

Tuesday, 31 March 2026

1
2 (1.59 pm)
3 **MR BLAKE:** Good afternoon, Chair. Can I please call
4 Michelle Mannion.
5 **THE CHAIR:** Yes, Mr Blake.
6 **MR BLAKE:** Thank you.
7 **MICHELLE MANNION (sworn)**
8 **Questioned by MR BLAKE**
9 **MR BLAKE:** Ms Mannion, you should have in front of you
10 a witness statement dated 30 October 2025; is that
11 right?
12 **A.** That's correct.
13 **Q.** It has a URN of WITN0081001.
14 **A.** That's correct.
15 **Q.** Can you please confirm that that is true to the best of
16 your knowledge and belief?
17 **A.** It is.
18 **Q.** Thank you very much. You've set out your career history
19 in the statement, you've essentially spent your career
20 in various roles at the CPS; is that right?
21 **A.** That's right.
22 **Q.** You're currently District Crown Prosecutor at East
23 Midlands CPS Complex Case Unit?
24 **A.** Yes.
25 **Q.** You've been in that position, I think, since

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1 who was Mr Murphy.
2 Ms Shallow was the head of the unit, I was the
3 deputy head. Andrew Baxter sits above Ms Shallow,
4 Ms McKinney and he then reports into Ms McKinney.
5 **Q.** Thank you. You came into this matter after VC had been
6 charged; is that right?
7 **A.** That's right.
8 **Q.** You've set out a lot of detail in your witness
9 statement, but a lot of it relates to the activities of
10 other people. What do you consider to be your principal
11 involvement in this matter?
12 **A.** Because the relationship between Ms Shallow and
13 Mr Murphy had been established as of 13 June, 14 June,
14 because I was originally transferred to the unit on
15 a temporary basis, it was made clear that Ms Shallow was
16 effectively going to have oversight and managerial
17 responsibility of the case. So that effectively meant
18 that I was copied into things for information and I was
19 on hand in the event that Ms Shallow or Mr Murphy were
20 not available or there was some further assistance
21 needed.
22 **Q.** Is there anything in particular that you feel you had
23 a particular hand in?
24 **A.** No.
25 **Q.** I want to focus on the receipt of the defence

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1 17 July 2023.
2 **A.** That's correct.
3 **Q.** Your line manager is the Senior District Crown
4 Prosecutor, Samantha Shallow, who we're going to hear
5 from after the Easter break.
6 **A.** That's right, it was at the time. It's no longer
7 Ms Shallow, but it was at the time of the matter.
8 **Q.** Thank you very much. It's because of her seniority to
9 you that your evidence today will be relatively limited
10 in scope.
11 **A.** Correct.
12 **Q.** We're going to see some other names, Andrew Baxter is
13 one of them, we've already seen his name in some
14 documents. He was the Deputy Chief Crown Prosecutor; is
15 that right?
16 **A.** He was.
17 **Q.** And Janine McKinney, the Chief Crown Prosecutor?
18 **A.** Correct.
19 **Q.** Can you assist us with where they all sit and also where
20 Alan Murphy sits in the hierarchy with regards to your
21 role?
22 **A.** So the Complex Case Unit is a specialist unit and
23 it's -- at the time of 13 June, or certainly at the
24 start of the time that I joined the unit, 17 July, it
25 consisted of five lawyers and one Specialist Prosecutor,

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1 psychiatric report?
2 **A.** Yes.
3 **Q.** If we can begin with CPSE0004789. It's an email that we
4 have seen. If we look at that bottom email on page 1,
5 it's an email we've already seen today --
6 **A.** Yes.
7 **Q.** -- of 2 October from Alan Murphy, the defence report has
8 been received.
9 **A.** Mm-hm.
10 **Q.** Fit to plead, and not insane:
11 "Diminished responsibility is available for the
12 murders."
13 It's been sent to Dr Blackwood.
14 Mr Murphy's view at that point was that the report
15 was balanced.
16 **A.** Mm-hm.
17 **Q.** If we can scroll up, we can see then responses from
18 Samantha Shallow and from yourself. Ms Shallow says:
19 "The ease with which such life changing things
20 happened is a challenging read."
21 She says:
22 "I can see no reason why this shouldn't be shared
23 with the police."
24 Which was one of the questions posed by Mr Murphy.
25 It's your answer at the top of the page that I'd really

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1 like to focus on. You say:
 2 "I have been pondering this report for several
 3 hours. I agree it is balanced. However, I am still
 4 struggling to reconcile it with the defendant's actions
 5 at and around Seely Hirst-House."
 6 What, in particular, at Seely Hirst House caused you
 7 to write that email?
 8 **A.** By that stage I was aware of the facts of the case, and
 9 I struggled to reconcile the conclusions of Dr McSweeney
 10 with the actions taken by VC around Seeley House where
 11 it appeared to me that he was aware of his surroundings,
 12 the interaction that he had, et cetera, and I, at that
 13 time, had difficulty reconciling that.
 14 **Q.** In essence, was your view that it may indicate rational
 15 judgement and self-control?
 16 **A.** Absolutely.
 17 **Q.** Thank you. If we could please then turn to CPSE0008370
 18 and if we start on page 2, please. This is an email
 19 from Ms Shallow and she says there:
 20 "Andrew has asked for sight of the letter of
 21 instruction to Dr Blackwood."
 22 Is that Andrew Baxter, the Deputy Chief Crown
 23 Prosecutor?
 24 **A.** Correct.
 25 **Q.** And she says:

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1 to the brother, but what I do -- and that's due to the
 2 passage of time -- but what I do remember is
 3 conversations we had in the office where we were talking
 4 about those elements that appeared to be rational.
 5 **Q.** In addition to rational, essentially, being able to
 6 distinguish between right and wrong, for example?
 7 **A.** Not the difference between right and wrong; more about
 8 an awareness of what was going on and responses, which
 9 would appear to be, shall we say, normal responses? For
 10 instance, slowing over the speed bumps. I remember that
 11 being part of that conversation.
 12 **Q.** By 4 October, then, is it fair to say that you, as the
 13 District Crown Prosecutor, Samantha Shallow as the
 14 Senior District Crown Prosecutor, and also Andrew
 15 Baxter, the Deputy Chief Crown Prosecutor, all shared
 16 some concerns that the evidence may -- and I don't put
 17 it any higher than may -- may point away from diminished
 18 responsibility?
 19 **A.** Yes, but I would also include Mr Murphy in that group of
 20 people as well.
 21 **Q.** Yes.
 22 **A.** We were very curious about establishing that.
 23 **Q.** At this stage, I don't think any of you had discussed
 24 the issue of diminished responsibility with, for
 25 example, the families of the bereaved. This was your

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1 "Can you assist?"
 2 This to Alan Murphy.
 3 **A.** Mm-hm.
 4 **Q.** She said:
 5 "I think he is concerned about the things we have
 6 already talked about - to ensure that there is
 7 consideration of the incongruous factual elements
 8 including the call to his brother and his behaviour at
 9 Seelyhurst House."
 10 **A.** Mm-hm.
 11 **Q.** If we scroll up, we can see a response from Alan Murphy.
 12 He says:
 13 "I haven't previously drafted a formal letter of
 14 instruction to Dr Blackwood. He is aware of the
 15 position through emails and telephone conversations.
 16 I agree that a formal letter setting out the position is
 17 appropriate, including our concerns about the findings
 18 in the defence report when set against some of the
 19 evidence in the case."
 20 So by this stage, Ms Shallow has concerns not only
 21 in relation to the Seely Hirst House aspect, but also
 22 the telephone call to the brother.
 23 **A.** Yes.
 24 **Q.** Was that a concern that you had as well?
 25 **A.** I don't specifically remember concerns around the call

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1 own independent thinking?
 2 **A.** Oh, absolutely.
 3 **Q.** Thank you. If we could perhaps bring up on to screen
 4 paragraph 70 of your witness statement. Thank you. You
 5 say in the second half of that paragraph, you say:
 6 "My involvement was limited to a conversation in the
 7 office with the reviewing lawyer and [Senior District
 8 Crown Prosecutor] about the contents of Dr Blackwood's
 9 letter of instruction (in particular the offender's
 10 behaviours which appeared to be suggestive of rational
 11 judgement and self-control) and being copied into the
 12 draft instruction."
 13 Are there any particular conversations that you can
 14 recall?
 15 **A.** In terms of this case, or just generally?
 16 **Q.** In terms of this case and the aspects of rational
 17 judgement and self-control?
 18 **A.** The conversation that I referred to in the previous
 19 question. So that was the conversation, the involvement
 20 was limited to conversation in the office about those
 21 aspects of VC's behaviour that should be included in the
 22 contents of the Letter of Instruction.
 23 **Q.** Then what follows is the Letter of Instruction and we
 24 can bring that on to screen at CPSE0000153. This is
 25 5 October. I think you said in your witness statement

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1 that there were two different Letters of Instruction,
 2 one had some further requests added; is that right?
 3 **A.** That's right, Ms Shallow made some further additions.
 4 **Q.** Was that both after this conversation had taken place or
 5 did one come after the other?
 6 **A.** I can't remember.
 7 **Q.** I'm just going to read to you, if we turn over the page,
 8 we can -- I'll just read to you a few passages from the
 9 instructions. So it says on the top substantive
 10 paragraph:
 11 "On 2 October the defence served on the Crown
 12 a psychiatric report of Dr ... McSweeney ... and [he
 13 has] concluded that the defendant was fit to plead and
 14 that he did not come within the ambit of a defence of
 15 insanity."
 16 Then it says:
 17 "Dr McSweeney did however opine that in his opinion
 18 the defendant could avail himself of the partial defence
 19 of diminished responsibility to the murder counts for
 20 the reasons set out in his report. He came to this
 21 conclusion on the basis of the defendant suffering from
 22 a recognised medical condition (paranoid schizophrenia)
 23 which was operative at the time of the killings,
 24 significantly contributed to the defendant's acts and
 25 substantially impaired his ability to form a rational

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1 down. It says:
 2 "Shortly after this (5.04am) the defendant twice
 3 tried to break into a property in Seeley-Hirst House and
 4 can clearly be seen on CCTV footage to react and stop
 5 what he is doing when a motorist drives past. Having
 6 been prevented from entering Seeley-Hirst House by the
 7 witness ... the defendant ... went onto kill the third
 8 victim ... and ... took his van before trying to kill
 9 the remaining three victims in two separate acts [acts]
 10 ... with the van in Nottingham city centre."
 11 Does that accurately reflect the concern that you
 12 had as set out in that first email that we saw?
 13 **A.** In terms of its -- I think it's important to carry on to
 14 the next paragraph, because:
 15 "Given that in the exchange with his brother at
 16 4.52... the defendant was plainly aware he had 'already
 17 done' something stupid that required his family to be
 18 removed ..."
 19 The letter continues:
 20 "... a few minutes later, with that knowledge, tried
 21 to break into an address and then went on to carry out
 22 the third killing, the Crown's concerns are that the
 23 sequence of events doesn't easily sit easily with
 24 a conclusion, at that stage, that the defendant couldn't
 25 form the ability to make a rational judgement or

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1 judgement or exercise self-control."
 2 If we scroll down slightly, I'll just start with the
 3 paragraph beginning "Nonetheless":
 4 "Nonetheless, the Crown has some particular
 5 reservations in [the] ... case concerning the issue of
 6 diminished responsibility which we would ask you to
 7 address when preparing your report. These concerns
 8 include the fact that there is evidence that, having
 9 committed the first two killings ... just after 4am, the
 10 defendant telephoned his brother Elias at 4.52... and
 11 during the course of [the] ... conversation the
 12 following exchange occurred ..."
 13 VC says: "This will be the last time I speak to you.
 14 Take the family out of the country".
 15 His brother says: "Are you going to do something
 16 stupid?"
 17 He says: "It's already done".
 18 So that's a reference there to the phone
 19 conversation we already saw in the email from
 20 Ms Shallow, is it?
 21 **A.** I'd have to be directed to Ms Shallow's email, I do
 22 apologise.
 23 **Q.** That's fine. We'll move on to the reference of Seely
 24 Hirst House which is the issue that you raise in your
 25 email, and we can see that just below, if we scroll

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1 exercise self-control."
 2 And I think that encompasses not only my concerns
 3 but the discussions that Mr Murphy, Ms Shallow and
 4 I had.
 5 **Q.** And it's the combination both of the phone call and also
 6 the subsequent actions at Seely Hirst House.
 7 **A.** Correct, and we accepted it was -- it wasn't
 8 an exhaustive list. There was a number of factors that
 9 would be relevant to that consideration.
 10 **Q.** Professor Blackwood's report is then drafted by
 11 20 November. And if we could bring up on to screen
 12 NGPF0000474, please. This is 30 November. This is the
 13 report by DC Beddoe that we've also seen today.
 14 **A.** Yes.
 15 **Q.** He was the Officer in the Case. Is this a report that
 16 you saw at the time?
 17 **A.** I seem to remember that it came in but I don't believe
 18 it came in on 30 November. I think it came in in
 19 December; is that correct?
 20 **Q.** Yes, that's correct.
 21 **A.** I do seem to remember that report coming in, yes.
 22 **Q.** I'll just read to you some extracts from this report.
 23 He says on the first page at the bottom paragraph:
 24 "The following are examples of rational thought
 25 process by [VC] ... that suggests an ability to

12

1 calculate, plan and deceive the authorities".
 2 He then sets out in detail what he considers to be
 3 the relevant evidence.
 4 If we scroll over the page, please, that middle
 5 paragraph says:
 6 "Despite all the above recorded psychotic episodes
 7 [VC] ... maintains his studies (with a short break) and
 8 graduates with a 2:1 ..."
 9 **A.** Yes.
 10 **Q.** This is a passage we've already seen today, and I think
 11 we also heard that Andrew Baxter had raised similar
 12 concerns in a meeting in November. Were you aware of
 13 those concerns?
 14 **A.** Yes.
 15 **Q.** Yes. If we could keep on going and we'll go over the
 16 page, please, to page 4. He sets out there some quotes,
 17 and he says that:
 18 "... shows his ability to calculate what a person
 19 wants to hear and lie to manipulate professionals."
 20 **A.** Sorry, I can't see that.
 21 **Q.** Just below the two quotes. Perhaps we could highlight
 22 that.
 23 **A.** Yes, just so I can read what's above it. Thank you.
 24 **Q.** Absolutely.
 25 **A.** Thank you.

13

1 ..."
 2 **A.** Sorry, apologies -- okay, thank you.
 3 **Q.** "... with his brother Elias. Whilst he was talking
 4 about 2-way voices in his head and threats being made,
 5 he stated this would be the last time he would talk to
 6 Elias and said, 'just disassociate yourself from me, if
 7 anything happens, don't come and see me in ...
 8 hospital'."
 9 He goes on to address reference to the train
 10 arriving in Blackfriars, which shows that VC "had the
 11 capacity to navigate the ... Underground," various
 12 issues of capacity mixed in with broader issues.
 13 If we go on to page 8, there's, for example, in that
 14 third paragraph:
 15 "[VC] ... states that when he got to Nottingham the
 16 voices were 'trying to mind control me, they were using
 17 mind control to tell me to attack people' They told him
 18 to stay in the City Centre and attack whomever he saw.
 19 He saw a few police officers and the voices told him to
 20 attack them, but he had the mental capacity to resist
 21 them, and he left the City Centre."
 22 At the bottom of that page he refers to VC turning
 23 his phone off. Over the page, please, I'm shortly going
 24 to get to the incident at Seely Hirst House.
 25 If we have a look at page 9, the bottom of the page,

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1 **Q.** Then if we just go over the page, I'm just taking you to
 2 a few passages that give an indication of the kinds of
 3 concerns that were raised by PC Beddoe.
 4 On page 6 there's a paragraph that begins "As
 5 mentioned". He says there in that second paragraph:
 6 "As mentioned previously in the next few months [VC]
 7 ... has the mental capacity to submit necessary reports
 8 to graduate with a degree in Mechanical Engineering ..."
 9 Very similar information to the passage that I sent
 10 to you before about VC's ability to maintain his
 11 studies.
 12 **A.** Yes.
 13 **Q.** At the bottom of that page, there's a reference to Sky
 14 Recruitment where VC had told the recruiter that he
 15 wanted all of his records to be cleared.
 16 Over the page:
 17 "When faced with being evicted and temporarily
 18 homeless [VC] ... had the mental capacity to approach
 19 contacts for somewhere to stay ..."
 20 Then it moves on to 12 June. It says:
 21 "[He] ... had the mental capacity to purchase
 22 a Vodafone top up voucher ..."
 23 And the receipt is written on a phone number.
 24 Next paragraph, 7.07:
 25 "... [He] ... had a 44-minute telephone conversation

14

1 it refers to VC making his way to Mapperley Road, about
 2 turning his phone off -- phone back on, sorry -- and
 3 calling his brother. And that's the conversation we've
 4 already seen in those instructions.
 5 **A.** Okay.
 6 **Q.** And then it's over the page we get to the Seely Hirst
 7 House section. He says:
 8 "At 5.01 ... [VC] arrives at Seely Hirst House and
 9 he states, 'The voices told him that he must enter the
 10 building and continue to kill others' ... but then he
 11 has a brief conversation with [Ivan] ... Why does he
 12 not attack Ivan if he has been instructed to kill and
 13 enter the door left open by Ivan? [VC] ... can then be
 14 seen in the CCTV assessing ways in through the windows
 15 into Seely Hirst House, but appearing to stop what he
 16 was doing when observed showing a mental capacity to
 17 avoid detection by people passing by. Having failed to
 18 gain entry and repelled by a resident, [VC] ... returns
 19 and appears to use the metal scaffolding pole in a bag
 20 to try to break the window, hitting it 4 times. When
 21 the CCTV compilation footage switches to 8 The Point
 22 Mapperley, you hear ... 4 strikes on the window just as
 23 Ian Coates drives ... his van on [to] Magdala Road."
 24 Does that paragraph set out some of the concerns
 25 that you had in that earlier period in October?

16

1 A. Which paragraph? All of the paragraphs that you have
2 read?
3 Q. That particular paragraph, your reference to -- your
4 concern about the activities at Seely Hirst House.
5 A. Yes.
6 Q. Yes. Over the page, please, DC Beddoe then sets out his
7 conclusion, and he says:
8 "In conclusion, whilst the prosecution accept that
9 [VC] ... has a well established and documented mental
10 health condition it is not possible to say with any
11 certainty that at the moment of the murders and
12 attempted murders 'his abnormality of mental functioning
13 substantially impaired his ability to form rational
14 judgement and to exercise self-control'".
15 So that is addressing the diminished responsibility
16 test in that paragraph; do you agree with that? Or
17 appears to?
18 A. It's DC Beddoe's conclusion, isn't it --
19 Q. Yes.
20 A. -- that's his assessment of what he's considered.
21 Q. Yes. It says:
22 "In fact, [VC] ... has exercised self-control
23 throughout Monday 12 [June] ... and Tuesday [the] 13[th]
24 ...] in order to achieve the aim of killing multiple
25 people in Nottingham and avoiding immediate location and
17

1 In your view, considering all of that, do you think
2 that there is at least some evidence that could
3 potentially have been used to rebut the defence of
4 diminished responsibility?
5 A. No. And the reason I say that is because neither DC
6 Beddoe or I are a forensic psychiatrist.
7 Q. Do you place the entire weight on forensic psychiatry in
8 the assessment as to whether to leave something to
9 a jury or not?
10 A. No.
11 Q. Because there is information, whether it was disputed by
12 Dr Blackwood or not, ultimately we don't know whether it
13 would have succeeded or not, and I'm not asking you to
14 comment at all on that. But reflecting on everything
15 we've heard, do you think that there is information that
16 could at least have been used to try to rebut the
17 defence of diminished responsibility?
18 A. No.
19 Q. What I want to take you to is an assessment, a report
20 that was produced by Mr Murphy and that's CPSE0000009.
21 Have you seen this review?
22 A. Could you just take me to the last page so I know the
23 date?
24 Q. Absolutely. That's page 7.
25 A. Thank you. 24 November, thank you.
19

1 arrest, an aim he appears to have been building towards
2 and preparing since he bought the knife and knife
3 sharpeners back in 2022. [VC] ... has also shown
4 himself capable of lying to Health Care [practitioners]
5 ... and identifying what they want to hear, to achieve
6 his own ends."
7 The Inquiry has seen a number of other features
8 outside of this report, for example the video of VC when
9 he was interviewed, very calm in that interview. The
10 video of him assaulting the police officer where he
11 takes off his glasses, he says he's not going to hit
12 women.
13 A. That's on a different day, correct?
14 Q. Yes, absolutely.
15 We've seen that there are two defence reports that
16 are not based on the full prosecution material. I don't
17 know if you heard that evidence earlier with Mr Murphy.
18 A. Yes.
19 Q. In addition to all of that, we also have heard from
20 Professor Blackwood and another expert essentially that
21 people's mental health declines when they're in
22 custody --
23 A. *(Witness nodded)*.
24 Q. -- and that we know that the expert reports were not
25 produced for some time after VC was detained?
18

1 Q. Is this a document that you recall seeing?
2 A. Yes.
3 Q. Yes? So it is his assessment of whether or not the
4 pleas of manslaughter on the grounds of diminished
5 responsibility should have been -- should be accepted?
6 A. Yes.
7 Q. If we could have a look at the conclusion on page 6, he
8 says as follows, he says:
9 "The burden of proof ..."
10 If we scroll down, sorry.
11 A. Sorry. Thank you.
12 Q. "The burden of proof in establishing the partial defence
13 of diminished responsibility in this case rests on the
14 defence ..."
15 So the starting point is the burden falls on the
16 defence to prove diminished responsibility?
17 A. Once the prosecution have provided sufficient evidence
18 to prove murder, then the burden falls to the defence.
19 Q. Then 3.2:
20 "The Crown do not have to accept the pleas, even if
21 all psychiatrists come to the same conclusion."
22 A. Yes.
23 Q. So even if all three of the psychiatrists come to that
24 conclusion, it's not something that the CPS has to
25 accept?
20

1 A. No.

2 Q. Do you agree with that?

3 A. I agree.

4 Q. Then it says:

5 "But, in such a case, if the Crown were to contest

6 matters, and insist on putting the defendant before the

7 jury on trial for murder, there would have to be

8 a proper basis for inviting the jury to reject the

9 findings of the psychiatrists. See in particular R v

10 Brennan ..."

11 And it has a quote over the next page, and it's

12 really this quote that I'd like to ask you about.

13 That says:

14 "If there were no other circumstances to consider,

15 unequivocal, uncontradicted medical evidence favourable

16 to a defendant should be accepted by a jury and they

17 should be so directed. Where there were other

18 circumstances, the medical evidence, though it be

19 unequivocal and uncontradicted, had to be assessed in

20 the light of ... other circumstances. Such other

21 circumstances had to amount to evidence which, looked at

22 in the round, was at least capable of rebutting the

23 defence."

24 We see below that Alan Murphy's conclusion that

25 there are no other such circumstances.

21

1 extensive, extensive experience, and he is known for his

2 legal knowledge and judgement. I don't think it's

3 appropriate for me to discuss what other prosecutors

4 would do. We have to deal with the facts, the

5 circumstances that we are faced with.

6 In relation to my initial response when

7 Dr McSweeney's report came in, can I just stress that

8 that was an opinion: that actually, after I had the

9 opportunity of reading Dr Blackwood's report and

10 particularly paragraph 103, helped me understand the

11 nature of this condition.

12 Q. Is it your view, then, that there are no other

13 circumstances, despite your initial concerns? Because

14 the test isn't, for example, whether there is sufficient

15 evidence on the balance of probabilities. We're not

16 looking at that kind of a test. The test here is

17 whether there are such other circumstances which, looked

18 at in the round, was at least capable of rebutting the

19 defence.

20 A. Yes.

21 Q. You certainly initially seemed to have those kinds of

22 concerns. You may have been satisfied by what you read

23 from the experts, but it's very clear here that you

24 don't need to contradict the medical evidence with other

25 medical evidence?

23

1 Your initial instinct though, when you first read

2 that report --

3 A. Yes.

4 Q. -- was that there may be relevant indicators that could

5 be looked at by a jury?

6 A. *(Witness nodded)*.

7 Q. In light of that and in light of all the other

8 information that I've drawn to your attention, the

9 Beddoe report, the other information that the Inquiry

10 has seen, would you accept that there are at least some

11 prosecutors who, in light of those concerns raised both

12 by yourself, by your team, the other prosecutors,

13 DC Beddoe and others that we've seen, may have left that

14 to a jury or pushed for it to be left to a jury in the

15 various circumstances that we've heard?

16 A. There's a number of things contained in that. If you

17 want to just break the question down for me.

18 Q. Absolutely. Are there other prosecutors, in your

19 experience, who, in light of all that other information,

20 who, looking -- when you picked up the case on the first

21 occasion, may well have pushed for the matter to be left

22 to a jury?

23 A. Okay. So in response to that, two aspects of it. The

24 first is that Mr Murphy is an extremely experienced

25 prosecutor. He's a Specialist Prosecutor, he has

22

1 A. I -- if I can just refer to the Code for Crown

2 Prosecutors because actually I think the answer lies in

3 that in terms of the evidential test. In order to bring

4 a prosecution, we have to be satisfied that there's a

5 realistic prospect of conviction, and the particular

6 facts, circumstances, and most importantly the evidence

7 that we'd obtained in this case was such that we were

8 satisfied that the evidential test in relation to murder

9 was no longer made out.

10 That decision wasn't just approved -- that decision

11 wasn't made unilaterally by Mr Murphy. The decision was

12 approved by Ms Shallow, the Deputy Chief Crown

13 Prosecutor and the Chief Crown Prosecutor as well as our

14 Director of Legal Services, and in respect of

15 Mr Murphy's reviews, you'll note that he, in his review

16 of 24 November, at paragraph 3.7, I believe it is --

17 Q. If we could scroll down, please. Thank you.

18 A. -- he refers to the fact that:

19 "The matter has been discussed in conference with

20 leading counsel, junior counsel, the Deputy Chief Crown

21 Prosecutor and the head of the Complex Case Unit. All

22 are in agreement with this decision." *(As read)*

23 There was then a subsequent review completed by

24 Mr Murphy on 17 December, an addendum to this particular

25 review, where again, he references paragraph 3.7 to,

24

1 again, reiterate that the decision was not made
 2 unilaterally and therefore there was ample opportunity
 3 for people, if they were concerned that the evidential
 4 test was not made out, to raise that.

5 **Q.** When you say people, who do you mean?

6 **A.** So the Deputy Chief Crown Prosecutor, the Chief Crown
 7 Prosecutor, or the Director of Legal Services.

8 **Q.** Thank you. That's all I have to ask on that topic. One
 9 very final topic and that is meeting with the survivors.
 10 I don't know if you heard Mr Murphy's evidence this
 11 morning?

12 **A.** I did.

13 **Q.** He mentioned your name in respect of meeting with the
 14 survivors. Can you assist us, what's your recollection
 15 of that?

16 **A.** Chair, if it helps, I've recovered the attendance notes
 17 that I made between 23 January and 25 January, which
 18 relates to the meetings that were held with Mr Birkett,
 19 Ms Newton and her sister, as well as the Coates family.
 20 That's CPSE0000214. And then I've also had the
 21 conference -- the attendance note from the particular
 22 meeting held with Mr Birkett and his supporters on
 23 25 January with counsel.

24 **Q.** Is there anything you'd like to say in relation to that?

25 **A.** Save that we met them, we, in fact, the DSI and I, in
 25

25

1 **Q.** Could I ask to be displayed first of all CPSE0007612.
 2 CPSE0007612. Thank you. This is an email exchange, but
 3 if we can move over to page 2, please. Thank you,
 4 that's what I want to look at. It's the email of
 5 27 November, and you're discussing the Bereaved Family
 6 Scheme.

7 **A.** Yes.

8 **Q.** You can see under "Attempted murder" which obviously
 9 relates to those I represent you set out:
 10 "It is not a qualifying offence under the [Bereaved
 11 Family Scheme]."

12 **A.** Mm-hm.

13 **Q.** Just pausing there, were you aware that others were
 14 treating the survivors as if the Bereaved Family Scheme
 15 did apply to them?

16 **A.** I was aware that FLOs had been appointed to the
 17 survivors, and I was also aware that from the BFS/1 form
 18 that was returned completed by the FLO in July of 2023,
 19 that the survivors at that stage had decided to opt out
 20 of the scheme.

21 **Q.** That's why, first of all, you've just mentioned FLOs and
 22 I want to pick up on that also, because the CPS opening
 23 reference that the survivors had access to two FLOs,
 24 including Johal and Melbourne. Were you aware that
 25 there's only a single FLO for all of the survivors,
 27

27

1 fact, first of all went down and spoke to Ms Newton and
 2 her sister and in the same room was Mr Birkett, his
 3 partner, and his brothers.

4 We introduced ourselves, we had a welfare check.
 5 They were placed in the same room. And then, before the
 6 case was called on, as I've mentioned, the reviewing
 7 lawyer, Mr Murphy, counsel, Mr Ratliff, again, DSI
 8 Sanders and I, together with the Coates -- sorry, the
 9 FLOs, met with the Coates family, Mr Newton (*sic*) and
 10 Mr Birkett, to talk about the process of the sentencing
 11 hearing and what would be involved in that.

12 Then I checked in again with Mr Birkett and his
 13 family at lunchtime. They mentioned the court was very
 14 warm, so I got water for them for the afternoon session.
 15 The following day I checked in again with Ms Newton and
 16 Mr Birkett to see how they were, and then, as I say,
 17 I was party to the meeting after the sentencing hearing
 18 with counsel to explain the sentence.

19 **MR BLAKE:** Thank you. I'm sure Ms Cartwright will ask any
 20 questions that arise from that.

21 **A.** Thank you.

22 **THE CHAIR:** Ms Cartwright.

23 **Questioned by MS CARTWRIGHT**

24 **Q.** Good afternoon, Ms Mannion?

25 **A.** Good afternoon.

26

1 Officer Johal?

2 **A.** I watched DC Johal's evidence, so I became aware of it
 3 at that stage.

4 **Q.** So you became aware during this Inquiry?

5 **A.** I may have already known that. I remember DC Johal
 6 being at court, that's correct, so I do remember that.
 7 But I couldn't honestly say if I knew at that stage they
 8 all had the same FLO.

9 **Q.** Right. I only ask that because it was part of the CPS's
 10 opening submissions that there were two FLOs for the
 11 survivors.

12 **A.** Okay.

13 **Q.** But looking at this, you can see you go on to say
 14 essentially there doesn't need to be a meeting for the
 15 survivors.

16 **A.** Yes.

17 **Q.** You also reference that there'd not been a request for
 18 a meeting.

19 **A.** Yes.

20 **Q.** So can I ask you, obviously you've just referenced the
 21 initial form that was returned, saying at that stage
 22 they didn't need a meeting. I think earlier on,
 23 certainly when Wayne was still very much in hospital and
 24 Sharon recovering, but were you aware that Mr Birkett
 25 and his partner had requested meeting at the end of
 28

28

1 August, and again in September?

2 **A.** No, I wasn't aware of that. I wasn't at those
3 particular meetings.

4 **Q.** Thank you. Would you agree that had you been aware that
5 there was a meeting requested, would you have done, at
6 this stage, would have assisted or facilitated a meeting
7 for Mr Birkett and his partner?

8 **A.** Absolutely, if at that stage Mr Birkett wanted to meet
9 with us. It's noted here that when I spoke to DSI
10 Sanders that he was intending to meet with all six sets
11 of FLOs on Friday to update them as to a position and
12 agree a comms strategy for each family, and then there
13 is a further email from Ms Shallow, if I remember
14 correctly, saying that albeit there hasn't been an
15 alteration to their charges, hence why we didn't write
16 to them, that we would still offer them meetings.
17 I think the email sits -- comes after my email at 7.31
18 am on the 27th.

19 **Q.** Thank you. That can be taken down. Then can I ask you,
20 as to general principles, even under the Victim Code,
21 those that I represent were entitled to enhanced rights?

22 **A.** Yes.

23 **Q.** The whole purpose of the Victim Code in reality is to
24 support victims to understand and to be able to be
25 understood.

29

1 sentence, to petition the Attorney General; is that
2 correct?

3 **A.** I would have to check that Ms Cartwright, but yes.

4 **Q.** I think that's also contained in the Code.

5 **A.** Thank you.

6 **Q.** Can we then just briefly look at your paragraph 50, just
7 to give some context to what you've just accepted in any
8 event. Thank you. It's WITN0081001, at page 14. Thank
9 you.

10 Paragraph 15.

11 **A.** 15?

12 **Q.** Sorry, paragraph 50, page 14. I do apologise. Thank
13 you.

14 **A.** Okay.

15 **Q.** And to perhaps just give some context.

16 **A.** Yes.

17 **Q.** Essentially, Wayne, his partner, his brothers, are in
18 the Witness Support Room with the Coates family and
19 Elaine Newton; would you agree?

20 **A.** Yes.

21 **Q.** And so the description of this is a small room,
22 windowless room, but not the biggest room.

23 **A.** I can't remember the room very well, but --

24 **Q.** All right, but you say this about the court:
25 "The court was exceptionally busy. [You] ... were

31

1 **A.** I couldn't agree more.

2 **Q.** For a meeting in advance of a decision as to change of
3 plea, if that's known by the CPS.

4 **A.** Yes, if they want to, yes.

5 **Q.** To be provided with all information about the
6 investigation and the prosecution.

7 **A.** Yes.

8 **Q.** To provide a familiarisation visit to court.

9 **A.** Yes.

10 **Q.** But also to provide a further meeting with the CPS,
11 following conviction and before sentence. So
12 essentially --

13 **A.** Yes.

14 **Q.** -- giving -- equipping victim participation --

15 **A.** Yes.

16 **Q.** -- but also enabling victims to fully know what's going
17 to happen rather than turning up at court on the day of
18 sentence in an unfamiliar environment where they're
19 going to meet the defendant, and plainly have lots of
20 stresses going on.

21 **A.** Yes.

22 **Q.** Would you agree?

23 **A.** Yes.

24 **Q.** I think one of the other rights, as well, is to be told
25 about the unduly lenient process and an ability, after

30

1 mindful of how upsetting the experience would be for the
2 families and [you] ... did not wish to overwhelm them.
3 In your view ..."

4 **A.** Sorry, can I stop you there, Ms Cartwright. That's not
5 paragraph 50. Unless I'm missing something, apologies,
6 but I don't think that's paragraph 50 of my statement.

7 **THE CHAIR:** It's paragraph 50 of the version I have.

8 **A.** Oh.

9 **MS CARTWRIGHT:** It should be on the screen. That's the one
10 that's been provided and disclosed. So --

11 **THE CHAIR:** It starts "The court was exceptionally busy".
12 Was yours different?

13 **A.** Oh, I apologise, sorry, yes.

14 **MS CARTWRIGHT:** So you then go on:
15 "In my view, there was not an appropriate
16 opportunity for me to introduce myself before the case
17 was called on."
18 Then you go on to say:
19 "At lunchtime, junior counsel wished to discuss the
20 Victim Impact Statements with the Webber and
21 O'Malley-Kumar families, but they had left the building
22 and given how upset the morning had been for them, we
23 were advised by the FLOs not to disturb them."
24 And then there was obviously an issue in the
25 afternoon with the court equipment. Then if we look at

32

1 that for context, so really what you were saying is you
 2 were conscious not to overwhelm --
 3 **A.** No. Ms Cartwright, if I can direct you to paragraph 49
 4 because that particular sentence around approaching the
 5 families was in relation to the Webber and
 6 O'Malley-Kumar families because I'd never met them
 7 before. So I didn't want to overwhelm them.
 8 **Q.** Let's just pause, then. You'd never met Wayne Birkett
 9 and Sharon before, and so why was it different you
 10 didn't want to overwhelm them?
 11 **A.** Sharon wasn't there.
 12 **Q.** Sorry, not Sharon --
 13 **A.** Elaine.
 14 **Q.** -- I've done this twice today. So why did that same
 15 principle not apply to Wayne and his partner, Tracey?
 16 **A.** Originally we'd intended to meet with the
 17 O'Malley-Kumars and the Webbers in the Witness Suite,
 18 and essentially what had happened was, when we were
 19 speaking to Mr Birkett, Elaine Newton and Mr Coates, and
 20 family, my recollection is that the O'Malley-Kumars and
 21 the Webbers were taken upstairs.
 22 So I'd missed that opportunity to introduce myself
 23 to them, and I felt in the circumstances, given how
 24 upsetting it was for everybody, everybody involved in
 25 the case, in terms of the families, the survivors, their

33

1 is that: that they're all in the same room together --
 2 **A.** Yes.
 3 **Q.** -- and these are people deeply grieving for their loved
 4 ones.
 5 **A.** Absolutely, and Mr Birkett, what he was going through
 6 was deeply upsetting as well. So I take on board the
 7 sensitivity point.
 8 **Q.** And had you appreciated that Wayne Birkett had
 9 a traumatic brain injury and cognitive impairment as
 10 a result of that? So his own -- he needed his own
 11 adjustments.
 12 **A.** Yes, we -- he -- we talked about it, spent some time,
 13 and explained to me how difficult it had been for him
 14 and the family as a result of it, his memory loss,
 15 et cetera. So I was aware.
 16 **Q.** Let's just briefly, then, look at the file note, please,
 17 CPSE0000214. Because essentially what that records
 18 I think is everyone -- there was an introduction in the
 19 morning by way of a general welfare check.
 20 **A.** Yes.
 21 **Q.** And then I think what's been described then as the
 22 "update" before the case was called on. Mr Murphy,
 23 yourself, counsel, Officer Sanders and the FLOs met with
 24 the Coates family and Mr Birkett together in one room to
 25 explain the process of the sentence hearing and what

35

1 families, et cetera, I just took the view that it
 2 wouldn't be appropriate at that stage in the busy
 3 courtroom to then make my introductions to them.
 4 **Q.** Right. Well, then we can see at paragraph 49 what
 5 you've described as essentially Elaine Newton, the
 6 Coates boys, Wayne, his brothers, and Tracey, all in
 7 a room together that are being addressed essentially all
 8 together?
 9 **A.** Yes.
 10 **Q.** Would you agree that's less than ideal?
 11 **A.** Absolutely, and we did ask them, we did ask them whether
 12 they had any objections to it, and I have listened -- in
 13 fact I watched Mr Birkett's and Tracey's evidence, and
 14 obviously they've referred to the fact that that was
 15 insensitive and --
 16 **Q.** I think they felt very conscious, they're meeting for
 17 the first time, individuals who had the most awful thing
 18 happen to their loved ones.
 19 **A.** Yes.
 20 **Q.** They've lost their loved ones, and I think they felt
 21 very uncomfortable that they had been placed in
 22 a room --
 23 **A.** They did.
 24 **Q.** -- with individuals that were grieving and the
 25 significance to them, so their issue as to insensitivity

34

1 would be involved.
 2 Could you appreciate that Mr Birkett -- I mean, how
 3 long did that last, first of all?
 4 **A.** I can't remember how long that meeting lasted for.
 5 **Q.** But would you also agree that for someone about to go
 6 into a court room and see the person that attacked them,
 7 alongside his cognitive impairment, he was not in the
 8 most receptive frame of mind to be receiving information
 9 at that time?
 10 **A.** I appreciate that now. The only thing I would say is
 11 that usually we receive updates from the FLOs in terms
 12 of what people are capable of, and/or what information
 13 they want to receive, how they want it to be addressed,
 14 et cetera. And I did spend some time speaking to
 15 Mr Birkett and his family, because I reference it when
 16 I'm then spoken to on 14 February 2023.
 17 **Q.** All right.
 18 **A.** Yes, 24 -- 2024.
 19 **Q.** So with you saying that you usually expect to have
 20 information from the FLOs in advance, did you receive
 21 that in this case?
 22 **A.** I don't recall receiving anything from DC Johal.
 23 **Q.** Similarly for Tracey, in -- sorry, for Sharon, who
 24 herself would have liked to have attended the hearing
 25 remotely?

36

1 A. No information about Sharon, I'm sorry.
 2 Q. Did you appreciate that Sharon had post-traumatic stress
 3 disorder as a result of the attack on her and has
 4 essentially been housebound since that attack?
 5 A. I've watched the pen portraits and seen that, yes.
 6 Q. Did you know that at the time?
 7 A. I don't recall at the time -- I read her VPS at the
 8 time, because she -- because she'd never requested
 9 a meeting, I couldn't comment and we'd not been made
 10 aware, unfortunately, we'd not been made aware that she
 11 wanted a CVP into the court.
 12 Q. But similarly, you said you weren't aware that Tracey
 13 had not requested a meeting -- well, Tracey hadn't
 14 requested a meeting, but similarly, Wayne had requested
 15 a meeting, and Tracey, and they'd not had a meeting?
 16 A. Yes, but for the reasons I've explained before, I wasn't
 17 aware of that.
 18 Q. Thank you. Perhaps then to go on to the next page,
 19 please. Perhaps, again, to underline the position, we
 20 can see on 25 January, again, in a direct approach to
 21 Elaine Newton, but again it's Wayne now directly asking
 22 for a meeting to understand the sentence, and I'm not
 23 going to take you to the note that I took Mr Murphy to
 24 earlier because the Chair has that.
 25 A. Thank you.

37

1 Q. -- did not have the information he needed, and did not
 2 have the reasonable adjustments that his disability
 3 required.
 4 A. Thank you.
 5 THE CHAIR: Ms Carey? No.
 6 MS CAREY: *(Unclear - speaking off mic)*.
 7 THE CHAIR: I'm sorry?
 8 MS CAREY: *(Unclear - speaking off mic)*.
 9 THE CHAIR: Thank you.
 10 Mr Moloney, you passed on this opportunity. Thank
 11 you.
 12 **Questioned by THE CHAIR**
 13 THE CHAIR: All right. I just wanted to ask you, because
 14 you've written quite a lot in your statement,
 15 Ms Mannion, about the process. It's dependent, isn't
 16 it, currently on a chain that you say you rely on the
 17 FLOs to provide you with information?
 18 A. Yes, Chair.
 19 THE CHAIR: But the FLOs are dealing with people, as we've
 20 heard, some of whom are traumatised because they've lost
 21 people, and are suffering from bereavement in very
 22 difficult circumstances, and some who are actually
 23 injured themselves with head injuries or physical
 24 disabilities that are going to make it rather difficult.
 25 A. Yes.

39

1 Q. But would you agree, therefore, in the context of
 2 a victim, Wayne and his partner, he would have been
 3 asking for meetings, not to have facilitated meetings
 4 suggests a failing here, whether it's by the FLOs and
 5 CPS or the CPS alone or the FLO alone, shows that that
 6 application of the Victim Code has gone seriously wrong
 7 in this case?
 8 A. No, I wouldn't agree that it's gone seriously wrong.
 9 Q. So it's just gone a little bit wrong?
 10 A. No, it hasn't gone --
 11 Q. All right.
 12 A. No, no, no, and I don't wish to make light of that, that
 13 there was ... yes, if Mr Birkett had wished to have
 14 a meeting, as I've now learnt that that's been relayed
 15 to us, then yes, that meeting should have been
 16 facilitated.
 17 Q. It's recorded twice in minutes of CPS documents.
 18 A. Yes.
 19 Q. So you still say it's not a serious failing of the
 20 Victim Code to have not facilitated those meetings?
 21 A. If Mr Birkett is unhappy with the service that we've
 22 provided him, then that is serious.
 23 Q. Well, he is a victim who was completely overwhelmed by
 24 the sentencing experience --
 25 A. Yes.

38

1 THE CHAIR: Do you think that the current system is suitable
 2 in that it would require, I think on the way you've
 3 described it, the initiative for attending, the
 4 initiative for meetings to come from the victims?
 5 A. I would say that it is very much reliant on the
 6 communication between the FLO, the victim, and then CPS.
 7 So if that works properly, then it works.
 8 THE CHAIR: But if it doesn't, so, for example, if the FLO
 9 is not asking the right questions or people feel too
 10 intimidated, if you like --
 11 A. Exactly.
 12 THE CHAIR: -- or unwell --
 13 A. I agree. And if the FLO isn't providing that
 14 information to CPS, isn't chasing it up, then, yes.
 15 THE CHAIR: Thank you.
 16 THE WITNESS: Thank you.
 17 THE CHAIR: Right. I think we'll --
 18 MR BLAKE: Thank you, Chair.
 19 THE CHAIR: Yes, you've come to the end of your evidence,
 20 thank you.
 21 THE WITNESS: Thank you.
 22 MR BLAKE: We can either take a break, or the next witness
 23 is in the room.
 24 THE CHAIR: We might just take a very short break, in fact.
 25 Why don't we take a ten-minute break, so we'll start

40

1 again at 3.00.

2 **MR BLAKE:** Thank you.

3 **THE CHAIR:** Thank you.

4 **(2.51 pm)**

5 **(A short break)**

6 **(3.00 pm)**

7 **THE CHAIR:** Thank you.

8 Yes, Mr Blake.

9 **MR BLAKE:** Thank you, chair. Can I please call Dr Frank

10 Farnham.

11 **DR FRANK READ FARNHAM (affirmed)**

12 **Questioned by MR BLAKE**

13 **THE CHAIR:** Yes, please sit down.

14 Mr Blake.

15 **MR BLAKE:** Thank you, Dr Farnham, you should have in front

16 of you a witness statement dated 20 February 2026 with

17 a URN of WITN0415001.

18 **A.** Yes.

19 **Q.** Can you please confirm that that is true to the best of

20 your knowledge and belief?

21 **A.** It is, yes.

22 **Q.** Thank you. You are a Consultant Forensic Psychiatric at

23 North London NHS Foundation Trust; is that right?

24 **A.** That's correct.

25 **Q.** You've set out your qualifications and background in

41

1 Midlands in Birmingham, and one in Manchester, looking

2 at attempting to divert individuals where there's a

3 concern about radicalisation or a concern that an

4 individual might be tending towards an act of

5 terrorism/offence into treatment or assessment if there

6 are issues around mental health.

7 **Q.** Dare I ask whether you are also involved in the

8 foundation of that?

9 **A.** I was, yes.

10 **Q.** Focusing now on FTAC, we've already heard from

11 Superintendent Busby-McVey.

12 **A.** Yes.

13 **Q.** You've set out in your witness statement, it's

14 paragraph 8, you say:

15 "The primary purpose of FTAC is the assessment and

16 management of threats posed to prominent individuals and

17 their working environments by 'isolated loners' who

18 pursue idiosyncratic quests or grievances."

19 You've distinguished in your statement also between

20 threat management and risk assessment. Can you assist

21 us with what the difference is between the two?

22 **A.** Yes. Threat management or threat assessment is, if you

23 like, that realtime fast-paced assessment of an

24 individual, often without -- with limited amounts of

25 information which would generally be the domain, for

43

1 your witness statement at paragraphs 4-5, and in respect

2 of FTAC, you have been a Consultant Forensic

3 Psychiatrist there for 20 years; is that right?

4 **A.** That's correct.

5 **Q.** In fact, I think it was your research that led to the

6 founding of FTAC?

7 **A.** A group of us, yes, but I was there at the beginning.

8 **Q.** Thank you. You're also a Consultant Psychiatrist at

9 something called STAC; is that right?

10 **A.** That's correct.

11 **Q.** Very briefly, what is STAC?

12 **A.** The Stalking Threat Assessment Centre is a joint police,

13 Metropolitan Police, Probation, Health and Suzy Lamplugh

14 Trust charity initiative, designed to improve the

15 quality of stalking processes, really, in relation to

16 the police, and/or health issues if they arise.

17 So it deals with all stalking cases that are within

18 the remit of the Metropolitan Police area.

19 **Q.** Were you again involved in the foundation of that?

20 **A.** Yes.

21 **Q.** You're also involved in something called CCS; can you

22 assist us with what that is?

23 **A.** Counterterrorism Clinical Consultancy Service is a unit

24 which is a joint -- it is a national unit with three

25 branches, if you like, one in London, one in the

42

1 example, of the police when in dealing in an acute

2 situation with, you know, an acute scenario.

3 Risk assessment is really a slower-paced process

4 where much more information is available and much more

5 information needs to be available in order to do it

6 properly, with an individual where the risk is contained

7 and really one is thinking about future risks. A threat

8 assessment is really about immediate risk, and risk

9 assessment is really about future risk, and future risk

10 planning.

11 **Q.** At paragraph 13 of your witness statement you say in

12 relation to FTAC:

13 "There has to be evidence of mental disorder,

14 fixation, and threat."

15 **A.** That's correct, yes.

16 **Q.** Am I right to understand by that that mental disorder

17 and fixation aren't enough on their own, and that there

18 has to be, for FTAC to become involved, some sort of

19 threat element?

20 **A.** Yes, we're not a mental health unit; we're a police-led

21 Fixated Threat Assessment Centre which happens to have

22 NHS staff working there. Being mentally ill is not

23 enough. There has to be an element of fixation and

24 an element of threat associated to the individuals that

25 what we would call the principals or principal sites in

44

1 order to be taken on.

2 **Q.** And is narrowly confined to particular individuals and
3 sites.

4 **A.** Yes, that's correct. The scope has increased over the
5 years, but generally speaking, it's members of the Royal
6 Family, MPs, ministers, obviously, the House of Lords,
7 iconic sites within the government security zone and
8 other areas, and then there are other individuals that
9 we would take on as the scope has grown.

10 **Q.** And you've referred also to isolated loners. What is an
11 isolated loner?

12 **A.** So I think that talks to the increasingly clear
13 literature about the notion of sort of lone actors or
14 individuals who are operating on their own, without them
15 being part of a group or, if they are part of group it's
16 because they've attracted like-minded individuals on the
17 internet, that sort of thing; compared to, you know,
18 an organised pressure group or an organised -- I suppose
19 the extreme example, an organised terrorism group.

20 So these are individuals, the vast majority of whom
21 are mentally ill and most of them have some sort of
22 fixation on a site for what it represents, perhaps, or
23 for an individual for who they are, what they represent,
24 and there has to be some notion of threat.

25 It doesn't have to just be threat of violence. The

45

1 **Q.** And focusing on that initial assessment, the triaging
2 process?

3 **A.** Yes.

4 **Q.** We've seen Superintendent Busby-McVey's second witness
5 statement, and for the record that is WITN0012005, and
6 she's confirmed that those already working at FTAC don't
7 have ready access to a subject's mental health history
8 at that stage; is that right?

9 **A.** That's right. I mean obviously the idea that working in
10 a police unit remotely one would have full access to
11 a individual's medical records, if you like, at
12 the press of a button, is arguably disproportionate and
13 would need to be thought about much more carefully.

14 In practice what happens is one engages in a process
15 of -- well, engagement, you know, with the general
16 practitioner, with the CMHT, in order to try to pass
17 on -- mostly pass on information that we're concerned
18 about, rather than ask for large amounts of information.

19 **Q.** Does that access to information, or difficulty in
20 accessing information, cause difficulty with that
21 initial triage process? Because you can't necessarily
22 see what lies underneath the initial incident.

23 **A.** Well, emphasising the threat management nature of the
24 work, one has to go on what one has received. The
25 police would routinely do police checks, and those have

47

1 risks can be to do with things like persistence, massive
2 use of resources, other areas of that sort of nature.

3 **Q.** In terms of the process, we've already heard that
4 there's a Forensic Nurse and a Detective Constable who
5 carry out a triage process, and allocate a particular
6 concern level; is that right?

7 **A.** That's correct.

8 **Q.** I think you've described in your witness statement FTAC
9 as essentially a Liaison and Diversion role for those
10 cases of sufficient seriousness. Can you assist us with
11 what you mean by that?

12 **A.** So the original research, and subsequently, has
13 demonstrated that the vast majority of the people that
14 present these problems are mentally ill. The vast
15 majority are suffering from a psychotic illness. Some
16 of them are known to services but the services are not
17 aware of what they're doing. Some are not known to
18 services because they've become unwell for the first
19 time or they've dropped out of care.

20 So we, when it's thought to be appropriate, would
21 liaise with probably initially the person's GP but then
22 the Community Mental Health Team or other services to
23 try to communicate the concerns that we have to them and
24 to encourage them to assess the individual and to put
25 forward a management plan.

46

1 been outlined, I think, in my statement and in the
2 material that FTAC have provided.

3 The decision to do a further health check would be
4 carried out, really, on a case-by-case basis and would
5 need to be proportionate. Those cases that are
6 concerned to be -- that are thought to be based on the
7 information available, low concern, we would not be
8 routinely accessing even, for example, the GP's find(?),
9 to find the GP practice.

10 **Q.** Are you satisfied with the ability of FTAC to identify
11 low concern without that access?

12 **A.** Well, you don't know what you don't know, and so there
13 is that. I mean I think that's an important point to
14 make. But I think one also has to balance FTAC's
15 primary duty to -- or primary role -- it's not
16 a statutory agency, it doesn't have a duty in that
17 sense -- primary role to protect sites and people with
18 the individual or mentally ill person's rights to have
19 some level of privacy and confidentiality. And that's
20 not an easy thing to balance. I mean that's -- I mean
21 perhaps obviously it's a difficult thing to balance, but
22 it's necessary to do that. It's not -- you know, large
23 numbers of mentally ill people congregate in London and
24 in other centres, the vast majority of whom are not
25 particularly posing any particular threat or risk to the

48

1 individuals that I'm involved with at FTAC.
 2 **Q.** I'm now going to bring up the nominal record in relation
 3 to VC's case.
 4 **A.** Yes.
 5 **Q.** If we could have a look at WITN0012004, please. This is
 6 a record we looked at with Detective Superintendent
 7 Busby-McVey. It says as follows, it says:
 8 "PSO request a name check from FTAC following the
 9 subject coming to the attention of staff at Thames
 10 House."
 11 Then in the next paragraph it says that he was:
 12 "... at the location ringing the buzzer and stated
 13 that he wanted to be arrested."
 14 If we scroll over the page, please, it has some
 15 information from the Police National Computer. So it
 16 looks as though, albeit a medical records check hasn't
 17 been possible, is it quite standard a check somebody's
 18 PNC?
 19 **A.** Yes.
 20 **Q.** We know, having heard evidence in this Inquiry, that one
 21 of the incidents of criminal damage was being treated as
 22 a GBH. Sorry, in fact, it wasn't criminal damage, it
 23 said assault but it was being treated as GBH. It
 24 doesn't appear here at all. I think there's a reference
 25 to ABH domestic there on PND, but there's no reference

1 I can't say for certain that we would have taken the
 2 case on, even with that, but certainly we would, I
 3 think, would have wanted to make some more
 4 investigations and I think the police would have done --
 5 when faced with that, you know, isolated statement,
 6 would want to make some inquiries about what that
 7 actually was to do with.
 8 **Q.** Then we see at the bottom of this page, it says,
 9 "Nominal only at this time" and we've already heard
 10 essentially that that is case closed for now; is that
 11 right?
 12 **A.** Yes, it's important to say it's not -- it's case closed
 13 for now. It's like a front sheet. Of course, if the
 14 individual, if VC had turned up again the following day,
 15 we may well have opened it. I mean, any evidence of
 16 persistence or any other concerning behaviour might lead
 17 the case to be open, but what it does is place a marker
 18 at the beginning of what might be, you know, quite
 19 a long journey. Some people start and then we find that
 20 we are dealing with them for years.
 21 **Q.** Is that marker spread sufficiently wide? I mean, we've
 22 seen an email to the police providing them with certain
 23 information. Do you provide that kind of information to
 24 mental health authorities?
 25 **A.** No, not for a nominal, no. I mean, almost by definition

1 there to GBH.
 2 If that had featured on this record, would it, in
 3 your view, have affected the way that VC's case was
 4 assessed?
 5 **A.** It might have done, yes. Obviously violence is relevant
 6 and serious violence is relevant when thinking about
 7 both threat and risk. I think the Inquiry has heard
 8 some evidence about the importance of understanding
 9 somebody's previous violent history.
 10 But it perhaps might show what somebody is capable
 11 of doing when they're in a certain mental state and it's
 12 a risk factor for -- previous violence is a risk factor
 13 for future violence. So if there had been a conviction,
 14 for example, of GBH then that would have obviously
 15 featured strongly in our thinking.
 16 **Q.** If it had just shown up there as currently subject to
 17 investigation, or hadn't been yet completed but it was
 18 recorded as a GBH, do you think it is more likely that
 19 it may have led to a further level of assessment by
 20 FTAC?
 21 **A.** I think it -- yes, I think it might. I think, you know,
 22 GBH is, if you like, at that kind of tipping point where
 23 one would want to be a little bit more inquisitive about
 24 what the nature of that is. You know, somebody who has
 25 been investigated for causing really serious harm.

1 we are at that stage saying that we're not taking this
 2 case on. There are issues about wanting to make sure
 3 that one doesn't make the situation worse by interfering
 4 at a very early stage.
 5 A referral from FTAC or a letter from FTAC or an
 6 email from FTAC may well follow an individual around in
 7 their medical records for a long time, and it needs to
 8 be proportionate. So we wouldn't be routinely passing
 9 on nominal information to health.
 10 **Q.** So again, perhaps the greater the record of previous
 11 violence, for example, the more likely it is that you
 12 would have passed something on?
 13 **A.** I think the greater the record of previous violence more
 14 likely is we would have taken the case on and part of
 15 that would be then to liaise with local health, be that
 16 the GP or Community Mental Health Team depending on what
 17 the individual circumstances were. Or, you know, the
 18 local authorities or education, or other agencies that
 19 may -- because in our experience what often happens is
 20 individuals are well known to lots of different agencies
 21 but they're not communicating with each other, and
 22 sometimes FTAC is able to broker some relationships
 23 between those different agencies.
 24 **Q.** We know that VC asked to be arrested when he pressed on
 25 the doorbell of Thames House. He doesn't appear to have

1 been asked to explain that at all. We've seen the
2 body-worn footage of the officers who attended. Do you
3 think that that would have assisted your enquiries?

4 **A.** Well, I think it was pretty clear that he was mentally
5 unwell, but as I've said, that would not be enough in
6 and of itself to take on the case.

7 Could more questions have been asked? I mean,
8 always, and there are always more questions that could
9 be asked. He's travelled down from Nottingham, he's
10 rung on the bell of MI5 and has asked to be arrested.
11 I mean, that in itself suggests there's some degree of
12 mental disorder.

13 If -- yes, I mean, if we'd asked why and he'd
14 engaged in a fuller conversation about what he's
15 thinking around that, that obviously might be relevant
16 because it might talk to fixation, and then one of
17 our -- one of the limbs of our triage, if you like,
18 would be fulfilled.

19 **Q.** But is it your evidence that albeit fixation may be
20 satisfied and mental illness may be satisfied, you still
21 wouldn't have sufficient information regarding the
22 threat?

23 **A.** I think that's correct, yes. I mean, if an individual
24 continued to turn up, you know, daily or weekly over
25 a long period of time, and made no threat, one, I think,

53

1 he was tired for being in the hospital. When I said
2 that ... this is so important for him to tell ..."

3 If this paragraph perhaps could be blown up a little
4 bit, that would be helpful. Thank you.

5 "When I said that this is so important for him to
6 tell [us] this when he could have easily wait till his
7 appointment this Thursday he said that because 'the
8 voices that I hear can see other people as well and he
9 don't want that other people to get into the trouble'.
10 Auditory hallucinations are the same that he hear for
11 sometime and characterised by 'group of people, both men
12 and women that he don't recognise, group identify
13 themselves with the title "Something else" and consist
14 of people from many different departments including MI6,
15 Police, etc, speak in clear words both to him telling
16 that he should be punished for the crimes ... he
17 committed in the past and also because he threatened one
18 of the group member. Voices also talk to each other
19 about him and make comments on what he is doing. Voices
20 don't give him command but suggest to him that he should
21 do to 'prove his power'."

22 I'm going to take you to another document before
23 I ask the question, and that's IPTR0000002. We're now
24 later, this is now two years on, so we're in May 2022,
25 and this is a claim that VC filed with the Investigatory

55

1 would have to make a pragmatic decision about whether to
2 take it on or not because it would then talk to other
3 risks around, you know -- you know, substantial risk of
4 waste of resources, other things that are relevant.

5 But you're right, I mean -- or rather, it is my
6 evidence that you'd need those three limbs.

7 **Q.** I'm going to ask you about very much a hypothetical, so
8 you're going to have to bear with me a little bit, but
9 if we go to VC's medical records from later on,
10 November 2020, NHFT0000168, page 138.

11 These are VC's medical records, as I say, from the
12 visit by the Early Intervention and Psychosis Team in
13 that second paragraph it says:

14 "When we arrived at his shared accommodation he
15 welcomed us to the door, look well and cleanly dressed
16 ... He looks more engaging and was able to narrate about
17 himself much better than [when] ... we saw him [a]
18 couple of month[s] ago."

19 So presenting well dressed, well spoken, et cetera.

20 Then the next paragraph it says -- it's the second
21 sentence, it says:

22 "He said that just before his discharge from
23 admission at Highbury Hospital back in July, he told
24 a ward doctor that he no longer hear[s] voices, but he
25 said that is not the case and he only said that because

54

1 Powers Tribunal. If we could turn over the page,
2 please, and in the box. That asks what happened, if
3 that could be enlarged, please.

4 It says:

5 "From September 2019 the complainant moved to an
6 accommodation at Salisbury Street, Nottingham. From
7 this date there took place a 24/7 covert surveillance
8 conducted by a British intelligence agency that only
9 became obvious a few months later. From May 2022 at an
10 accommodation at Player Street, Nottingham, this
11 surveillance devolved into 24/7 harassment using
12 directed energy. A major consequence of this was
13 a constant 24/7 malign and hostile inner ear
14 communication."

15 I'll just skip out a few sentences and if we go
16 towards the bottom of this page, it continues:

17 "The objective of this activity, as far as the
18 complainant can ascertain, is to harass and misinform
19 him so as to drain him mentally, to coerce him to commit
20 criminal activities that retroactively justify the
21 illegal surveillance that the agencies committed." (As
22 read)

23 We can see the letter that accompanied this at
24 IPTR0000004. He's writing at this stage from
25 Ilkeston Road, so that's the very location where he

56

1 ultimately committed the attacks, and he again repeats
2 about the 24/7 surveillance and harassment, and at the
3 bottom of that paragraph he repeats that:

4 "The objective of the activity as far as the
5 complainant can ascertain is to harass and misinform
6 him, so as to drain him mentally to coerce him to commit
7 criminal activities ..."

8 Essentially being forced to commit criminal
9 activities.

10 A. Yes.

11 Q. Now these are after the visits to MI5. If he had
12 attended MI5 on 28 May, so the day after filing that IPT
13 claim, in your view, would his FTAC assessment have been
14 different and, if so, how?

15 A. Do you mean if we'd had evidence of the IPT claim?

16 Q. Well, that's actually the very question, because of
17 course if he had attended the next day and you didn't
18 have access to his medical records, for example, you
19 wouldn't have seen that first document?

20 A. Yes. I mean, so, in a sense the first document negates
21 the need for FTAC because local mental health have
22 already ascertained a very clear picture of his mental
23 health concerns, and should be able to formulate a plan
24 to address them. FTAC is mostly about trying to provide
25 local services with information about concerning mental

57

1 a significant concern here. Even without knowledge that
2 attending MI5 -- that he had attended MI5. I suppose
3 for completeness it would be useful to know that, but
4 that he's describing a very markedly disordered mental
5 state and that should be sufficient to galvanise
6 services -- (*overspeaking*) --

7 Q. What about the IPT? What should IPT have done with the
8 information that we see here? Should they themselves
9 have contacted FTAC?

10 A. I think this is really difficult because of course an
11 individual has a right to make a complaint to the IPT
12 and even if the person is quite disordered, somebody has
13 the right to complain in a disordered way. So to
14 immediately make a referral to health services I think
15 is problematic. There would, I think, have to be -- and
16 this comes up quite a lot with ombudsman and other
17 settings where there's concerns about someone who is
18 mentally ill, but nonetheless they're allowed process
19 because there may be some, you know, there may be some
20 nub of truth to what they're saying. And to
21 immediately -- I'm not saying that -- I don't think
22 you're asking me would they dismiss his case, you're not
23 saying that; you're saying would it be useful to know
24 that.

25 Q. I mean, there's reference, for example, to committing

59

1 states or concerning behaviours.

2 In that case, that had already been discovered by
3 local services. So FTAC would not have much of a role,
4 really, other than perhaps, I suppose, providing a
5 little bit more information about what he'd actually
6 done when he arrived in London.

7 Q. What they wouldn't have been aware of, that those who
8 were looking after VC, treating him, et cetera, what
9 they wouldn't have known is that he went that one stage
10 further and actually attended MI5, rang on the
11 doorbell --

12 A. Yes.

13 Q. -- asking to be arrested. There seems to be, correct me
14 if I'm wrong, but there does seem to be a gap there in
15 information sharing, if you're not able to access his
16 medical records?

17 A. I mean, I suppose so, but he's describing a markedly
18 disordered mental state in that passage. He's
19 describing being a targeted individual who is the victim
20 of mind control. These sorts of ideas go back centuries
21 and there are descriptions in the literature of just
22 that same type of suffering, really, from individuals
23 with serious mental illness.

24 So that in and of itself should have got him over
25 the line for people to realise that there was

58

1 criminal activities in light of the voices that he's
2 hearing.

3 A. Yeah.

4 Q. Who should be passing this information on, and who
5 should they be passing it on to?

6 A. I'm not sure that this within my -- you know, within my
7 area of expertise.

8 Q. It doesn't have to be within your expertise, just in
9 your experience, in your greater knowledge as a matter
10 of best practice or not even in reference to your
11 practice, are you able to assist?

12 A. So ombudsmen encounter this sort of difficulty all the
13 time, about where to strike the right balance between,
14 for example, dismissing a persistent complaint versus
15 giving the person the right to be heard.

16 I think, if an individual is making a credible
17 threat, and of course credible to one person might not
18 be credible to another, but is in terms writing
19 something very concerning about something they're going
20 to do, for example, to a named individual or they're
21 putting some time on it, you know. We at FTAC get very
22 concerned about, for example, "end of tether" language.

23 So if somebody says, "I'm at the end of my tether,
24 something needs to be done now". If I was reading
25 that I would contact the police and pass on my concern

60

1 about that person.

2 Health is more different because it can't be right
3 that that scenario occurs where somebody makes
4 a complaint, even if it is a quite disordered complaint
5 and the response is that psychiatrists arrive. Well, it
6 can't be, it might be, but you can see the difficulty, I
7 think, that trying to is -- it's a very thorny area to
8 try to think proportionately about what should be
9 a proportionate response to a concern about someone when
10 they also have a right to complain.

11 **Q.** Thank you. I'll move on to a totally different topic
12 and that is risk assessments. You've addressed that in
13 your witness statement.

14 **A.** Yes.

15 **Q.** HCR-20 is the most widely used evidence-based tool for
16 assessing and managing the risk of violence, and you've
17 said that in your statement.

18 **A.** Yes.

19 **Q.** Particularly in a forensic setting; is that right?

20 **A.** Yes.

21 **Q.** We'll hear more about that as the Inquiry progresses,
22 but, briefly, how does that work?

23 I'm sure you could give a whole lecture on it, but
24 -- (*overspeaking*) --

25 **A.** There are a number of risk factors that are known from
61

1 formulation, to think about what would be the likely
2 factors that might lead to the same scenario occurring
3 again that occurred before, say in a forensic setting?
4 What would be the worst-case scenario in terms of
5 a scenario planning and a formulation? And what would
6 be sort of the best-case scenario? To reintroduce the
7 narrative into the thinking about the person.

8 But the route to good quality risk assessment is
9 knowing the patient really well. If you know the
10 patient really well and you have a relationship with
11 them, then that's, you know, more than half the battle,
12 in terms of thinking about the risks that they might
13 pose under certain circumstances.

14 **Q.** Are there any improvements to the actual assessment
15 process, other than getting to know your patient better,
16 that you consider would be valuable?

17 **A.** There are lots of these tools. They all turn on very
18 similar sorts of facts and in a forensic setting, you
19 know, in my statement I drew attention to some
20 criticisms of the HCR-20 in the way that it's
21 administered, but nonetheless, risk assessment runs
22 through forensic services and is at the forefront of
23 everybody's -- in everybody in the multidisciplinary
24 team's mind, I mean, it has to be.

25 But there is still that concern that somehow, if you
63

1 the literature to increase the risk in a group. So the
2 point about that is that risk prediction -- and I think
3 one of the other witnesses covered this -- at an
4 individual level is impossible. You cannot predict with
5 any accuracy whether an individual is going to go on and
6 commit a violent act. But you can identify a group of
7 people who have a number of risk factors that increase
8 their risk, and HCR-20 helps you to do that. So there
9 are some historical factors that the H of the HR20 which
10 are things like -- things that can't change, like
11 previous violence, arguably, open and established
12 diagnosis of mental illness. There are clinical factors
13 to do perhaps with substance abuse and other things, and
14 then the risk assessment factors about how to make --
15 how to plan going forward.

16 One of the problems with these tools early on, so
17 I'm -- I practised long enough to be practising before
18 the HCR-20 at a time when risk assessment was done
19 differently.

20 One of the problems with, if you like, a tick box is
21 you lose information because there's no narrative about
22 the person, it's very hard to understand what some ticks
23 mean. You know, what does an individual risk factor
24 mean in relation to that person?

25 So the HCR-20 has moved on to think about
62

1 just produced a better tool, you would find some sort of
2 magic bullet which would identify individuals that
3 are -- and then you could address those. And that's
4 just not possible. What you need is good quality care
5 across the board, in a group that you've identified as
6 being of concern.

7 So you are able to find a group that have a lot of
8 risk factors that we know from the literature elevate
9 their risk, and then apply good-quality care to that
10 group without trying to predict who is going to go on
11 and do something of concern.

12 **Q.** I think you've referred in your witness statement to
13 issues with "completing the journey".

14 **A.** Yes.

15 **Q.** What do you mean by that and is that part of the process
16 that you're addressing?

17 **A.** So the first stage is to complete a risk assessment.
18 The second phase is to construct a risk management plan
19 from that, and that might be the scenario that the
20 HCR-20 version 3 encourages. But the final point is to
21 actually implement that plan. And if you can't -- if
22 you don't have the resources to implement the plan, then
23 you've broken that cycle, and you may have done the best
24 quality risk assessment possible and you may have
25 formulated the best quality risk plan but if you can't
64

1 implement it, it's sort of, you know, it's not
 2 worthless; it's there as a record. But it's obviously
 3 not completing the cycle to actually reduce the risk
 4 that you've identified.

5 **Q.** In your experience, is there a deterioration in that at
 6 present?

7 **A.** Across the board? Yes.

8 **Q.** Does it include medication plans? So following up to
 9 ensure that medication is being taken; is that part of
 10 the overall plan that you're concerned about?

11 **A.** Yes. So for some individuals the major risk factor for
 12 any particular behaviour of concern, but let's say
 13 violence, might be a deterioration of their mental state
 14 arising from non-compliance with medication and the
 15 re-emergence of psychosis. So that might be the single
 16 most important factor to ensure reduced risk is
 17 a comprehensive plan around their medication.

18 **Q.** And again, in your experience, is that kind of a plan
 19 something that we are seeing less resourcing for or less
 20 commitment to?

21 **A.** It's almost -- it's sometimes almost symptomatic of
 22 serious mental illness that the individual doesn't think
 23 that they're unwell. Antipsychotic medication has very
 24 significant side effects for nearly everybody that takes
 25 it, not all, but very much so. And what often happens

65

1 can be, you know, a major risk -- especially if there's
 2 a predictable pattern that in the past when they've
 3 stopped the medication they acted violently, I think one
 4 is safe to assume that that may happen again.

5 **Q.** And looking forward to recommendations, do you have any
 6 views on how that can be improved?

7 **A.** I think that there is a very significant tension between
 8 the need to provide the least restricted option for
 9 a group of individuals who are, you know, very unwell
 10 and very vulnerable, versus the need to protect the
 11 public from the small number of those individuals who go
 12 on and commit serious violence. And that is not
 13 an easy -- those two positions are not easy to
 14 reconcile.

15 I think that better information sharing would be
 16 useful. I think that generally services sometimes are
 17 overwhelmed by the volume of patients. My view is that
 18 there aren't enough beds, my view is that services are
 19 poorly resourced. I don't think that's controversial,
 20 to be frank.

21 General services, I think, are sometimes anxious
 22 about risk assessments because it's not part of core
 23 training for an adult general psychiatrist, but
 24 ultimately it's about knowing the patient really well.
 25 And if you know the patient really well, you're dealing

67

1 is that if somebody has been admitted, for example, to
 2 a forensic service, that they're on perhaps a depot
 3 medication, so we know they're taking it because it's
 4 an injection. They will go into the community and
 5 perhaps be followed up by the Community Forensic
 6 Service, who will be very alive to risk, and will be
 7 continuing on their medication as a depot.

8 But at some point they're no longer being -- there
 9 is no longer any statutory, perhaps. Individuals who
 10 are conditionally discharged from a hospital or with
 11 restrictions aside, there will come a point where
 12 individuals are not constrained to take their medication
 13 and then there's a negotiation. And often what
 14 happens -- "often" may be too strong. Sometimes what
 15 happens is that individuals will go from forensic
 16 services to general services to the GP, and will
 17 negotiate a reduction or perhaps stopping the depot so
 18 then you don't know if they're taking their medication,
 19 and/or a reduction in the medication.

20 And for some patients that can be right. I mean
 21 some individuals have a serious episode of mental
 22 illness and never have another episode; they recover and
 23 they don't need medication.

24 But for some, obviously there is a relapsing and
 25 remitting concern and, if they stop the medication, that

66

1 with most of that risk assessment by that process.

2 But if you're in services where there is massive
 3 turnover of staff, large numbers of people are not being
 4 seen, you inevitably don't get to know the person very
 5 well.

6 I think there's some mileage in thinking about risk
 7 assessment that's scalable, so by that I mean if you've
 8 got a large number of patients, perhaps you could weed
 9 out the ones that you think are probably low risk, based
 10 on the knowledge that we have, so you could concentrate
 11 on the higher risk ones and, as I say, I think you're
 12 going to hear from Professor Fazel, I'm attracted to
 13 that approach. I think in a forensic setting you need
 14 a bespoke risk assessment. The HCR-20, despite its
 15 faults, is probably -- and other similar to that is the
 16 way to approach it.

17 In a general setting where there hasn't been
 18 a concern particularly about violence, but you're
 19 wanting to make sure you're doing something
 20 appropriately and structurally within a service,
 21 something like a screening tool along the OxRisk, OxMiv
 22 approach I think is attractive.

23 **Q.** Thank you. Moving on to a slightly different topic,
 24 which is your knowledge of matters in custody. We have
 25 heard from some witnesses about a deterioration in

68

1 forensic psychiatric practice over the past 30 years,
2 including no longer having, or not necessarily having in
3 all cases, Consultant Psychiatrists visiting the
4 custodial setting in police custody. Is that something
5 you're aware of, have any experience of?

6 **A.** I think different -- so there isn't uniformity, and
7 different units will have different approaches. At the
8 forensic service that I work at, the on-call consultant
9 would not routinely be called into a custody -- I mean,
10 they could be and they have been, but they wouldn't be
11 routinely called into the custody suite.

12 In practice, it may vary in different parts of the
13 country. Some areas may have freer availability of
14 forensic beds, medium secure beds. In London, there are
15 never any beds, really. There may be one or two for
16 emergency recall-type scenarios. So even if you did an
17 assessment and identified somebody as unwell, you
18 wouldn't be able to admit them immediately.

19 **Q.** Who is it that would call you in? Is it the Liaison and
20 Diversion Team or something else?

21 **A.** I think it would depend on local arrangements. It could
22 be the Custody Sergeant, I think, if that was the local
23 arrangement, but mostly I think it would be Liaison and
24 Diversion Service. If a Mental Health Act assessment,
25 a formal Mental Health Act assessment was being

69

1 sharing. I think that would be useful. Better-quality
2 information sharing. I think police often have
3 information that's very relevant to health decisions
4 that, you know, aren't routinely shared.

5 Sometimes I think that's ignorance on the part of
6 local services. They don't know actually they probably
7 could contact the police and ask for some information
8 about a particular situation. Sometimes it would be
9 reluctance to pass that on.

10 So I think the start would be to try to improve
11 information sharing, and to not be siloed into, you
12 know, police being police work and health being health
13 work.

14 Because often there's, you know, there's a crossover
15 between the two. In forensic services, often
16 a perpetrator one day is the victim the next, you know,
17 and so there are -- there is a blurring of these sorts
18 of boundaries that probably needs to be thought about.

19 **Q.** You've been involved in two, if not three bodies that
20 join up those services together and actually work
21 essentially embedded together.

22 **A.** Yes.

23 **Q.** Is that something that could be rolled out on a larger
24 scale, or not?

25 **A.** It could, but it comes down to money again, I think.

71

1 contemplated, some areas would incorporate a forensic
2 psychiatrist into that. Others areas wouldn't, and it
3 would be two Section 12 approved doctors or on a rota
4 that would come in.

5 **Q.** In the homicide cases, given the number of those cases
6 that involved mental disorders of some kind, should
7 there be access to those specialists in police custody,
8 in your view? Greater access?

9 **A.** I think that it would be -- ideally, yes, yes.

10 **Q.** Are there any ways that you consider the situation would
11 be improved, other than money?

12 **A.** Other than money? No.

13 **Q.** Moving on, then, to the final recommendation in relation
14 to the FTAC model itself. I think you've said in your
15 statement that it could be rolled out linking health,
16 social care and the police in some other circumstances,
17 because we've heard that the FTAC model is quite
18 narrowly confined in who the threat is directed towards.

19 **A.** Yes.

20 **Q.** What do you have in mind for the criteria of some larger
21 body or other body?

22 **A.** It's obviously fraught with difficulty trying to roll
23 out something like that across the country. I would
24 have thought that modest improvements would be trying to
25 link up health with police, in terms of some information

70

1 I mean I think it would be an extraordinarily expensive
2 endeavour probably, I mean I haven't costed it but you
3 can imagine it would be very expensive. And there would
4 be those issues about trying to balance a proportionate
5 response to someone's mental illness without necessarily
6 getting the police involved or vice versa.

7 But I think for some individuals, and where you draw
8 the line, you know, where you set the boundary is up for
9 debate but for some individuals clearly much better
10 information sharing is needed. And I mean that's
11 recognised in MAPA and the other multi-agencies,
12 existing multi-agency arrangements that are there.

13 **MR BLAKE:** Unless there's anything further that you wish to
14 draw to the attention of the Inquiry, I don't have any
15 further questions.

16 **A.** No.

17 **MR BLAKE:** I don't think there are any questions from any
18 core participants.

19 **THE CHAIR:** No?

20 **MR BLAKE:** I think Ms Cartwright has.

21 **THE CHAIR:** Ms Cartwright.

22 **Questioned by MS CARTWRIGHT**

23 **MS CARTWRIGHT:** Good afternoon, Dr Farnham. Can I just very
24 briefly take you back to the medical record that

25 Mr Blake took you to which is NHFT0000168, and -- thank

72

1 you.
 2 Thank you, and if we can go to the next page,
 3 please. In fact no, it's page 16. I think in summary
 4 what you said in that description about what's recorded
 5 about VC linked to MI6 and feeling the power, you're
 6 essentially saying that's evidence of a seriously
 7 disordered individual; is that correct?
 8 **A.** Yes.
 9 **Q.** And then can I ask you, because we can see the reference
 10 of MI6 and I think one of the roles of FTAC is
 11 protection of sites such as Thames House, for example,
 12 where VC turned up at in May, is there any reciprocal
 13 arrangement where you would expect healthcare or, for
 14 example, the Investigatory Powers Tribunal where they've
 15 got relevant information about a fixation on
 16 a government building or a government agency, to share
 17 the information with FTAC for their own -- so that they
 18 can be factoring in whether that's then reached the
 19 threshold for FTAC involvement?
 20 **A.** There aren't any formal arrangements but I can think of
 21 examples of situations where, you know, various ... so
 22 the core referrals into FTAC come obviously from
 23 correspondence officers and from, you know, protection
 24 officers, but occasionally we get referrals in from
 25 other settings; sometimes from health, a concern about

73

1 **A.** It depends how you define "seriously", but I think one
 2 would be thinking about cases where individuals are
 3 losing contact with reality because they're psychotic,
 4 for example. So I think serious mental illness in that
 5 sense, relapsing and remitting but enduring conditions.
 6 So not individuals who have a one-off -- because some
 7 people have an episode of psychosis and recover and we
 8 are increasingly understanding that that's the case.
 9 But obviously some people never recover and the
 10 concerning group are the ones that relapse and remit and
 11 I think it would be that group that I'd be interested in
 12 trying to construct a better quality information sharing
 13 and better quality sort of thinking because the
 14 police -- FTAC's experience is often that an individual
 15 in a local area is causing some difficulty, Health know
 16 about it, the local authority know about it, perhaps
 17 Education knows about it, but nobody is talking to each
 18 other. And to try and share that information does
 19 happen, but it happens, I think, on a kind of case by
 20 case, a non-formalised basis. So to try to improve that
 21 I think would be useful.

22 **THE CHAIR:** You're involved with STAC, that's the stalking,
 23 isn't it?

24 **A.** Yes.

25 **THE CHAIR:** Can I just ask you to look at WITN0415008, at

75

1 one of their own patients and sometimes from other
 2 organisations. So there's no statutory or formal
 3 arrangement but it can and does happen, yes.
 4 **Q.** Thank you. Then can I ask you, because obviously you
 5 were taken to the document that had been submitted by VC
 6 to the Investigatory Powers Tribunal, which I suspect
 7 may be candidates for quite high volume of information
 8 where it is of concern. Is there any information
 9 sharing arrangement that exists between the Tribunal and
 10 FTAC regarding information that reaches a threshold of
 11 concern?

12 **A.** Not that I'm aware of, no.

13 **MS CARTWRIGHT:** Thank you very much indeed.

Questioned by THE CHAIR

15 **THE CHAIR:** Yes, Dr Farnham, I just want to ask you about
 16 paragraph 38 of your statement and I think you've
 17 referred there when you've been asked by Mr Blake about
 18 various different organisations, so there's the MAPA,
 19 the MARAC and what you refer to as the FTAC model.

20 How would, in relation to mental health, how could
 21 that be done any better than it is currently done? So
 22 this sort of multiagency work with seriously mentally
 23 ill, so you would draw the line at someone who was
 24 seriously mentally ill, rather than mentally ill? There
 25 is a very large number of people who are mentally ill.

74

1 page 24. It'll come up in a moment. Page 24. Thank
 2 you. Yes, just looking at "High-risk psychotic
 3 phenomena". Can we blow up that? Yes, if you can look
 4 at number (iii):

5 "... widespread, although largely unsupported, view
 6 that auditory command hallucinations to commit violence
 7 are associated with heightened risk of violence ... the
 8 presence of command hallucinations of this nature must
 9 be investigated, and managed as appropriate if present."

10 Is that one of the risk factors that might be
 11 important in looking at serious mental health?

12 **A.** Yes, very much so.

13 **THE CHAIR:** And in fact the other factors which are here,
 14 "high-risk psychotic phenomena", would also perhaps fall
 15 within that category, would they?

16 **A.** Yes.

17 **THE CHAIR:** Although this is a stalking --

18 **A.** But those -- all of those four factors, morbid jealousy,
 19 threat-control-override symptoms, command
 20 hallucinations, and delusional misidentification
 21 symptoms are all, in my view, really inarguably
 22 associated with serious violence.

23 **THE CHAIR:** So where it says:

24 "A history of acting upon command hallucinations
 25 offers crucial insights into the risk of violence with

76

1 the re-emergence of these symptoms."

2 A. Yes.

3 **THE CHAIR:** Yes.

4 A. I think an important point is that sometimes patients
5 are dismissed because they've had these symptoms for
6 a long time, and we used to hear it at FTAC very early
7 on the idea of kind of harmless delusions. You can't be
8 in this mental state for a very long time without
9 something happening. Often it involves the patient
10 harming themselves but it could involve the patient
11 harming somebody else. These are very disordered mental
12 states that are torturing the individual.

13 **THE CHAIR:** Yes, thank you. Just in relation to I think
14 finally the point that you make in your -- in relation
15 to the -- yes, paragraph 27 of your statement. If we
16 can have that, WITN0415001, paragraph 27. Thank you.
17 It's page 12.

18 Yes, you've referred there to the question of risk
19 assessments, and perhaps the scepticism about them
20 amongst psychiatrists:

21 "This house believes ... it is time to stop doing
22 long risk assessments ... because they have not improved
23 patient outcomes."

24 What about public protection? Is that part of the
25 debate there?

77

1 psychiatry and general psychiatry, largely speaking, in
2 this context with the criminal justice system, people
3 are diverted, perhaps, away from forensic psychiatry
4 because the police may not wish to proceed and think
5 that it's a mental health issue rather than a criminal
6 justice issue. You said there ends up being no criminal
7 justice process in relation to somebody with mental
8 health difficulties.

9 A. Yes.

10 **THE CHAIR:** So do you think that where there's a greater
11 perhaps experience in forensic assessment of risk, that
12 it's necessary, if that is the process, for general
13 psychiatry to be more trained in the sort of risk
14 assessments that you are, as a forensic psychiatrist?
15 That's a rather long way of putting it, I think.

16 A. I'm not -- I don't necessarily agree with that. I think
17 I would -- so whatever general psychiatry approaches are
18 adopted need to be scalable. They need to be able or
19 capable of operating at volume because --

20 **THE CHAIR:** Because of time and resources.

21 A. Time and resources and large numbers of patients. So
22 a good start would be to screen out the patients that --
23 and of course, bad outcomes can come from low-risk
24 cases. This is not exact, but one would want to screen
25 out the cases and then concentrate resources on the

79

1 A. Of course. And the context of that, of course, was
2 a debate at the Forensic Faculty of the Royal College
3 of Psychiatrists' annual meeting, I think was reflecting
4 a concern that -- a concern about kind of reifying the
5 tool and not actually -- and then not thinking about the
6 patient. I think patient outcomes and protecting the
7 public go hand in hand, certainly in a forensic setting.

8 Structured professional judgement approaches to risk
9 are required. I'm not suggesting that's not the case,
10 and in a forensic setting I think sometimes the HR-20 is
11 appropriate. But it's important not to lose sight of,
12 you know, the person and the -- a proper discussion
13 about the risks that are posed, which may in some ways
14 a tool might artificially limit because there may be
15 other things that are relevant and if one sticks
16 slavishly to the tool, whichever one it is, you may miss
17 other things about the person.

18 I feel quite strongly about, you talk about
19 structured professional judgement, these tools are all
20 about the structure, but I want to emphasise the
21 professional, the P within the SPJ, because that's the
22 crucial part of this. If you haven't got time because
23 your resources are, you know, strapped, etc, etc, the P
24 might become under-emphasised inappropriately.

25 **THE CHAIR:** Yes, and the difference between forensic

78

1 higher risk ones, and perhaps, for example, if a general
2 psychiatrist is concerned about a group of patients,
3 screen out the ones that come out as kind of low concern
4 and then make a request for forensic referral for the
5 ones that are higher concern, and get -- and attain,
6 then, a more bespoke risk assessment from a forensic
7 psychiatrist.

8 But I go back to the point that most of this is
9 about knowing the patient really well, and I have
10 general psychiatry colleagues who are more than capable
11 of conducting very good-quality risk assessments, but
12 they're constrained by time and by resources and volume.

13 **THE CHAIR:** Yes, thank you. As you say, you have to
14 complete the circle about actually putting plans into
15 practice, don't you?

16 A. Yes, I mean, I don't think there's -- I think there is
17 a point to doing a risk assessment, you know, and
18 I think there's a point in developing a risk management
19 plan, but unless you've got the resources to actually
20 adopt that plan, you know, it's extremely frustrating.
21 And some of this is structural. I mean, you can argue
22 about, you know, doses of medication or some other
23 thing, but if you're routinely putting somebody into
24 absolutely appalling accommodation that, you know, where
25 they're being preyed upon by, you know, drug dealers,

80

1 that sort of thing, which is obviously a common scenario
 2 in London, you're not managing that risk because you're
 3 not thinking very carefully about the social and the
 4 psychological aspects of the case; you're concentrating
 5 on the psychiatry, which is obviously right, but
 6 certainly in forensic services, there's a reason why
 7 multidisciplinary teams have a psychologist, a
 8 psychiatrist and a social worker because a social
 9 situation of the patient is so important, both for their
 10 wellbeing, but also for risk.
 11 **THE CHAIR:** So you have to really take into account what you
 12 mean by the community? When somebody is in the
 13 community, it can vary, can't it --
 14 **A.** Yes.
 15 **THE CHAIR:** -- as to where they're living, what their
 16 circumstances are, and whether they do really have
 17 a community that supports them.
 18 **A.** Exactly, and some individuals will be discharged from
 19 services, will have some sort of accommodation, will
 20 lose it, and will find themselves homeless.
 21 It's not, obviously, it varies up and down the
 22 countries and there are worst-case scenarios, but it's
 23 not an unusual scenario to see individuals who have been
 24 sofa surfing or, frankly, street homeless for periods of
 25 time with mental -- and the ability to access healthcare

1 in that setting, even if you have enough insight to want
 2 to do so, obviously is challenging if you haven't
 3 actually got an address. If you haven't got an address,
 4 you may not be able to register with a GP. If you don't
 5 have a GP, you may not be able to get referred on to
 6 secondary care. You may access care through A&E, and
 7 A&E -- you know, et cetera.
 8 **THE CHAIR:** Thank you. I've got no further questions.
 9 Thank you. Right.
 10 **MR BLAKE:** Thank you, Chair. We are now having a break
 11 until 13 April.
 12 **THE CHAIR:** 13 April, yes. Thank you.
 13 **(3.59 pm)**
 14 **(The hearing adjourned until 10.00 am on 13 April 2026)**
 15
 16
 17
 18
 19
 20
 21
 22
 23
 24
 25

INDEX

	Page
1 MICHELLE MANNION (sworn)	1
2 Questioned by MR BLAKE	1
3 Questioned by MS CARTWRIGHT	26
4 Questioned by THE CHAIR	39
5 DR FRANK READ FARNHAM (affirmed)	41
6 Questioned by MR BLAKE	41
7 Questioned by MS CARTWRIGHT	72
8 Questioned by THE CHAIR	74
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	

<p>MR BLAKE: [13] 1/3 1/6 1/9 26/19 40/18 40/22 41/2 41/9 41/15 72/13 72/17 72/20 82/10</p> <p>MS CAREY: [2] 39/6 39/8</p> <p>MS CARTWRIGHT: [4] 32/9 32/14 72/23 74/13</p> <p>THE CHAIR: [37] 1/5 26/22 32/7 32/11 39/5 39/7 39/9 39/13 39/19 40/1 40/8 40/12 40/15 40/17 40/19 40/24 41/3 41/7 41/13 72/19 72/21 74/15 75/22 75/25 76/13 76/17 76/23 77/3 77/13 78/25 79/10 79/20 80/13 81/11 81/15 82/8 82/12</p> <p>THE WITNESS: [2] 40/16 40/21</p> <hr/> <p>'</p> <p>'already [1] 11/16 'group [1] 55/11 'his [1] 17/12 'isolated [1] 43/17 'just [1] 15/6 'prove [1] 55/21 'The [2] 16/9 55/7 'trying [1] 15/16</p> <hr/> <p>1</p> <p>1.59 pm [1] 1/2 10.00 am [1] 82/14 103 [1] 23/10 12 [4] 14/20 17/23 70/3 77/17 13 [3] 17/23 44/11 82/14 13 April [2] 82/11 82/12 13 June [2] 2/23 3/13 138 [1] 54/10 14 [3] 31/8 31/12 36/16 14 June [1] 3/13 15 [2] 31/10 31/11 16 [1] 73/3 17 December [1] 24/24 17 July [1] 2/24 17 July 2023 [1] 2/1</p> <hr/> <p>2</p> <p>2-way [1] 15/4 2.51 pm [1] 41/4 20 [8] 61/15 62/8 62/18 62/25 63/20 64/20 68/14 78/10 20 February 2026 [1] 41/16</p>	<p>20 November [1] 12/11 20 years [1] 42/3 2019 [1] 56/5 2020 [1] 54/10 2022 [3] 18/3 55/24 56/9 2023 [3] 2/1 27/18 36/16 2024 [1] 36/18 2025 [1] 1/10 2026 [3] 1/1 41/16 82/14 23 January [1] 25/17 24 [4] 24/16 36/18 76/1 76/1 24 November [1] 19/25 24/7 [3] 56/11 56/13 57/2 25 January [3] 25/17 25/23 37/20 27 [2] 77/15 77/16 27 November [1] 27/5 27th [1] 29/18 28 May [1] 57/12 2:1 [1] 13/8</p> <hr/> <p>3</p> <p>3.00 [2] 41/1 41/6 3.2 [1] 20/19 3.59 pm [1] 82/13 3.7 [2] 24/16 24/25 30 November [2] 12/12 12/18 30 October 2025 [1] 1/10 30 years [1] 69/1 31 [1] 1/1 38 [1] 74/16</p> <hr/> <p>4</p> <p>4-5 [1] 42/1 4.52 [2] 10/10 11/16 49 [2] 33/3 34/4 4am [1] 10/9</p> <hr/> <p>5</p> <p>5 October [1] 8/25 5.01 [1] 16/8 5.04am [1] 11/2 50 [5] 31/6 31/12 32/5 32/6 32/7</p> <hr/> <p>7</p> <p>7.07 [1] 14/24 7.31 [1] 29/17 70 [1] 8/4</p> <hr/> <p>A</p> <p>ABH [1] 49/25 ability [9] 9/25 11/25 12/25 13/18 14/10 17/13 30/25 48/10 81/25</p>	<p>able [12] 7/5 29/24 52/22 54/16 57/23 58/15 60/11 64/7 69/18 79/18 82/4 82/5 abnormality [1] 17/12 about [91] above [3] 3/3 13/6 13/23 absolutely [10] 5/16 8/2 13/24 18/14 19/24 22/18 29/8 34/11 35/5 80/24 abuse [1] 62/13 accept [4] 17/8 20/20 20/25 22/10 accepted [4] 12/7 20/5 21/16 31/7 access [11] 27/23 47/7 47/10 47/19 48/11 57/18 58/15 70/7 70/8 81/25 82/6 accessing [2] 47/20 48/8 accommodation [5] 54/14 56/6 56/10 80/24 81/19 accompanied [1] 56/23 account [1] 81/11 accuracy [1] 62/5 accurately [1] 11/11 achieve [2] 17/24 18/5 across [3] 64/5 65/7 70/23 act [4] 43/4 62/6 69/24 69/25 acted [1] 67/3 acting [1] 76/24 actions [3] 5/4 5/10 12/6 activities [6] 3/9 17/4 56/20 57/7 57/9 60/1 activity [2] 56/17 57/4 actors [1] 45/13 acts [3] 9/24 11/9 11/9 actual [1] 63/14 actually [15] 23/8 24/2 39/22 51/7 57/16 58/5 58/10 64/21 65/3 71/6 71/20 78/5 80/14 80/19 82/3 acute [2] 44/1 44/2 added [1] 9/2 addendum [1] 24/24 addition [2] 7/5 18/19 additions [1] 9/3 address [7] 10/7 11/21 15/9 57/24 64/3 82/3 82/3 addressed [3] 34/7 36/13 61/12 addressing [2] 17/15</p>	<p>64/16 adjoined [1] 82/14 adjustments [2] 35/11 39/2 administered [1] 63/21 admission [1] 54/23 admit [1] 69/18 admitted [1] 66/1 adopt [1] 80/20 adopted [1] 79/18 adult [1] 67/23 adult general [1] 67/23 advance [2] 30/2 36/20 advised [1] 32/23 affected [1] 50/3 affirmed [2] 41/11 83/7 after [14] 2/5 3/5 9/4 9/5 10/9 11/2 18/25 23/8 26/17 29/17 30/25 57/11 57/12 58/8 afternoon [6] 1/3 26/14 26/24 26/25 32/25 72/23 again [18] 24/25 25/1 26/7 26/12 26/15 29/1 37/19 37/20 37/21 41/1 42/19 51/14 52/10 57/1 63/3 65/18 67/4 71/25 against [1] 6/18 agencies [5] 52/18 52/20 52/23 56/21 72/11 agency [4] 48/16 56/8 72/12 73/16 ago [1] 54/18 agree [16] 5/3 6/16 17/16 21/2 21/3 29/4 29/12 30/1 30/22 31/19 34/10 36/5 38/1 38/8 40/13 79/16 agreement [1] 24/22 aim [2] 17/24 18/1 Alan [5] 2/20 4/7 6/2 6/11 21/24 albeit [3] 29/14 49/16 53/19 alive [1] 66/6 all [39] 2/19 7/15 13/6 14/15 17/1 18/19 19/1 19/14 20/21 20/23 22/7 22/19 24/21 25/8 26/1 27/1 27/21 27/25 28/8 29/10 30/5 31/24 34/6 34/7 35/1 36/3 36/17 38/11 39/13 42/17 49/24 53/1 60/12 63/17 65/25 69/3 76/18 76/21 78/19 allocate [1] 46/5</p>	<p>allowed [1] 59/18 almost [3] 51/25 65/21 65/21 alone [2] 38/5 38/5 along [1] 68/21 alongside [1] 36/7 already [14] 2/13 4/5 6/6 10/17 10/19 13/10 16/4 28/5 43/10 46/3 47/6 51/9 57/22 58/2 also [28] 2/19 6/21 7/14 7/19 12/5 12/13 13/11 18/3 18/19 25/20 27/17 27/22 28/17 30/10 30/16 31/4 36/5 42/8 42/21 43/7 43/19 45/10 48/14 55/17 55/18 61/10 76/14 81/10 alteration [1] 29/15 although [2] 76/5 76/17 always [2] 53/8 53/8 am [4] 5/3 29/18 44/16 82/14 ambit [1] 9/14 amongst [1] 77/20 amount [1] 21/21 amounts [2] 43/24 47/18 ample [1] 25/2 Andrew [6] 2/12 3/3 5/20 5/22 7/14 13/11 annual [1] 78/3 another [4] 18/20 55/22 60/18 66/22 answer [2] 4/25 24/2 Antipsychotic [1] 65/23 anxious [1] 67/21 any [25] 7/17 7/23 8/13 17/10 26/19 31/7 34/12 48/25 51/15 51/16 62/5 63/14 65/12 66/9 67/5 69/5 69/15 70/10 72/14 72/17 72/17 73/12 73/20 74/8 74/21 anything [5] 3/22 15/7 25/24 36/22 72/13 apologies [2] 15/2 32/5 apologise [3] 10/22 31/12 32/13 appalling [1] 80/24 appear [3] 7/9 49/24 52/25 appeared [3] 5/11 7/4 8/10 appearing [1] 16/15 appears [3] 16/19 17/17 18/1 application [1] 38/6 apply [3] 27/15 33/15 64/9</p>
--	---	--	---	---

<p>A</p> <p>appointed [1] 27/16 appointment [1] 55/7 appreciate [3] 36/2 36/10 37/2 appreciated [1] 35/8 approach [5] 14/18 37/20 68/13 68/16 68/22 approaches [3] 69/7 78/8 79/17 approaching [1] 33/4 appropriate [7] 6/17 23/3 32/15 34/2 46/20 76/9 78/11 appropriately [1] 68/20 approved [3] 24/10 24/12 70/3 April [3] 82/11 82/12 82/14 April 2026 [1] 82/14 are [100] area [4] 42/18 60/7 61/7 75/15 areas [5] 45/8 46/2 69/13 70/1 70/2 aren't [4] 44/17 67/18 71/4 73/20 arguably [2] 47/12 62/11 argue [1] 80/21 arise [2] 26/20 42/16 arising [1] 65/14 around [9] 5/5 5/10 6/25 33/4 43/6 52/6 53/15 54/3 65/17 arrangement [4] 69/23 73/13 74/3 74/9 arrangements [3] 69/21 72/12 73/20 arrest [1] 18/1 arrested [4] 49/13 52/24 53/10 58/13 arrive [1] 61/5 arrived [2] 54/14 58/6 arrives [1] 16/8 arriving [1] 15/10 artificially [1] 78/14 as [64] 3/13 6/24 7/12 7/13 7/20 11/12 14/4 14/6 16/22 19/8 20/8 24/13 24/13 24/22 25/19 25/19 26/6 26/16 27/14 29/11 29/20 30/2 30/24 34/5 34/25 35/6 35/9 35/14 35/21 37/3 38/14 39/19 45/9 46/9 49/7 49/16 49/21 49/23 50/16 50/18 53/5 54/11 55/8 56/17 56/17 56/19 56/21 57/4 57/4 57/6 60/9</p>	<p>61/21 64/5 65/2 66/7 68/11 69/17 73/11 74/19 76/9 79/14 80/3 80/13 81/15 ascertain [2] 56/18 57/5 ascertained [1] 57/22 aside [1] 66/11 ask [20] 10/6 21/12 25/8 26/19 27/1 28/9 28/20 29/19 34/11 34/11 39/13 43/7 47/18 54/7 55/23 71/7 73/9 74/4 74/15 75/25 asked [8] 5/20 52/24 53/1 53/7 53/9 53/10 53/13 74/17 asking [6] 19/13 37/21 38/3 40/9 58/13 59/22 asks [1] 56/2 aspect [1] 6/21 aspects [4] 8/16 8/21 22/23 81/4 assault [1] 49/23 assaulting [1] 18/10 assess [1] 46/24 assessed [2] 21/19 50/4 assessing [2] 16/14 61/16 assessment [33] 17/20 19/8 19/19 20/3 42/12 43/5 43/15 43/20 43/22 43/23 44/3 44/8 44/9 44/21 47/1 50/19 57/13 62/14 62/18 63/8 63/14 63/21 64/17 64/24 68/1 68/7 68/14 69/17 69/24 69/25 79/11 80/6 80/17 assessments [6] 61/12 67/22 77/19 77/22 79/14 80/11 assist [7] 2/19 6/1 25/14 42/22 43/20 46/10 60/11 assistance [1] 3/20 assisted [2] 29/6 53/3 associated [3] 44/24 76/7 76/22 assume [1] 67/4 at [117] at page 14 [1] 31/8 attack [6] 15/17 15/18 15/20 16/12 37/3 37/4 attacked [1] 36/6 attacks [1] 57/1 attain [1] 80/5 attempted [2] 17/12 27/8 attempting [1] 43/2</p>	<p>attendance [2] 25/16 25/21 attended [6] 36/24 53/2 57/12 57/17 58/10 59/2 attending [2] 40/3 59/2 attention [4] 22/8 49/9 63/19 72/14 Attorney [1] 31/1 attracted [2] 45/16 68/12 attractive [1] 68/22 auditory [2] 55/10 76/6 August [1] 29/1 authorities [3] 13/1 51/24 52/18 authority [1] 75/16 avail [1] 9/18 availability [1] 69/13 available [5] 3/20 4/11 44/4 44/5 48/7 avoid [1] 16/17 avoiding [1] 17/25 aware [23] 5/8 5/11 6/14 11/16 13/12 27/13 27/16 27/17 27/24 28/2 28/4 28/24 29/2 29/4 35/15 37/10 37/10 37/12 37/17 46/17 58/7 69/5 74/12 awareness [1] 7/8 away [2] 7/17 79/3 awful [1] 34/17</p> <hr/> <p>B</p> <p>back [6] 16/2 18/3 54/23 58/20 72/24 80/8 background [1] 41/25 bad [1] 79/23 bag [1] 16/19 balance [6] 23/15 48/14 48/20 48/21 60/13 72/4 balanced [2] 4/15 5/3 based [4] 18/16 48/6 61/15 68/9 basis [5] 3/15 9/21 21/8 48/4 75/20 battle [1] 63/11 Baxter [5] 2/12 3/3 5/22 7/15 13/11 be [156] bear [1] 54/8 became [3] 28/2 28/4 56/9 because [53] 2/8 3/12 3/14 11/14 19/5 19/11 23/13 24/2 27/22 28/9 33/4 33/6 35/17 36/15 37/8 37/8 37/24 39/13 39/20 45/16 46/18 47/21</p>	<p>52/19 53/16 54/2 54/25 55/7 55/17 57/16 57/21 59/10 59/19 61/2 62/21 66/3 67/22 70/17 71/14 73/9 74/4 75/3 75/6 75/13 77/5 77/22 78/14 78/21 78/22 79/4 79/19 79/20 81/2 81/8 become [3] 44/18 46/18 78/24 Beddoe [6] 12/13 14/3 17/6 19/6 22/9 22/13 Beddoe's [1] 17/18 beds [4] 67/18 69/14 69/14 69/15 been [47] 1/25 3/5 3/13 4/8 4/13 5/2 11/6 16/12 18/1 19/3 19/16 20/5 23/22 24/19 27/16 28/17 29/4 29/14 32/10 32/22 34/21 35/13 35/21 37/4 37/9 37/10 38/2 38/14 38/15 42/2 48/1 49/17 50/13 50/17 50/25 53/1 53/7 57/13 58/2 58/7 66/1 68/17 69/10 71/19 74/5 74/17 81/23 before [14] 11/8 14/10 21/6 26/5 30/11 32/16 33/7 33/9 35/22 37/16 54/22 55/22 62/17 63/3 begin [1] 4/3 beginning [3] 10/3 42/7 51/18 begins [1] 14/4 behaviour [4] 6/8 8/21 51/16 65/12 behaviours [2] 8/10 58/1 being [23] 7/5 7/11 8/11 14/17 15/4 28/6 34/7 44/22 45/15 49/21 49/23 55/1 57/8 58/19 64/6 65/9 66/8 68/3 69/25 71/12 71/12 79/6 80/25 belief [2] 1/16 41/20 believe [2] 12/17 24/16 believes [1] 77/21 bell [1] 53/10 below [3] 10/25 13/21 21/24 bereaved [4] 7/25 27/5 27/10 27/14 bereavement [1] 39/21 bespoke [2] 68/14 80/6 best [6] 1/15 41/19</p>	<p>60/10 63/6 64/23 64/25 best-case [1] 63/6 better [9] 54/17 63/15 64/1 67/15 71/1 72/9 74/21 75/12 75/13 Better-quality [1] 71/1 between [13] 3/12 7/6 7/7 25/17 40/6 43/19 43/21 52/23 60/13 67/7 71/15 74/9 78/25 BFS [1] 27/17 BFS/1 [1] 27/17 biggest [1] 31/22 Birkett [18] 25/18 25/22 26/2 26/10 26/12 26/16 28/24 29/7 29/8 33/8 33/19 35/5 35/8 35/24 36/2 36/15 38/13 38/21 Birkett's [1] 34/13 Birmingham [1] 43/1 bit [5] 38/9 50/23 54/8 55/4 58/5 Blackfriars [1] 15/10 Blackwood [5] 4/13 5/21 6/14 18/20 19/12 Blackwood's [3] 8/8 12/10 23/9 Blake [9] 1/5 1/8 41/8 41/12 41/14 72/25 74/17 83/4 83/8 blow [1] 76/3 blown [1] 55/3 blurring [1] 71/17 board [3] 35/6 64/5 65/7 bodies [1] 71/19 body [3] 53/2 70/21 70/21 body-worn [1] 53/2 both [7] 9/4 12/5 22/11 50/7 55/11 55/15 81/9 bottom [8] 4/4 12/23 14/13 15/22 15/25 51/8 56/16 57/3 bought [1] 18/2 boundaries [1] 71/18 boundary [1] 72/8 box [2] 56/2 62/20 boys [1] 34/6 brain [1] 35/9 branches [1] 42/25 break [11] 2/5 11/3 11/21 13/7 16/20 22/17 40/22 40/24 40/25 41/5 82/10 Brennan [1] 21/10 brief [1] 16/11 briefly [5] 31/6 35/16 42/11 61/22 72/24 bring [5] 8/3 8/24</p>
--	--	---	--	---

<p>B</p> <p>bring... [3] 12/11 24/3 49/2</p> <p>British [1] 56/8</p> <p>broader [1] 15/12</p> <p>broken [1] 64/23</p> <p>broker [1] 52/22</p> <p>brother [8] 6/8 6/22 7/1 10/10 10/15 11/15 15/3 16/3</p> <p>brothers [3] 26/3 31/17 34/6</p> <p>building [4] 16/10 18/1 32/21 73/16</p> <p>bullet [1] 64/2</p> <p>bumps [1] 7/10</p> <p>burden [4] 20/9 20/12 20/15 20/18</p> <p>Busby [3] 43/11 47/4 49/7</p> <p>Busby-McVey [2] 43/11 49/7</p> <p>Busby-McVey's [1] 47/4</p> <p>busy [3] 31/25 32/11 34/2</p> <p>but [101]</p> <p>button [1] 47/12</p> <p>buzzer [1] 49/12</p>	<p>candidates [1] 74/7</p> <p>cannot [1] 62/4</p> <p>capable [7] 18/4 21/22 23/18 36/12 50/10 79/19 80/10</p> <p>capacity [7] 14/7 14/18 14/21 15/11 15/12 15/20 16/16</p> <p>care [7] 18/4 46/19 64/4 64/9 70/16 82/6 82/6</p> <p>career [2] 1/18 1/19</p> <p>carefully [2] 47/13 81/3</p> <p>Carey [1] 39/5</p> <p>carried [1] 48/4</p> <p>carry [3] 11/13 11/21 46/5</p> <p>Cartwright [11] 26/19 26/22 26/23 31/3 32/4 33/3 72/20 72/21 72/22 83/5 83/9</p> <p>case [42] 1/23 2/22 3/17 5/8 6/19 8/15 8/16 10/5 12/15 20/13 21/5 22/20 24/7 24/21 26/6 32/16 33/25 35/22 36/21 38/7 48/4 48/4 49/3 50/3 51/2 51/10 51/12 51/17 52/2 52/14 53/6 54/25 58/2 59/22 63/4 63/6 75/8 75/19 75/20 78/9 81/4 81/22</p> <p>cases [9] 42/17 46/10 48/5 69/3 70/5 70/5 75/2 79/24 79/25</p> <p>category [1] 76/15</p> <p>cause [1] 47/20</p> <p>caused [1] 5/6</p> <p>causing [2] 50/25 75/15</p> <p>CCS [1] 42/21</p> <p>CCTV [3] 11/4 16/14 16/21</p> <p>centre [5] 11/10 15/18 15/21 42/12 44/21</p> <p>centres [1] 48/24</p> <p>centuries [1] 58/20</p> <p>certain [4] 50/11 51/1 51/22 63/13</p> <p>certainly [6] 2/23 23/21 28/23 51/2 78/7 81/6</p> <p>certainty [1] 17/11</p> <p>cetera [7] 5/12 34/1 35/15 36/14 54/19 58/8 82/7</p> <p>chain [1] 39/16</p> <p>chair [11] 1/3 25/16 37/24 39/12 39/18 40/18 41/9 74/14 82/10 83/6 83/10</p> <p>challenging [2] 4/20 82/2</p>	<p>change [2] 30/2 62/10</p> <p>changing [1] 4/19</p> <p>characterised [1] 55/11</p> <p>charged [1] 3/6</p> <p>charges [1] 29/15</p> <p>charity [1] 42/14</p> <p>chasing [1] 40/14</p> <p>check [7] 26/4 31/3 35/19 48/3 49/8 49/16 49/17</p> <p>checked [2] 26/12 26/15</p> <p>checks [1] 47/25</p> <p>Chief [9] 2/14 2/17 5/22 7/15 24/12 24/13 24/20 25/6 25/6</p> <p>circle [1] 80/14</p> <p>circumstances [16] 21/14 21/18 21/20 21/21 21/25 22/15 23/5 23/13 23/17 24/6 33/23 39/22 52/17 63/13 70/16 81/16</p> <p>city [3] 11/10 15/18 15/21</p> <p>claim [3] 55/25 57/13 57/15</p> <p>cleanly [1] 54/15</p> <p>clear [6] 3/15 23/23 45/12 53/4 55/15 57/22</p> <p>cleared [1] 14/15</p> <p>clearly [2] 11/4 72/9</p> <p>clinical [2] 42/23 62/12</p> <p>closed [2] 51/10 51/12</p> <p>CMHT [1] 47/16</p> <p>Coates [8] 16/23 25/19 26/8 26/9 31/18 33/19 34/6 35/24</p> <p>Code [6] 24/1 29/20 29/23 31/4 38/6 38/20</p> <p>coerce [2] 56/19 57/6</p> <p>cognitive [2] 35/9 36/7</p> <p>colleagues [1] 80/10</p> <p>College [1] 78/2</p> <p>combination [1] 12/5</p> <p>come [13] 9/5 9/14 15/7 20/21 20/23 40/4 40/19 66/11 70/4 73/22 76/1 79/23 80/3</p> <p>comes [3] 29/17 59/16 71/25</p> <p>coming [2] 12/21 49/9</p> <p>command [5] 55/20 76/6 76/8 76/19 76/24</p> <p>comment [2] 19/14 37/9</p> <p>comments [1] 55/19</p> <p>commit [6] 56/19 57/6 57/8 62/6 67/12</p>	<p>76/6</p> <p>commitment [1] 65/20</p> <p>committed [4] 10/9 55/17 56/21 57/1</p> <p>committing [1] 59/25</p> <p>common [1] 81/1</p> <p>comms [1] 29/12</p> <p>communicate [1] 46/23</p> <p>communicating [1] 52/21</p> <p>communication [2] 40/6 56/14</p> <p>community [7] 46/22 52/16 66/4 66/5 81/12 81/13 81/17</p> <p>compared [1] 45/17</p> <p>compilation [1] 16/21</p> <p>complain [2] 59/13 61/10</p> <p>complainant [3] 56/5 56/18 57/5</p> <p>complaint [4] 59/11 60/14 61/4 61/4</p> <p>complete [2] 64/17 80/14</p> <p>completed [3] 24/23 27/18 50/17</p> <p>completely [1] 38/23</p> <p>completeness [1] 59/3</p> <p>completing [2] 64/13 65/3</p> <p>Complex [3] 1/23 2/22 24/21</p> <p>compliance [1] 65/14</p> <p>comprehensive [1] 65/17</p> <p>Computer [1] 49/15</p> <p>concentrate [2] 68/10 79/25</p> <p>concentrating [1] 81/4</p> <p>concern [24] 6/24 11/11 17/4 43/3 43/3 46/6 48/7 48/11 59/1 60/25 61/9 63/25 64/6 64/11 65/12 66/25 68/18 73/25 74/8 74/11 78/4 78/4 80/3 80/5</p> <p>concerned [7] 6/5 25/3 47/17 48/6 60/22 65/10 80/2</p> <p>concerning [6] 10/5 51/16 57/25 58/1 60/19 75/10</p> <p>concerns [17] 6/17 6/20 6/25 7/16 10/7 11/22 12/2 13/12 13/13 14/3 16/24 22/11 23/13 23/22 46/23 57/23 59/17</p> <p>concluded [1] 9/13</p>	<p>conclusion [9] 9/21 11/24 17/7 17/8 17/18 20/7 20/21 20/24 21/24</p> <p>conclusions [1] 5/9</p> <p>condition [3] 9/22 17/10 23/11</p> <p>conditionally [1] 66/10</p> <p>conditions [1] 75/5</p> <p>conducted [1] 56/8</p> <p>conducting [1] 80/11</p> <p>conference [2] 24/19 25/21</p> <p>confidentiality [1] 48/19</p> <p>confined [2] 45/2 70/18</p> <p>confirm [2] 1/15 41/19</p> <p>confirmed [1] 47/6</p> <p>congregate [1] 48/23</p> <p>conscious [2] 33/2 34/16</p> <p>consequence [1] 56/12</p> <p>consider [4] 3/10 21/14 63/16 70/10</p> <p>consideration [2] 6/7 12/9</p> <p>considered [1] 17/20</p> <p>considering [1] 19/1</p> <p>considers [1] 13/2</p> <p>consist [1] 55/13</p> <p>consisted [1] 2/25</p> <p>Constable [1] 46/4</p> <p>constant [1] 56/13</p> <p>constrained [2] 66/12 80/12</p> <p>construct [2] 64/18 75/12</p> <p>Consultancy [1] 42/23</p> <p>consultant [5] 41/22 42/2 42/8 69/3 69/8</p> <p>contact [3] 60/25 71/7 75/3</p> <p>contacted [1] 59/9</p> <p>contacts [1] 14/19</p> <p>contained [3] 22/16 31/4 44/6</p> <p>contemplated [1] 70/1</p> <p>contents [2] 8/8 8/22</p> <p>contest [1] 21/5</p> <p>context [6] 31/7 31/15 33/1 38/1 78/1 79/2</p> <p>continue [1] 16/10</p> <p>continued [1] 53/24</p> <p>continues [2] 11/19 56/16</p> <p>continuing [1] 66/7</p> <p>contradict [1] 23/24</p> <p>contributed [1] 9/24</p> <p>control [10] 5/15</p>
--	---	---	--	---

<p>C</p> <p>control... [9] 8/11 8/17 10/1 12/1 15/16 15/17 17/22 58/20 76/19</p> <p>control' [1] 17/14</p> <p>controversial [1] 67/19</p> <p>conversation [12] 7/11 8/6 8/18 8/19 8/20 9/4 10/11 10/19 14/25 16/3 16/11 53/14</p> <p>conversations [3] 6/15 7/3 8/13</p> <p>conviction [3] 24/5 30/11 50/13</p> <p>copied [2] 3/18 8/11</p> <p>core [3] 67/22 72/18 73/22</p> <p>correct [21] 1/12 1/14 2/2 2/11 2/18 5/24 12/7 12/19 12/20 18/13 28/6 31/2 41/24 42/4 42/10 44/15 45/4 46/7 53/23 58/13 73/7</p> <p>correctly [1] 29/14</p> <p>correspondence [1] 73/23</p> <p>costed [1] 72/2</p> <p>could [33] 5/17 8/3 9/18 12/11 13/15 13/21 19/2 19/16 19/22 20/7 22/4 24/17 27/1 36/2 49/5 53/7 53/8 55/3 55/6 56/1 56/3 61/23 64/3 68/8 68/10 69/10 69/21 70/15 71/7 71/23 71/25 74/20 77/10</p> <p>couldn't [4] 11/24 28/7 30/1 37/9</p> <p>counsel [7] 24/20 24/20 25/23 26/7 26/18 32/19 35/23</p> <p>Counterterrorism [1] 42/23</p> <p>countries [1] 81/22</p> <p>country [3] 10/14 69/13 70/23</p> <p>counts [1] 9/19</p> <p>couple [1] 54/18</p> <p>course [8] 10/11 51/13 57/17 59/10 60/17 78/1 78/1 79/23</p> <p>court [10] 26/13 28/6 30/8 30/17 31/24 31/25 32/11 32/25 36/6 37/11</p> <p>courtroom [1] 34/3</p> <p>covered [1] 62/3</p> <p>covert [1] 56/7</p> <p>CPS [11] 1/20 1/23 20/24 27/22 30/3 30/10 38/5 38/5 38/17</p>	<p>40/6 40/14</p> <p>CPS's [1] 28/9</p> <p>CPSE0000009 [1] 19/20</p> <p>CPSE0000153 [1] 8/24</p> <p>CPSE0000214 [2] 25/20 35/17</p> <p>CPSE0004789 [1] 4/3</p> <p>CPSE0007612 [2] 27/1 27/2</p> <p>CPSE0008370 [1] 5/17</p> <p>credible [3] 60/16 60/17 60/18</p> <p>crimes [1] 55/16</p> <p>criminal [9] 49/21 49/22 56/20 57/7 57/8</p> <p>criteria [1] 70/20</p> <p>criticisms [1] 63/20</p> <p>crossover [1] 71/14</p> <p>Crown [19] 1/22 2/3 2/14 2/17 5/22 7/13 7/14 7/15 8/8 9/11 10/4 20/20 21/5 24/1 24/12 24/13 24/20 25/6 25/6</p> <p>Crown's [1] 11/22</p> <p>crucial [2] 76/25 78/22</p> <p>curious [1] 7/22</p> <p>current [1] 40/1</p> <p>currently [4] 1/22 39/16 50/16 74/21</p> <p>custodial [1] 69/4</p> <p>custody [7] 18/22 68/24 69/4 69/9 69/11 69/22 70/7</p> <p>CVP [1] 37/11</p> <p>cycle [2] 64/23 65/3</p>	<p>deceive [1] 13/1</p> <p>December [2] 12/19 24/24</p> <p>decided [1] 27/19</p> <p>decision [8] 24/10 24/10 24/11 24/22 25/1 30/2 48/3 54/1</p> <p>decisions [1] 71/3</p> <p>declines [1] 18/21</p> <p>deeply [2] 35/3 35/6</p> <p>defence [15] 3/25 4/7 6/18 9/11 9/14 9/18 18/15 19/3 19/17 20/12 20/14 20/16 20/18 21/23 23/19</p> <p>defendant [11] 9/13 9/18 9/21 10/10 11/2 11/7 11/16 11/24 21/6 21/16 30/19</p> <p>defendant's [2] 5/4 9/24</p> <p>define [1] 75/1</p> <p>definition [1] 51/25</p> <p>degree [2] 14/8 53/11</p> <p>delusional [1] 76/20</p> <p>delusions [1] 77/7</p> <p>demonstrated [1] 46/13</p> <p>departments [1] 55/14</p> <p>depend [1] 69/21</p> <p>dependent [1] 39/15</p> <p>depending [1] 52/16</p> <p>depends [1] 75/1</p> <p>depot [3] 66/2 66/7 66/17</p> <p>deputy [7] 2/14 3/3 5/22 7/15 24/12 24/20 25/6</p> <p>Deputy Chief [1] 2/14</p> <p>described [4] 34/5 35/21 40/3 46/8</p> <p>describing [3] 58/17 58/19 59/4</p> <p>description [2] 31/21 73/4</p> <p>descriptions [1] 58/21</p> <p>designed [1] 42/14</p> <p>despite [3] 13/6 23/13 68/14</p> <p>detail [2] 3/8 13/2</p> <p>detained [1] 18/25</p> <p>detection [1] 16/17</p> <p>Detective [2] 46/4 49/6</p> <p>deterioration [3] 65/5 65/13 68/25</p> <p>developing [1] 80/18</p> <p>devolved [1] 56/11</p> <p>diagnosis [1] 62/12</p> <p>did [18] 9/5 9/14 9/17 25/12 27/15 32/2 33/14 34/11 34/11 34/23 36/3 36/14</p>	<p>36/20 37/2 37/6 39/1 39/1 69/16</p> <p>didn't [5] 28/22 29/15 33/7 33/10 57/17</p> <p>difference [3] 7/7 43/21 78/25</p> <p>different [16] 9/1 18/13 32/12 33/9 52/20 52/23 55/14 57/14 61/2 61/11 68/23 69/6 69/7 69/7 69/12 74/18</p> <p>differently [1] 62/19</p> <p>difficult [5] 35/13 39/22 39/24 48/21 59/10</p> <p>difficulties [1] 79/8</p> <p>difficulty [7] 5/13 47/19 47/20 60/12 61/6 70/22 75/15</p> <p>diminished [11] 4/11 7/17 7/24 9/19 10/6 17/15 19/4 19/17 20/4 20/13 20/16</p> <p>direct [2] 33/3 37/20</p> <p>directed [4] 10/21 21/17 56/12 70/18</p> <p>directly [1] 37/21</p> <p>Director [2] 24/14 25/7</p> <p>disabilities [1] 39/24</p> <p>disability [1] 39/2</p> <p>disassociate [1] 15/6</p> <p>discharge [1] 54/22</p> <p>discharged [2] 66/10 81/18</p> <p>disclosed [1] 32/10</p> <p>discovered [1] 58/2</p> <p>discuss [2] 23/3 32/19</p> <p>discussed [2] 7/23 24/19</p> <p>discussing [1] 27/5</p> <p>discussion [1] 78/12</p> <p>discussions [1] 12/3</p> <p>dismiss [1] 59/22</p> <p>dismissed [1] 77/5</p> <p>dismissing [1] 60/14</p> <p>disorder [4] 37/3 44/13 44/16 53/12</p> <p>disordered [7] 58/18 59/4 59/12 59/13 61/4 73/7 77/11</p> <p>disorders [1] 70/6</p> <p>displayed [1] 27/1</p> <p>disproportionate [1] 47/12</p> <p>disputed [1] 19/11</p> <p>distinguish [1] 7/6</p> <p>distinguished [1] 43/19</p> <p>District [5] 1/22 2/3 7/13 7/14 8/7</p> <p>disturb [1] 32/23</p> <p>Diversion [3] 46/9 69/20 69/24</p>	<p>divert [1] 43/2</p> <p>diverted [1] 79/3</p> <p>do [38] 3/10 7/1 7/2 10/15 10/21 12/21 17/16 19/1 19/7 19/15 20/20 21/2 23/4 25/5 28/6 31/12 40/1 44/5 46/1 47/25 48/3 48/22 50/18 51/7 51/23 53/2 55/21 57/15 60/20 62/8 62/13 64/11 64/15 67/5 70/20 79/10 81/16 82/2</p> <p>doctor [1] 54/24</p> <p>doctors [1] 70/3</p> <p>document [5] 20/1 55/22 57/19 57/20 74/5</p> <p>documented [1] 17/9</p> <p>documents [2] 2/14 38/17</p> <p>does [11] 11/11 16/11 16/24 47/19 51/17 58/14 61/22 62/23 65/8 74/3 75/18</p> <p>Does it [1] 65/8</p> <p>doesn't [10] 11/23 28/14 40/8 45/25 48/16 49/24 52/3 52/25 60/8 65/22</p> <p>doing [8] 11/5 16/16 46/17 50/11 55/19 68/19 77/21 80/17</p> <p>domain [1] 43/25</p> <p>domestic [1] 49/25</p> <p>don't [34] 6/25 7/16 7/23 12/17 15/7 18/16 19/12 23/2 23/24 25/10 32/6 36/22 37/7 38/12 40/25 47/6 48/12 48/12 55/9 55/12 55/20 59/21 64/22 66/18 66/23 67/19 68/4 71/6 72/14 72/17 79/16 80/15 80/16 82/4</p> <p>done [12] 10/17 29/5 33/14 50/5 51/4 58/6 59/7 60/24 62/18 64/23 74/21 74/21</p> <p>done' [1] 11/17</p> <p>door [2] 16/13 54/15</p> <p>doorbell [2] 52/25 58/11</p> <p>doses [1] 80/22</p> <p>down [11] 10/2 11/1 20/10 22/17 24/17 26/1 29/19 41/13 53/9 71/25 81/21</p> <p>Dr [16] 4/13 5/9 5/21 6/14 8/8 9/12 9/17 19/12 23/7 23/9 41/9 41/11 41/15 72/23 74/15 83/7</p> <p>Dr Blackwood [4] 4/13 5/21 6/14 19/12</p>
--	---	---	--	--

<p>D</p> <p>Dr Blackwood's [2] 8/8 23/9</p> <p>Dr Farnham [3] 41/15 72/23 74/15</p> <p>Dr Frank [3] 41/9 41/11 83/7</p> <p>Dr McSweeney [2] 5/9 9/17</p> <p>Dr McSweeney's [1] 23/7</p> <p>draft [1] 8/12</p> <p>drafted [2] 6/13 12/10</p> <p>drain [2] 56/19 57/6</p> <p>draw [3] 72/7 72/14 74/23</p> <p>drawn [1] 22/8</p> <p>dressed [2] 54/15 54/19</p> <p>drew [1] 63/19</p> <p>drives [2] 11/5 16/23</p> <p>dropped [1] 46/19</p> <p>drug [1] 80/25</p> <p>DSI [3] 25/25 26/7 29/9</p> <p>due [1] 7/1</p> <p>during [2] 10/11 28/4</p> <p>duty [2] 48/15 48/16</p>	<p>10/25 11/12 27/2 27/4 29/13 29/17 29/17 51/22 52/6</p> <p>emails [1] 6/15</p> <p>embedded [1] 71/21</p> <p>emergence [2] 65/15 77/1</p> <p>emergency [1] 69/16</p> <p>emphasise [1] 78/20</p> <p>emphasised [1] 78/24</p> <p>emphasising [1] 47/23</p> <p>enabling [1] 30/16</p> <p>encompasses [1] 12/2</p> <p>encounter [1] 60/12</p> <p>encourage [1] 46/24</p> <p>encourages [1] 64/20</p> <p>end [4] 28/25 40/19 60/22 60/23</p> <p>endeavour [1] 72/2</p> <p>ends [2] 18/6 79/6</p> <p>enduring [1] 75/5</p> <p>energy [1] 56/12</p> <p>engaged [1] 53/14</p> <p>engagement [1] 47/15</p> <p>engages [1] 47/14</p> <p>engaging [1] 54/16</p> <p>Engineering [1] 14/8</p> <p>enhanced [1] 29/21</p> <p>enlarged [1] 56/3</p> <p>enough [6] 44/17 44/23 53/5 62/17 67/18 82/1</p> <p>enquiries [1] 53/3</p> <p>ensure [3] 6/6 65/9 65/16</p> <p>enter [2] 16/9 16/13</p> <p>entering [1] 11/6</p> <p>entire [1] 19/7</p> <p>entitled [1] 29/21</p> <p>entry [1] 16/18</p> <p>environment [1] 30/18</p> <p>environments [1] 43/17</p> <p>episode [3] 66/21 66/22 75/7</p> <p>episodes [1] 13/6</p> <p>equipment [1] 32/25</p> <p>equipping [1] 30/14</p> <p>especially [1] 67/1</p> <p>essence [1] 5/14</p> <p>essentially [16] 1/19 7/5 18/20 28/14 30/12 31/17 33/18 34/5 34/7 35/17 37/4 46/9 51/10 57/8 71/21 73/6</p> <p>established [3] 3/13 17/9 62/11</p> <p>establishing [2] 7/22 20/12</p> <p>et [7] 5/12 34/1 35/15</p>	<p>36/14 54/19 58/8 82/7</p> <p>et cetera [7] 5/12 34/1 35/15 36/14 54/19 58/8 82/7</p> <p>etc [3] 55/15 78/23 78/23</p> <p>even [11] 20/20 20/23 29/20 48/8 51/2 59/1 59/12 60/10 61/4 69/16 82/1</p> <p>event [2] 3/19 31/8</p> <p>events [1] 11/23</p> <p>everybody [4] 33/24 33/24 63/23 65/24</p> <p>everybody's [1] 63/23</p> <p>everyone [1] 35/18</p> <p>everything [1] 19/14</p> <p>evicted [1] 14/17</p> <p>evidence [28] 2/9 6/19 7/16 10/8 13/3 18/17 19/2 20/17 21/15 21/18 21/21 23/15 23/24 23/25 24/6 25/10 28/2 34/13 40/19 44/13 49/20 50/8 51/15 53/19 54/6 57/15 61/15 73/6</p> <p>evidence-based [1] 61/15</p> <p>evidential [3] 24/3 24/8 25/3</p> <p>exact [1] 79/24</p> <p>Exactly [2] 40/11 81/18</p> <p>example [21] 7/6 7/25 15/13 18/8 23/14 40/8 44/1 45/19 48/8 50/14 52/11 57/18 59/25 60/14 60/20 60/22 66/1 73/11 73/14 75/4 80/1</p> <p>examples [2] 12/24 73/21</p> <p>exceptionally [2] 31/25 32/11</p> <p>exchange [3] 10/12 11/15 27/2</p> <p>exercise [3] 10/1 12/1 17/14</p> <p>exercised [1] 17/22</p> <p>exhaustive [1] 12/8</p> <p>existing [1] 72/12</p> <p>exists [1] 74/9</p> <p>expect [2] 36/19 73/13</p> <p>expensive [2] 72/1 72/3</p> <p>experience [11] 22/19 23/1 32/1 38/24 52/19 60/9 65/5 65/18 69/5 75/14 79/11</p> <p>experienced [1] 22/24</p> <p>expert [2] 18/20 18/24</p>	<p>expertise [2] 60/7 60/8</p> <p>experts [1] 23/23</p> <p>explain [3] 26/18 35/25 53/1</p> <p>explained [2] 35/13 37/16</p> <p>extensive [2] 23/1 23/1</p> <p>extracts [1] 12/22</p> <p>extraordinarily [1] 72/1</p> <p>extreme [1] 45/19</p> <p>extremely [2] 22/24 80/20</p>	<p>41/16</p> <p>February 2023 [1] 36/16</p> <p>feel [3] 3/22 40/9 78/18</p> <p>feeling [1] 73/5</p> <p>felt [3] 33/23 34/16 34/20</p> <p>few [7] 9/8 11/20 14/2 14/6 15/19 56/9 56/15</p> <p>file [1] 35/16</p> <p>filed [1] 55/25</p> <p>filing [1] 57/12</p> <p>final [3] 25/9 64/20 70/13</p> <p>finally [1] 77/14</p> <p>find [6] 48/8 48/9 51/19 64/1 64/7 81/20</p> <p>findings [2] 6/17 21/9</p> <p>fine [1] 10/23</p> <p>first [15] 10/9 11/12 12/23 22/1 22/20 22/24 26/1 27/1 27/21 34/17 36/3 46/18 57/19 57/20 64/17</p> <p>fit [2] 4/10 9/13</p> <p>five [1] 2/25</p> <p>Fixated [1] 44/21</p> <p>fixation [7] 44/14 44/17 44/23 45/22 53/16 53/19 73/15</p> <p>FLO [7] 27/18 27/25 28/8 38/5 40/6 40/8 40/13</p> <p>FLOs [13] 26/9 27/16 27/21 27/23 28/10 29/11 32/23 35/23 36/11 36/20 38/4 39/17 39/19</p> <p>focus [2] 3/25 5/1</p> <p>focusing [2] 43/10 47/1</p> <p>follow [1] 52/6</p> <p>followed [1] 66/5</p> <p>following [7] 10/12 12/24 26/15 30/11 49/8 51/14 65/8</p> <p>follows [3] 8/23 20/8 49/7</p> <p>footage [3] 11/4 16/21 53/2</p> <p>forced [1] 57/8</p> <p>forefront [1] 63/22</p> <p>forensic [28] 19/6 19/7 41/22 42/2 46/4 61/19 63/3 63/18 63/22 66/2 66/5 66/15 68/13 69/1 69/8 69/14 70/1 71/15 78/2 78/7 78/10 78/25 79/3 79/11 79/14 80/4 80/6 81/6</p> <p>form [5] 9/25 11/25 17/13 27/17 28/21</p> <p>formal [5] 6/13 6/16</p>
<p>E</p> <p>E -- you [1] 82/7</p> <p>each [4] 29/12 52/21 55/18 75/17</p> <p>ear [1] 56/13</p> <p>earlier [4] 16/25 18/17 28/22 37/24</p> <p>early [4] 52/4 54/12 62/16 77/6</p> <p>ease [1] 4/19</p> <p>easily [3] 11/23 11/23 55/6</p> <p>East [1] 1/22</p> <p>Easter [1] 2/5</p> <p>easy [3] 48/20 67/13 67/13</p> <p>education [2] 52/18 75/17</p> <p>effectively [2] 3/16 3/17</p> <p>effects [1] 65/24</p> <p>either [1] 40/22</p> <p>Elaine [5] 31/19 33/13 33/19 34/5 37/21</p> <p>element [3] 44/19 44/23 44/24</p> <p>elements [2] 6/7 7/4</p> <p>elevate [1] 64/8</p> <p>Elias [3] 10/10 15/3 15/6</p> <p>else [3] 55/13 69/20 77/11</p> <p>email [16] 4/3 4/4 4/5 5/7 5/18 10/19 10/21</p>	<p>encounter [1] 60/12</p> <p>encourage [1] 46/24</p> <p>encourages [1] 64/20</p> <p>end [4] 28/25 40/19 60/22 60/23</p> <p>endeavour [1] 72/2</p> <p>ends [2] 18/6 79/6</p> <p>enduring [1] 75/5</p> <p>energy [1] 56/12</p> <p>engaged [1] 53/14</p> <p>engagement [1] 47/15</p> <p>engages [1] 47/14</p> <p>engaging [1] 54/16</p> <p>Engineering [1] 14/8</p> <p>enhanced [1] 29/21</p> <p>enlarged [1] 56/3</p> <p>enough [6] 44/17 44/23 53/5 62/17 67/18 82/1</p> <p>enquiries [1] 53/3</p> <p>ensure [3] 6/6 65/9 65/16</p> <p>enter [2] 16/9 16/13</p> <p>entering [1] 11/6</p> <p>entire [1] 19/7</p> <p>entitled [1] 29/21</p> <p>entry [1] 16/18</p> <p>environment [1] 30/18</p> <p>environments [1] 43/17</p> <p>episode [3] 66/21 66/22 75/7</p> <p>episodes [1] 13/6</p> <p>equipment [1] 32/25</p> <p>equipping [1] 30/14</p> <p>especially [1] 67/1</p> <p>essence [1] 5/14</p> <p>essentially [16] 1/19 7/5 18/20 28/14 30/12 31/17 33/18 34/5 34/7 35/17 37/4 46/9 51/10 57/8 71/21 73/6</p> <p>established [3] 3/13 17/9 62/11</p> <p>establishing [2] 7/22 20/12</p> <p>et [7] 5/12 34/1 35/15</p>	<p>example [21] 7/6 7/25 15/13 18/8 23/14 40/8 44/1 45/19 48/8 50/14 52/11 57/18 59/25 60/14 60/20 60/22 66/1 73/11 73/14 75/4 80/1</p> <p>examples [2] 12/24 73/21</p> <p>exceptionally [2] 31/25 32/11</p> <p>exchange [3] 10/12 11/15 27/2</p> <p>exercise [3] 10/1 12/1 17/14</p> <p>exercised [1] 17/22</p> <p>exhaustive [1] 12/8</p> <p>existing [1] 72/12</p> <p>exists [1] 74/9</p> <p>expect [2] 36/19 73/13</p> <p>expensive [2] 72/1 72/3</p> <p>experience [11] 22/19 23/1 32/1 38/24 52/19 60/9 65/5 65/18 69/5 75/14 79/11</p> <p>experienced [1] 22/24</p> <p>expert [2] 18/20 18/24</p>	<p>fact [12] 10/8 17/22 24/18 25/25 26/1 34/13 34/14 40/24 42/5 49/22 73/3 76/13</p> <p>factor [5] 50/12 50/12 62/23 65/11 65/16</p> <p>factoring [1] 73/18</p> <p>factors [11] 12/8 61/25 62/7 62/9 62/12 62/14 63/2 64/8 76/10 76/13 76/18</p> <p>facts [4] 5/8 23/4 24/6 63/18</p> <p>factual [1] 6/7</p> <p>Faculty [1] 78/2</p> <p>failed [1] 16/17</p> <p>failing [2] 38/4 38/19</p> <p>fair [1] 7/12</p> <p>fall [1] 76/14</p> <p>falls [2] 20/15 20/18</p> <p>familiarisation [1] 30/8</p> <p>families [7] 7/25 32/2 32/21 33/5 33/6 33/25 34/1</p> <p>family [15] 10/14 11/17 25/19 26/9 26/13 27/5 27/11 27/14 29/12 31/18 33/20 35/14 35/24 36/15 45/6</p> <p>far [2] 56/17 57/4</p> <p>Farnham [6] 41/10 41/11 41/15 72/23 74/15 83/7</p> <p>fast [1] 43/23</p> <p>fast-paced [1] 43/23</p> <p>faults [1] 68/15</p> <p>favourable [1] 21/15</p> <p>Fazel [1] 68/12</p> <p>featured [2] 50/2 50/15</p> <p>features [1] 18/7</p> <p>February [2] 36/16</p>	<p>February 2023 [1] 36/16</p> <p>feel [3] 3/22 40/9 78/18</p> <p>feeling [1] 73/5</p> <p>felt [3] 33/23 34/16 34/20</p> <p>few [7] 9/8 11/20 14/2 14/6 15/19 56/9 56/15</p> <p>file [1] 35/16</p> <p>filed [1] 55/25</p> <p>filing [1] 57/12</p> <p>final [3] 25/9 64/20 70/13</p> <p>finally [1] 77/14</p> <p>find [6] 48/8 48/9 51/19 64/1 64/7 81/20</p> <p>findings [2] 6/17 21/9</p> <p>fine [1] 10/23</p> <p>first [15] 10/9 11/12 12/23 22/1 22/20 22/24 26/1 27/1 27/21 34/17 36/3 46/18 57/19 57/20 64/17</p> <p>fit [2] 4/10 9/13</p> <p>five [1] 2/25</p> <p>Fixated [1] 44/21</p> <p>fixation [7] 44/14 44/17 44/23 45/22 53/16 53/19 73/15</p> <p>FLO [7] 27/18 27/25 28/8 38/5 40/6 40/8 40/13</p> <p>FLOs [13] 26/9 27/16 27/21 27/23 28/10 29/11 32/23 35/23 36/11 36/20 38/4 39/17 39/19</p> <p>focus [2] 3/25 5/1</p> <p>focusing [2] 43/10 47/1</p> <p>follow [1] 52/6</p> <p>followed [1] 66/5</p> <p>following [7] 10/12 12/24 26/15 30/11 49/8 51/14 65/8</p> <p>follows [3] 8/23 20/8 49/7</p> <p>footage [3] 11/4 16/21 53/2</p> <p>forced [1] 57/8</p> <p>forefront [1] 63/22</p> <p>forensic [28] 19/6 19/7 41/22 42/2 46/4 61/19 63/3 63/18 63/22 66/2 66/5 66/15 68/13 69/1 69/8 69/14 70/1 71/15 78/2 78/7 78/10 78/25 79/3 79/11 79/14 80/4 80/6 81/6</p> <p>form [5] 9/25 11/25 17/13 27/17 28/21</p> <p>formal [5] 6/13 6/16</p>

<p>F</p> <p>formal... [3] 69/25 73/20 74/2</p> <p>formalised [1] 75/20</p> <p>formulate [1] 57/23</p> <p>formulated [1] 64/25</p> <p>formulation [2] 63/1 63/5</p> <p>forward [3] 46/25 62/15 67/5</p> <p>foundation [3] 41/23 42/19 43/8</p> <p>founding [1] 42/6</p> <p>four [1] 76/18</p> <p>frame [1] 36/8</p> <p>frank [4] 41/9 41/11 67/20 83/7</p> <p>frankly [1] 81/24</p> <p>fraught [1] 70/22</p> <p>freer [1] 69/13</p> <p>Friday [1] 29/11</p> <p>front [3] 1/9 41/15 51/13</p> <p>frustrating [1] 80/20</p> <p>FTAC [32] 42/2 42/6 43/10 43/15 44/12 44/18 46/8 47/6 48/2 48/10 49/1 49/8 50/20 52/5 52/5 52/6 52/22 57/13 57/21 57/24 58/3 59/9 60/21 70/14 70/17 73/10 73/17 73/19 73/22 74/10 74/19 77/6</p> <p>FTAC's [2] 48/14 75/14</p> <p>fulfilled [1] 53/18</p> <p>full [2] 18/16 47/10</p> <p>fuller [1] 53/14</p> <p>fully [1] 30/16</p> <p>functioning [1] 17/12</p> <p>further [11] 3/20 9/2 9/3 29/13 30/10 48/3 50/19 58/10 72/13 72/15 82/8</p> <p>future [4] 44/7 44/9 44/9 50/13</p>	<p>getting [2] 63/15 72/6</p> <p>give [5] 14/2 31/7 31/15 55/20 61/23</p> <p>given [4] 11/15 32/22 33/23 70/5</p> <p>giving [2] 30/14 60/15</p> <p>glasses [1] 18/11</p> <p>go [20] 13/15 14/1 15/13 28/13 32/14 32/18 36/5 37/18 47/24 54/9 56/15 58/20 62/5 64/10 66/4 66/15 67/11 73/2 78/7 80/8</p> <p>goes [1] 15/9</p> <p>going [24] 2/4 2/12 3/16 7/8 9/7 10/15 13/15 15/23 18/11 30/16 30/19 30/20 35/5 37/23 39/24 49/2 54/7 54/8 55/22 60/19 62/5 62/15 64/10 68/12</p> <p>gone [4] 38/6 38/8 38/9 38/10</p> <p>good [9] 1/3 26/24 26/25 63/8 64/4 64/9 72/23 79/22 80/11</p> <p>good-quality [2] 64/9 80/11</p> <p>got [10] 15/15 26/14 58/24 68/8 73/15 78/22 80/19 82/3 82/3 82/8</p> <p>government [3] 45/7 73/16 73/16</p> <p>GP [6] 46/21 48/9 52/16 66/16 82/4 82/5</p> <p>GP's [1] 48/8</p> <p>graduate [1] 14/8</p> <p>graduates [1] 13/8</p> <p>greater [5] 52/10 52/13 60/9 70/8 79/10</p> <p>grievances [1] 43/18</p> <p>grieving [2] 34/24 35/3</p> <p>grounds [1] 20/4</p> <p>group [17] 7/19 42/7 45/15 45/15 45/18 45/19 55/12 55/18 62/1 62/6 64/5 64/7 64/10 67/9 75/10 75/11 80/2</p> <p>grown [1] 45/9</p>	<p>28/25 29/4 32/21 32/22 33/18 34/12 34/17 34/21 35/8 35/8 35/13 37/2 37/13 37/14 37/15 38/13 50/2 50/13 50/16 51/14 57/11 57/15 57/17 58/2 59/2 74/5 77/5</p> <p>had a [1] 26/4</p> <p>hadn't [2] 37/13 50/17</p> <p>half [2] 8/5 63/11</p> <p>hallucinations [5] 55/10 76/6 76/8 76/20 76/24</p> <p>hand [4] 3/19 3/23 78/7 78/7</p> <p>happen [5] 30/17 34/18 67/4 74/3 75/19</p> <p>happened [3] 4/20 33/18 56/2</p> <p>happening [1] 77/9</p> <p>happens [8] 15/7 44/21 47/14 52/19 65/25 66/14 66/15 75/19</p> <p>harass [2] 56/18 57/5</p> <p>harassment [2] 56/11 57/2</p> <p>hard [1] 62/22</p> <p>harm [1] 50/25</p> <p>harming [2] 77/10 77/11</p> <p>harmless [1] 77/7</p> <p>has [42] 1/13 4/7 5/20 6/20 9/13 10/4 14/7 16/11 16/12 17/9 17/22 18/3 18/7 20/24 21/11 22/10 22/25 24/19 37/3 37/24 38/6 44/13 44/18 44/23 45/4 45/9 45/24 46/12 47/24 47/24 48/14 49/14 50/7 50/24 53/10 59/11 59/12 62/25 63/24 65/23 66/1 72/20</p> <p>hasn't [4] 29/14 38/10 49/16 68/17</p> <p>have [118]</p> <p>haven't [5] 6/13 72/2 78/22 82/2 82/3</p> <p>having [7] 10/8 11/5 16/17 49/20 69/2 69/2 82/10</p> <p>HCR [7] 61/15 62/8 62/18 62/25 63/20 64/20 68/14</p> <p>HCR-20 [7] 61/15 62/8 62/18 62/25 63/20 64/20 68/14</p> <p>he [94]</p> <p>he'd [2] 53/13 58/5</p> <p>he's [11] 17/20 18/11 22/25 53/9 53/9 53/14</p>	<p>56/24 58/17 58/18 59/4 60/1</p> <p>head [5] 3/2 3/3 15/4 24/21 39/23</p> <p>health [31] 17/10 18/4 18/21 42/13 42/16 43/6 44/20 46/22 47/7 48/3 51/24 52/9 52/15 52/16 57/21 57/23 59/14 61/2 69/24 69/25 70/15 70/25 71/3 71/12 71/12 73/25 74/20 75/15 76/11 79/5 79/8</p> <p>healthcare [2] 73/13 81/25</p> <p>hear [10] 2/4 13/19 16/22 18/5 54/24 55/8 55/10 61/21 68/12 77/6</p> <p>heard [14] 13/11 18/17 18/19 19/15 22/15 25/10 43/10 46/3 49/20 50/7 51/9 60/15 68/25 70/17</p> <p>heard, [1] 39/20</p> <p>heard, some [1] 39/20</p> <p>hearing [6] 26/11 26/17 35/25 36/24 60/2 82/14</p> <p>heightened [1] 76/7</p> <p>held [2] 25/18 25/22</p> <p>helped [1] 23/10</p> <p>helpful [1] 55/4</p> <p>helps [2] 25/16 62/8</p> <p>hence [1] 29/15</p> <p>her [5] 2/8 25/19 26/2 37/3 37/7</p> <p>here [8] 23/16 23/23 29/9 38/4 49/24 59/1 59/8 76/13</p> <p>herself [1] 36/24</p> <p>hierarchy [1] 2/20</p> <p>high [3] 74/7 76/2 76/14</p> <p>high-risk [2] 76/2 76/14</p> <p>Highbury [1] 54/23</p> <p>higher [4] 7/17 68/11 80/1 80/5</p> <p>highlight [1] 13/21</p> <p>him [21] 15/17 15/19 16/9 18/10 35/13 38/22 54/17 55/2 55/5 55/15 55/19 55/20 55/20 56/19 56/19 56/19 57/6 57/6 57/6 58/8 58/24</p> <p>himself [3] 9/18 18/4 54/17</p> <p>Hirst [12] 5/5 5/6 6/21 10/24 11/3 11/6 12/6 15/24 16/6 16/8 16/15 17/4</p>	<p>Hirst-House [1] 5/5</p> <p>his [57] 2/13 5/11 6/8 6/8 9/17 9/20 9/25 10/10 10/15 11/8 11/15 11/17 13/7 13/18 14/10 14/15 15/3 15/4 15/23 16/1 16/2 16/3 16/23 17/6 17/13 17/20 18/6 18/11 20/3 23/1 24/15 25/22 26/2 26/3 26/12 28/25 29/7 31/17 31/17 33/15 34/6 35/10 35/10 35/14 36/7 36/15 38/2 39/2 54/14 54/22 55/6 55/21 57/13 57/18 57/22 58/15 59/22</p> <p>historical [1] 62/9</p> <p>history [4] 1/18 47/7 50/9 76/24</p> <p>hit [1] 18/11</p> <p>hitting [1] 16/20</p> <p>hm [5] 4/9 4/16 6/3 6/10 27/12</p> <p>homeless [3] 14/18 81/20 81/24</p> <p>homicide [1] 70/5</p> <p>honestly [1] 28/7</p> <p>hospital [4] 28/23 54/23 55/1 66/10</p> <p>hospital' [1] 15/8</p> <p>hostile [1] 56/13</p> <p>hours [1] 5/3</p> <p>house [19] 5/5 5/6 5/10 6/9 6/21 10/24 11/3 11/6 12/6 15/24 16/7 16/8 16/15 17/4 45/6 49/10 52/25 73/11 77/21</p> <p>housebound [1] 37/4</p> <p>how [16] 26/16 32/1 32/22 33/23 35/13 36/2 36/4 36/13 57/14 61/22 62/14 62/15 67/6 74/20 74/20 75/1</p> <p>however [2] 5/3 9/17</p> <p>HR [1] 78/10</p> <p>HR-20 [1] 78/10</p> <p>HR20 [1] 62/9</p> <p>hypothetical [1] 54/7</p>
<p>G</p> <p>gain [1] 16/18</p> <p>galvanise [1] 59/5</p> <p>gap [1] 58/14</p> <p>GBH [6] 49/22 49/23 50/1 50/14 50/18 50/22</p> <p>general [13] 29/20 31/1 35/19 47/15 66/16 67/21 67/23 68/17 79/1 79/12 79/17 80/1 80/10</p> <p>generally [4] 8/15 43/25 45/5 67/16</p> <p>get [8] 15/24 16/6 55/9 60/21 68/4 73/24 80/5 82/5</p>	<p>H</p> <p>had [57] 3/5 3/13 3/22 5/12 5/13 6/24 7/3 7/23 9/2 9/4 11/12 11/16 12/4 13/11 14/14 14/18 14/21 14/25 15/10 15/20 16/25 21/19 21/21 23/8 25/20 26/4 27/16 27/19 27/23 28/8</p>			<p>I</p> <p>I agree [3] 6/16 21/3 40/13</p> <p>I apologise [1] 32/13</p> <p>I appreciate [1] 36/10</p> <p>I are [1] 19/6</p> <p>I ask [4] 27/1 43/7 55/23 74/4</p> <p>I became [1] 28/2</p> <p>I believe [1] 24/16</p> <p>I can [4] 13/23 24/1 33/3 73/20</p> <p>I can't [2] 13/20 51/1</p>

<p>I</p> <p>I checked [2] 26/12 26/15</p> <p>I couldn't [3] 28/7 30/1 37/9</p> <p>I did [2] 25/12 36/14</p> <p>I didn't [1] 33/7</p> <p>I do [6] 7/1 7/2 10/21 12/21 28/6 31/12</p> <p>I don't [14] 6/25 7/16 7/23 18/16 23/2 25/10 32/6 36/22 59/21 67/19 72/14 72/17 79/16 80/16</p> <p>I drew [1] 63/19</p> <p>I feel [1] 78/18</p> <p>I felt [1] 33/23</p> <p>I go [1] 80/8</p> <p>I got [1] 26/14</p> <p>I had [2] 12/4 23/8</p> <p>I have [4] 25/8 32/7 34/12 80/9</p> <p>I haven't [2] 6/13 72/2</p> <p>I hear [1] 55/8</p> <p>I just [5] 23/7 34/1 39/13 72/23 74/15</p> <p>I knew [1] 28/7</p> <p>I know [1] 19/22</p> <p>I may [1] 28/5</p> <p>I mean [25] 36/2 47/9 48/13 48/20 48/20 51/15 51/21 51/25 53/7 53/11 53/13 53/23 54/5 57/20 58/17 59/25 63/24 66/20 68/7 69/9 72/1 72/2 72/10 80/16 80/21</p> <p>I only [1] 28/9</p> <p>I please [2] 1/3 41/9</p> <p>I practised [1] 62/17</p> <p>I read [1] 37/7</p> <p>I reference [1] 36/15</p> <p>I remember [2] 7/10 29/13</p> <p>I represent [1] 27/9</p> <p>I right [1] 44/16</p> <p>I said [2] 55/1 55/5</p> <p>I say [4] 19/5 26/16 54/11 68/11</p> <p>I seem [1] 12/17</p> <p>I speak [1] 10/13</p> <p>I spoke [1] 29/9</p> <p>I stop [1] 32/4</p> <p>I struggled [1] 5/9</p> <p>I suspect [1] 74/6</p> <p>I take [1] 35/6</p> <p>I think [73] 1/25 6/5 8/25 11/13 12/2 12/18 24/2 28/22 29/17 30/24 31/4 34/16 34/20 35/18 35/21 40/2 40/17 42/5 45/12 46/8 48/13 48/14</p>	<p>49/24 50/7 50/21 50/21 50/21 51/4 52/13 53/4 53/23 59/10 59/14 60/16 62/2 64/12 67/3 67/7 67/15 67/16 67/21 68/6 68/11 68/13 68/22 69/6 69/21 69/22 69/23 70/9 70/14 71/1 71/2 71/5 71/10 71/25 72/1 72/7 72/20 73/10 75/1 75/4 75/11 75/19 75/21 77/4 77/13 78/3 78/10 79/15 79/16 80/16 80/18</p> <p>I want [5] 3/25 19/19 27/4 27/22 78/20</p> <p>I was [12] 3/2 3/14 3/18 3/18 5/8 26/17 27/16 27/17 35/15 42/7 43/9 60/24</p> <p>I wasn't [3] 29/2 29/2 37/16</p> <p>I watched [2] 28/2 34/13</p> <p>I work [1] 69/8</p> <p>I would [6] 7/19 31/3 36/10 40/5 70/23 79/17</p> <p>I'd [6] 4/25 10/21 21/12 33/6 33/22 75/11</p> <p>I'll [5] 9/8 10/2 12/22 56/15 61/11</p> <p>I'm [24] 9/7 14/1 15/23 19/13 26/19 32/5 36/16 37/1 37/22 39/7 49/1 49/2 54/7 55/22 58/14 59/21 60/6 60/23 61/23 62/17 68/12 74/12 78/9 79/16</p> <p>I've [10] 22/8 25/16 25/20 26/6 33/14 37/5 37/16 38/14 53/5 82/8</p> <p>Ian [1] 16/23</p> <p>iconic [1] 45/7</p> <p>idea [2] 47/9 77/7</p> <p>ideal [1] 34/10</p> <p>ideally [1] 70/9</p> <p>ideas [1] 58/20</p> <p>identified [3] 64/5 65/4 69/17</p> <p>identify [4] 48/10 55/12 62/6 64/2</p> <p>identifying [1] 18/5</p> <p>idiosyncratic [1] 43/18</p> <p>if [111]</p> <p>ignorance [1] 71/5</p> <p>iii [1] 76/4</p> <p>Ilkeston [1] 56/25</p> <p>Ilkeston Road [1] 56/25</p> <p>ill [10] 44/22 45/21</p>	<p>46/14 48/18 48/23 59/18 74/23 74/24 74/24 74/25</p> <p>illegal [1] 56/21</p> <p>illness [8] 46/15 53/20 58/23 62/12 65/22 66/22 72/5 75/4</p> <p>imagine [1] 72/3</p> <p>immediate [2] 17/25 44/8</p> <p>immediately [3] 59/14 59/21 69/18</p> <p>Impact [1] 32/20</p> <p>impaired [2] 9/25 17/13</p> <p>impairment [2] 35/9 36/7</p> <p>implement [3] 64/21 64/22 65/1</p> <p>importance [1] 50/8</p> <p>important [10] 11/13 48/13 51/12 55/2 55/5 65/16 76/11 77/4 78/11 81/9</p> <p>importantly [1] 24/6</p> <p>impossible [1] 62/4</p> <p>improve [3] 42/14 71/10 75/20</p> <p>improved [3] 67/6 70/11 77/22</p> <p>improvements [2] 63/14 70/24</p> <p>inappropriately [1] 78/24</p> <p>inarguably [1] 76/21</p> <p>incident [2] 15/24 47/22</p> <p>incidents [1] 49/21</p> <p>include [3] 7/19 10/8 65/8</p> <p>included [1] 8/21</p> <p>including [5] 6/8 6/17 27/24 55/14 69/2</p> <p>incongruous [1] 6/7</p> <p>incorporate [1] 70/1</p> <p>increase [2] 62/1 62/7</p> <p>increased [1] 45/4</p> <p>increasingly [2] 45/12 75/8</p> <p>indeed [1] 74/13</p> <p>independent [1] 8/1</p> <p>indicate [1] 5/14</p> <p>indication [1] 14/2</p> <p>indicators [1] 22/4</p> <p>individual [21] 43/4 43/24 44/6 45/23 46/24 48/18 51/14 52/6 52/17 53/23 58/19 59/11 60/16 60/20 62/4 62/5 62/23 65/22 73/7 75/14 77/12</p> <p>individual's [1] 47/11</p> <p>individuals [27] 34/17 34/24 43/2</p>	<p>43/16 44/24 45/2 45/8 45/14 45/16 45/20 49/1 52/20 58/22 64/2 65/11 66/9 66/12 66/15 66/21 67/9 67/11 72/7 72/9 75/2 75/6 81/18 81/23</p> <p>inevitably [1] 68/4</p> <p>information [48] 3/18 14/9 19/11 19/15 22/8 22/9 22/19 30/5 36/8 36/12 36/20 37/1 39/1 39/17 40/14 43/25 44/4 44/5 47/17 47/18 47/19 47/20 48/7 49/15 51/23 51/23 52/9 53/21 57/25 58/5 58/15 59/8 60/4 62/21 67/15 70/25 71/2 71/3 71/7 71/11 72/10 73/15 73/17 74/7 74/8 74/10 75/12 75/18</p> <p>initial [7] 22/1 23/6 23/13 28/21 47/1 47/21 47/22</p> <p>initially [2] 23/21 46/21</p> <p>initiative [3] 40/3 40/4 42/14</p> <p>injection [1] 66/4</p> <p>injured [1] 39/23</p> <p>injuries [1] 39/23</p> <p>injury [1] 35/9</p> <p>inner [1] 56/13</p> <p>inquiries [1] 51/6</p> <p>Inquiry [7] 18/7 22/9 28/4 49/20 50/7 61/21 72/14</p> <p>inquisitive [1] 50/23</p> <p>insane [1] 4/10</p> <p>insanity [1] 9/15</p> <p>insensitive [1] 34/15</p> <p>insensitivity [1] 34/25</p> <p>insight [1] 82/1</p> <p>insights [1] 76/25</p> <p>insist [1] 21/6</p> <p>instance [1] 7/10</p> <p>instinct [1] 22/1</p> <p>instructed [1] 16/12</p> <p>instruction [7] 5/21 6/14 8/9 8/12 8/22 8/23 9/1</p> <p>instructions [2] 9/9 16/4</p> <p>intelligence [1] 56/8</p> <p>intended [1] 33/16</p> <p>intending [1] 29/10</p> <p>interaction [1] 5/12</p> <p>interested [1] 75/11</p> <p>interfering [1] 52/3</p> <p>internet [1] 45/17</p> <p>Intervention [1] 54/12</p> <p>interview [1] 18/9</p> <p>interviewed [1] 18/9</p>	<p>intimidated [1] 40/10</p> <p>into [23] 3/4 3/5 3/18 8/11 11/3 11/21 16/15 36/6 37/11 43/5 55/9 56/11 63/7 66/4 69/9 69/11 70/2 71/11 73/22 76/25 80/14 80/23 81/11</p> <p>introduce [2] 32/16 33/22</p> <p>introduced [1] 26/4</p> <p>introduction [1] 35/18</p> <p>introductions [1] 34/3</p> <p>investigated [2] 50/25 76/9</p> <p>investigation [2] 30/6 50/17</p> <p>investigations [1] 51/4</p> <p>Investigatory [3] 55/25 73/14 74/6</p> <p>inviting [1] 21/8</p> <p>involve [1] 77/10</p> <p>involved [12] 26/11 33/24 36/1 42/19 42/21 43/7 44/18 49/1 70/6 71/19 72/6 75/22</p> <p>involvement [4] 3/11 8/6 8/19 73/19</p> <p>involves [1] 77/9</p> <p>IPT [5] 57/12 57/15 59/7 59/7 59/11</p> <p>IPTR000002 [1] 55/23</p> <p>IPTR000004 [1] 56/24</p> <p>is [216]</p> <p>isn't [7] 17/18 23/14 39/15 40/13 40/14 69/6 75/23</p> <p>isolated [3] 45/10 45/11 51/5</p> <p>issue [7] 7/24 10/5 10/24 32/24 34/25 79/5 79/6</p> <p>issues [7] 15/12 15/12 42/16 43/6 52/2 64/13 72/4</p> <p>it [159]</p> <p>It'll [1] 76/1</p> <p>it's [62] 2/6 2/8 2/23 4/3 4/5 4/13 4/25 10/17 11/13 12/5 16/6 17/18 20/24 21/11 23/2 23/23 27/4 29/9 31/8 32/7 37/21 38/4 38/8 38/9 38/17 38/19 39/15 43/13 45/5 45/15 46/20 48/15 48/21 48/22 48/22 50/11 51/12 51/12 51/12 51/13 54/20 61/7 62/22 63/20 65/1 65/1 65/2 65/2 65/21</p>
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<p>I</p> <p>it's... [13] 65/21 66/3 67/22 67/24 70/22 73/3 77/17 78/11 79/5 79/12 80/20 81/21 81/22</p> <p>its [2] 11/13 68/14</p> <p>itself [4] 53/6 53/11 58/24 70/14</p> <p>Ivan [3] 16/11 16/12 16/13</p>	<p>knife [2] 18/2 18/2</p> <p>know [59] 18/17 18/24 19/12 19/22 25/10 30/16 37/6 44/2 45/17 47/15 48/12 48/12 48/22 49/20 50/21 50/24 51/5 51/18 52/17 52/24 53/24 54/3 54/3 59/3 59/19 59/23 60/6 60/21 62/23 63/9 63/11 63/15 63/19 64/8 65/1 66/3 66/18 67/1 67/9 67/25 68/4 71/4 71/6 71/12 71/14 71/16 72/8 73/21 73/23 75/15 75/16 78/12 78/23 80/17 80/20 80/22 80/24 80/25 82/7</p> <p>knowing [3] 63/9 67/24 80/9</p> <p>knowledge [8] 1/16 11/20 23/2 41/20 59/1 60/9 68/10 68/24</p> <p>known [8] 23/1 28/5 30/3 46/16 46/17 52/20 58/9 61/25</p> <p>knows [1] 75/17</p> <p>Kumar [2] 32/21 33/6</p> <p>Kumars [2] 33/17 33/20</p>	<p>let's [3] 33/8 35/16 65/12</p> <p>letter [9] 5/20 6/13 6/16 8/9 8/22 8/23 11/19 52/5 56/23</p> <p>Letters [1] 9/1</p> <p>level [4] 46/6 48/19 50/19 62/4</p> <p>liaise [2] 46/21 52/15</p> <p>Liaison [3] 46/9 69/19 69/23</p> <p>lie [1] 13/19</p> <p>lies [2] 24/2 47/22</p> <p>life [1] 4/19</p> <p>light [7] 21/20 22/7 22/7 22/11 22/19 38/12 60/1</p> <p>like [17] 5/1 21/12 25/24 40/10 42/25 43/23 45/16 46/1 47/11 50/22 51/13 53/17 62/10 62/10 62/20 68/21 70/23</p> <p>like-minded [1] 45/16</p> <p>liked [1] 36/24</p> <p>likely [4] 50/18 52/11 52/14 63/1</p> <p>limbs [2] 53/17 54/6</p> <p>limit [1] 78/14</p> <p>limited [4] 2/9 8/6 8/20 43/24</p> <p>line [4] 2/3 58/25 72/8 74/23</p> <p>link [1] 70/25</p> <p>linked [1] 73/5</p> <p>linking [1] 70/15</p> <p>list [1] 12/8</p> <p>listened [1] 34/12</p> <p>listened -- in [1] 34/12</p> <p>literature [4] 45/13 58/21 62/1 64/8</p> <p>little [5] 38/9 50/23 54/8 55/3 58/5</p> <p>living [1] 81/15</p> <p>local [10] 52/15 52/18 57/21 57/25 58/3 69/21 69/22 71/6 75/15 75/16</p> <p>location [3] 17/25 49/12 56/25</p> <p>London [6] 41/23 42/25 48/23 58/6 69/14 81/2</p> <p>lone [1] 45/13</p> <p>loner [1] 45/11</p> <p>loners [1] 45/10</p> <p>loners' [1] 43/17</p> <p>long [10] 36/3 36/4 51/19 52/7 53/25 62/17 77/6 77/8 77/22 79/15</p> <p>longer [6] 2/6 24/9 54/24 66/8 66/9 69/2</p> <p>look [11] 4/4 15/25 20/7 27/4 31/6 32/25</p>	<p>35/16 49/5 54/15 75/25 76/3</p> <p>looked [4] 21/21 22/5 23/17 49/6</p> <p>looking [8] 22/20 23/16 28/13 43/1 58/8 67/5 76/2 76/11</p> <p>looks [2] 49/16 54/16</p> <p>Lords [1] 45/6</p> <p>lose [3] 62/21 78/11 81/20</p> <p>losing [1] 75/3</p> <p>loss [1] 35/14</p> <p>lost [2] 34/20 39/20</p> <p>lot [5] 3/8 3/9 39/14 59/16 64/7</p> <p>lots [3] 30/19 52/20 63/17</p> <p>loved [3] 34/18 34/20 35/3</p> <p>low [5] 48/7 48/11 68/9 79/23 80/3</p> <p>low-risk [1] 79/23</p> <p>lunchtime [2] 26/13 32/19</p> <p>lying [1] 18/4</p>	<p>MAPA [2] 72/11 74/18</p> <p>Mapperley [2] 16/1 16/22</p> <p>MARAC [1] 74/19</p> <p>March [1] 1/1</p> <p>markedly [2] 58/17 59/4</p> <p>marker [2] 51/17 51/21</p> <p>massive [2] 46/1 68/2</p> <p>material [2] 18/16 48/2</p> <p>matter [6] 2/7 3/5 3/11 22/21 24/19 60/9</p> <p>matters [2] 21/6 68/24</p> <p>may [36] 5/14 7/16 7/17 7/17 22/4 22/13 22/21 23/22 28/5 50/19 51/15 52/6 52/19 53/19 53/20 55/24 56/9 57/12 59/19 59/19 64/23 64/24 66/14 67/4 69/12 69/13 69/15 73/12 74/7 78/13 78/14 78/16 79/4 82/4 82/5 82/6</p> <p>May 2022 [2] 55/24 56/9</p> <p>McKinney [3] 2/17 3/4 3/4</p> <p>McSweeney [3] 5/9 9/12 9/17</p> <p>McSweeney's [1] 23/7</p> <p>McVey [2] 43/11 49/7</p> <p>McVey's [1] 47/4</p> <p>me [14] 5/11 15/6 15/7 15/16 15/17 19/22 22/17 23/3 23/10 32/16 35/13 54/8 58/13 59/22</p> <p>mean [32] 25/5 36/2 46/11 47/9 48/13 48/20 48/20 51/15 51/21 51/25 53/7 53/11 53/13 53/23 54/5 57/15 57/20 58/17 59/25 62/23 62/24 63/24 64/15 66/20 68/7 69/9 72/1 72/2 72/10 80/16 80/21 81/12</p> <p>meant [1] 3/17</p> <p>Mechanical [1] 14/8</p> <p>medical [13] 9/22 21/15 21/18 23/24 23/25 47/11 49/16 52/7 54/9 54/11 57/18 58/16 72/24</p> <p>medication [14] 65/8 65/9 65/14 65/17 65/23 66/3 66/7 66/12</p>
<p>J</p> <p>Janine [1] 2/17</p> <p>January [4] 25/17 25/17 25/23 37/20</p> <p>jealousy [1] 76/18</p> <p>Johal [4] 27/24 28/1 28/5 36/22</p> <p>Johal's [1] 28/2</p> <p>join [1] 71/20</p> <p>joined [1] 2/24</p> <p>joint [2] 42/12 42/24</p> <p>journey [2] 51/19 64/13</p> <p>judgement [9] 5/15 8/11 8/17 10/1 11/25 17/14 23/2 78/8 78/19</p> <p>July [4] 2/1 2/24 27/18 54/23</p> <p>June [5] 2/23 3/13 3/13 14/20 17/23</p> <p>junior [2] 24/20 32/19</p> <p>jury [8] 19/9 21/7 21/8 21/16 22/5 22/14 22/14 22/22</p> <p>just [43] 8/15 9/7 9/8 10/2 10/9 10/25 12/22 13/21 13/23 14/1 14/1 16/22 19/22 22/17 23/7 24/1 24/10 27/13 27/21 28/20 31/6 31/6 31/7 31/15 33/8 34/1 35/16 38/9 39/13 40/24 45/25 50/16 54/22 56/15 58/21 60/8 64/1 64/4 72/23 74/15 75/25 76/2 77/13</p> <p>justice [3] 79/2 79/6 79/7</p> <p>justify [1] 56/20</p>	<p>L</p> <p>Lamplugh [1] 42/13</p> <p>language [1] 60/22</p> <p>large [6] 47/18 48/22 68/3 68/8 74/25 79/21</p> <p>largely [2] 76/5 79/1</p> <p>larger [2] 70/20 71/23</p> <p>last [4] 10/13 15/5 19/22 36/3</p> <p>lasted [1] 36/4</p> <p>later [4] 11/20 54/9 55/24 56/9</p> <p>lawyer [2] 8/7 26/7</p> <p>lawyers [1] 2/25</p> <p>lead [2] 51/16 63/2</p> <p>leading [1] 24/20</p> <p>learnt [1] 38/14</p> <p>least [6] 19/2 19/16 21/22 22/10 23/18 67/8</p> <p>leave [1] 19/8</p> <p>lecture [1] 61/23</p> <p>led [3] 42/5 44/20 50/19</p> <p>left [6] 15/21 16/13 22/13 22/14 22/21 32/21</p> <p>legal [3] 23/2 24/14 25/7</p> <p>lenient [1] 30/25</p> <p>less [3] 34/10 65/19 65/19</p>	<p>limbs [2] 53/17 54/6</p> <p>limit [1] 78/14</p> <p>limited [4] 2/9 8/6 8/20 43/24</p> <p>line [4] 2/3 58/25 72/8 74/23</p> <p>link [1] 70/25</p> <p>linked [1] 73/5</p> <p>linking [1] 70/15</p> <p>list [1] 12/8</p> <p>listened [1] 34/12</p> <p>listened -- in [1] 34/12</p> <p>literature [4] 45/13 58/21 62/1 64/8</p> <p>little [5] 38/9 50/23 54/8 55/3 58/5</p> <p>living [1] 81/15</p> <p>local [10] 52/15 52/18 57/21 57/25 58/3 69/21 69/22 71/6 75/15 75/16</p> <p>location [3] 17/25 49/12 56/25</p> <p>London [6] 41/23 42/25 48/23 58/6 69/14 81/2</p> <p>lone [1] 45/13</p> <p>loner [1] 45/11</p> <p>loners [1] 45/10</p> <p>loners' [1] 43/17</p> <p>long [10] 36/3 36/4 51/19 52/7 53/25 62/17 77/6 77/8 77/22 79/15</p> <p>longer [6] 2/6 24/9 54/24 66/8 66/9 69/2</p> <p>look [11] 4/4 15/25 20/7 27/4 31/6 32/25</p>	<p>M</p> <p>made [11] 3/15 9/3 15/4 24/9 24/11 25/1 25/4 25/17 37/9 37/10 53/25</p> <p>Magdala [1] 16/23</p> <p>magic [1] 64/2</p> <p>maintain [1] 14/10</p> <p>maintains [1] 13/7</p> <p>major [3] 56/12 65/11 67/1</p> <p>majority [4] 45/20 46/13 46/15 48/24</p> <p>make [17] 11/25 34/3 38/12 39/24 48/14 51/3 51/6 52/2 52/3 54/1 55/19 59/11 59/14 62/14 68/19 77/14 80/4</p> <p>makes [1] 61/3</p> <p>making [2] 16/1 60/16</p> <p>malign [1] 56/13</p> <p>managed [1] 76/9</p> <p>management [7] 43/16 43/20 43/22 46/25 47/23 64/18 80/18</p> <p>manager [1] 2/3</p> <p>managerial [1] 3/16</p> <p>managing [2] 61/16 81/2</p> <p>Manchester [1] 43/1</p> <p>manipulate [1] 13/19</p> <p>Mannion [6] 1/4 1/7 1/9 26/24 39/15 83/3</p> <p>manslaughter [1] 20/4</p> <p>many [1] 55/14</p>	<p>made [11] 3/15 9/3 15/4 24/9 24/11 25/1 25/4 25/17 37/9 37/10 53/25</p> <p>Magdala [1] 16/23</p> <p>magic [1] 64/2</p> <p>maintain [1] 14/10</p> <p>maintains [1] 13/7</p> <p>major [3] 56/12 65/11 67/1</p> <p>majority [4] 45/20 46/13 46/15 48/24</p> <p>make [17] 11/25 34/3 38/12 39/24 48/14 51/3 51/6 52/2 52/3 54/1 55/19 59/11 59/14 62/14 68/19 77/14 80/4</p> <p>makes [1] 61/3</p> <p>making [2] 16/1 60/16</p> <p>malign [1] 56/13</p> <p>managed [1] 76/9</p> <p>management [7] 43/16 43/20 43/22 46/25 47/23 64/18 80/18</p> <p>manager [1] 2/3</p> <p>managerial [1] 3/16</p> <p>managing [2] 61/16 81/2</p> <p>Manchester [1] 43/1</p> <p>manipulate [1] 13/19</p> <p>Mannion [6] 1/4 1/7 1/9 26/24 39/15 83/3</p> <p>manslaughter [1] 20/4</p> <p>many [1] 55/14</p>

<p>M</p> <p>medication... [6] 66/18 66/19 66/23 66/25 67/3 80/22</p> <p>medium [1] 69/14</p> <p>meet [4] 29/8 29/10 30/19 33/16</p> <p>meeting [24] 13/12 25/9 25/13 25/22 26/17 28/14 28/18 28/22 28/25 29/5 29/6 30/2 30/10 34/16 36/4 37/9 37/13 37/14 37/15 37/15 37/22 38/14 38/15 78/3</p> <p>meetings [7] 25/18 29/3 29/16 38/3 38/3 38/20 40/4</p> <p>Melbourne [1] 27/24</p> <p>member [1] 55/18</p> <p>members [1] 45/5</p> <p>memory [1] 35/14</p> <p>men [1] 55/11</p> <p>mental [41] 14/7 14/18 14/21 15/20 16/16 17/9 17/12 18/21 43/6 44/13 44/16 44/20 46/22 47/7 50/11 51/24 52/16 53/12 53/20 57/21 57/22 57/25 58/18 58/23 59/4 62/12 65/13 65/22 66/21 69/24 69/25 70/6 72/5 74/20 75/4 76/11 77/8 77/11 79/5 79/7 81/25</p> <p>mentally [13] 44/22 45/21 46/14 48/18 48/23 53/4 56/19 57/6 59/18 74/22 74/24 74/24 74/25</p> <p>mentioned [6] 14/5 14/6 25/13 26/6 26/13 27/21</p> <p>met [5] 25/25 26/9 33/6 33/8 35/23</p> <p>metal [1] 16/19</p> <p>Metropolitan [2] 42/13 42/18</p> <p>MI5 [6] 53/10 57/11 57/12 58/10 59/2 59/2</p> <p>MI6 [3] 55/14 73/5 73/10</p> <p>mic [2] 39/6 39/8</p> <p>Michelle [3] 1/4 1/7 83/3</p> <p>middle [1] 13/4</p> <p>Midlands [2] 1/23 43/1</p> <p>might [19] 40/24 43/4 50/5 50/10 50/21 51/16 51/18 53/15 53/16 60/17 61/6 63/2 63/12 64/19 65/13</p>	<p>65/15 76/10 78/14 78/24</p> <p>mileage [1] 68/6</p> <p>mind [6] 15/16 15/17 36/8 58/20 63/24 70/20</p> <p>minded [1] 45/16</p> <p>mindful [1] 32/1</p> <p>ministers [1] 45/6</p> <p>minute [2] 14/25 40/25</p> <p>minutes [2] 11/20 38/17</p> <p>misidentification [1] 76/20</p> <p>misinform [2] 56/18 57/5</p> <p>miss [1] 78/16</p> <p>missed [1] 33/22</p> <p>missing [1] 32/5</p> <p>mixed [1] 15/12</p> <p>Mm [5] 4/9 4/16 6/3 6/10 27/12</p> <p>Mm-hm [5] 4/9 4/16 6/3 6/10 27/12</p> <p>model [3] 70/14 70/17 74/19</p> <p>modest [1] 70/24</p> <p>Moloney [1] 39/10</p> <p>moment [2] 17/11 76/1</p> <p>Monday [1] 17/23</p> <p>money [3] 70/11 70/12 71/25</p> <p>month [1] 54/18</p> <p>months [2] 14/6 56/9</p> <p>morbid [1] 76/18</p> <p>more [20] 7/7 30/1 44/4 44/4 47/13 50/18 50/23 51/3 52/11 52/13 53/7 53/8 54/16 58/5 61/2 61/21 63/11 79/13 80/6 80/10</p> <p>morning [3] 25/11 32/22 35/19</p> <p>most [8] 24/6 34/17 36/8 45/21 61/15 65/16 68/1 80/8</p> <p>mostly [3] 47/17 57/24 69/23</p> <p>motorist [1] 11/5</p> <p>move [3] 10/23 27/3 61/11</p> <p>moved [2] 56/5 62/25</p> <p>moves [1] 14/20</p> <p>Moving [2] 68/23 70/13</p> <p>MPs [1] 45/6</p> <p>Mr [47] 1/5 1/8 3/1 3/13 3/19 4/14 4/24 7/19 12/3 18/17 19/20 22/24 24/11 24/15 24/24 25/10 25/18 25/22 26/2 26/7 26/7 26/9 26/10 26/12 26/16 28/24 29/7 29/8</p>	<p>33/19 33/19 34/13 35/5 35/22 35/24 36/2 36/15 37/23 38/13 38/21 39/10 41/8 41/12 41/14 72/25 74/17 83/4 83/8</p> <p>Mr Birkett [16] 25/18 25/22 26/2 26/10 26/12 26/16 28/24 29/7 29/8 33/19 35/5 35/24 36/2 36/15 38/13 38/21</p> <p>Mr Birkett's [1] 34/13</p> <p>MR BLAKE [8] 1/8 41/8 41/12 41/14 72/25 74/17 83/4 83/8</p> <p>Mr Coates [1] 33/19</p> <p>Mr Moloney [1] 39/10</p> <p>Mr Murphy [14] 3/1 3/13 3/19 4/24 7/19 12/3 18/17 19/20 22/24 24/11 24/24 26/7 35/22 37/23</p> <p>Mr Murphy's [3] 4/14 24/15 25/10</p> <p>Mr Newton [1] 26/9</p> <p>Mr Ratliff [1] 26/7</p> <p>Ms [35] 1/9 2/7 3/2 3/3 3/4 3/4 3/12 3/15 3/19 4/18 5/19 6/20 9/3 10/20 10/21 12/3 24/12 25/19 26/1 26/15 26/19 26/22 26/23 26/24 29/13 31/3 32/4 33/3 39/5 39/15 72/20 72/21 72/22 83/5 83/9</p> <p>Ms Carey [1] 39/5</p> <p>Ms Cartwright [11] 26/19 26/22 26/23 31/3 32/4 33/3 72/20 72/21 72/22 83/5 83/9</p> <p>Ms Mannion [3] 1/9 26/24 39/15</p> <p>Ms McKinney [2] 3/4 3/4</p> <p>Ms Newton [3] 25/19 26/1 26/15</p> <p>Ms Shallow [14] 2/7 3/2 3/3 3/12 3/15 3/19 4/18 5/19 6/20 9/3 10/20 12/3 24/12 29/13</p> <p>Ms Shallow's [1] 10/21</p> <p>much [14] 1/18 2/8 28/23 40/5 44/4 44/4 47/13 54/7 54/17 58/3 65/25 72/9 74/13 76/12</p> <p>multi [2] 72/11 72/12</p> <p>multi-agencies [1] 72/11</p> <p>multi-agency [1] 72/12</p> <p>multiagency [1]</p>	<p>74/22</p> <p>multidisciplinary [2] 63/23 81/7</p> <p>multiple [1] 17/24</p> <p>murder [5] 9/19 20/18 21/7 24/8 27/8</p> <p>murders [3] 4/12 17/11 17/12</p> <p>Murphy [18] 2/20 3/1 3/13 3/19 4/7 4/24 6/2 6/11 7/19 12/3 18/17 19/20 22/24 24/11 24/24 26/7 35/22 37/23</p> <p>Murphy's [4] 4/14 21/24 24/15 25/10</p> <p>must [2] 16/9 76/8</p> <p>my [18] 8/6 12/2 23/6 29/17 32/6 32/15 33/20 34/3 48/1 54/5 60/6 60/6 60/23 60/25 63/19 67/17 67/18 76/21</p> <p>myself [2] 32/16 33/22</p>	<p>40/22 49/11 54/20 57/17 71/16 73/2</p> <p>NGPF0000474 [1] 12/12</p> <p>NHFT0000168 [2] 54/10 72/25</p> <p>NHS [2] 41/23 44/22</p> <p>no [37] 2/6 3/24 4/22 19/5 19/10 19/18 21/1 21/14 21/25 23/12 24/9 29/2 33/3 37/1 38/8 38/10 38/12 38/12 38/12 39/5 49/25 51/25 51/25 53/25 54/24 62/21 66/8 66/9 69/2 70/12 72/16 72/19 73/3 74/2 74/12 79/6 82/8</p> <p>nobody [1] 75/17</p> <p>nodded [2] 18/23 22/6</p> <p>nominal [4] 49/2 51/9 51/25 52/9</p> <p>non [2] 65/14 75/20</p> <p>non-compliance [1] 65/14</p> <p>nonetheless [4] 10/3 10/4 59/18 63/21</p> <p>normal [1] 7/9</p> <p>North [1] 41/23</p> <p>North London [1] 41/23</p> <p>not [97]</p> <p>note [4] 24/15 25/21 35/16 37/23</p> <p>noted [1] 29/9</p> <p>notes [1] 25/16</p> <p>notion [2] 45/13 45/24</p> <p>Nottingham [6] 11/10 15/15 17/25 53/9 56/6 56/10</p> <p>November [8] 12/11 12/12 12/18 13/12 19/25 24/16 27/5 54/10</p> <p>November 2020 [1] 54/10</p> <p>now [12] 36/10 37/21 38/14 43/10 49/2 51/10 51/13 55/23 55/24 57/11 60/24 82/10</p> <p>nub [1] 59/20</p> <p>number [11] 12/8 14/23 18/7 22/16 61/25 62/7 67/11 68/8 70/5 74/25 76/4</p> <p>numbers [3] 48/23 68/3 79/21</p> <p>Nurse [1] 46/4</p>
<p>O</p> <p>O'Malley [4] 32/21 33/6 33/17 33/20</p> <p>O'Malley-Kumar [2]</p>				

<p>O</p> <p>O'Malley-Kumar... [2] 32/21 33/6</p> <p>O'Malley-Kumars [2] 33/17 33/20</p> <p>objections [1] 34/12</p> <p>objective [2] 56/17 57/4</p> <p>observed [1] 16/16</p> <p>obtained [1] 24/7</p> <p>obvious [1] 56/9</p> <p>obviously [20] 27/8 28/20 32/24 34/14 45/6 47/9 48/21 50/5 50/14 53/15 65/2 66/24 70/22 73/22 74/4 75/9 81/1 81/5 81/21 82/2</p> <p>occasion [1] 22/21</p> <p>occasionally [1] 73/24</p> <p>occurred [2] 10/12 63/3</p> <p>occurring [1] 63/2</p> <p>occurs [1] 61/3</p> <p>October [6] 1/10 4/7 7/12 8/25 9/11 16/25</p> <p>off [6] 15/23 16/2 18/11 39/6 39/8 75/6</p> <p>offence [2] 27/10 43/5</p> <p>offender's [1] 8/9</p> <p>offer [1] 29/16</p> <p>offers [1] 76/25</p> <p>office [3] 7/3 8/7 8/20</p> <p>officer [4] 12/15 18/10 28/1 35/23</p> <p>officers [4] 15/19 53/2 73/23 73/24</p> <p>often [10] 43/24 52/19 65/25 66/13 66/14 71/2 71/14 71/15 75/14 77/9</p> <p>Oh [3] 8/2 32/8 32/13</p> <p>okay [5] 15/2 16/5 22/23 28/12 31/14</p> <p>ombudsman [1] 59/16</p> <p>ombudsmen [1] 60/12</p> <p>on [130]</p> <p>on-call [1] 69/8</p> <p>Once [1] 20/17</p> <p>one [41] 2/13 2/25 4/24 9/2 9/5 25/8 30/24 32/9 35/24 42/25 42/25 43/1 44/7 47/10 47/14 47/24 47/24 48/14 49/20 50/23 52/3 53/16 53/17 53/25 55/17 58/9 60/17 62/3 62/16 62/20 67/3 69/15 71/16 73/10 74/1 75/1 75/6 76/10 78/15</p>	<p>78/16 79/24</p> <p>ones [9] 34/18 34/20 35/4 68/9 68/11 75/10 80/1 80/3 80/5</p> <p>only [8] 6/20 12/2 27/25 28/9 36/10 51/9 54/25 56/8</p> <p>onto [1] 11/7</p> <p>open [3] 16/13 51/17 62/11</p> <p>opened [1] 51/15</p> <p>opening [2] 27/22 28/10</p> <p>operating [2] 45/14 79/19</p> <p>operative [1] 9/23</p> <p>opine [1] 9/17</p> <p>opinion [2] 9/17 23/8</p> <p>opportunity [5] 23/9 25/2 32/16 33/22 39/10</p> <p>opt [1] 27/19</p> <p>option [1] 67/8</p> <p>or [70] 2/23 3/19 3/20 8/15 9/4 10/1 11/25 17/16 19/6 19/9 19/12 19/13 20/3 22/14 25/7 29/6 36/12 38/5 38/5 39/23 40/9 40/12 40/22 42/16 43/3 43/5 43/18 43/22 44/25 45/13 45/15 45/18 45/22 46/19 46/22 47/19 48/15 48/18 48/25 50/17 51/16 52/5 52/5 52/16 52/17 52/18 52/18 53/24 54/2 54/5 58/1 60/10 60/20 65/19 66/10 66/17 66/19 69/2 69/15 69/20 70/3 70/21 71/24 72/6 73/13 73/16 74/2 79/18 80/22 81/24</p> <p>order [5] 17/24 24/3 44/5 45/1 47/16</p> <p>organisations [2] 74/2 74/18</p> <p>organised [3] 45/18 45/18 45/19</p> <p>original [1] 46/12</p> <p>originally [2] 3/14 33/16</p> <p>other [50] 2/12 3/10 9/5 18/7 21/14 21/17 21/20 21/20 21/25 22/7 22/9 22/12 22/18 22/19 23/3 23/12 23/17 23/24 30/24 45/8 45/8 46/2 46/22 48/24 51/16 52/18 52/21 54/2 54/4 55/8 55/9 55/18 58/4 59/16 62/3 62/13 63/15 68/15 70/11 70/12 70/16 70/21 72/11</p>	<p>73/25 74/1 75/18 76/13 78/15 78/17 80/22</p> <p>others [3] 22/13 27/13 70/2</p> <p>others' [1] 16/10</p> <p>our [6] 6/17 24/13 50/15 52/19 53/17 53/17</p> <p>ourselves [1] 26/4</p> <p>out [29] 1/18 3/8 6/16 9/20 10/14 11/12 11/21 13/2 13/16 16/24 17/6 24/9 25/4 27/9 27/19 41/25 43/13 46/5 46/19 48/4 56/15 68/9 70/15 70/23 71/23 79/22 79/25 80/3 80/3</p> <p>outcomes [3] 77/23 78/6 79/23</p> <p>outlined [1] 48/1</p> <p>outside [1] 18/8</p> <p>over [17] 7/10 9/7 13/4 13/15 14/1 14/16 15/23 16/6 17/6 21/11 27/3 45/4 49/14 53/24 56/1 58/24 69/1</p> <p>overall [1] 65/10</p> <p>override [1] 76/19</p> <p>oversight [1] 3/16</p> <p>overspeaking [2] 59/6 61/24</p> <p>overwhelm [4] 32/2 33/2 33/7 33/10</p> <p>overwhelmed [2] 38/23 67/17</p> <p>own [8] 8/1 18/6 35/10 35/10 44/17 45/14 73/17 74/1</p> <p>OxMiv [1] 68/21</p> <p>OxRisk [1] 68/21</p> <hr/> <p>P</p> <p>paced [2] 43/23 44/3</p> <p>page [38] 4/4 4/25 5/18 9/7 12/23 13/4 13/16 13/16 14/1 14/4 14/13 14/16 15/13 15/22 15/23 15/25 15/25 16/6 17/6 19/22 19/24 20/7 21/11 27/3 31/8 31/12 37/18 49/14 51/8 54/10 56/1 56/16 73/2 73/3 76/1 76/1 77/17 83/2</p> <p>page 1 [1] 4/4</p> <p>page 12 [1] 77/17</p> <p>page 138 [1] 54/10</p> <p>page 14 [1] 31/12</p> <p>page 16 [1] 73/3</p> <p>page 2 [2] 5/18 27/3</p> <p>page 24 [2] 76/1 76/1</p> <p>page 4 [1] 13/16</p> <p>page 6 [2] 14/4 20/7</p> <p>page 7 [1] 19/24</p>	<p>page 8 [1] 15/13</p> <p>page 9 [1] 15/25</p> <p>paragraph [36] 8/4 8/5 9/10 10/3 11/14 12/23 13/5 14/4 14/5 14/24 15/14 16/24 17/1 17/3 17/16 23/10 24/16 24/25 31/6 31/10 31/12 32/5 32/6 32/7 33/3 34/4 43/14 44/11 49/11 54/13 54/20 55/3 57/3 74/16 77/15 77/16</p> <p>paragraph 103 [1] 23/10</p> <p>paragraph 13 [1] 44/11</p> <p>Paragraph 15 [1] 31/10</p> <p>paragraph 27 [1] 77/16</p> <p>paragraph 3.7 [2] 24/16 24/25</p> <p>paragraph 38 [1] 74/16</p> <p>paragraph 49 [2] 33/3 34/4</p> <p>paragraph 50 [5] 31/6 31/12 32/5 32/6 32/7</p> <p>paragraph 70 [1] 8/4</p> <p>paragraph 8 [1] 43/14</p> <p>paragraphs [2] 17/1 42/1</p> <p>paranoid [1] 9/22</p> <p>part [11] 7/11 28/9 45/15 45/15 52/14 64/15 65/9 67/22 71/5 77/24 78/22</p> <p>partial [2] 9/18 20/12</p> <p>participants [1] 72/18</p> <p>participation [1] 30/14</p> <p>particular [18] 3/22 3/23 5/6 8/9 8/13 10/4 17/3 21/9 24/5 24/24 25/21 29/3 33/4 45/2 46/5 48/25 65/12 71/8</p> <p>particularly [4] 23/10 48/25 61/19 68/18</p> <p>partner [6] 26/3 28/25 29/7 31/17 33/15 38/2</p> <p>parts [1] 69/12</p> <p>party [1] 26/17</p> <p>pass [4] 47/16 47/17 60/25 71/9</p> <p>passage [4] 7/2 13/10 14/9 58/18</p> <p>passages [2] 9/8 14/2</p> <p>passed [2] 39/10 52/12</p> <p>passing [4] 16/17</p>	<p>52/8 60/4 60/5</p> <p>past [4] 11/5 55/17 67/2 69/1</p> <p>patient [12] 63/9 63/10 63/15 67/24 67/25 77/9 77/10 77/23 78/6 78/6 80/9 81/9</p> <p>patients [8] 66/20 67/17 68/8 74/1 77/4 79/21 79/22 80/2</p> <p>pattern [1] 67/2</p> <p>pause [1] 33/8</p> <p>pausing [1] 27/13</p> <p>PC [1] 14/3</p> <p>PC Beddoe [1] 14/3</p> <p>pen [1] 37/5</p> <p>people [26] 3/10 7/20 16/17 17/25 25/3 25/5 35/3 36/12 39/19 39/21 40/9 46/13 48/17 48/23 51/19 55/8 55/9 55/11 55/14 58/25 62/7 68/3 74/25 75/7 75/9 79/2</p> <p>people' [1] 15/17</p> <p>people's [1] 18/21</p> <p>perhaps [23] 8/3 13/21 31/15 37/18 37/19 45/22 48/21 50/10 52/10 55/3 58/4 62/13 66/2 66/5 66/9 66/17 68/8 75/16 76/14 77/19 79/3 79/11 80/1</p> <p>period [2] 16/25 53/25</p> <p>periods [1] 81/24</p> <p>perpetrator [1] 71/16</p> <p>persistence [2] 46/1 51/16</p> <p>persistent [1] 60/14</p> <p>person [12] 13/18 36/6 59/12 60/15 60/17 61/1 62/22 62/24 63/7 68/4 78/12 78/17</p> <p>person's [2] 46/21 48/18</p> <p>petition [1] 31/1</p> <p>phase [1] 64/18</p> <p>phenomena [2] 76/3 76/14</p> <p>phone [6] 10/18 12/5 14/23 15/23 16/2 16/2</p> <p>physical [1] 39/23</p> <p>pick [1] 27/22</p> <p>picked [1] 22/20</p> <p>picture [1] 57/22</p> <p>place [4] 9/4 19/7 51/17 56/7</p> <p>placed [2] 26/5 34/21</p> <p>plainly [2] 11/16 30/19</p> <p>plan [13] 13/1 46/25 57/23 62/15 64/18</p>
--	---	--	---	--

<p>P</p> <p>plan... [8] 64/21 64/22 64/25 65/10 65/17 65/18 80/19 80/20</p> <p>planning [2] 44/10 63/5</p> <p>plans [2] 65/8 80/14</p> <p>Player [1] 56/10</p> <p>plea [1] 30/3</p> <p>plead [2] 4/10 9/13</p> <p>pleas [2] 20/4 20/20</p> <p>please [21] 1/3 1/15 5/17 5/18 12/12 13/4 13/16 15/23 17/6 24/17 27/3 35/16 37/19 41/9 41/13 41/19 49/5 49/14 56/2 56/3 73/3</p> <p>pm [4] 1/2 41/4 41/6 82/13</p> <p>PNC [1] 49/18</p> <p>PND [1] 49/25</p> <p>point [16] 4/14 7/17 16/21 20/15 35/7 48/13 50/22 62/2 64/20 66/8 66/11 77/4 77/14 80/8 80/17 80/18</p> <p>pole [1] 16/19</p> <p>police [28] 4/23 15/19 18/10 42/12 42/13 42/16 42/18 44/1 44/20 47/10 47/25 47/25 49/15 51/4 51/22 55/15 60/25 69/4 70/7 70/16 70/25 71/2 71/7 71/12 71/12 72/6 75/14 79/4</p> <p>pondering [1] 5/2</p> <p>poorly [1] 67/19</p> <p>portraits [1] 37/5</p> <p>pose [1] 63/13</p> <p>posed [3] 4/24 43/16 78/13</p> <p>posing [1] 48/25</p> <p>position [5] 1/25 6/15 6/16 29/11 37/19</p> <p>positions [1] 67/13</p> <p>possible [4] 17/10 49/17 64/4 64/24</p> <p>post [1] 37/2</p> <p>post-traumatic [1] 37/2</p> <p>potentially [1] 19/3</p> <p>power [1] 73/5</p> <p>power' [1] 55/21</p> <p>Powers [3] 56/1 73/14 74/6</p> <p>practice [7] 47/14 48/9 60/10 60/11 69/1 69/12 80/15</p> <p>practised [1] 62/17</p> <p>practising [1] 62/17</p> <p>practitioner [1] 47/16</p>	<p>practitioners [1] 18/4</p> <p>pragmatic [1] 54/1</p> <p>predict [2] 62/4 64/10</p> <p>predictable [1] 67/2</p> <p>prediction [1] 62/2</p> <p>preparing [2] 10/7 18/2</p> <p>presence [1] 76/8</p> <p>present [3] 46/14 65/6 76/9</p> <p>presenting [1] 54/19</p> <p>press [1] 47/12</p> <p>pressed [1] 52/24</p> <p>pressure [1] 45/18</p> <p>pretty [1] 53/4</p> <p>prevented [1] 11/6</p> <p>previous [6] 8/18 50/9 50/12 52/10 52/13 62/11</p> <p>previously [2] 6/13 14/6</p> <p>preyed [1] 80/25</p> <p>primary [4] 43/15 48/15 48/15 48/17</p> <p>principal [2] 3/10 44/25</p> <p>principals [1] 44/25</p> <p>principle [1] 33/15</p> <p>principles [1] 29/20</p> <p>privacy [1] 48/19</p> <p>probabilities [1] 23/15</p> <p>probably [6] 46/21 68/9 68/15 71/6 71/18 72/2</p> <p>Probation [1] 42/13</p> <p>problematic [1] 59/15</p> <p>problems [3] 46/14 62/16 62/20</p> <p>proceed [1] 79/4</p> <p>process [17] 12/25 26/10 30/25 35/25 39/15 44/3 46/3 46/5 47/2 47/14 47/21 59/18 63/15 64/15 68/1 79/7 79/12</p> <p>processes [1] 42/15</p> <p>produced [3] 18/25 19/20 64/1</p> <p>professional [3] 78/8 78/19 78/21</p> <p>professionals [1] 13/19</p> <p>Professor [3] 12/10 18/20 68/12</p> <p>Professor Blackwood [1] 18/20</p> <p>Professor Blackwood's [1] 12/10</p> <p>Professor Fazel [1] 68/12</p> <p>progresses [1] 61/21</p>	<p>prominent [1] 43/16</p> <p>proof [2] 20/9 20/12</p> <p>proper [2] 21/8 78/12</p> <p>properly [2] 40/7 44/6</p> <p>property [1] 11/3</p> <p>proportionate [4] 48/5 52/8 61/9 72/4</p> <p>proportionately [1] 61/8</p> <p>prosecution [5] 17/8 18/16 20/17 24/4 30/6</p> <p>prosecutor [17] 1/22 2/4 2/14 2/17 2/25 5/23 7/13 7/14 7/15 8/8 22/25 22/25 24/13 24/13 24/21 25/6 25/7</p> <p>prosecutors [5] 22/11 22/12 22/18 23/3 24/2</p> <p>prospect [1] 24/5</p> <p>protect [2] 48/17 67/10</p> <p>protecting [1] 78/6</p> <p>protection [3] 73/11 73/23 77/24</p> <p>prove [2] 20/16 20/18</p> <p>provide [6] 30/8 30/10 39/17 51/23 57/24 67/8</p> <p>provided [5] 20/17 30/5 32/10 38/22 48/2</p> <p>providing [3] 40/13 51/22 58/4</p> <p>PSO [1] 49/8</p> <p>psychiatric [4] 4/1 9/12 41/22 69/1</p> <p>psychiatrist [9] 19/6 42/3 42/8 67/23 70/2 79/14 80/2 80/7 81/8</p> <p>psychiatrists [6] 20/21 20/23 21/9 61/5 69/3 77/20</p> <p>Psychiatrists' [1] 78/3</p> <p>psychiatry [8] 19/7 79/1 79/1 79/3 79/13 79/17 80/10 81/5</p> <p>psychological [1] 81/4</p> <p>psychologist [1] 81/7</p> <p>psychosis [3] 54/12 65/15 75/7</p> <p>psychotic [5] 13/6 46/15 75/3 76/2 76/14</p> <p>public [3] 67/11 77/24 78/7</p> <p>punished [1] 55/16</p> <p>purchase [1] 14/21</p> <p>purpose [2] 29/23 43/15</p> <p>pursue [1] 43/18</p> <p>pushed [2] 22/14 22/21</p> <p>put [2] 7/16 46/24</p>	<p>putting [5] 21/6 60/21 79/15 80/14 80/23</p> <p>Q</p> <p>qualifications [1] 41/25</p> <p>qualifying [1] 27/10</p> <p>quality [10] 42/15 63/8 64/4 64/9 64/24 64/25 71/1 75/12 75/13 80/11</p> <p>question [5] 8/19 22/17 55/23 57/16 77/18</p> <p>Questioned [12] 1/8 26/23 39/12 41/12 72/22 74/14 83/4 83/5 83/6 83/8 83/9 83/10</p> <p>questions [8] 4/24 26/20 40/9 53/7 53/8 72/15 72/17 82/8</p> <p>quests [1] 43/18</p> <p>quite [9] 39/14 49/17 51/18 59/12 59/16 61/4 70/17 74/7 78/18</p> <p>quote [2] 21/11 21/12</p> <p>quotes [2] 13/16 13/21</p> <p>R</p> <p>radicalisation [1] 43/3</p> <p>raise [2] 10/24 25/4</p> <p>raised [3] 13/11 14/3 22/11</p> <p>rang [1] 58/10</p> <p>rather [7] 30/17 39/24 47/18 54/5 74/24 79/5 79/15</p> <p>rational [9] 5/14 7/4 7/5 8/10 8/16 9/25 11/25 12/24 17/13</p> <p>Ratliff [1] 26/7</p> <p>re [2] 65/15 77/1</p> <p>re-emergence [2] 65/15 77/1</p> <p>reached [1] 73/18</p> <p>reaches [1] 74/10</p> <p>react [1] 11/4</p> <p>read [13] 4/20 9/7 9/8 12/22 13/23 17/2 22/1 23/22 24/22 37/7 41/11 56/22 83/7</p> <p>reading [2] 23/9 60/24</p> <p>ready [1] 47/7</p> <p>realise [1] 58/25</p> <p>realistic [1] 24/5</p> <p>reality [2] 29/23 75/3</p> <p>really [22] 4/25 21/12 33/1 42/15 44/3 44/7 44/8 44/9 48/4 50/25 58/4 58/22 59/10 63/9 63/10 67/24 67/25 69/15 76/21 80/9</p>	<p>81/11 81/16</p> <p>realtime [1] 43/23</p> <p>reason [3] 4/22 19/5 81/6</p> <p>reasonable [1] 39/2</p> <p>reasons [2] 9/20 37/16</p> <p>rebut [2] 19/3 19/16</p> <p>rebutting [2] 21/22 23/18</p> <p>recall [5] 8/14 20/1 36/22 37/7 69/16</p> <p>recall-type [1] 69/16</p> <p>receipt [2] 3/25 14/23</p> <p>receive [3] 36/11 36/13 36/20</p> <p>received [2] 4/8 47/24</p> <p>receiving [2] 36/8 36/22</p> <p>receptive [1] 36/8</p> <p>reciprocal [1] 73/12</p> <p>recognise [1] 55/12</p> <p>recognised [2] 9/22 72/11</p> <p>recollection [2] 25/14 33/20</p> <p>recommendation [1] 70/13</p> <p>recommendations [1] 67/5</p> <p>reconcile [3] 5/4 5/9 67/14</p> <p>reconciling [1] 5/13</p> <p>record [8] 47/5 49/2 49/6 50/2 52/10 52/13 65/2 72/24</p> <p>recorded [4] 13/6 38/17 50/18 73/4</p> <p>records [9] 14/15 35/17 47/11 49/16 52/7 54/9 54/11 57/18 58/16</p> <p>recover [3] 66/22 75/7 75/9</p> <p>recovered [1] 25/16</p> <p>recovering [1] 28/24</p> <p>recruiter [1] 14/14</p> <p>Recruitment [1] 14/14</p> <p>reduce [1] 65/3</p> <p>reduced [1] 65/16</p> <p>reduction [2] 66/17 66/19</p> <p>refer [2] 24/1 74/19</p> <p>reference [13] 10/18 10/23 14/13 15/9 17/3 27/23 28/17 36/15 49/24 49/25 59/25 60/10 73/9</p> <p>referenced [1] 28/20</p> <p>references [1] 24/25</p> <p>referral [3] 52/5 59/14 80/4</p> <p>referrals [2] 73/22 73/24</p>
--	--	--	--	--

<p>R</p> <p>referred [7] 8/18 34/14 45/10 64/12 74/17 77/18 82/5</p> <p>refers [3] 15/22 16/1 24/18</p> <p>reflect [1] 11/11</p> <p>reflecting [2] 19/14 78/3</p> <p>regarding [2] 53/21 74/10</p> <p>regards [1] 2/20</p> <p>register [1] 82/4</p> <p>reifying [1] 78/4</p> <p>reintroduce [1] 63/6</p> <p>reiterate [1] 25/1</p> <p>reject [1] 21/8</p> <p>relapse [1] 75/10</p> <p>relapsing [2] 66/24 75/5</p> <p>relates [3] 3/9 25/18 27/9</p> <p>relation [14] 6/21 23/6 24/8 25/24 33/5 42/15 44/12 49/2 62/24 70/13 74/20 77/13 77/14 79/7</p> <p>relationship [2] 3/12 63/10</p> <p>relationships [1] 52/22</p> <p>relatively [1] 2/9</p> <p>relayed [1] 38/14</p> <p>relevant [10] 12/9 13/3 22/4 50/5 50/6 53/15 54/4 71/3 73/15 78/15</p> <p>reliant [1] 40/5</p> <p>reluctance [1] 71/9</p> <p>rely [1] 39/16</p> <p>remaining [1] 11/9</p> <p>remember [11] 6/25 7/2 7/10 9/6 12/17 12/21 28/5 28/6 29/13 31/23 36/4</p> <p>remit [2] 42/18 75/10</p> <p>remitting [2] 66/25 75/5</p> <p>remotely [2] 36/25 47/10</p> <p>removed [1] 11/18</p> <p>repeats [2] 57/1 57/3</p> <p>repelled [1] 16/18</p> <p>report [19] 4/1 4/7 4/14 5/2 6/18 9/12 9/20 10/7 12/10 12/13 12/15 12/21 12/22 18/8 19/19 22/2 22/9 23/7 23/9</p> <p>reports [4] 3/4 14/7 18/15 18/24</p> <p>represent [3] 27/9 29/21 45/23</p> <p>represents [1] 45/22</p> <p>request [3] 28/17</p>	<p>49/8 80/4</p> <p>requested [6] 28/25 29/5 37/8 37/13 37/14 37/14</p> <p>requests [1] 9/2</p> <p>require [1] 40/2</p> <p>required [3] 11/17 39/3 78/9</p> <p>research [2] 42/5 46/12</p> <p>reservations [1] 10/5</p> <p>resident [1] 16/18</p> <p>resist [1] 15/20</p> <p>resourced [1] 67/19</p> <p>resources [9] 46/2 54/4 64/22 78/23 79/20 79/21 79/25 80/12 80/19</p> <p>resourcing [1] 65/19</p> <p>respect [3] 24/14 25/13 42/1</p> <p>response [6] 6/11 22/23 23/6 61/5 61/9 72/5</p> <p>responses [3] 4/17 7/8 7/9</p> <p>responsibility [12] 3/17 4/11 7/18 7/24 9/19 10/6 17/15 19/4 19/17 20/5 20/13 20/16</p> <p>restricted [1] 67/8</p> <p>restrictions [1] 66/11</p> <p>rests [1] 20/13</p> <p>result [3] 35/10 35/14 37/3</p> <p>retroactively [1] 56/20</p> <p>returned [2] 27/18 28/21</p> <p>returns [1] 16/18</p> <p>review [4] 19/21 24/15 24/23 24/25</p> <p>reviewing [2] 8/7 26/6</p> <p>reviews [1] 24/15</p> <p>right [38] 1/11 1/20 1/21 2/6 2/15 3/6 3/7 7/6 7/7 9/2 9/3 28/9 31/24 34/4 36/17 38/11 39/13 40/9 40/17 41/23 42/3 42/9 44/16 46/6 47/8 47/9 51/11 54/5 59/11 59/13 60/13 60/15 61/2 61/10 61/19 66/20 81/5 82/9</p> <p>rights [3] 29/21 30/24 48/18</p> <p>ringing [1] 49/12</p> <p>risk [59] 43/20 44/3 44/6 44/8 44/8 44/9 44/9 48/25 50/7 50/12 50/12 54/3 61/12 61/16 61/25 62/1 62/2 62/7 62/8 62/14 62/18</p>	<p>62/23 63/8 63/21 64/8 64/9 64/17 64/18 64/24 64/25 65/3 65/11 65/16 66/6 67/1 67/22 68/1 68/6 68/9 68/11 68/14 76/2 76/7 76/10 76/14 76/25 77/18 77/22 78/8 79/11 79/13 79/23 80/1 80/6 80/11 80/17 80/18 81/2 81/10</p> <p>risks [5] 44/7 46/1 54/3 63/12 78/13</p> <p>Road [3] 16/1 16/23 56/25</p> <p>role [5] 2/21 46/9 48/15 48/17 58/3</p> <p>roles [2] 1/20 73/10</p> <p>roll [1] 70/22</p> <p>rolled [2] 70/15 71/23</p> <p>room [13] 26/2 26/5 31/18 31/21 31/22 31/22 31/23 34/7 34/22 35/1 35/24 36/6 40/23</p> <p>rota [1] 70/3</p> <p>round [2] 21/22 23/18</p> <p>route [1] 63/8</p> <p>routinely [7] 47/25 48/8 52/8 69/9 69/11 71/4 80/23</p> <p>Royal [2] 45/5 78/2</p> <p>rung [1] 53/10</p> <p>runs [1] 63/21</p>	<p>saying [10] 28/21 29/14 33/1 36/19 52/1 59/20 59/21 59/23 59/23 73/6</p> <p>says [34] 4/18 4/21 5/19 5/25 6/12 9/9 9/16 10/13 10/15 10/17 11/1 12/23 13/5 13/17 14/5 14/20 16/7 17/7 17/21 18/11 20/8 20/8 21/4 21/13 49/7 49/7 49/11 51/8 54/13 54/20 54/21 56/4 60/23 76/23</p> <p>scaffolding [1] 16/19</p> <p>scalable [2] 68/7 79/18</p> <p>scale [1] 71/24</p> <p>scenario [9] 44/2 61/3 63/2 63/4 63/5 63/6 64/19 81/1 81/23</p> <p>scenarios [2] 69/16 81/22</p> <p>scepticism [1] 77/19</p> <p>scheme [4] 27/6 27/11 27/14 27/20</p> <p>schizophrenia [1] 9/22</p> <p>scope [3] 2/10 45/4 45/9</p> <p>screen [7] 8/3 8/24 12/11 32/9 79/22 79/24 80/3</p> <p>screening [1] 68/21</p> <p>scroll [8] 4/17 6/11 10/2 10/25 13/4 20/10 24/17 49/14</p> <p>second [6] 8/5 14/5 47/4 54/13 54/20 64/18</p> <p>secondary [1] 82/6</p> <p>section [2] 16/7 70/3</p> <p>Section 12 [1] 70/3</p> <p>secure [1] 69/14</p> <p>security [1] 45/7</p> <p>see [23] 2/12 4/17 4/22 6/11 10/25 13/20 15/7 21/9 21/24 26/16 27/8 28/13 34/4 36/6 37/20 47/22 51/8 55/8 56/23 59/8 61/6 73/9 81/23</p> <p>seeing [2] 20/1 65/19</p> <p>Seeley [3] 5/10 11/3 11/6</p> <p>Seeley-Hirst [2] 11/3 11/6</p> <p>Seely [10] 5/5 5/6 6/21 10/23 12/6 15/24 16/6 16/8 16/15 17/4</p> <p>Seelyhurst [1] 6/9</p> <p>seem [3] 12/17 12/21 58/14</p> <p>seemed [1] 23/21</p> <p>seems [1] 58/13</p> <p>seen [19] 2/13 4/4</p>	<p>4/5 11/4 12/13 13/10 16/4 16/14 18/7 18/15 19/21 22/10 22/13 37/5 47/4 51/22 53/1 57/19 68/4</p> <p>self [7] 5/15 8/11 8/17 10/1 12/1 17/14 17/22</p> <p>self-control [6] 5/15 8/11 8/17 10/1 12/1 17/22</p> <p>self-control' [1] 17/14</p> <p>Senior [3] 2/3 7/14 8/7</p> <p>seniority [1] 2/8</p> <p>sense [3] 48/17 57/20 75/5</p> <p>sensitivity [1] 35/7</p> <p>sent [2] 4/13 14/9</p> <p>sentence [8] 26/18 30/11 30/18 31/1 33/4 35/25 37/22 54/21</p> <p>sentences [1] 56/15</p> <p>sentencing [3] 26/10 26/17 38/24</p> <p>separate [1] 11/9</p> <p>September [2] 29/1 56/5</p> <p>September 2019 [1] 56/5</p> <p>sequence [1] 11/23</p> <p>Sergeant [1] 69/22</p> <p>serious [11] 38/19 38/22 50/6 50/25 58/23 65/22 66/21 67/12 75/4 76/11 76/22</p> <p>seriously [6] 38/6 38/8 73/6 74/22 74/24 75/1</p> <p>seriousness [1] 46/10</p> <p>served [1] 9/11</p> <p>service [7] 38/21 42/23 66/2 66/6 68/20 69/8 69/24</p> <p>services [22] 24/14 25/7 46/16 46/16 46/18 46/22 57/25 58/3 59/6 59/14 63/22 66/16 66/16 67/16 67/18 67/21 68/2 71/6 71/15 71/20 81/6 81/19</p> <p>session [1] 26/14</p> <p>set [10] 1/18 3/8 6/18 9/20 11/12 16/24 27/9 41/25 43/13 72/8</p> <p>sets [4] 13/2 13/16 17/6 29/10</p> <p>setting [10] 6/16 61/19 63/3 63/18 68/13 68/17 69/4 78/7 78/10 82/1</p> <p>settings [2] 59/17</p>
---	--	---	---	--

<p>S</p> <p>settings... [1] 73/25</p> <p>several [1] 5/2</p> <p>shall [1] 7/9</p> <p>Shallow [17] 2/4 2/7 3/2 3/3 3/12 3/15 3/19 4/18 4/18 5/19 6/20 7/13 9/3 10/20 12/3 24/12 29/13</p> <p>Shallow's [1] 10/21</p> <p>share [2] 73/16 75/18</p> <p>shared [4] 4/22 7/15 54/14 71/4</p> <p>sharing [8] 58/15 67/15 71/1 71/2 71/11 72/10 74/9 75/12</p> <p>Sharon [7] 28/24 33/9 33/11 33/12 36/23 37/1 37/2</p> <p>sharpeners [1] 18/3</p> <p>she [6] 4/21 5/19 5/25 6/4 37/8 37/10</p> <p>she'd [1] 37/8</p> <p>she's [1] 47/6</p> <p>sheet [1] 51/13</p> <p>short [3] 13/7 40/24 41/5</p> <p>shortly [2] 11/2 15/23</p> <p>should [20] 1/9 8/21 20/5 20/5 21/16 21/17 32/9 38/15 41/15 55/16 55/20 57/23 58/24 59/5 59/7 59/8 60/4 60/5 61/8 70/6</p> <p>shouldn't [1] 4/22</p> <p>show [1] 50/10</p> <p>showing [1] 16/16</p> <p>shown [2] 18/3 50/16</p> <p>shows [3] 13/18 15/10 38/5</p> <p>sic [1] 26/9</p> <p>side [1] 65/24</p> <p>sight [2] 5/20 78/11</p> <p>significance [1] 34/25</p> <p>significant [3] 59/1 65/24 67/7</p> <p>significantly [1] 9/24</p> <p>siloed [1] 71/11</p> <p>similar [4] 13/11 14/9 63/18 68/15</p> <p>similarly [3] 36/23 37/12 37/14</p> <p>since [3] 1/25 18/2 37/4</p> <p>single [2] 27/25 65/15</p> <p>sister [2] 25/19 26/2</p> <p>sit [3] 2/19 11/23 41/13</p> <p>site [1] 45/22</p> <p>sites [5] 44/25 45/3 45/7 48/17 73/11</p> <p>sits [3] 2/20 3/3 29/17</p>	<p>situation [5] 44/2 52/3 70/10 71/8 81/9</p> <p>situations [1] 73/21</p> <p>six [1] 29/10</p> <p>skip [1] 56/15</p> <p>Sky [1] 14/13</p> <p>slavishly [1] 78/16</p> <p>slightly [2] 10/2 68/23</p> <p>slower [1] 44/3</p> <p>slowing [1] 7/10</p> <p>small [2] 31/21 67/11</p> <p>so [101]</p> <p>social [4] 70/16 81/3 81/8 81/8</p> <p>sofa [1] 81/24</p> <p>some [64] 2/12 2/13 3/20 6/18 7/16 9/2 9/3 10/4 12/22 13/16 16/24 18/25 19/2 22/10 31/7 31/15 35/12 36/14 39/20 39/22 44/18 45/21 45/24 46/15 46/17 48/19 49/14 50/8 51/3 51/6 51/19 52/22 53/11 59/19 59/19 60/21 62/9 62/22 63/19 64/1 65/11 66/8 66/20 66/21 66/24 68/6 68/25 69/13 70/1 70/6 70/16 70/20 70/25 71/7 72/7 72/9 75/6 75/9 75/15 78/13 80/21 80/22 81/18 81/19</p> <p>somebody [11] 50/10 50/24 59/12 60/23 61/3 66/1 69/17 77/11 79/7 80/23 81/12</p> <p>somebody's [2] 49/17 50/9</p> <p>somehow [1] 63/25</p> <p>someone [4] 36/5 59/17 61/9 74/23</p> <p>someone's [1] 72/5</p> <p>something [21] 10/15 11/17 19/8 20/24 32/5 42/9 42/21 52/12 55/13 60/19 60/19 60/24 64/11 65/19 68/19 68/21 69/4 69/20 70/23 71/23 77/9</p> <p>sometime [1] 55/11</p> <p>sometimes [11] 52/22 65/21 66/14 67/16 67/21 71/5 71/8 73/25 74/1 77/4 78/10</p> <p>somewhere [1] 14/19</p> <p>sorry [14] 13/20 15/2 16/2 20/10 20/11 26/8 31/12 32/4 32/13 33/12 36/23 37/1 39/7 49/22</p> <p>sort [14] 44/18 45/13</p>	<p>45/17 45/21 46/2 60/12 63/6 64/1 65/1 74/22 75/13 79/13 81/1 81/19</p> <p>sorts [3] 58/20 63/18 71/17</p> <p>speak [2] 10/13 55/15</p> <p>speaking [6] 33/19 36/14 39/6 39/8 45/5 79/1</p> <p>specialist [3] 2/22 2/25 22/25</p> <p>specialists [1] 70/7</p> <p>specifically [1] 6/25</p> <p>speed [1] 7/10</p> <p>spend [1] 36/14</p> <p>spent [2] 1/19 35/12</p> <p>SPJ [1] 78/21</p> <p>spoke [2] 26/1 29/9</p> <p>spoken [2] 36/16 54/19</p> <p>spread [1] 51/21</p> <p>STAC [3] 42/9 42/11 75/22</p> <p>staff [3] 44/22 49/9 68/3</p> <p>stage [17] 5/8 6/20 7/23 11/24 27/19 28/3 28/7 28/21 29/6 29/8 34/2 47/8 52/1 52/4 56/24 58/9 64/17</p> <p>stalking [5] 42/12 42/15 42/17 75/22 76/17</p> <p>standard [1] 49/17</p> <p>start [7] 2/24 5/18 10/2 40/25 51/19 71/10 79/22</p> <p>starting [1] 20/15</p> <p>starts [1] 32/11</p> <p>state [5] 50/11 58/18 59/5 65/13 77/8</p> <p>stated [2] 15/5 49/12</p> <p>statement [23] 1/10 1/19 3/9 8/4 8/25 32/6 39/14 41/16 42/1 43/13 43/19 44/11 46/8 47/5 48/1 51/5 61/13 61/17 63/19 64/12 70/15 74/16 77/15</p> <p>Statements [1] 32/20</p> <p>states [4] 15/15 16/9 58/1 77/12</p> <p>statutory [3] 48/16 66/9 74/2</p> <p>stay [2] 14/19 15/18</p> <p>sticks [1] 78/15</p> <p>still [6] 5/3 28/23 29/16 38/19 53/20 63/25</p> <p>stop [5] 11/4 16/15 32/4 66/25 77/21</p> <p>stopped [1] 67/3</p> <p>stopping [1] 66/17</p>	<p>strapped [1] 78/23</p> <p>strategy [1] 29/12</p> <p>street [3] 56/6 56/10 81/24</p> <p>stress [2] 23/7 37/2</p> <p>stresses [1] 30/20</p> <p>strike [1] 60/13</p> <p>strikes [1] 16/22</p> <p>strong [1] 66/14</p> <p>strongly [2] 50/15 78/18</p> <p>structural [1] 80/21</p> <p>structurally [1] 68/20</p> <p>structure [1] 78/20</p> <p>structured [2] 78/8 78/19</p> <p>struggled [1] 5/9</p> <p>struggling [1] 5/4</p> <p>studies [2] 13/7 14/11</p> <p>stupid [2] 10/16 11/17</p> <p>subject [2] 49/9 50/16</p> <p>subject's [1] 47/7</p> <p>submissions [1] 28/10</p> <p>submit [1] 14/7</p> <p>submitted [1] 74/5</p> <p>subsequent [2] 12/6 24/23</p> <p>subsequently [1] 46/12</p> <p>substance [1] 62/13</p> <p>substantial [1] 54/3</p> <p>substantially [2] 9/25 17/13</p> <p>substantive [1] 9/9</p> <p>succeeded [1] 19/13</p> <p>such [7] 4/19 21/5 21/20 21/25 23/17 24/7 73/11</p> <p>suffering [4] 9/21 39/21 46/15 58/22</p> <p>sufficient [5] 20/17 23/14 46/10 53/21 59/5</p> <p>sufficiently [1] 51/21</p> <p>suggest [1] 55/20</p> <p>suggesting [1] 78/9</p> <p>suggestive [1] 8/10</p> <p>suggests [3] 12/25 38/4 53/11</p> <p>suitable [1] 40/1</p> <p>suite [2] 33/17 69/11</p> <p>summary [1] 73/3</p> <p>Superintendent [3] 43/11 47/4 49/6</p> <p>support [2] 29/24 31/18</p> <p>supporters [1] 25/22</p> <p>supports [1] 81/17</p> <p>suppose [4] 45/18 58/4 58/17 59/2</p> <p>sure [5] 26/19 52/2 60/6 61/23 68/19</p>	<p>surfing [1] 81/24</p> <p>surroundings [1] 5/11</p> <p>surveillance [4] 56/7 56/11 56/21 57/2</p> <p>survivors [10] 25/9 25/14 27/14 27/17 27/19 27/23 27/25 28/11 28/15 33/25</p> <p>suspect [1] 74/6</p> <p>Suzu [1] 42/13</p> <p>Suzu Lamplugh [1] 42/13</p> <p>switches [1] 16/21</p> <p>sworn [2] 1/7 83/3</p> <p>symptomatic [1] 65/21</p> <p>symptoms [4] 76/19 76/21 77/1 77/5</p> <p>system [2] 40/1 79/2</p> <hr/> <p>T</p> <p>take [15] 10/14 19/19 19/22 35/6 37/23 40/22 40/24 40/25 45/9 53/6 54/2 55/22 66/12 72/24 81/11</p> <p>taken [9] 5/10 9/4 29/19 33/21 45/1 51/1 52/14 65/9 74/5</p> <p>takes [2] 18/11 65/24</p> <p>taking [4] 14/1 52/1 66/3 66/18</p> <p>talk [6] 15/5 26/10 53/16 54/2 55/18 78/18</p> <p>talked [2] 6/6 35/12</p> <p>talking [3] 7/3 15/3 75/17</p> <p>talks [1] 45/12</p> <p>targeted [1] 58/19</p> <p>team [5] 22/12 46/22 52/16 54/12 69/20</p> <p>team's [1] 63/24</p> <p>teams [1] 81/7</p> <p>telephone [3] 6/15 6/22 14/25</p> <p>telephoned [1] 10/10</p> <p>tell [3] 15/17 55/2 55/6</p> <p>telling [1] 55/15</p> <p>temporarily [1] 14/17</p> <p>temporary [1] 3/15</p> <p>ten [1] 40/25</p> <p>tending [1] 43/4</p> <p>tension [1] 67/7</p> <p>terms [11] 8/15 8/16 11/13 24/3 33/25 36/11 46/3 60/18 63/4 63/12 70/25</p> <p>terrorism [2] 43/5 45/19</p> <p>terrorism/offence [1] 43/5</p> <p>test [7] 17/16 23/14 23/16 23/16 24/3 24/8</p>
---	---	--	--	--

<p>T</p> <p>test... [1] 25/4</p> <p>tether [2] 60/22 60/23</p> <p>th [1] 17/23</p> <p>Thames [3] 49/9 52/25 73/11</p> <p>than [14] 7/17 30/17 34/10 47/18 54/17 58/4 63/11 63/15 70/11 70/12 74/21 74/24 79/5 80/10</p> <p>thank [57] 1/6 1/18 2/8 3/5 5/17 8/3 8/4 13/23 13/25 15/2 19/25 19/25 20/11 24/17 25/8 26/19 26/21 27/2 27/3 29/4 29/19 31/5 31/8 31/8 31/12 37/18 37/25 39/4 39/9 39/10 40/15 40/16 40/18 40/20 40/21 41/2 41/3 41/7 41/9 41/15 41/22 42/8 55/4 61/11 68/23 72/25 73/2 74/4 74/13 76/1 77/13 77/16 80/13 82/8 82/9 82/10 82/12</p> <p>that [522]</p> <p>that I [7] 2/24 8/18 14/9 25/17 29/21 37/23 60/25</p> <p>that's [57] 1/12 1/14 1/21 2/2 2/6 3/7 7/1 9/3 10/18 10/23 12/20 16/3 17/20 18/13 19/20 19/24 25/8 25/20 27/4 27/21 28/6 30/3 31/4 32/4 32/6 32/9 32/10 34/10 38/14 41/24 42/4 42/10 44/15 45/4 46/7 47/9 48/13 48/19 48/20 53/23 55/23 56/25 57/16 63/11 64/3 67/19 68/7 71/3 71/5 72/10 73/6 73/18 75/8 75/22 78/9 78/21 79/15</p> <p>their [21] 29/15 33/25 34/18 34/20 34/25 35/3 43/17 44/17 45/14 52/7 62/8 64/9 65/13 65/17 66/7 66/12 66/18 73/17 74/1 81/9 81/15</p> <p>them [33] 2/13 15/20 15/21 25/25 26/14 27/15 29/11 29/16 29/16 32/2 32/22 32/23 33/6 33/7 33/10 33/23 34/3 34/11 34/11 34/25 36/6 45/14 45/21 46/16</p>	<p>46/23 46/24 51/20 51/22 57/24 63/11 69/18 77/19 81/17</p> <p>themselves [5] 39/23 55/13 59/8 77/10 81/20</p> <p>then [69] 3/4 4/17 5/17 7/12 8/23 9/16 11/21 12/10 13/2 14/1 14/20 16/6 16/10 16/13 17/6 20/18 20/19 21/4 23/12 24/23 25/20 26/5 26/12 26/16 29/12 29/19 31/6 32/14 32/18 32/24 32/25 33/8 34/3 34/4 35/16 35/21 35/21 36/16 37/18 38/15 38/22 40/6 40/7 40/14 45/8 46/21 49/11 50/14 51/8 51/19 52/15 53/16 54/2 54/20 62/14 63/11 64/3 64/9 64/22 66/13 66/18 70/13 73/9 73/18 74/4 78/5 79/25 80/4 80/6</p> <p>there [101]</p> <p>there'd [1] 28/17</p> <p>there's [26] 14/4 14/13 15/13 22/16 24/4 27/25 43/2 46/4 49/24 49/25 53/11 59/17 59/25 62/21 66/13 67/1 68/6 71/14 71/14 72/13 74/2 74/18 79/10 80/16 80/18 81/6</p> <p>therefore [2] 25/2 38/1</p> <p>these [14] 10/7 35/3 45/20 46/14 54/11 57/11 58/20 62/16 63/17 71/17 77/1 77/5 77/11 78/19</p> <p>they [47] 2/19 15/16 15/17 18/5 21/16 25/3 26/5 26/13 26/16 28/7 28/22 30/4 32/21 34/12 34/16 34/20 34/21 34/23 36/13 36/13 42/16 45/15 45/23 45/23 58/7 58/9 59/8 59/22 60/5 61/10 63/12 63/17 66/4 66/22 66/23 66/25 67/3 69/10 69/10 69/10 71/6 71/6 73/17 76/15 77/22 79/18 81/16</p> <p>they'd [1] 37/15</p> <p>they're [20] 18/21 30/18 34/16 35/1 46/17 50/11 52/21 59/18 59/20 60/19 60/20 65/23 66/2 66/3</p>	<p>66/8 66/18 75/3 80/12 80/25 81/15</p> <p>they've [9] 34/14 34/20 39/20 45/16 46/18 46/19 67/2 73/14 77/5</p> <p>thing [7] 34/17 36/10 45/17 48/20 48/21 80/23 81/1</p> <p>things [11] 3/18 4/19 6/5 22/16 46/1 54/4 62/10 62/10 62/13 78/15 78/17</p> <p>think [102]</p> <p>thinking [12] 8/1 44/7 50/6 50/15 53/15 63/7 63/12 68/6 75/2 75/13 78/5 81/3</p> <p>third [3] 11/7 11/22 15/14</p> <p>this [78] 3/5 3/11 4/22 5/2 5/18 6/2 6/20 7/23 7/25 8/15 8/16 8/24 9/4 9/20 10/13 11/2 12/12 12/12 12/15 12/22 13/10 15/5 18/8 19/21 20/1 20/13 21/12 23/11 24/7 24/22 24/24 25/10 27/2 28/4 28/13 29/6 31/21 31/24 33/14 36/21 38/7 39/10 49/5 49/20 50/2 51/8 51/9 52/1 55/2 55/3 55/5 55/6 55/7 55/24 55/25 56/7 56/10 56/12 56/16 56/17 56/23 56/24 59/10 59/16 60/4 60/6 60/12 62/3 74/22 76/8 76/17 77/8 77/21 78/22 79/2 79/24 80/8 80/21</p> <p>thorny [1] 61/7</p> <p>those [26] 7/4 8/20 13/13 16/4 22/11 23/21 27/9 29/2 29/21 38/20 46/9 47/6 47/25 48/5 52/23 54/6 58/7 64/3 67/11 67/13 70/5 70/7 71/20 72/4 76/18 76/18</p> <p>though [3] 21/18 22/1 49/16</p> <p>thought [6] 12/24 46/20 47/13 48/6 70/24 71/18</p> <p>threat [19] 42/12 43/20 43/22 43/22 44/7 44/14 44/19 44/21 44/24 45/24 45/25 47/23 48/25 50/7 53/22 53/25 60/17 70/18 76/19</p> <p>threat-control-overri de [1] 76/19</p>	<p>threatened [1] 55/17</p> <p>threats [2] 15/4 43/16</p> <p>three [5] 11/9 20/23 42/24 54/6 71/19</p> <p>threshold [2] 73/19 74/10</p> <p>through [5] 6/15 16/14 35/5 63/22 82/6</p> <p>throughout [1] 17/23</p> <p>Thursday [1] 55/7</p> <p>tick [1] 62/20</p> <p>ticks [1] 62/22</p> <p>till [1] 55/6</p> <p>time [33] 2/6 2/7 2/23 2/24 5/13 7/2 9/23 10/13 12/16 15/5 18/25 34/17 35/12 36/9 36/14 37/6 37/7 37/8 46/19 51/9 52/7 53/25 60/13 60/21 62/18 77/6 77/8 77/21 78/22 79/20 79/21 80/12 81/25</p> <p>times [1] 16/20</p> <p>tipping [1] 50/22</p> <p>tired [1] 55/1</p> <p>title [1] 55/13</p> <p>today [5] 2/9 4/5 12/13 13/10 33/14</p> <p>together [7] 26/8 34/7 34/8 35/1 35/24 71/20 71/21</p> <p>told [6] 14/14 15/17 15/19 16/9 30/24 54/23</p> <p>too [2] 40/9 66/14</p> <p>took [5] 11/8 34/1 37/23 56/7 72/25</p> <p>tool [6] 61/15 64/1 68/21 78/5 78/14 78/16</p> <p>tools [3] 62/16 63/17 78/19</p> <p>top [3] 4/25 9/9 14/22</p> <p>topic [4] 25/8 25/9 61/11 68/23</p> <p>torturing [1] 77/12</p> <p>totally [1] 61/11</p> <p>towards [4] 18/1 43/4 56/16 70/18</p> <p>Tracey [6] 33/15 34/6 36/23 37/12 37/13 37/15</p> <p>Tracey's [1] 34/13</p> <p>train [1] 15/9</p> <p>trained [1] 79/13</p> <p>training [1] 67/23</p> <p>transferred [1] 3/14</p> <p>traumatic [2] 35/9 37/2</p> <p>traumatised [1] 39/20</p> <p>travelled [1] 53/9</p> <p>treated [2] 49/21 49/23</p>	<p>treating [2] 27/14 58/8</p> <p>treatment [1] 43/5</p> <p>triage [3] 46/5 47/21 53/17</p> <p>triaging [1] 47/1</p> <p>trial [1] 21/7</p> <p>Tribunal [4] 56/1 73/14 74/6 74/9</p> <p>tried [2] 11/3 11/20</p> <p>trouble [1] 55/9</p> <p>true [2] 1/15 41/19</p> <p>Trust [2] 41/23 42/14</p> <p>truth [1] 59/20</p> <p>try [8] 16/20 19/16 46/23 47/16 61/8 71/10 75/18 75/20</p> <p>trying [8] 11/8 57/24 61/7 64/10 70/22 70/24 72/4 75/12</p> <p>Tuesday [2] 1/1 17/23</p> <p>turn [5] 5/17 9/7 53/24 56/1 63/17</p> <p>turned [2] 51/14 73/12</p> <p>turning [3] 15/22 16/2 30/17</p> <p>turnover [1] 68/3</p> <p>twice [3] 11/2 33/14 38/17</p> <p>two [15] 9/1 10/9 11/9 13/21 18/15 22/23 27/23 28/10 43/21 55/24 67/13 69/15 70/3 71/15 71/19</p> <p>two years [1] 55/24</p> <p>type [2] 58/22 69/16</p> <hr/> <p>U</p> <p>ultimately [3] 19/12 57/1 67/24</p> <p>Unclear [2] 39/6 39/8</p> <p>uncomfortable [1] 34/21</p> <p>uncontradicted [2] 21/15 21/19</p> <p>under [5] 27/8 27/10 29/20 63/13 78/24</p> <p>under-emphasised [1] 78/24</p> <p>Underground [1] 15/11</p> <p>underline [1] 37/19</p> <p>underneath [1] 47/22</p> <p>understand [5] 23/10 29/24 37/22 44/16 62/22</p> <p>understanding [2] 50/8 75/8</p> <p>understood [1] 29/25</p> <p>unduly [1] 30/25</p> <p>unequivocal [2] 21/15 21/19</p> <p>unfamiliar [1] 30/18</p>
---	--	---	---	---

<p>U</p> <p>unfortunately [1] 37/10</p> <p>unhappy [1] 38/21</p> <p>uniformity [1] 69/6</p> <p>unilaterally [2] 24/11 25/2</p> <p>unit [11] 1/23 2/22 2/22 2/24 3/2 3/14 24/21 42/23 42/24 44/20 47/10</p> <p>units [1] 69/7</p> <p>unless [3] 32/5 72/13 80/19</p> <p>unsupported [1] 76/5</p> <p>until [2] 82/11 82/14</p> <p>unusual [1] 81/23</p> <p>unwell [6] 40/12 46/18 53/5 65/23 67/9 69/17</p> <p>up [25] 4/17 6/11 8/3 12/11 14/22 22/20 27/22 30/17 40/14 49/2 50/16 51/14 53/24 55/3 59/16 65/8 66/5 70/25 71/20 72/8 73/12 76/1 76/3 79/6 81/21</p> <p>update [2] 29/11 35/22</p> <p>updates [1] 36/11</p> <p>upon [2] 76/24 80/25</p> <p>upset [1] 32/22</p> <p>upsetting [3] 32/1 33/24 35/6</p> <p>upstairs [1] 33/21</p> <p>URN [2] 1/13 41/17</p> <p>us [10] 2/19 25/14 29/9 38/15 42/7 42/22 43/21 46/10 54/15 55/6</p> <p>use [2] 16/19 46/2</p> <p>used [4] 19/3 19/16 61/15 77/6</p> <p>useful [5] 59/3 59/23 67/16 71/1 75/21</p> <p>using [2] 15/16 56/11</p> <p>usually [2] 36/11 36/19</p>	<p>16/13 16/18 17/9 17/22 18/3 18/8 18/25 51/14 52/24 55/25 58/8 73/5 73/12 74/5</p> <p>VC's [6] 8/21 14/10 49/3 50/3 54/9 54/11</p> <p>versa [1] 72/6</p> <p>version [2] 32/7 64/20</p> <p>versus [2] 60/14 67/10</p> <p>very [45] 1/18 2/8 7/22 14/9 18/9 23/23 25/9 26/13 28/23 31/23 34/16 34/21 39/21 40/5 40/24 42/11 52/4 54/7 56/25 57/16 57/22 59/4 60/19 60/21 61/7 62/22 63/17 65/23 65/25 66/6 67/7 67/9 67/10 68/4 71/3 72/3 72/23 74/13 74/25 76/12 77/6 77/8 77/11 80/11 81/3</p> <p>vice [1] 72/6</p> <p>victim [12] 11/8 29/20 29/23 30/14 32/20 38/2 38/6 38/20 38/23 40/6 58/19 71/16</p> <p>victims [4] 11/9 29/24 30/16 40/4</p> <p>video [2] 18/8 18/10</p> <p>view [14] 4/14 5/14 19/1 23/12 32/3 32/15 34/1 50/3 57/13 67/17 67/18 70/8 76/5 76/21</p> <p>views [1] 67/6</p> <p>violence [16] 45/25 50/5 50/6 50/12 50/13 52/11 52/13 61/16 62/11 65/13 67/12 68/18 76/6 76/7 76/22 76/25</p> <p>violent [2] 50/9 62/6</p> <p>violently [1] 67/3</p> <p>visit [2] 30/8 54/12</p> <p>visiting [1] 69/3</p> <p>visits [1] 57/11</p> <p>Vodafone [1] 14/22</p> <p>voices [9] 15/4 15/16 15/19 16/9 54/24 55/8 55/18 55/19 60/1</p> <p>volume [4] 67/17 74/7 79/19 80/12</p> <p>voucher [1] 14/22</p> <p>VPS [1] 37/7</p> <p>vulnerable [1] 67/10</p>	<p>51/6 55/9 74/15 78/20 79/24 82/1</p> <p>wanted [6] 14/15 29/8 37/11 39/13 49/13 51/3</p> <p>wanting [2] 52/2 68/19</p> <p>wants [1] 13/19</p> <p>ward [1] 54/24</p> <p>warm [1] 26/14</p> <p>was [102]</p> <p>wasn't [8] 12/7 24/10 24/11 29/2 29/2 33/11 37/16 49/22</p> <p>waste [1] 54/4</p> <p>watched [3] 28/2 34/13 37/5</p> <p>water [1] 26/14</p> <p>way [9] 15/4 16/1 35/19 40/2 50/3 59/13 63/20 68/16 79/15</p> <p>Wayne [9] 28/23 31/17 33/8 33/15 34/6 35/8 37/14 37/21 38/2</p> <p>ways [3] 16/14 70/10 78/13</p> <p>we [106]</p> <p>we'd [6] 24/7 33/16 37/9 37/10 53/13 57/15</p> <p>we'll [5] 10/23 13/15 40/17 40/25 61/21</p> <p>we're [9] 2/4 2/12 23/15 44/20 44/20 47/17 52/1 55/23 55/24</p> <p>we've [18] 2/13 4/5 12/13 13/10 16/3 18/15 19/15 22/13 22/15 38/21 39/19 43/10 46/3 47/4 51/9 51/21 53/1 70/17</p> <p>Webber [2] 32/20 33/5</p> <p>Webbers [2] 33/17 33/21</p> <p>weed [1] 68/8</p> <p>weekly [1] 53/24</p> <p>weight [1] 19/7</p> <p>welcomed [1] 54/15</p> <p>welfare [2] 26/4 35/19</p> <p>well [31] 6/24 7/20 17/9 22/21 24/13 25/19 30/24 31/23 34/4 35/6 37/13 38/23 47/15 47/23 48/12 51/15 52/6 52/20 53/4 54/15 54/19 54/19 55/8 57/16 61/5 63/9 63/10 67/24 67/25 68/5 80/9</p> <p>wellbeing [1] 81/10</p> <p>went [4] 11/7 11/21 26/1 58/9</p> <p>were [34] 3/19 7/3</p>	<p>7/22 9/1 13/12 14/3 15/16 15/16 18/24 21/5 21/14 21/17 24/7 25/3 25/18 26/5 26/16 27/13 27/13 27/24 28/10 28/24 29/21 31/25 32/23 33/1 33/2 33/18 33/21 34/24 42/19 52/17 58/8 74/5</p> <p>weren't [1] 37/12</p> <p>what [72] 3/10 5/6 7/1 7/2 7/8 8/23 11/5 13/2 13/18 16/15 17/20 18/5 19/19 23/3 23/22 26/11 27/4 31/7 33/1 33/18 34/4 35/5 35/17 35/25 36/12 36/12 42/11 42/22 43/21 44/25 45/10 45/22 45/23 46/11 46/17 47/14 47/22 47/24 48/12 50/10 50/24 51/6 51/17 51/18 52/16 52/19 53/14 55/19 56/2 58/5 58/7 58/8 59/7 59/7 59/20 61/8 62/22 62/23 63/1 63/4 63/5 64/4 64/15 65/25 66/13 66/14 70/20 73/4 74/19 77/24 81/11 81/15</p> <p>what's [5] 13/23 25/14 30/16 35/21 73/4</p> <p>whatever [1] 79/17</p> <p>when [34] 6/18 10/7 11/5 14/17 15/15 16/16 16/20 18/8 18/21 22/1 22/20 23/6 25/5 28/23 29/9 33/18 36/15 44/1 46/20 50/6 50/11 51/5 52/24 54/14 54/17 55/1 55/5 55/6 58/6 61/9 62/18 67/2 74/17 81/12</p> <p>where [32] 2/19 2/19 5/10 7/3 14/14 18/10 21/17 24/25 30/18 43/2 44/4 44/6 50/22 56/25 59/17 60/13 61/3 66/11 68/2 68/17 72/7 72/8 73/12 73/13 73/14 73/21 74/8 75/2 76/23 79/10 80/24 81/15</p> <p>whether [13] 19/8 19/11 19/12 20/3 23/14 23/17 34/11 38/4 43/7 54/1 62/5 73/18 81/16</p> <p>which [25] 4/19 4/24 7/8 8/10 9/23 10/6 10/24 15/10 17/1 21/21 23/17 25/17 27/8 42/24 43/25</p>	<p>44/21 62/9 64/2 68/24 72/25 74/6 76/13 78/13 81/1 81/5</p> <p>whichever [1] 78/16</p> <p>whilst [2] 15/3 17/8</p> <p>who [34] 2/4 3/1 22/11 22/19 22/20 25/5 34/17 36/23 38/23 39/22 43/17 45/14 45/23 46/4 50/24 53/2 58/7 58/19 59/17 60/4 60/4 62/7 64/10 66/6 66/9 67/9 67/11 69/19 70/18 74/23 74/25 75/6 80/10 81/23</p> <p>whole [2] 29/23 61/23</p> <p>whom [3] 39/20 45/20 48/24</p> <p>whomever [1] 15/18</p> <p>why [9] 4/22 16/11 27/21 29/15 33/9 33/14 40/25 53/13 81/6</p> <p>wide [1] 51/21</p> <p>widely [1] 61/15</p> <p>widespread [1] 76/5</p> <p>will [14] 2/9 10/13 26/19 66/4 66/6 66/6 66/11 66/15 66/16 69/7 81/18 81/19 81/19 81/20</p> <p>window [2] 16/20 16/22</p> <p>windowless [1] 31/22</p> <p>windows [1] 16/14</p> <p>wish [4] 32/2 38/12 72/13 79/4</p> <p>wished [2] 32/19 38/13</p> <p>within [9] 9/14 42/17 45/7 60/6 60/6 60/8 68/20 76/15 78/21</p> <p>without [7] 43/24 45/14 48/11 59/1 64/10 72/5 77/8</p> <p>WITN0012004 [1] 49/5</p> <p>WITN0012005 [1] 47/5</p> <p>WITN0081001 [2] 1/13 31/8</p> <p>WITN0415001 [2] 41/17 77/16</p> <p>WITN0415008 [1] 75/25</p> <p>witness [18] 1/10 3/8 8/4 8/25 11/7 18/23 22/6 31/18 33/17 40/22 41/16 42/1 43/13 44/11 46/8 47/4 61/13 64/12</p> <p>witnesses [2] 62/3 68/25</p>
--	--	--	--	---

<p>W</p> <p>women [2] 18/12 55/12</p> <p>words [1] 55/15</p> <p>work [7] 47/24 61/22 69/8 71/12 71/13 71/20 74/22</p> <p>worker [1] 81/8</p> <p>working [4] 43/17 44/22 47/6 47/9</p> <p>works [2] 40/7 40/7</p> <p>worn [1] 53/2</p> <p>worse [1] 52/3</p> <p>worst [2] 63/4 81/22</p> <p>worst-case [2] 63/4 81/22</p> <p>worthless [1] 65/2</p> <p>would [97]</p> <p>wouldn't [10] 34/2 38/8 52/8 53/21 57/19 58/7 58/9 69/10 69/18 70/2</p> <p>write [2] 5/7 29/15</p> <p>writing [2] 56/24 60/18</p> <p>written [2] 14/23 39/14</p> <p>wrong [6] 7/6 7/7 38/6 38/8 38/9 58/14</p>	<p>40/19 41/20 41/25 42/1 42/5 43/13 43/19 44/11 46/8 50/3 53/3 53/19 57/13 60/8 60/9 60/9 60/10 61/13 61/17 63/15 64/12 65/5 65/18 68/24 70/8 70/14 74/16 77/14 77/15 78/23</p> <p>yours [1] 32/12</p> <p>yourself [4] 4/18 15/6 22/12 35/23</p>			
<p>Y</p> <p>Yeah [1] 60/3</p> <p>years [5] 42/3 45/5 51/20 55/24 69/1</p> <p>yes [111]</p> <p>yet [1] 50/17</p> <p>you [303]</p> <p>you'd [3] 25/24 33/8 54/6</p> <p>you'll [1] 24/15</p> <p>you're [24] 1/22 27/5 42/8 42/21 54/5 54/8 58/15 59/22 59/22 59/23 64/16 65/10 67/25 68/2 68/11 68/18 68/19 69/5 73/5 75/22 80/23 81/2 81/2 81/4</p> <p>you've [29] 1/18 1/19 1/25 3/8 27/21 28/20 31/7 34/5 39/14 40/2 40/19 41/25 43/13 43/19 45/10 46/8 61/12 61/16 64/5 64/12 64/23 65/4 68/7 70/14 71/19 74/16 74/17 77/18 80/19</p> <p>your [59] 1/16 1/18 1/19 2/3 2/9 2/20 3/8 3/10 4/25 5/14 7/25 8/4 8/25 10/7 10/24 17/3 17/3 19/1 22/1 22/8 22/12 22/18 23/12 23/13 25/13 25/14 31/6 32/3 39/14</p>	<p>Z</p> <p>zone [1] 45/7</p>			