schizophrenia and violence.
6. I have been asked to suggest recommendations as to how the scope of the work of the NCI Homicide Inquiry could be expanded to enhance learning, understanding and public safety.

Methodology and breadth of NCI’s data collection

History and remit

7. The NCI was originally set up in the early 1990s and established at the University of Manchester in 1996. This was a period of public and political concern over the risk to the public from mental health patients with severe mental illness living in the

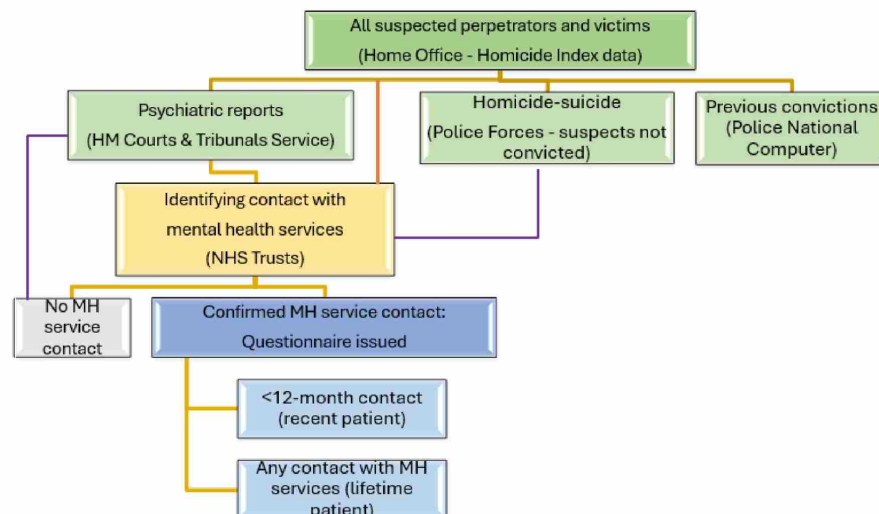
community and the policy of closing long-stay hospital wards. Alarm about what were referred to as “community care homicides” followed several serious incidents, in particular the killing of a member of the public, Jonathan Zito, in 1992. This led to a public inquiry and the 1994 Ritchie Report into the care of a patient, Christopher Clunis, that highlighted serious failures by mental health services and partner agencies.

8. The core remit of the NCI was therefore to examine the care that had been provided by specialist mental health services when an individual committed a homicide offence or died by suicide, with the aim of improving prevention. Data collection was established UK-wide. We published in-depth national reports in the first ten years of our work: Safer Care (1999) [WITN0069008], Safety First (2001) [WITN0069009] and Avoidable Deaths (2006) [WITN0069010]. From 2009 we published annual reports, shorter and more focused, updating key figures and highlighting areas of concern.
9. In 2018 detailed homicide data collection was ended, as described in my first witness statement, though we maintained a record of patient homicide numbers. In 2025 funding was provided by NHS England to resume and expand the homicide component of the NCI. “Homicide” has been restored to our project title.

Methodology

10. Data collection follows a stepwise process described below and illustrated in Figure 1.

Figure 1: Method of NCI data collection



11. **Step 1:** We obtain information from the Home Office Homicide Index on all individuals convicted of a homicide offence (murder, manslaughter or infanticide), on those found not guilty by reason of insanity or unfit to plead, on perpetrators who

took their own lives after committing a homicide (known as “homicide-suicides”), and on victims of these offences.

Step 2: We obtain available psychiatric reports from His Majesty’s Courts & Tribunals Service for anyone charged with homicide who has undergone a psychiatric assessment. This is irrespective of whether they were mental health patients. From this data, we identify mental health-related homicides by people not in contact with mental health services. We extract information including demographic details, previous violence, symptoms of mental illness and details of the offence.

Step 3: We obtain “antecedent data” from the Police National Computer (PNC) on people convicted of homicide and those groups described in Step 1 above. This details criminal history, including convictions, cautions, reprimands, and pending prosecutions. It is the main source of data used to identify previous convictions for violence.

Step 4: With the help of NHS Mental Health Trusts, we determine if individuals convicted of homicide, those who were found not guilty by reason of insanity or unfit to plead, and those who carried out homicide-suicide were mental health patients. Each Trust confirms if an individual was under the care of their services and, if so, when their last contact occurred. We can therefore identify patients in recent contact (i.e. within 12 months of the offence) and those with previous contact at some time.

Step 5: Once it is established that an individual was a mental health patient, we ask the supervising clinician at the Trust to complete a detailed questionnaire. The questionnaire covers demographic and clinical data such as diagnosis and it provides extensive information about the patient’s clinical care prior to the offence, including whether they had been “non-adherent” with medication or had disengaged from services. Our response rate from clinicians has been high, around 90-95%.

NCI data collection 1996-2018

12. From 1996 to 2018 we collected extensive data for all four UK countries. We published findings in reports and academic papers on the various mental health homicides outlined above, though our primary focus remained people in recent contact with services and patients with schizophrenia, in line with our core remit to study homicide by patients under community care. Our database for these years consisted of 14,776 perpetrators and 15,512 victims over 20 years. We reported on trends in key figures over time, on patients as victims, on court outcomes and other topics.

13. We made recommendations to services to improve safety with particular emphasis on co-existing mental illness and drug or alcohol misuse, and treatment refusal and disengagement (see my previous witness statement [WITN0069001]). We specifically supported assertive outreach teams and the introduction of the community treatment order in the 2007 Mental Health Act.

Future data collection

14. The homicide work of the NCI is now being re-established and at the time of this statement, national data collection (for England only) is about to begin. The new homicide inquiry will build on our previous work, updating previous figures, and it will respond to issues raised by the Nottingham tragedy and by other recent high-profile incidents. There will be an emphasis on schizophrenia, the management of previous violence, and the use of the Mental Health Act. We will examine homicides by patients, former patients and people who were never patients, and we will report victim numbers alongside perpetrators. We will aim to understand why some suspected homicides by patients do not lead to conviction. We will aim to work with victims' families and have appointed a dedicated member of staff to lead this. We will explore early notification of cases by Mental Health Trusts, before conviction.

**Comments on the description of NCI methodology in Julian Hendy's statement
[WITN0258001]**

15. I am responding to comments made by Julian Hendy on NCI methodology in his evidence to the Inquiry and welcome the opportunity to offer factual correction and clarification. There are three main points to address.

Reporting the number of victims

16. NCI has consistently reported the number of victims of homicide in its reports and academic publications. Since 2014, the number of victims of has been prominently reported in all annual reports alongside the number of perpetrators, among patients and in the general population, and reporting of these numbers continued after 2018 despite the de-commissioning of the homicide inquiry.

17. Although reports have included limited details about victims, our main remit remains the mental health care of perpetrators. However, in the new homicide inquiry, we will report the range of relationships between victim and perpetrator, updating previous analysis, and examine specifically cases in which victims were children, in response to recent cases.

Defining homicide by conviction

18. In our study it is important that we have a reliable and valid definition of homicide and in our view this is best provided by the courts. This is not quite the same as conviction as it includes the small number of cases where the outcome is not guilty by reason of insanity or unfit to plead. It is more accurately described as a legal determination but we generally refer to conviction as a convenient shorthand. We also use a legal determination in defining suicide, in the form of inquest conclusion, so there is a consistency in our overall methodology.

19. We also present figures in our annual reports for homicide-suicide cases in which the perpetrator takes their own life before trial. We present these figures separately because there has been no legal determination. We have found in total around 20 such cases annually but few involve mental health patients – 1-2 per year.
20. In illustrating his criticism of our methodology, Mr Hendy raises a specific case (DB), a man who killed multiple victims and himself who, it is suggested, would not be in our figures. In fact, this unusual case is in our data, in our homicide-suicide figures, and the number of victims is presented in our report for that year.
21. Defining homicide by legal determination is in my view the correct approach. Collecting detailed data on people in a study of homicide when they were never convicted would be ethically dubious, their clinicians might refuse to take part, and our findings might be made less accurate by the inclusion of ineligible individuals. However, it would be useful to know why some people with mental illness are suspected of homicide but not convicted and we will explore this question in the new homicide inquiry.

Reporting mental illness by different definitions

22. Mental illness can be defined in various ways and in NCI reports we have presented figures based on different definitions, according to:
- a. Contact with mental health services, either within the 12 months before the homicide (current or recent patients) or at some time previously (“lifetime” contact).
 - b. Mental illness at the time of the offence, found by psychiatric assessment as part of court proceedings.
 - c. Diagnosis of schizophrenia, whether patients, former patients or non-patients.
 - d. A combined group, including all current or previous diagnoses, and any or no contact with mental health services.
 - e. Outcome in court – verdict of diminished responsibility or hospital disposal.
23. Table 1, from our 2006 Avoidable Deaths report [WITN0069010], sets out these figures for England and Wales over an approximately 5-year period.

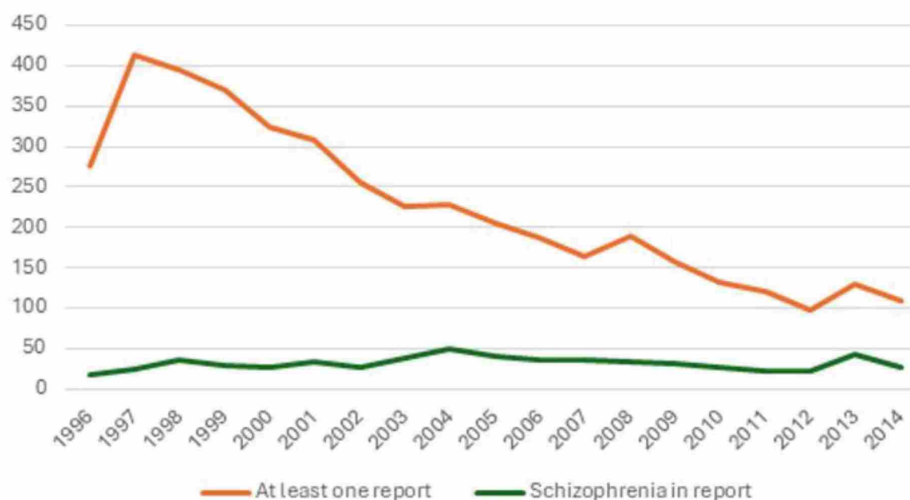
Table 1: Definitions of mental health homicide

Definitions	Number (2,684)	%	(95% CI)
Mental illness at the time of the offence ^a	261	10	(9-11)
Convicted of manslaughter section 2 (diminished responsibility)	106	4	(3-5)
Commitment to psychiatric hospital (hospital order)	154	6	(5-7)
Lifetime mental disorder	806	30	(28-32)
Schizophrenia (lifetime)	141	5	(4-6)
Contact with mental health services (lifetime)	486	18	(17-20)
Contact with mental health services within 12 months of the offence	249	9	(8-10)

24. From these figures and our subsequent reports, the following conclusions can be drawn.

- There is no single definition of mental illness and the number of “mental health homicides” varies widely according to definition.
- Around 30 people with schizophrenia commit homicide per year. This group is key to the NCI core remit, as a group with severe mental illness in the community. However, not all – around 20 per year – are recent patients.
- In total around 50 recent patients per year, including all diagnoses, commit homicide. This is also a key group, being in contact with mental health services, making prevention more feasible. However, most do not have schizophrenia or related psychosis, so they do not equate to “community care homicides”.
- Including all definitions of mental illness gives a much larger figure. However, the broader the definition, the higher proportion of people who did not have severe mental illness such as schizophrenia but whose mental disorder was alcohol or drug dependence or personality disorder, conditions that are not normally regarded as mental illness. In some, there may be no causal link to the homicide.

Figure 2: Psychiatric reports over time (NB. Graph is unpublished data)



25. We have continued to publish homicide figures for recent patients and for people with schizophrenia. However, it has not been possible to maintain reliable figures based on psychiatric reports prepared for the courts as these are no longer mandatory. Figure 2 shows the decline in the number of reports overall. However, the fall is likely to be in people with less severe illness. Figure 2 also shows that the number of reports for people with schizophrenia is relatively unchanged and we are confident that our figures for this group remain reliable.

26. In the new homicide inquiry we intend to resume the collection of available reports (approval awaited). Some of these will be about patients known to primary care or A&E departments. People seen in A&E by mental health liaison services will be in our patient figures as part of our core data collection, identified by Mental Health Trusts.

Further data and learning regarding schizophrenia and homicide

27. NCI reports provide national case series data on people with schizophrenia who committed homicide. Our figures describe the characteristics of these individuals and, if they were mental health patients, some aspects of their care, highlighting possible areas for prevention.

28. The precise figures vary between reports covering different time periods but illustrative figures are presented in our 2017 annual report [WITN0069003], referring to convictions in 2005-15. Detailed data collection ended in 2018. Some of these figures also appear in my first witness statement [WITN0069001].

29. During these years there was an average of 32 homicides annually by people with schizophrenia in England, of whom 20 were recent patients, i.e. had been in contact with mental health services in the 12 months before the offence, with 21 victims on average. Schizophrenia was the most common diagnosis among patients.

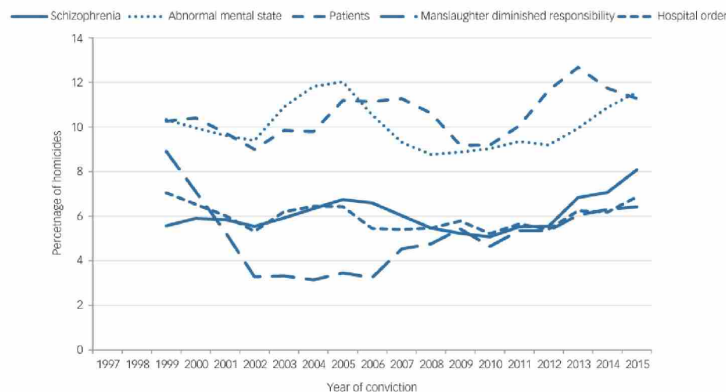
30. In the patient group, 32% were non-adherent with drug treatment at the time of the offence, suggesting treatment refusal, and 39% had missed their final contact with services, suggesting disengagement. These features overlap and the combined figure was 59% not in receipt of care as planned. In total 92% were said to have symptoms of psychosis at the time of the offence. In other studies we have found that the main reason for non-adherence is the patient's lack of insight into their illness.

31. 71% had a history of alcohol misuse, 84% drug misuse and because of considerable overlap, 88% had either or both.

32. Despite severe mental illness, 34% were convicted of murder and 41% received a custodial sentence. In other studies we have shown this is likely to reflect co-existing drug or alcohol misuse and, we believe, the perception of culpability when these features are present.
33. In other reports we have found characteristics of perpetrators with schizophrenia as follows: male (86%), ethnic minority (35%), unmarried (78%), living alone (25%). 32% had previous convictions for violent offences.
34. We also conducted the first national case–control study of previously admitted males diagnosed with schizophrenia, convicted of homicide in England and Wales between 1997-2012. The comparison group differed only in having no such conviction. This type of study design identifies possible risk factors, although differences between cases and controls may not be causal. This study was referred to in my first witness statement [WITN0069001] and submitted as [WITN0069005].
35. Patients with schizophrenia who committed homicide were more likely to have a history of violence, co-existing personality disorder and drug misuse. They were more likely to have missed their last contact with services prior to the offence and to have been non-adherent with their treatment plan. We found that almost all (94%) homicides in this study were committed by patients who had a history of alcohol or drug misuse or who were not in receipt of planned care, frequently both. Nine homicides occurred in the absence of any of these clinical features – fewer than 1 per year.
36. Our evidence therefore points to a strong relationship between schizophrenia and homicides, accounting for around 6% of all convictions despite a population prevalence estimated to be around 0.5-1%. It highlights high rates of previous violence. It emphasises the importance to prevention of two factors: co-existing alcohol or drug misuse and not receiving treatment as planned through loss of contact or treatment refusal. Because of these findings, our reports have consistently supported assertive outreach teams and community treatment orders. In our data for 2000-2016, we have identified 29 homicides by patients under assertive outreach (1-2 per year), 26 of whom had schizophrenia. From 2011-2016, we have identified 3 patients under CTO at the time of the offence (less than 1 per year), all with schizophrenia, and 10 previously under CTO, 8 of whom had schizophrenia.
37. We have examined trends in general population homicide and homicide by people with mental disorder by different definitions, including schizophrenia [WITN0069011]. Over the period 1997-2015, there was a significant fall in the rate of homicide convictions in the general population in England and Wales (Figure 3). Against this background trend, the number of homicides by people with schizophrenia did not

fall, therefore the proportion with this diagnosis rose in the later years of the study. We concluded that, as a result, mental disorder, particularly severe mental illness, had become proportionately more important to preventing homicide overall.

Figure 3: Three-year moving average proportion of mental health homicides by five definitions and year of conviction.



Serious non-fatal violence by patients with schizophrenia

38. We have also studied serious non-fatal violence by mental health patients using the same methodology as in the homicide inquiry [WITN0069012]. We included all people convicted of a serious violent offence (attempted murder, malicious wounding, wounding or other act endangering life, and threats or conspiracy to murder) in England and Wales in a single year. Of 5,966 serious violent offenders, 293 (5%) had been in contact with mental health services in the 12 months prior to the offence. Personality disorder (22%) and schizophrenia (19%) were the most common primary diagnoses. Of those with schizophrenia (0.9% of all serious violent offenders), 85% had co-existing drug and/or alcohol misuse or dependence.

39. Lower figures for the contribution of schizophrenia to serious non-fatal violence compared to homicide (5% compared to around 11%) may suggest under-reporting and/or lower rates of conviction. It may also reflect a greater likelihood of a fatal outcome when the perpetrator has schizophrenia.

Future scope of NCI data collection and work

Recommendations on the scope of the work of the NCI

40. The homicide work of the NCI is being re-established and, as outlined above (paragraph 14), there will be a number of differences and developments from the previous programme, many of these arising from the Nottingham tragedy. There will be a focus on severe mental illness, particularly schizophrenia. We will update homicide figures for different definitions of mental illness and show how these are related. We will aim to explain why some suspected cases do not lead to conviction.

We will investigate early notification by Mental Health Trusts. We will examine in more detail previous episodes of violence. There will a greater emphasis on victims. We will work with victims' families and aim to address their questions.

41. Features of other high-profile incidents will also be reflected in our work plan: eg autism, child victims, terrorist motives, domestic violence, ethnicity. These sensitive areas are already part of the public discourse on mental health homicides and reliable evidence is needed.
42. We believe there would be benefits in extending our data collection to serious non-fatal violence, with a focus on perpetrators with schizophrenia. Including incidents with a non-fatal outcome would increase the number of cases on which robust conclusions would be based, though there may be important differences in these cases – see our previous time-limited study outlined above (paragraphs 34-35).
43. We would like to investigate the possible use of linkage studies, ie connecting criminal justice and NHS databases, in identifying mental health homicides. This might add to case numbers but has not been carried out previously in the UK and at this stage would be exploratory. It would not provide the level of detail about clinical care that we currently collect from clinical staff, so it would add to rather than replace our current methodology.
44. We will in the new homicide study identify mental health contacts in A&E departments, as new liaison services and better record systems have made this possible. We could also explore contact between perpetrators and other health settings such as primary care. However, this is a substantial, untested task and it is not clear how many as yet unidentified patients with severe mental illness this would deliver. A more focused alternative would be to reinstate the mandatory requirement for psychiatric reports for people charged with homicide, as these reports have the potential to identify contacts with a range of services and agencies.

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: 14th July 2026

Index to Supplementary Witness Statement of Professor Sir Louis Appleby

No.	Inquiry URN	Document Description
1	WITN0069008	Safer Services
2	WITN0069009	Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2001)
3	WITN0069010	Avoidable deaths: five-year report of the national confidential inquiry into suicide and homicide by people with mental illness (2006)
4	WITN0069011	Mental disorder in people convicted of homicide: long-term national trends in rates and court outcome
5	WITN0069012	Serious Violence by People With Mental Illness: National Clinical Survey