

Thursday, 23 April 2026

1
2 (1.55 pm)
3 **MS LANGDALE:** Dr Seedat, before the break we had looked at
4 your Mental Health Act Assessment and detention for the
5 second time. Can we have, please, NHFT0000203, page 3,
6 the Summary and Care Plan. It begins page 1. If we go,
7 thank you, straight to page 3, the Safety Plan:
8 "... [VC] went to a neighbour on top of his flat,
9 knocked at his door to confront him as to why he was
10 discussing him as he had heard voices to that effect and
11 he was certain that it was this person living above his
12 flat responsible. He barged into the persons flat and
13 wanted the person to admit what he was doing and other
14 neighbours came to the rescue and called the police."
15 So in terms of what we were saying about tracking
16 the delusionary beliefs, it was about somebody causing
17 him a problem, and him wanting to confront them.
18 **A.** That's correct.
19 **Q.** In terms of a safety plan, this refers to one of the
20 three episodes of violence in May. It would have been
21 better and more appropriate to put all of those events
22 together, wouldn't it, at this point on the summary and
23 care plan?
24 **A.** Yes.
25 **Q.** Doing so loses the significance of the pattern which was

1

1 honest with you, about medication?
2 **A.** Yes, I did.
3 **Q.** Did you? Did it make you question whether he was able
4 to think of his primary aim, which may be to get out of
5 hospital, when he was telling you that what he would do
6 with medication?
7 **A.** I did not form that opinion that he had said the right
8 things to me to get out of hospital. I did form the
9 opinion that VC reneged on his word in terms of whether
10 he would continue taking his medication or not whilst in
11 the community, and this was based on the fact that his
12 evidence and also on his own assertion that he had not
13 taken medications was confirmed. And this was why,
14 during the second admission, it was an important point
15 and factor to ensure that we worked on VC's insight and
16 understanding of the gravity of his symptoms and the
17 potential risk that they would potentially confer to
18 others.
19 **Q.** He did not consider that he was mentally unwell, did he?
20 **A.** At the time of the mental health assessment, he did not
21 feel that. I think he also stated that he didn't feel
22 that this was as bad as the first one.
23 **Q.** You, by now, had a lot of information around what his
24 beliefs were and they were that his mind had been taken
25 over and that people around him were responsible for it,

3

1 clearly emerging here, which was a serious risk to his
2 neighbours and those around him?
3 **A.** Yes, and I think there was an understanding on the ward,
4 or at least in my understanding that the three incidents
5 were of significance.
6 **Q.** Can we have, please, NHFT0000168, page 61, a RiO note,
7 not made by yourself, reflecting when section 3 rights
8 were read to VC. So it's NHFT0000168, page 61, thank
9 you. We see it three boxes up from the bottom:
10 "[VC] was asking me questions, ie the purpose of an
11 advocate, how long the tribunal purpose takes ... [VC]
12 did appear to understand all of the information given to
13 him. He said he will have a think about whether he
14 wants to appeal and will let staff know."
15 We know from an analysis of the phone records, we
16 don't know precisely when it was done, but that he has
17 perused and looked up the Mental Health Act and police
18 powers. He was very aware of his rights and understood
19 them, didn't he, was that your --
20 **A.** Yes.
21 **Q.** -- experience dealing with him?
22 **A.** It was.
23 **Q.** Again, dealing with his level of intelligence generally,
24 and the ability to mask, did you factor that into
25 account when you were considering whether he was being

2

1 and it wasn't that he was mentally ill. He didn't
2 accept that he was mentally ill, did he?
3 **A.** Yes, that was at the time of the assessment, yes.
4 The --
5 **Q.** Did he ever accept that?
6 **A.** I think he did towards the end of the first admission
7 and also, after having done quite a lot of work around
8 insight, that he did develop that view as well at the
9 end of the second admission.
10 **Q.** I didn't ask you whether he appeared to accept that.
11 Did he ever actually accept that, as far as you are
12 aware?
13 **A.** I can just go by what he said to me in the interactions
14 that I had, the interactions I had, which would be very
15 similar to other patients. I was convinced that and
16 I was of the opinion that he had developed insight, he
17 had an understanding of what his symptoms meant and how
18 they equated to a diagnosis of psychosis.
19 **Q.** So in conversation with you, you accepted what he said
20 about understanding that he may have psychosis?
21 **A.** Yes.
22 **Q.** Can we have a look, please, at NHFT0000168, page 64.
23 This is your 72-hour review, and patient comments:
24 "[VC] describes stopping medication two weeks after
25 discharge from his last admission because he read that

4

1 it could 'slow the mind'. He concedes that doing so may
2 have 'made me a little more paranoid'."

3 Pausing there, he had read that it can slow the mind
4 rather than experiencing that it could slow the mind.
5 Did that concern you that --

6 **A.** Yes.

7 **Q.** -- that was just an academic response to it?

8 **A.** It did concern me because he relayed -- he used more in
9 terms of what he read rather than exactly what he
10 experienced. This is why it was an important focus
11 during the second admission to try and determine whether
12 VC was actually experiencing any symptoms rather than
13 what he had read.

14 **Q.** "Seems nonplussed when confronted with the effects of
15 his behaviour with the neighbour during this incident
16 and also the previous admission."

17 Set out for us the conversation you had with him
18 that's described in these two paragraphs, please.

19 **A.** The conversation I was having is I reiterated the
20 incident that had taken place and I was trying to get
21 a view or understanding of how VC was going to react or
22 respond to these concerns in terms of his behaviours.
23 And it was at this point that I made the conclusion that
24 VC did not demonstrate effective, I guess, recognition
25 of the impact of his behaviours to others.

5

1 was a very frank discussion with him, and I made it --
2 I painted a worst-case scenario in terms of what could
3 happen if he continued with his behaviours.

4 And I reminded him that: "If you recall during your
5 first admission, due to your behaviours, an individual
6 jumped and hurt themselves, and if this continues,
7 because you are not taking or fully taking on board the
8 implications of your illness on you and your behaviours,
9 this could be at a point that next time, if you did
10 continue this, that you would end up killing someone."

11 So it was in that context, to try and --

12 **Q.** Did you think --

13 **A.** -- maybe shock or highlight the importance of the
14 implications of his behaviours in order to try and help
15 him, I guess, develop, or start to develop, some sort of
16 understanding of the gravity of the situation.

17 **Q.** Did you think he could end up killing someone?

18 **A.** No, I didn't.

19 **Q.** Why did you say that to him, then?

20 **A.** I was trying to paint a -- and when I said he would kill
21 someone, this would be unintendedly, ie if somebody --
22 if he went and did the same thing and somebody jumped
23 out of the window and maybe if they were on a higher
24 floor, the consequences could be very different, and it
25 was with that that I made that comment. Not that he

7

1 **Q.** Why do you say that? What did he say that made you
2 conclude that?

3 **A.** Because VC did not in any way exhibit or at that point
4 describe behaviours or views that would show some level
5 of understanding, some level of recognition, some level
6 of, I guess, putting one and one together, you know, to
7 say this led to this, and this is because of this. And
8 VC was not demonstrating that at the time.

9 **Q.** You say in terms:

10 "No signs of remorse or insight into how his actions
11 have affected others."

12 No signs of remorse, so no concern for victim impact
13 or anything like that?

14 **A.** At the time he didn't, yes.

15 **Q.** The note here records:

16 "Dr Seedat observed that there seems to be no
17 insight or remorse and that the danger is that this will
18 happen again and perhaps [VC] will end up killing
19 someone. [VC] simply responds by saying 'it will not
20 happen again'."

21 How did that exchange arise?

22 **A.** So that exchange arose, having determined that VC was
23 not demonstrating any remorse or any true understanding
24 of what had just happened, I wanted to have a very frank
25 conversation, which is clearly documented, that there

6

1 would kill someone physically by his hand; it would be
2 an unintended consequence.

3 **Q.** But the consequences of your actions could be killing
4 someone.

5 **A.** Well, the person would have died from the actions that
6 they took on board, but it wouldn't be VC himself
7 intending, or with intent, killing someone.

8 **Q.** You record here:

9 "... [exploring] [VC's] insight ... and possible
10 serious mental illness. Very frank discussion. [VC]
11 does not accept that he may have an enduring mental
12 illness. Dr Seedat reflected ...it seemed strange he
13 had not chosen to read up on psychosis and possible
14 causes. In his opinion it appears increasingly likely
15 that [VC] has schizophrenia. [VC] does not fully accept
16 this -- he is hoping it will go away 'that I will use my
17 will to power through it'."

18 Yes?

19 **A.** Yes.

20 **Q.** So no acceptance of an enduring mental illness. And you
21 never heard anything else from him to suggest otherwise,
22 that he appreciated it was psychosis, that he understood
23 it's onset and the like. You didn't ever get that
24 reassurance from him.

25 **A.** Not on this occasion.

8

1 Q. Did you at all, when you put all of the occasions
2 together?
3 A. In the first -- at the end of the first admission he
4 did, and I believe that, and have the opinion that, at
5 the end of the second admission we did get to that
6 point.
7 Q. If we go to page 66, please, the "Impression":
8 "Acute relapse due to non-concordance with
9 medication, seems calmer in general and no management
10 problems on the ward, Likely schizophrenia".
11 The fact that there were no management problems on
12 the ward and he was stable on the ward, was of no real
13 relevance as to assessing how he might be in the
14 community, was it?
15 A. I think the relevance of that statement was more to do
16 with how he had been on the ward and whether there was
17 any acute interventions that were required, for example
18 management of violence, or aggression, or hostility. It
19 was more in relation to that that that comment was made,
20 because at that 72-hour review I needed, or was trying
21 to get, an understanding whether one -- there is
22 obviously the regular treatment that one needs to think
23 about, but there also needs to be a thought process
24 around "Do I need to think about any rapid
25 tranquilisation treatments or protocols in place, in

9

1 "No psychological assessment or interventions
2 related to psychoeducation and relapse were offered
3 despite the new diagnosis and [VC] and his mother
4 expressing difficulties coming to terms with it. This
5 was a missed opportunity in [VC's] care and goes against
6 NICE guidelines on first-episode psychosis." (As read)
7 But you say what was the reason for that?
8 A. We didn't have any psychologist, psychological support
9 on the ward. I concur that, yes, would have been
10 helpful to have psychological support to try and work
11 with some of these things. But I would say that I do
12 not agree that completely an opportunity was lost,
13 because there were various conversations had with both
14 VC and his mother about his condition, what it meant,
15 what were the potential implications, the importance of
16 treatment. I mean those discussions did take place.
17 They may not have taken place in a psychological space.
18 Q. What's the significance of the psychological space?
19 A. I think within an acute setting it's very difficult to
20 start delivering psychological interventions. It has
21 been my experience that patients are -- can be chaotic,
22 their presentations fluctuate, they take very little on
23 board in terms of the interventions that are being
24 provided, and the focus tends to be around helping with
25 assessment, formulation, et cetera, rather than giving

11

1 case?" And having noted the first admission where VC
2 was chaotic within the early phases of his treatment,
3 I was trying to determine whether that was the case by
4 any chance during this admission, so that appropriate
5 interventions could be put in place.
6 Q. In terms of risk management in the community,
7 non-concordance with medication, you'd identified it as
8 the issue, a key issue, and you'd also diagnosed likely
9 schizophrenia with the associated risks for violence,
10 particularly for younger men, as we spoke about earlier.
11 A. I made the conclusion that VC was clearly a high risk of
12 aggression. My assessment in terms of risk to violence
13 was low.
14 Q. Can we have a look please at NHFT0000168, page 75. This
15 is one of your colleague's notes, Mrs Angela Purdue. Do
16 you know if Mrs Purdue had had much dealing with VC
17 before this?
18 A. No.
19 Q. Acute psychological interventions, it doesn't look like
20 he'd had any psychological interventions at all in his
21 first admission, had he?
22 A. No, because we didn't have any psychological support on
23 the ward during the first admission.
24 Q. Because that was one of the criticisms, wasn't it, from
25 the CQC report that on his first admission:

10

1 specific interventions.
2 And particularly with psychotic illnesses, you would
3 want somebody who has a particular expertise and focus
4 in CBT for psychosis to be of any effective, and that
5 takes time. I don't think you can deliver it within two
6 or three weeks of an admission; it takes a prolonged
7 period of time and it was hoped that this was something
8 that would be delivered within the EIP services.
9 Q. And it takes continuity of care to really make progress?
10 A. Yes, and I think it's important that that psychological
11 intervention is with the same therapist, because one of
12 the important things you have to think about in the very
13 beginning is developing the therapeutic relationship, to
14 get -- to build that trust and confidence to actually
15 have meaningful discussions and conversations.
16 Q. So given that, would you take any comfort from the
17 penultimate paragraph:
18 "[VC] stated ... he fully understands the need for
19 ongoing medication for a time after discharge.
20 "P(lan) ... aware he can ask for support where
21 needed, [whether] ... that be an informal chat about his
22 medication ... mental health and support. [He] will
23 seek support from the GP [at] LMHT if he wants to make
24 any changes to ... medication when discharged from
25 hospital."

12

1 Do you get any reassurance from that? At the time,
 2 not now.

3 **A.** Yes. I think, as I said, we had done quite a lot of
 4 work with VC around his insight, the importance of
 5 compliance to medication, helping him understand and
 6 recognise the connection between his behaviours and his
 7 symptoms of illness. And I did feel that there was some
 8 assurance that was reached at the time of -- at the end
 9 of the admission around that.

10 **Q.** If we can have page 79, please, on the screen. This is
 11 the 21 July ward review. We see in the second paragraph
 12 at the top, discussion:

13 "Dr Seedat explained to [VC's] mother that section 3
 14 allows [VC] to be treated in the hospital for up to 6
 15 months ..."

16 **A.** I can't see where --

17 **Q.** You can't see? Sorry, page 79 at the top.

18 "... however, 6 months is the maximum. He may need
 19 to be here for less."

20 What period of time did you think at this point he
 21 was going to be there for the second admission?

22 **A.** I did not make any deductions in terms of how long
 23 somebody is going to stay from the point they are
 24 admitted, it all depends on how the admission progresses
 25 and whether the goals that we have in terms of the

13

1 immediate risk to himself or others, do you think you
 2 can continue to detain them or not?

3 **A.** Yeah, I'm not looking at it in terms of the powers that
 4 help me make a decision about whether to discharge
 5 someone or not. The discharge was based on clinical
 6 evidence; not whether he still fulfilled the criteria
 7 for detention.

8 On the first admission, the criteria decision only
 9 any allowed 28 days' detention, whereas this was
 10 different, this was a Section 3. I don't need to
 11 continue justifying it unless the patient had appealed
 12 their section and if they went to tribunal, the tribunal
 13 could discharge them if there wasn't sufficient evidence
 14 or satisfactory evidence --

15 **Q.** So what does the --

16 **A.** -- to defend the legal position at the time.

17 **Q.** So why do you say the least restrictive option? How
 18 does that play in your mind as a factor in these
 19 circumstances -- (*overspeaking*) --

20 **A.** -- is not keeping the patient detained in hospital for
 21 longer than they need to be, rather than the period of
 22 time. If someone has reached the treatment goal, it's
 23 difficult to justify why you would still be keeping the
 24 patient on the ward.

25 **Q.** Well, let's look at the treatment goal. So you say at

15

1 patient's management are achieved and how quickly that
 2 could be achieved.

3 **Q.** It's a very short admission, again, isn't it --

4 **A.** Yes.

5 **Q.** -- it's two weeks; do you think it was long enough?

6 **A.** I think it -- again, as I said, it all depends on what
 7 progress a patient makes. It is not necessary that
 8 length of time dictates whether effective interventions
 9 have been achieved or not. If all the markers suggest
 10 that whatever the goals of the treatment and the
 11 assessment and the management are at that time, if they
 12 have been achieved, we have to move things back into the
 13 community.

14 Discharging someone from the ward doesn't
 15 necessarily mean that treatment stops. Treatment still
 16 has to continue, it's just that the acute phase has been
 17 managed such that this patient can now be safely managed
 18 in the community and once one reaches that point,
 19 I think we have to start looking at discharge, because
 20 the Mental Health Act clearly says that the period of
 21 detention should be for the least amount of period of
 22 time.

23 **Q.** You keep referring to the legal powers and the grounds
 24 for detention. What's your understanding about that?
 25 If you consider the patient represent a risk to himself,

14

1 the bottom, under "Patient comments", seven lines up:
 2 "Dr Seedat explained to [VC] that it was his view
 3 that if he had not stopped taking his medication, he
 4 probably would not be here again. [VC] understands he
 5 must take his medication regularly."

6 So the treatment goal for you is identified; he must
 7 take his treatment regularly.

8 **A.** Yes, treatment was important, because treatment
 9 controlled his symptoms, and if symptoms were
 10 controlled, this would also control his behaviour and
 11 risk.

12 **Q.** So it's the goal?

13 **A.** Yes.

14 **Q.** It's a key goal?

15 **A.** Yes.

16 **Q.** In this meeting there was discussion about treatment,
 17 and VC's mother, if we go back up to "Family/Carer's
 18 Involvement" queries use of a depot.

19 So what's your view at this point about a depot? If
 20 it helps, we can have your statement that deals with it.

21 **A.** Yes.

22 **Q.** That's WITN0163001, if we can have page 158 and 159
 23 alongside each other, please.

24 You say at the bottom of page 158:
 25 "... I raised with him the option of taking the

16

1 depot version of the medication. It was my belief that
2 [VC] understood what a depot medication was, he
3 understood what it involved."

4 Pausing there, in terms of his capacity to make an
5 informed decision about treatment, was the starting
6 point that he needed to understand he was mentally
7 unwell and that the treatment would assist him?

8 **A.** That would be an important starting point, the --

9 **Q.** Did he have that starting point at that stage? You said
10 at this point you weren't clear that he understood he
11 had a mental illness. Do you think he understood he had
12 a mental illness from this point onwards?

13 **A.** At this point, I didn't think he had fully understood
14 and taken on board that based on the 72-hour review,
15 that VC had made the view that he had an enduring mental
16 illness. In fact, he believed that he could control
17 this by his own will. And that was an important area to
18 work on.

19 The discussion here about the depot was to start the
20 conversation around depot, rather than it was
21 a discussion had that this was something that I was
22 planning to do. The discussion was around medications
23 can be given in two ways: one could take oral
24 medication; the other option could be about taking depot
25 medication. I explained to both him and Mum to say

17

1 **A.** Yes.

2 **Q.** We have the evidence.

3 **A.** Yes.

4 **Q.** And the past is a good predictor of the future?

5 **A.** It does, yes.

6 **Q.** If we look at page 159 in front of us:

7 "The main decision [top paragraph] was oral versus
8 depot injection. It was my view that he now understood
9 how important medication was in controlling his symptoms
10 and his risk. He said he was not fond of needles, and
11 it was ... preferred option to continue with oral
12 medication ..."

13 You were aware he'd had Covid vaccines, blood tests
14 at the hospital, so what was the significance of not
15 being fond of needles either way?

16 **A.** Yes, his assertion that he was not fond of needles did
17 not have any bearing in terms of my decision whether to
18 give him depot or not give him depot.

19 **Q.** Did you think it was not true? Do you think he was just
20 saying that if he was having blood tests without arguing
21 about having them. Did you question the validity of
22 that suggestion?

23 **A.** I did. He continued to maintain that he would prefer
24 not being given an injection.

25 **Q.** Because of the injection, or because he didn't want the

19

1 that, you know, sometimes people who may find it
2 difficult to take tablets may find it helpful to just
3 take an injection because you take an injection, you are
4 assured you're taking medication. People who are
5 looking after you are also assured you are taking
6 medication. There can't be any ambivalence to say or
7 any concern that you're not taking medication. If
8 you've had your injection, you've had your medication.

9 And the discussion with VC was at this time was that
10 well, there is the option that we can consider you
11 taking depot if that's going to make it easier for you
12 to remember, and continue taking your medication. And
13 it was on that, and having explained what depot was,
14 that it was an injection, it would have been the same
15 medication that he had been taking, or that he had
16 taken, I formed the opinion, even though VC was not
17 fully in -- fully accepting that he had enduring mental
18 illness, that he understood at least the basics of what
19 depot medication is, and what it entails.

20 It was not to do with anything to do with capacity
21 or whether a depot -- whether he should choose to have
22 a depot or not have a depot. The depot was offered as
23 or discussed as a helpful aid, if he was struggling with
24 being compliant with oral medication.

25 **Q.** It wasn't if, he had been?

18

1 medication because he wasn't ill?

2 **A.** He kept on saying it was more to do with the needle,
3 with the fact that he didn't want the injection rather
4 than the medication. What he did say was that he would
5 take the oral medication.

6 **Q.** If that can come down, please, and if we can go to
7 a ward review on 28 July, NHFT0000168, page 106. "MDT
8 discussion", when it comes on the screen. We'll wait
9 until it does. Thank you. And if we have 107 next to
10 it, if we can. If we see in the middle of the page,
11 106, Dr Seedat:

12 "MDT discussion":

13 "Dr Seedat explained we have called the Crisis Team
14 as we feel as though [VC] may need more support when he
15 is discharged. Explained we have done some work on
16 insight, concordance and it seems as though he is saying
17 the right things."

18 So he doesn't have insight, you're not saying he
19 understands the importance. You're saying here: "He is
20 saying the right things."

21 **A.** Yes.

22 **Q.** That rather suggests you don't know whether he means it
23 or not; in fact, probably don't.

24 **A.** I think I was taking into consideration what happened
25 after the first admission, and in view of what had

20

1 happened I was trying to be cautious here in trying to
2 put in plans to try and ensure that whatever
3 improvements we had achieved within the inpatient
4 setting, are then continued within the community
5 services.

6 As you will understand that the reality of things is
7 only when someone does something or not to do something,
8 and I was of the opinion that we had reached a point
9 where we had done quite a lot of work around VC in terms
10 of understanding his difficulties. My comment there did
11 not infer or should -- was not intended to infer that I
12 didn't trust whether he understood or recognised the
13 link between his symptoms and his behaviour.

14 And what I meant by saying that he is saying the
15 right things was whether he would continue taking his
16 medications. And the only way I was going to test that
17 is if he goes back in the community; on an inpatient
18 ward, he has regular supervision. The test is going to
19 be is when he goes back into the community, will he do
20 this? Will he continue taking his medication on this
21 occasion? And on that premise, I felt it was important
22 to try and get the Crisis Team, who can monitor the
23 medicating, at least for a period of time, to see
24 whether there were any concerns around non-compliance to
25 medication.

21

1 view that his understanding, recognition of things was
2 not impacted by his illness. He was able to understand
3 the information that I was giving. He was able to give
4 me back what I had said to him, and I was of the opinion
5 that he did have capacity to understand treatment, and
6 how important treatment was. And I go back to the frank
7 conversations that I had with him about the risks and
8 concerns that I had if he didn't remain compliant with
9 medication, and I believe that that information did have
10 an impact on VC.

11 **Q.** You've referred a number of times now to "frank
12 conversations", but they weren't frank, were they? He
13 didn't do what he was telling you during this admission.

14 **A.** I don't understand that.

15 **Q.** He wasn't frank with you; he didn't take his medication.
16 We know that from subsequent events --

17 **A.** I think the frank conversation was about highlighting to
18 him the importance of his symptoms and his behaviours.

19 **Q.** Well, you're being frank; was he being frank? You've
20 referred to frank conversations.

21 **A.** Yes.

22 **Q.** Does this mean your own frankness?

23 **A.** I mean by my own frank conversation towards him, trying
24 to impress on him the importance of, I guess,
25 controlling his illness.

23

1 **Q.** The concerns, when they arose, involved assaults on
2 others and him being arrested. That's how you
3 discovered when he was non-concordant with medication.
4 Did that factor in your thinking at this stage?

5 **A.** Yes, it did. I think, as I said, that did factor --
6 this was why it was important that the focus of the
7 second admission was around ensuring ways to convince
8 him about his illness, about the importance of
9 medication and how they control his symptoms and have
10 an impact then on his risky behaviour. And the
11 importance of being compliant with medication.

12 **Q.** On page 107, if we look under "Mental Capacity", it
13 says:

14 "On the balance of probabilities and existing
15 capacity guidance, this person DOES NOT have the
16 capacity to make decisions about admission and/or
17 treatment."

18 Is that just pulled through from other --

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

20 **Q.** -- references?

21 **A.** It has.

22 **Q.** So that's not a -- did you do a capacity assessment to
23 see if he understood treatment and depot, and the
24 benefits?

25 **A.** Yes. I think at the time where he had got to, it was my

22

1 **Q.** If we have, please, NHFT0000168, page 115. This is the
2 30 July, a psychological appointment with VC. Tells the
3 psychologist, in the bottom box:

4 "... does not use drugs."

5 We'll see it in a moment.

6 "... not had any 'strange experiences' or voices in
7 recent weeks.

8 "We spoke about recognising signs of ... mental
9 health and deterioration ... VC said he will be able to
10 do this by recognising that he is paranoid, feeling
11 a 'lack of control' over himself, feeling as though
12 people might be following him, and feeling very
13 irritable can be a warning sign for him struggling with
14 his mental health. VC said that if anything does arise,
15 he will contact the [Crisis Team]/family/his GP.

16 "VC is being discharged on [31st July] ... no
17 recommendation for further Clinical Psychology input has
18 been made at this point."

19 We know if we have on the screen now, please,
20 NHFT0000168, 138, after the second admission,
21 10 November 2020, on a home visit.

22 This Dr Burri's note, he's going to be giving
23 evidence. Second paragraph:

24 "He said ... just before his discharge from Highbury
25 Hospital back in July, He told ward doctor that he no

24

1 longer hear voices but he said that is not the case and
2 he only said that because he was tired for being in the
3 hospital. When I said that why this is so important for
4 him to tell us this when he could have easily wait[ed]
5 till his appointment this Thursday he said because 'the
6 voices that I can hear can see other people as well and
7 he [doesn't] ... want that other people to get into ...
8 trouble'."

9 So hallucinations, on the face of it, continuing,
10 and listening to people taking over his mind, and he
11 says in terms, he said at Highbury what he needed to
12 because he was tired of being in hospital.

13 So he was not frank at all with you on that second
14 admission, was he?

15 **A.** I think in hindsight, yes, you could make that comment.
16 But in terms of interactions with me, I wasn't left with
17 the impression that he wasn't.

18 **Q.** So what's your learning from that then? That you
19 thought he was being, and he was being honest and that
20 you were making progress for insight, and in fact
21 nothing further from the case.

22 **A.** I think in psychiatry, in view that we don't have any
23 objective ways of determining whether somebody is
24 telling us the truth or not, it becomes very difficult
25 and hard to, in the time that you're with the person, to

25

1 the patient is saying and I also look at any objective
2 evidence. This is why I was important that I vigorously
3 looked at RiO records to try and determine or to try to
4 check whether there was anything that was suggestive of
5 symptoms of illness during this period where he was
6 demonstrating recovery.

7 And I didn't find any evidence, there was no
8 suggestion from any of the observations we had made,
9 that he was exhibiting psychotic symptoms when we were
10 coming close towards discharge.

11 **Q.** Why, when you knew of the first, certainly second, and
12 definitely the third, three arrests from the police,
13 didn't you obtain direct information from the police for
14 yourself to know what had happened in those events?

15 **A.** The information was available in the RiO records. The
16 Liaison and Diversion service had already put all the
17 information on RiO. Yes, the details, the exact details
18 of the incident did not appear. In my experience with
19 the police, the only information we get back from the
20 police when we request is the outcome of PNC checks
21 and --

22 **Q.** What else do you request? Have you ever asked for
23 anything else, apart from that?

24 **A.** We ask -- we ask for all information the police has
25 about an individual.

27

1 determine that.

2 I think we all have to work with the premise and
3 principle that we are working together in the benefit of
4 the patient and the patient understands that.

5 The learning is with that, one will have to --
6 I will have to think about how and whether there are any
7 practical and clear ways of determining whether somebody
8 is being truthful or not, and that will be difficult to
9 do.

10 **Q.** Can we have, please, on the screen, NHFT0015099, page 1.
11 And it's a Good Practice Guide, Dr Seedat, from the
12 Royal College. If we can go please to page 7: "Tips for
13 psychiatrists", a number of tips here. Third one:

14 "Be curious and look beyond face value."

15 You had material to assist you right from the
16 beginning from the family, didn't you, with the texts
17 and the insight into his mind and what he was thinking?
18 You had more to be curious about and more to ask about,
19 didn't you, in this situation?

20 **A.** And I think -- I would say that I was curious, I did
21 make assessments. But at the same time I also have the
22 patient in front of me having discussions with me, and
23 I can't work with the premise that the patient in front
24 of me is basically not -- is lying to me all the time.

25 I have a level of curiosity. I look at both what

26

1 **Q.** How do you do that?

2 **A.** We have the Ward Manager who will make the request and
3 will escalate this through senior pathways within the
4 Trust to try and determine and get this information.
5 It's -- it takes weeks to get information. Sometimes
6 the only thing we get back is a PNC check, and unless
7 somebody has -- my understanding is that unless somebody
8 has convictions, that's the only thing that appears on a
9 PNC check; incidences doesn't occur on a PNC check.

10 **Q.** So is your understanding, as you sit there today, if
11 there's not been a conviction, you can't get any other
12 information from the police?

13 **A.** It has been difficult to get.

14 **Q.** Have you ever got it?

15 **A.** Never.

16 **Q.** Incidents, events; have you ever requested it?

17 **A.** Yes, I have, many times in other cases.

18 **Q.** In Nottingham?

19 **A.** In Nottingham.

20 **Q.** So you've asked for Nottinghamshire Police to give you
21 information about something that resulted in an arrest
22 but not a prosecution and conviction?

23 **A.** For example, there are times when patients have been
24 admitted on a 136, which means that there has been some
25 police involvement, and if there hasn't been any

28

1 concrete detail about it, we would try and seek
 2 information to gather what the actual details were,
 3 because sometimes the details are not clear.
 4 **Q.** The patient will give you details and if you want to
 5 test them, you need to have information to know whether
 6 they are accurate or not.
 7 **A.** That's correct.
 8 **Q.** So you work just on what the patient says in those
 9 circumstances; that's not satisfactory at all, is it?
 10 **A.** Well, it isn't, but I don't have any other recourse. If
 11 the police don't give me information, they don't give me
 12 information. And I think that is an area, I think, that
 13 needs to improve, and there needs to be some sort of way
 14 where we can easily access, because the other difficulty
 15 is one doesn't know where exactly to go. We just send
 16 a generic email to the police and we don't really know
 17 who is going to answer, what information we're going to
 18 get back. So it would be helpful to know whether there
 19 is somebody specific we could get, and this information
 20 would be readily made available in all situations.
 21 **Q.** Could we have please WITN0412015, page 1. This is
 22 a request form that was followed up in evidence from
 23 a doctor who gave evidence to the Inquiry, it's actually
 24 a Leeds and York Partnership with the West Yorkshire
 25 Police. Just have a quick look at this form, if you

29

1 that he is -- well, expressing thoughts and views that
 2 we've seen in those texts.
 3 Did you ever sit and think: what don't I know here?
 4 Is this is an unquantifiable risk but such a serious
 5 risk that I need to do or take steps to ensure the
 6 public and other people are protected from him?
 7 **A.** The one area was about whether VC had any interactions
 8 with the police ever, and that was something I think
 9 would have been helpful to know whether there had been
 10 any actual purported evidence of violence, et cetera,
 11 which would then help and inform risk assessment.
 12 I would -- it would have also been helpful, as you
 13 have alluded to, to try and get perspective from others
 14 who maybe had significant contact with VC. That could
 15 be people that he was living with, that could be
 16 employers or educational establishments that could share
 17 these sorts of information about an individual to try
 18 and get, I guess, a fuller picture of the individual in
 19 question.
 20 **Q.** Can we go, please, to WITN0163008, page 3 first. The
 21 beginning of this email chain is Eleanor Turner,
 22 Nottingham University to Geoff Culpin, an AMHP, and she
 23 says:
 24 "Following the most recent incident, I was surprised
 25 to learn that [VC] is being discharged tomorrow to the

31

1 could. If we have page 1, 2, on the screen. You see
 2 the way it sets out seeking information about
 3 a particular individual. Why you're entitled to it.
 4 Ticking various boxes if you're from the Trust, and
 5 sending that, if we go over the page, to the police:
 6 "... information sought relating to:
 7 "Violence
 8 "Assault
 9 "Use of weapons."
 10 Justified --
 11 "Justify your assessed Risk ...
 12 "Remember to give specifics ..."
 13 Et cetera.
 14 Have you got any form or way that clinicians can
 15 access information in such a way?
 16 **A.** No.
 17 **Q.** No. Would it be helpful to have that?
 18 **A.** I think so.
 19 **Q.** That can come down, thank you.
 20 We don't need to put it back on the screen, tips for
 21 psychiatrists from the guidance, is "think about what
 22 you don't know". Very important, isn't it, in your
 23 role? "Think about what you don't know." You've got
 24 somebody who you know is a risk to other people in the
 25 community. You know from the texts you've been sent

30

1 same address. I remain concerned for the residents but
 2 I am also increasingly concerned for [VC] in terms of
 3 the other residents and their fears around his mental
 4 health. If this was a university managed accommodation
 5 we would be carrying out a detailed risk assessment and
 6 it is likely that we would be supporting him to return
 7 to Wales. [VC] is citing his academic work as a
 8 rationale ... but all his work is now online and there
 9 is no need for him to be located near to the
 10 University."
 11 If we go to page 2, Geoff Culpin forwards that to
 12 you and your email, we see, to Mr Culpin:
 13 "I cannot dictate where people go and live, he has a
 14 paid up tenancy, the landlords will not give him his
 15 money back and he has no income.
 16 "Maybe that is the work Eleanor needs to do is to
 17 work with landlords and see how they support their
 18 students in such situations.
 19 "On both occasions the incidence happened in his
 20 other flat and not in the one he is returning to.
 21 "He is well, he is taking his meds, he will have
 22 close follow up and not sure what else she wants. You
 23 can just tell people what ..."
 24 Presumably you meant:
 25 "... [you can't just tell] people where they should

32

1 go, he is an adult."
 2 What do you say about that exchange?
 3 **A.** Yeah, having reflected on this email, I guess my tone
 4 and frustration could have been demonstrated, should not
 5 have tried to come out. I guess what I was trying to
 6 convey was my understanding was the University was not
 7 aware that VC had two accommodations; one that he had
 8 been living in when he came to university in his third
 9 year and one where he had moved, because of the
 10 experiences he had, to another accommodation.
 11 The accommodation where the incident happened was
 12 coming to an end within the next few days, hence there
 13 was already a concern about what would happen with
 14 stability with VC's accommodation.
 15 Mum highlighted and reminded us, by the way, that VC
 16 does have his old accommodation still, and that is until
 17 September. And a conversation was then had with VC to
 18 say that, you know, "Do you recall that you have this
 19 accommodation? What are your views about returning to
 20 this accommodation?" Because this is accommodation that
 21 VC had actually moved away from, in view of his beliefs
 22 that people in that area or in that flat were reading
 23 his mind, et cetera.
 24 And so there was a visit made with VC, and a member
 25 of staff, to go and look at this accommodation estate to

33

1 **A.** Not -- not on this -- (*overspeaking*) --
 2 **Q.** No, not on this date, but on the first time she did.
 3 **A.** I did call her on certain occasions. I did.
 4 **Q.** Can we look at the top of this.
 5 "It's the well bit that [is] important ..."
 6 This is what Geoff Culpin says to you:
 7 "... is he on a depot? oral meds?
 8 "Will he have a team following ... up -- or crisis?"
 9 If we go to page 1 of the same INQ number, you
 10 respond to Geoff Culpin:
 11 "He is on meds, oral meds, he had demonstrated good
 12 insight."
 13 How could you say he had demonstrated good insight?
 14 **A.** Because at the end of that admission it was my opinion
 15 that VC had understood that he had an illness, VC had
 16 understood the link between his symptoms and his
 17 behaviour, and VC had recognised the importance of
 18 taking medication which controlled his symptoms, which
 19 would then control his behaviour. VC was able to link
 20 his readmission to hospital at this point in time, in
 21 terms of stopping his medication and his symptoms
 22 reappearing.
 23 **Q.** He had no remorse for his behaviour. You'd recorded
 24 that. So --
 25 **A.** That was at the beginning of the admission which there

35

1 see whether he had access to this flat and whether VC
 2 would be comfortable going back living to that
 3 environment.
 4 It was a surprise to me that Ms Turner knew my
 5 email, had my contact details, which I had shared during
 6 the first admission, and she could have contacted me
 7 directly, and I didn't understand going -- how things
 8 going to Geoff Culpin would have changed things.
 9 So we have thought about those concerns that she had
 10 and we had addressed them in some ways in terms of the
 11 eventual discharge address that VC was going to.
 12 **Q.** Well, she was concerned, wasn't she, about risk
 13 management and seeing what was going to be done, and in
 14 fact it was proven to be the case that when he was
 15 discharged the first time he came back in again because
 16 he was a risk to others again, wasn't he?
 17 **A.** Yes, and, as I said, if she had directly communicated
 18 with me, I would have discussed with her about the risk
 19 management and the things that we had done, the things
 20 we had put in place.
 21 **Q.** Well, I'm not going to get into the weeds of that,
 22 Dr Seedat. She had phoned the ward, she had asked if
 23 you would speak with her. The message was recorded
 24 there. You knew that she wanted to speak to you. That
 25 was on the last occasion, on the first discharge --

34

1 was no remorse. Subsequently VC did demonstrate
 2 remorse. He actually even wanted to go and apologise to
 3 the people in the first flat, and the first flat that he
 4 was on. He actually did actually try and go and see
 5 them with a staff member to try and -- to go and
 6 apologise for his behaviours of confronting them about
 7 them controlling his mind.
 8 **Q.** That's not recorded in the notes, but you remember that.
 9 **A.** Yeah, it's in the RiO records.
 10 **Q.** Okay. And he went with a staff member, did he?
 11 **A.** He did, yes.
 12 **Q.** So can we have a look now, please, NHFT0000222, page 3.
 13 This is the discharge summary:
 14 "... he believed others were trying to control
 15 him/spy on him/torment his mind and has broken into his
 16 neighbours' flats multiple times to confront them, there
 17 have been no incidents of violence yet but this would be
 18 a potential concern if acutely unwell."
 19 Do you think that adequately sums up the risk?
 20 **A.** No, I agree that the documentation could have been
 21 better and more detailed than that within the risk
 22 assessment.
 23 **Q.** Do you think the decision to discharge at that time
 24 adequately reflected the risk?
 25 **A.** Yes, I think it did.

36

1 Q. Can we go, please, to WITN0163011, page 1. This is an
 2 exchange between you and VC's mother:
 3 "Dear Dr Seedat,
 4 "I hope you're well ... I'd just like to asked you
 5 a question about [VC]. He's been having ... problems
 6 with his memory, regrading the situations that occurred
 7 the last couple of months. I ... want... to know if
 8 this is normal or not? ... really appreciated if you
 9 could give me a ring ..."
 10 You respond:
 11 "I am not the right person to be speaking ... with
 12 regards to his current care as I am not currently
 13 involved in his care.
 14 "It is my suggestion and advice ... you discuss this
 15 with his current team, they will be up to date what is
 16 going on with [VC] and ... will be better placed to be
 17 able to discuss with you and [VC] the question[s] you
 18 ask about his memory."
 19 Before you respond to that, because there's a number
 20 of people that approach you after this discharge, isn't
 21 there. So if we go, please, to WITN0163006, page 1.
 22 11.00:
 23 "Hi Faizal
 24 "I've just had one of your former patients on the
 25 phone ... [he said] His name is [VC] ... He ... [wanted]

37

1 to his then consultant.
 2 A. Yes.
 3 Q. "I was surprised that a patient ... under your care rang
 4 [me] ... asking me to call him ...
 5 "I told him I was not able to discuss his care ...
 6 "He said I should look into his records and let him
 7 know who his team was and his nurse, which I did.
 8 I told him I was going to contact you to let him know
 9 about this contact.
 10 "Can I please urge you that you visit him face to
 11 face, assess his mental state and make sure that he is
 12 okay. I feel based on this interaction that he needs
 13 more close monitoring and regular visits otherwise will
 14 end up in hospital."
 15 You say there was nothing of concern. It sounds
 16 like you were concerned?
 17 A. I was concerned because of the -- I guess the surprise
 18 nature of him contacting me. It's -- I can't ever
 19 remember a situation, other than meeting former patients
 20 in passing by, like in outpatients clinic, if I happen
 21 to be walking past because my office is near an
 22 outpatient building.
 23 Patients don't normally contact me via phone and so
 24 it was a bit of a surprise that VC was contacting me and
 25 I just wanted to make sure and highlight this to the

39

1 to speak to you about his care, he didn't want to give
 2 any more information."
 3 And she provided the number. Did you phone back
 4 then?
 5 A. Yes.
 6 Q. What did you say to him?
 7 A. I asked him, in terms of why was he contacting me.
 8 I reminded him that I was no longer involved in his
 9 care. We did not have a very productive, prolonged
 10 conversation. I said to him that it was important that
 11 he contacted his Community Team, if he was having any
 12 difficulties. I asked him whether he knew who his
 13 mental health team were. He said: "Could you please
 14 tell me?"
 15 So I quickly checked his RiO records because
 16 otherwise I don't access people's records because that
 17 would be a data breach, but in view that he had
 18 interacted with me I also wanted to make an entry, and
 19 also to inform his Community Team about the contact with
 20 myself, and I remind him as to the team and the contact
 21 details, and we ended the conversation there.
 22 Q. If we --
 23 A. -- during that conversation, VC did not express or say
 24 anything to me that concerned me at the time.
 25 Q. Can we look, please, at WITN0163009, page 1. You write

38

1 mental health team, and I gave a suggestion that it
 2 would be important at this point to try and see him just
 3 to make sure that everything was okay and if it wasn't,
 4 because one of the important things I was considering at
 5 the point is that you wouldn't want VC to be admitted
 6 back into hospital.
 7 Q. Well, look at the reply you get from Dr Lloyd:
 8 "Hi Faizal, it looks as if the team have been making
 9 a concerted effort to visit and follow up this patient
 10 but the patient has not been in/engaging. Attempts have
 11 been made to see him weekly and mum has also been
 12 contacted to get further support. His CPN Gary Carter
 13 has now seen him. As you can imagine patients with
 14 psychosis can sometimes behave in quite erratic ways and
 15 are not always predictable in their actions."
 16 Did you take any comfort from that response in terms
 17 of your concern that he needs close monitoring and
 18 regular visits?
 19 A. He had said that his CPN Gary had now seen him. Once
 20 someone gets admitted -- or discharged from my ward, it
 21 is very difficult for me to then be clinically involved.
 22 And my intention here was just to convey my interaction
 23 with VC and my concerns, and I guess leaving the rest of
 24 the decisions and management plans to the treating team
 25 that to whom I have conveyed the information.

40

1 Q. Did you think to email her the texts and the documents
2 that you'd got about him, sent from the family?
3 A. Ah -- no, I didn't.
4 Q. Why not? At this point --
5 A. As I said, I have admitted that maybe I should have.
6 Not maybe: I should have put those text messages within
7 his RiO records.
8 Q. Because she makes it clear, doesn't she, that he has not
9 been engaging. You knew when he wasn't engaging before,
10 he stopped taking his aripiprazole; you knew because
11 you'd had those two admissions with him as his
12 Responsible Clinician, that it was the treatment goal
13 that it was essential for him to take his medication.
14 You didn't need to go back to records to know that,
15 did you?
16 A. No.
17 Q. That would have been in your memory at this time. So
18 why not just send something back that reiterates that or
19 gives her more information about risk?
20 A. And I would have, I would have -- I would have assumed
21 at the time also that Dr Lloyd also understood that
22 there were concerns around that, and that was clearly
23 documented and highlighted within the RiO documents,
24 which I'm sure she must have had knowledge about.
25 Q. Can we go, please, to NHFT0000168, page 160, and this is
41

1 to the ward and she said that this is the following
2 things they had done and at the time I was not aware
3 that I -- that Valdo was asking to speak to me. And
4 I think even if he was, in view that he is now being
5 managed by the Community Team, it was important that the
6 community develop that therapeutic relationship with him
7 rather than myself.

8 I can't get involved as an inpatient. I have 16
9 patients that I'm looking after. I can't be picking
10 other patients up in the community where I would have
11 little recourse in terms of what resources are
12 available, where I would go for help and support if he
13 required it, who I would contact. Because mental health
14 teams are constantly changing. It's -- I am focused,
15 within my area of work, and this was -- this would have
16 complicated the treatment pathway, and it is my general
17 principle not to be involved if patients are not on my
18 ward, because it complicates matters for me.
19 Q. It might have provided crucial information that they
20 were in the same position you were; they were being told
21 he was going to take medication when he never did. And
22 you said before, the past predicts the future to a large
23 extent on these issues. You could have assisted on the
24 facts about that, couldn't you?

25 A. The Community Team should have -- were informed that
43

1 a reference in August 2021, and it's an attempt by VC
2 again to speak with you, you see in the second box, in
3 August 2021:

4 "He spoke about whether he could speak to
5 Dr Seedat -- reported that I could maybe help in the
6 first instance. [VC] reported that Dr Seedat had said
7 that ... he was hearing voices during his admission and
8 wondered if this was correct or if there was an
9 alternative explanation. I asked [VC] whether he
10 thought there was [that must be 'there was'] and he then
11 went onto ask whether staff can hear voices on the ward,
12 and whether they communicate with Artificial
13 Intelligence. He continued to ask whether Dr Seedat
14 could confirm this."

15 You spoke earlier about a therapeutic relationship.
16 If you used your time to establish one, and it may be if
17 he wanted to speak to you, there was one, from his
18 perspective, why was it not appropriate for you, having
19 treated him twice, to not speak with him again?

20 A. This was a conversation that was had, I think, with the
21 Ward Manager at the time. I do not recall very clearly
22 whether the Ward Manager had told me that VC was
23 expecting a -- an intention to speak to me. What
24 I recall was that I was told that VC had -- this was
25 through a corridor conversation -- that VC had presented
42

1 they should go and see VC, and if they felt that it was
2 important that I have a conversation, the Community Team
3 should have contacted me.

4 Q. If we go please to NHFT0019071, page 1. Dr Lomas,
5 21 February 2022, he emails you. He's had to go over to
6 see VC:
7 "During the conversation [VC] asked if he could have
8 the opportunity to speak with Dr Seedat about his
9 previous admissions, and asked for a copy of his medical
10 records. I said I wasn't sure it would be possible, but
11 ... I would email in case it was."
12 So another request in February 2022, and if we go,
13 please, to WITN0163017 page 1. The requests continue.
14 We see at the bottom of the page, Dr Gibson, a higher
15 trainee doctor at that point -- you're the consultant --
16 VC, third line down:

17 "... has asked to speak to you ... about his
18 previous admission and how he can prevent future
19 admissions. He's a tricky chap in that he's very
20 guarded and poor at engaging with services. He also
21 seems to present with few psychotic symptoms at the
22 moment, but I see he's been very unwell in the past.
23 I explained that you are busy and there's a good chance
24 that you wouldn't be able to, but I wonder whether it
25 could be helpful if you could explain the importance of
44

1 engaging with the community team? We've explained the
2 same at every opportunity."

3 You respond:

4 "I have been going through my emails having just
5 returned from leave.

6 "Is there still a required need for me in the
7 management of this patient?

8 "I am guessing he is still on your ward.

9 "Let me know."

10 And Dr Gibson:

11 "There's not a requirement. I think he'd just like
12 a chat to clarify things that happened previously and
13 the ongoing need for mental health service involvement.
14 (he's likely to have different ideas to us). If you've
15 got time it might be interesting/helpful ..."

16 I don't know if that means that "I would prioritise
17 it" -- that "I wouldn't" --

18 **A.** That I wouldn't prioritise it.

19 **Q.** Yes, he may or may not. Look at what he's said before
20 that, and he's giving evidence, so he'll clarify that:

21 "... the ongoing need for mental health service
22 involvement (he's likely to have different ideas to
23 us)."

24 He is making clear they are struggling for him to
25 even recognise that he's mentally ill.

45

1 I said, I am the sole consultant on a ward, I have a lot
2 of my own responsibilities that I had. If Dr Gibson had
3 said, "This would have been helpful for you to come and
4 see" and if VC was still asking and it was -- and "it
5 would be helpful for you to come in and help us in terms
6 of", I would have.

7 **Q.** But he says it was helpful at the bottom, whether it
8 could be helpful --

9 **A.** But he said it was not a requirement and that's what
10 I took that it was no longer a requirement.

11 **Q.** Well, it's not a requirement. You have said it's not a
12 requirement because he wasn't on your ward.

13 But he's saying to you it would be helpful, he's
14 a higher trainee doctor, you're the consultant, it would
15 be helpful to have your view for a patient that you know
16 has been involved in violence in the community, even if
17 you didn't know about the later events, serious
18 violence, serious risk, and they're asking for some
19 help. It's not a requirement, you want some help.

20 **A.** If it was help, Dr Gibson would have actually personally
21 come and spoken to me if they felt that it was strongly
22 warranted, and they would have had that opportunity. I,
23 our offices are very close by. If that need was
24 required, they could have done that.

25 **Q.** He didn't need to speak to you, he wanted you to speak

47

1 Agreed?

2 **A.** Yeah.

3 **Q.** You know that he struggles with the nature of him having
4 an enduring mental illness. Yes?

5 **A.** Yes.

6 **Q.** You know that, you've recorded that.

7 By February 2022, the Trust know that he has
8 assaulted a police officer; did you know that?

9 **A.** No.

10 **Q.** Have you seen in the context of this Inquiry, the video
11 of that assault?

12 **A.** Yes, I have, yes.

13 **Q.** So he has assaulted a police officer, he has assaulted
14 a flatmate, holding him in a headlock, stopping two from
15 leaving the accommodation, described as hostage-style
16 situation? Yes? You knew that at this point? Did you
17 know that at this point when this email came through?

18 **A.** No. No information was passed to me in terms of VC's
19 presentation other than the request to see him. The
20 request was made whilst I was on leave and when I came
21 back, I followed that email up to say, "Is there a need"
22 and he said there was not a requirement. VC was on
23 another ward.

24 Again, one has to ensure that we maintain our
25 boundaries in terms of the care that we provide. As

46

1 to VC. So popping in to tell you exactly what he's said
2 in the email, isn't it? He wanted you to see the
3 patient.

4 **A.** And, as I said, I'd just come back from leave, I had
5 a lot of my own ward to think about and patients to see,
6 it's -- it would be very difficult for me then take on
7 another -- patient on in terms of their assessment, or
8 help.

9 **Q.** It was a conversation --

10 **A.** I was --

11 **Q.** -- not an assessment. They were asking you to have
12 a conversation to tell him whether he was ill or not ill
13 because he wasn't accepting that he was ill.

14 **A.** They could do it -- I don't see how my conversation
15 would have changed anything. If he wasn't listening to
16 them, why would he listen to me? I hadn't seen him for
17 a long time.

18 **Q.** But he's remembered you. He's asked for you on a number
19 of occasions by now.

20 **A.** Which in itself -- I don't really know what that means,
21 whether he would openly speak to me or not. I don't
22 know. At the point, I didn't feel that I should be
23 getting involved in a patient that is not on my ward.
24 I had my responsibilities, which is what I focused my
25 duties on. If I was asked to come and do a joint

48

1 assessment with the team, that would be different.

2 **MS LANGDALE:** Chair, those are all my questions. It's 3.00,
3 I don't know if it is better to have Mr Moloney before
4 the break or after the break.

5 **THE CHAIR:** Yes, Mr Moloney, do you want to go before the
6 break or after?

7 **MR MOLONEY:** [Off microphone].

8 **THE CHAIR:** Yes, thank you. We will do that now, thank you.

9 **Questioned by MR MOLONEY**

10 **MR MOLONEY:** Good afternoon, Dr Seedat. I ask questions on
11 behalf of the bereaved families and I've just got four
12 topics to ask you about, please, if I may.

13 Firstly, your relationship with VC, which
14 Ms Langdale has in effect concluded with it; secondly,
15 the messages that you received from VC's family.

16 **A.** Yes.

17 **Q.** Thirdly, the potential role of forensic psychiatry in
18 this; and fourthly depot medication.

19 **A.** Yes.

20 **Q.** So I could take those in turn, please.

21 Firstly, your relationship with VC. You've spoken
22 today about how you had very open and candid
23 conversations with VC, and you had contact with him for
24 a considerable time. And, as Ms Langdale has just
25 addressed with you, VC sought you out to discuss his

49

1 "He always came across as quite polite and friendly.
2 I think, and maybe Mum will contest this, I actually
3 formed a good working relationship with him, on balance,
4 because I do know that even after he was discharged from
5 my ward he did come looking for me. Obviously, because
6 of my roles and my boundaries, I never breached those
7 boundaries. I wouldn't see a patient outside my
8 inpatient work."

9 Is that essentially what you've just said now --

10 **A.** Yes.

11 **Q.** -- confirming that?

12 **A.** Yes.

13 **Q.** So you never got the feeling -- just to elaborate on
14 that -- you never got the feeling that VC thought you
15 were part of a conspiracy against him, for example.

16 **A.** I didn't think that, no.

17 **Q.** In your experience, did he interact well with other
18 medical staff, you say he always came across as quite
19 polite and friendly, was it the same with other medical
20 staff as well?

21 **A.** Yes, yes, and I think a lot of people commented on that.

22 **Q.** Yes, and were you aware that VC sought out Dr Burri as
23 well, Dr Bilal Burri?

24 **A.** No.

25 **Q.** I'll deal with that with Dr Burri then. That's that

51

1 previous admissions on two occasions?

2 **A.** *(The witness nodded).*

3 **Q.** Yeah. And do you feel, that that fact that he sought
4 you out to discuss things with you was a reflection of
5 the quality of the relationship between you?

6 **A.** I would think that at some level I would be speculating.
7 I don't really know what VC's intentions were in terms
8 of seeking me out specifically, whether -- and there
9 were lots of things that I can postulate, whether this
10 was the fact that we had built a good rapport and
11 I think from very early on we did have quite lengthy
12 conversations. But it was also important, in terms of
13 myself, that I maintained appropriate boundaries, there
14 are situations where --

15 **Q.** Of course. So you didn't see him. In fact can I take
16 you to a passage in your interview with Theemis where
17 you essentially reflect both of those themes in the
18 things that you say to them. The document I'd like to
19 go to, please, if I may, is a document TCLT0000758.
20 That's TCLT0000758.

21 It could be four zeros, I'm very grateful for that
22 prompt.

23 To page 7 of this, if we could, please, where you
24 say, and it's the first remark of yours, five lines
25 down:

50

1 first topic. If we could move onto the messages now,
2 please, Dr Seedat.

3 **A.** Yes.

4 **Q.** You've said at the start of the evidence -- and you've
5 said it quite a few times -- that whilst you were the
6 Responsible Clinician in VC's case, the responsibility
7 was really shared between you and the MDT, the
8 Multidisciplinary Team, and other people had
9 responsibilities in relation to his care.

10 One of the things you did take responsibility for
11 was consideration of the messages that were provided to
12 you by VC's family. Now, obviously communications like
13 that would be important in the context of any assessment
14 of risk, wouldn't they?

15 **A.** Yes.

16 **Q.** Yes. I'm not going to ask you about how those messages
17 were reflected in the RiO entry that you made,
18 Ms Langdale asked you about that, but I just want to
19 spend a bit more time, if I may, on the messages, and
20 the first message I'd like to take you to, please, is --
21 and this is NGPF0002527, and it is page 18 of this,
22 please. This is a message you've been asked about.

23 It is at 15:19 on the page, which is a message from
24 VC to his brother where he says:
25 "I thought why do I feel like this now? I know

52

1 I didn't work myself into this state of mind. I was
 2 thinking about red rum not 120 minutes ago. Now not
 3 only do I not care, I feel appreciation."
 4 Can I just ask you just a couple of questions about
 5 red rum. Did you consider what "red rum" meant there,
 6 Dr Seedat?
 7 **A.** I did answer that question to say that I made the
 8 insertion that it had some sort of religions context.
 9 **Q.** Religious context?
 10 **A.** Yes.
 11 **Q.** You made the assumption that it had a religious context?
 12 **A.** I didn't know what else to make of it at the time.
 13 **Q.** Did you not seek to look into it? I mean, just so you
 14 didn't research online what it might mean, for example?
 15 **A.** No, I didn't.
 16 **Q.** Because, if I may, if you research, just put in the term
 17 "red rum slang" into a search engine, the urban
 18 dictionary comes up and it tells you "red rum"
 19 a catchphrase for people that secretly just want to kill
 20 everyone. "Red rum means 'murder' backwards."
 21 Why did you assume it was a religious phrase?
 22 **A.** That's something I need to reflect on, and maybe pay
 23 more attention and -- (*overspeaking*) --
 24 **Q.** Can I be -- press that question slightly?
 25 **A.** Yeah.

53

1 messages.
 2 Now, if we go back to page 17, you can see this
 3 sequence starts only 17 minutes earlier at 14:52, okay?
 4 14:52, on the same date, we see VC saying:
 5 "That previous night I felt immense anguish,
 6 paranoia, anger, hatred.
 7 "Because of this spying monitoring thing.
 8 "Couldn't sleep, had the darkest thoughts of could
 9 imagine.
 10 "Wanted to hurt ... permanently ...
 11 "It was overwhelming, so at some point something in
 12 me begged 'Take it away, nothing else, just take it
 13 away'.
 14 "I didn't say it, I'm not sure I even thought it".
 15 Then this will give a clue to the 120 minutes.
 16 "Finally dozed off for a couple of hours about 7 am.
 17 "When I woke up close to 9 am, I felt the greatest
 18 peace I've ever felt in my life.
 19 "Something that I can't quite put into words."
 20 Then there's a reply from his brother and that, if
 21 we go over the page, he carries on that theme, but over
 22 the page at 15:13 he says:
 23 "A particular pivotal point was in my second year of
 24 uni where I felt I met with God for the first time - and
 25 I was not the same person after that.

55

1 **Q.** Red rum, why would that be evocative of a religious
 2 theme, for example?
 3 **A.** I think it was just in relation to --
 4 **Q.** Because the dialogue, essentially, between them was of
 5 a religious nature?
 6 **A.** Yeah -- (*overspeaking*) --
 7 **Q.** So you assumed it was red rum?
 8 **A.** Yes.
 9 **Q.** Did you ever ask VC what he meant by he was thinking
 10 about red rum?
 11 **A.** No, I didn't.
 12 **Q.** Why not, Dr Seedat? If you didn't know what it was, if
 13 you were considering these messages as an important part
 14 of risk assessment and you didn't know what red rum
 15 meant, why didn't you ask VC what "red rum" meant in
 16 that context?
 17 **A.** I guess maybe that was predicated by the fact that I
 18 made the assumption and connection that it had
 19 a religious connotation -- (*overspeaking*) --
 20 **Q.** So the assumption precluded the question?
 21 **A.** I think so.
 22 **Q.** Right. Okay. Now, I want to just try and put this
 23 message in context, if I may, please. If we could go
 24 back to page 17, please, because this is part of -- that
 25 message I've just taken you to is part of a sequence of

54

1 "My point is that these changes have in many ways
 2 shown to me that what they wrote about Jesus is true, in
 3 ways that just reasoning about it could never do.
 4 "I dunno if that makes sense."
 5 So there was a question there that comes in response
 6 to what VC has just said and then he says:
 7 "It does.
 8 "What you just said is that very thing.
 9 "I thought why do I feel like this now? I know
 10 I didn't work myself into this state of mind. I was
 11 thinking about red rum not 120 minutes [2 hours] ago.
 12 Now, not only do I not care, I feel appreciation.
 13 "I want people to know I love them and want to be
 14 there for them.
 15 "Like something left me.
 16 "That state lasted for about half a day ... then
 17 I gradually returned to myself."
 18 Now, that message to his brother was to another
 19 young man, even younger than VC, and he didn't ask for
 20 any clarity as to red rum, but seeing that message in
 21 context reveals an extremely volatile human being,
 22 doesn't it?
 23 **A.** It does.
 24 **Q.** It does.
 25 **A.** It showed that he -- (*overspeaking*) --

56

1 Q. Yes, he's thinking of murder, it's not self-harm, he's
2 thinking of murder. Nothing in these messages about
3 self-harm. He wants to harm permanently. He is feeling
4 anger and hatred, he had the darkest thoughts you can
5 imagine, then he fell asleep for a bit, less than 120
6 minutes, 2 hours, he woke up, he felt the greatest peace
7 he'd ever felt in his life, words couldn't describe it.
8 That's very volatile, isn't it?

9 A. Yes, and driven by his experiences that he was having.

10 Q. Then if we go to page 6 of this document, please, this
11 is 20 May 2020. So it's just over a month later and
12 it's just short of a week before the first admission.

13 This is the paraphrasing of a call at 11.02 on that day.

14 Halfway down the page he says -- and this is
15 probably after -- if we can imagine two hole punches,
16 it's just below the second hole punch in that way:

17 "He says he knows the voices/people wouldn't dare
18 say anything/mock him to his face. Pride spikes
19 dramatically. Makes a remark about harming the people
20 he's hearing (hard to tell when he's making
21 a distinction between the voices as people and just
22 voices)."

23 Now this is how VC's brother is relating how VC
24 presents to him, isn't it? That in that telephone
25 conversation after he says that they wouldn't dare say

57

1 A. I asked him about this comment where he said that he was
2 thinking -- he had made a remark about harming people
3 he's hearing.

4 Q. So is that by reference to the messages?

5 A. Yes.

6 Q. Right.

7 A. Just to that message. Not the red rum message.

8 Q. Just to that message, not the red rum message.

9 Can we just then, please, have a look at the RiO
10 record, please, which is NHFT0000168, page 21, please.

11 Your entry:

12 "3rd party information not to be disclosed to
13 patient."

14 At the top, then down at the bottom in blue:

15 "3rd party information not to be disclosed to
16 patient."

17 How was it disclosed?

18 A. So the way it was discussed was I didn't --

19 Q. Disclosed. Not discussed. Disclosed.

20 A. Disclosed to VC?

21 Q. To VC?

22 A. Yeah, it was -- it was -- I didn't -- I didn't
23 specifically say to him that these were the messages
24 that --

25 Q. I asked you just now, Dr Seedat, whether or not it was

59

1 anything or mock him to his face, his pride spikes
2 dramatically. He's talking about a dramatic emotional
3 change, isn't he?

4 A. Yes.

5 Q. Yes. Then he goes on to talk about harming the people
6 he's hearing and the people he was hearing were the
7 people in the neighbouring rooms who were talking about
8 his dreams.

9 A. Yes.

10 Q. That's less than a week before he tries to break into
11 two flats on the same day. And he previously talked
12 about wanting to murder people. And even without red
13 rum, let's just keep red rum out of this for now, he'd
14 talked about anger, hatred, and hurting permanently,
15 hadn't he?

16 A. Yes.

17 Q. He's talking about harming. Are you sure you asked VC
18 about these messages, Dr Seedat?

19 A. I did ask him about the message about wanting to harm
20 people in view that I recognised that in view of --
21 (*overspeaking*) --

22 Q. Can I clarify that question? Did you ask him about
23 harming people by reference to these messages, or did
24 you simply ask him about whether or not he was going to
25 harm people?

58

1 by reference to the messages, and you said it was --

2 A. -- (*overspeaking*) -- reference -- (*overspeaking*) --

3 Q. So you did not disclose that these were messages to VC?

4 A. No.

5 Q. No. Thank you. Now, I'd like to ask you to move on if
6 I can, please -- oh, and that was a theme. His family
7 didn't want things disclosed to him because they felt it
8 would undermine trust, didn't they?

9 A. I think it was third-party information which I had to --

10 Q. But there was a concern that essentially things coming
11 from the family to VC, that might undermine trust.

12 A. That's correct, yes.

13 Q. Absolutely. Now to forensic psychiatry if I may,
14 please. I'm just going to have a look at if I could,
15 please, TCLT0000758. And to page 8 of these, please.
16 Page 8 of this. Just to confirm here that you said --

17 A. -- (*overspeaking*) --

18 Q. It's coming up. I just want to use my time if I can,
19 please, Dr Seedat, you said essentially that:

20 "If there was --" and this is the top of the page:

21 We're talking about risk here:

22 "If it was a general statement, we would inform the
23 police that... In fact more recently, I have actually
24 followed this process anyway. It would be my intention
25 to also get a community forensic opinion to try to

60

1 determine his levels of risk. In my experience, it's
2 always been... One of the consistent factors, that
3 I have found, that predicts future risk has been past
4 risk."

5 And you didn't seek a reference from Forensic
6 Community Team, did you?

7 **A.** No.

8 **Q.** Because you didn't think there was any risk, any general
9 risk at that time.

10 **A.** No, I did think there was risk. I made and formed the
11 opinion that we had made an appropriate assessment of
12 his mental state. We -- I confirmed that his mental
13 state had an implication on his -- on his risk, and if
14 we controlled his symptoms, we would mitigate against
15 his risk.

16 **Q.** Okay.

17 **A.** I also made the thinking that, in -- based on the events
18 that had taken place, his presentation would not fulfil
19 the criteria for Community Forensic Services.

20 **Q.** Right. You appreciate now, don't you, whether it's
21 hindsight or not, that a reference to the Forensic
22 Community Team could have changed his entire pathway?

23 **A.** I am not convinced with whether it would have changed
24 within the first or second admission. Maybe
25 subsequently to that, maybe. But in the two admissions

61

1 distrust services. And I think what is important here
2 is that we try and create trust with this individual so
3 that he remains engaged with services. Rather than
4 distance himself from services."

5 **A.** Yes.

6 **Q.** So did ethnicity play any part in your decision as to
7 whether or not to pursue depot treatment?

8 **A.** No. What I was trying to say there was my decision
9 wasn't based on the fact that he was of a minority
10 background, I was trying to convey that there was
11 research evidence which suggested that people with
12 ethnic minorities are more harshly treated than those
13 who are not. And the thing I was trying to say was that
14 that did not influence me, despite knowing that
15 evidence.

16 **Q.** I see. Can I just explore that in the minute or so
17 I have left?

18 **A.** Yes.

19 **Q.** "And that is the, I guess, decision I made to continue
20 with, rather than pressing the matter around depot
21 injection."

22 Having spoken about him giving assurance:

23 "Because as I said, I think, it's common, we know
24 people from ethnic minority backgrounds do feel that
25 they're somehow, more harshly treated within inpatient

63

1 that he had I wouldn't say with certainty that it would
2 have.

3 **Q.** Okay. I'm going to deal with my fourth topic third,
4 just to make sure it's dealt with. Can I ask you about
5 depot medication, which is TCLT0000754 again, please,
6 and can I ask you this: did VC's ethnicity have any
7 impact on your decision whether or not to implement
8 depot medication when he refused it on his second --

9 **A.** None so whatever.

10 **Q.** None whatsoever?

11 **A.** None so whatever.

12 **Q.** Can we please go to page 18 of this document, please.
13 So at the top of the page you were saying:

14 "Okay, you take some responsibility. You need to
15 take hold of this. This is something that's important,
16 show us that you are able to be responsible.' So he'd
17 made it very clear that he did not want to go on to the
18 injections, and he would comply, and take the oral
19 medications.

20 "And that is the, I guess, decision I made to
21 continue with, rather than pressing the matter around
22 depot injection. Because as I said, I think, it's
23 common, we know people from ethnic minority backgrounds
24 do feel that they're somehow, more harshly treated
25 within inpatient services. And they tend to then

62

1 services. And they tend to then distrust services. And
2 I think what is important here is that we try and create
3 trust with this individual so that he remains engaged
4 with services."

5 Right, so that did not play any part in your
6 decision-making? That's simply you looking back later,
7 you didn't think about that at the time, this is just
8 when you were introduced -- interviewed by Theemis and
9 you just say "Actually, I've just thought, actually,
10 that there's research around this" and that's all you
11 were saying?

12 **A.** That's correct. Ethnicity never comes into my
13 decision-making, be it around detention or being around
14 treatment options.

15 **Q.** Then just one --

16 **A.** And I never ever have thought about race.

17 **Q.** Thank you. And then just one final thing, if I may,
18 that -- just to -- if I could please take you to just
19 one example of essentially --

20 Well, no, I'll leave it there, Dr Seedat. I won't
21 bother with that sample, it's now 3.20 and thank you
22 very much.

23 **THE CHAIR:** Thank you, Mr Moloney.

24 We'll take a break now and we'll come back at
25 3.35 pm. Thank you.

64

1 (3.20 pm)

2 (A short break)

3 (3.35 pm)

4 Questioned by MS CARTWRIGHT

5 MS CARTWRIGHT: Good afternoon, Dr Seedat.

6 A. Good afternoon.

7 Q. I ask questions on behalf of the survivors.

8 Now you've already told us in evidence with
9 Ms Langdale KC that you were VC's Responsible Clinician
10 during his first two admissions, but you were also
11 discharging the role at the same time on both of those
12 two admissions as the Clinical Lead for the Trust for
13 the Acute Mental Health Services; would you agree?

14 A. That's correct.

15 Q. So as well as the professional and personal
16 responsibilities you had to VC and the wider public, you
17 were also, if we look at what you did or didn't do
18 during this period of time, it would be fair to look at
19 it through the perspective and lens that you are
20 a senior manager at the Trust; would you agree?

21 A. Yes.

22 Q. With a responsibility for clinical governance.

23 A. Yes.

24 Q. Clinical audit.

25 A. Yes.

65

1 contains the key information so that there is -- which
2 is important for continuity of care to ensure that there
3 is the accurate record and exchange of information
4 leading to decisions in a patient record that informs
5 future care?

6 A. Yes.

7 Q. So non-contentious. But also the reason why that
8 standard is so essential is it helps you to explain and
9 justify your decisions and actions.

10 A. Yes.

11 Q. We'll come to look at some of your records but we know
12 you only made a number of records in the entries in your
13 own name.

14 A. Yes.

15 Q. Your statement deals with the fact that you did not even
16 review the records that were made by the doctor who was
17 recording the MDT.

18 A. Yes.

19 Q. So you did not check those at any point for accuracy,
20 completeness, or to sign them off as reflecting
21 a complete and accurate picture of and encounters(?) and
22 Multi-Disciplinary Teams that you were involved in.

23 A. I did have view of some of them.

24 Q. Pardon?

25 A. I did have view of some of them --

67

1 Q. Setting of standards.

2 A. Yes.

3 Q. Ensuring that everyone who was applying those standards
4 well understood them.

5 A. Yes.

6 Q. The same would apply to you.

7 A. That's correct.

8 Q. To ensure that those operating in the Trust within
9 mental health knew what they were doing when they were
10 assessing risk; would you agree?

11 A. Yes. It was a joint role.

12 Q. Pardon?

13 A. It was a joint role.

14 Q. I appreciate it was a joint role and Multi-Disciplinary
15 Team, but ultimately you are the clinician.

16 A. Yes.

17 Q. When you are discharging a patient, it's your decision
18 having looked at the statutory questions, informed by
19 the views of the Multi-Disciplinary Team.

20 A. Yes.

21 Q. So let's start with something that I hope is
22 non-contentious.

23 You would agree, in accordance with your
24 professional guidance as issued by the General Medical
25 Council, that you have to ensure that the patient record

66

1 Q. But we don't see --

2 A. -- during my --

3 Q. Sorry, I --

4 A. During my review of weekly events that may have been
5 transpired on the ward. I did look at the RiO records
6 and did go through to remind myself what things had been
7 agreed on.

8 Q. I think your statement deals with the fact that there
9 wasn't an expectation that that would be needed.

10 A. The ward review notes, yes.

11 Q. That's just why I want to understand that. So from you
12 as a clinical lead now, was that essentially the system
13 you were communicating to all of the consultants and
14 doctors of the MDT? If someone else is doing the notes
15 you don't have to review them?

16 A. I think the process was that I would have given guidance
17 to my Resident Doctors, as you call them today, in terms
18 of what important documentation needs to be made.
19 I accept that I should have reviewed the records in
20 terms of what was being documented.

21 However, in terms of the role that I have, the
22 responsibilities that I have, it's -- unless I have
23 a system where I have somebody who records the
24 interactions that I have with patients, or with family
25 or whatever, verbatim in terms of everything I say, it's

68

1 always going to be a challenge in terms of accurately
 2 recording what is being said or discussed.
 3 The timeframe that I have in terms of reviewing
 4 every single record would be very difficult to achieve
 5 unless this is put within the job plan that I have,
 6 which many consultants would argue the same point. It's
 7 very difficult to fully check every single record that
 8 one makes. And in fact I did check with other
 9 consultants whether they were checking medical records,
 10 and everyone had a similar view: that it would be very
 11 difficult to check every single record.

12 **Q.** As a result --

13 **A.** Having reflected on this, I do accept that I probably
 14 need to find ways how I actually document my own
 15 interactions as opposed to leaving it to others. And
 16 I have made some changes to that, upon my reflection.

17 **Q.** Now, would you agree, though, that it's absolutely
 18 essential if you, as the consultant here, information as
 19 to risk, you need to ensure it's accurately reflected in
 20 those records --

21 **A.** I agree, yes.

22 **Q.** -- for a patient presenting with first psychosis, and
 23 then, secondly, presenting with essentially a
 24 formulation where you had accepted amounting to
 25 schizophrenia?

69

1 **Q.** Really, where you apply the principles of good medical
 2 practice, people can be highly sceptical; if you didn't
 3 write it down, it didn't happen. Would you agree?

4 **A.** Yes, I agree.

5 **Q.** If we then just look more broadly to that, you've
 6 essentially said today, regarding risk, that it would be
 7 necessary to speak to VC to understand those issues,
 8 because without that, you can never have an accurate
 9 assessment of risk; would you agree?

10 **A.** Could you say that again?

11 **Q.** So you've given evidence today to the effect of, unless
 12 you -- there's a willingness of VC to discuss those
 13 issues of risk, you're never going to have an accurate
 14 assessment of risk.

15 **A.** I think that would apply to all patients, that in order
 16 to fully appreciate what the risks may be you have to
 17 ask difficult questions.

18 **Q.** And I think you've already accepted with Mr Moloney that
 19 the highly concerning information as to risk and
 20 dangerousness contained in the notes that the family
 21 provided in the first admission, you at no point
 22 discussed those with VC.

23 **A.** And that was something that was requested by the family:
 24 to not disclose this information. However, having said
 25 that, I did take concepts of the messages, not

71

1 **A.** Yes.

2 **Q.** One of the things where some of your evidence,
 3 Dr Seedat, it's been difficult to follow and appreciate
 4 is because you've given evidence about things you did
 5 with VC and discussed with VC, and I'll give you one
 6 example.

7 You've discussed today in evidence that you
 8 discussed about the very concerning risk information
 9 about capital punishment that he had disclosed to the
 10 doctor, and about him having a "solution". But you
 11 would agree that there's no evidence in the records that
 12 you at any point spoke to VC about the capital
 13 punishment issue?

14 **A.** I accept that, and I've recognised and accepted that,
 15 yes. My documentation could have been and should have
 16 been better than where it was.

17 **Q.** So when we see Dr Ludvigsen herself raising it in the
 18 MDT, and for your note, Ma'am, it's page 11 of the
 19 NHFT0000168, there's nothing that she's then record to
 20 suggest that you at any point then asked VC about that,
 21 explored that with VC.

22 So would you appreciate the scepticism, when you're
 23 giving evidence in 2026, saying that you remember
 24 discussions you had in 2020 --

25 **A.** Yes, I recognise that.

70

1 disclosing that these were from the text messages
 2 itself, asking about whether these belief systems were
 3 still something he held or he didn't.

4 **Q.** Well, Dr Seedat, you and I will well understand that if
 5 families share information as to risk, and I think we've
 6 looked at it repeatedly, the information in those notes
 7 is of the highest concern as to risk to the general
 8 public; would you agree?

9 **A.** I did recognise the risk and I did ask questions around
 10 those belief systems that he had. I didn't -- what
 11 I didn't do is that I specifically described to him that
 12 these were from text messages that he had written.

13 **Q.** But we'll go through it in a moment when we look at the
 14 note you recorded, but there's no evidence of you doing
 15 what was necessary. So there was no need to be worried
 16 about patient confidentiality; this went to the heart of
 17 a role of a Responsible Clinician who is considering
 18 detention for someone that is exhibiting signs of
 19 dangerousness, that you should have asked VC about each
 20 one of those risk incidents to understand significantly
 21 his insight, would you agree?

22 **A.** Yes.

23 **Q.** Because insight again is at the core of what you should
 24 be assessing, under your statutory criteria, about the
 25 nature and the degree of his mental disorder.

72

- 1 A. Yes.
- 2 Q. If he doesn't have insight then that's tipping the
3 balance that he still requires to be detained.
- 4 A. That's correct.
- 5 Q. If you therefore did not ask him questions about these
6 very real and significant information, I'm going to
7 suggest to you, Dr Seedat, that there was never a safe
8 discharge from the detention whilst you were ceasing and
9 treating VC.
- 10 A. I wouldn't necessarily agree with that. My view is that
11 we did do a comprehensive assessment of his symptoms,
12 and of the risk that he was continuing or posing. And
13 if the symptoms had abated and the risks were not
14 evident, then I would think that that would still relate
15 to the patient being well and being discharged back into
16 the community.
- 17 Q. Dr Seedat, how can you possibly say that when you've at
18 no point said to VC: "You said that you'd could crush
19 their heads with your hands when you feel angry, when
20 you're psychotic. What does that mean, VC? How does
21 that affect you when you are unwell?"
- 22 A. I understand what you're trying to ask, but at the same
23 time I would also say that if his psychotic symptoms
24 were controlled, he wouldn't be having those
25 experiences, because they were closely linked to his

73

- 1 and dangerousness and risk to the public, you were the
2 only person that considered it.
- 3 A. Can you say that again?
- 4 Q. You were the only person that considered it.
- 5 A. Considered?
- 6 Q. The document. You say it was only you that reviewed it.
7 We've got the --
- 8 A. You mean the text messages -- yes.
- 9 Q. -- summary in the notes. We'll go to the summary in
10 a moment. But you were not, when discharging VC to the
11 Crisis Team, saying: "Care coordinator, there is the
12 most highly relevant information as to dangerousness
13 that, as I pass the baton of care to you in the
14 community, that you need to be aware of, because this is
15 highly relevant to the dangerousness of VC and you need
16 to know."
- 17 A. I acknowledge that that email should have been
18 documented within the RiO records for everyone to see.
- 19 Q. But Dr Seedat, this was not a short email. This was
20 dated and timed, chronological first-hand accounts
21 provided from VC, shared with his brother, that gave the
22 most clear insight into a man that was dangerous.
- 23 And so why therefore did you not pass it on --
- 24 A. It indicated a-- (*overspeaking*) --
- 25 Q. -- in it's rawest form without your analysis?

75

- 1 psychotic experiences. In the text messages there was
2 a clear association between what he was experiencing,
3 which was psychotic symptoms, and the consequent beliefs
4 around risk.
- 5 Q. We'll look at those messages very briefly when I come to
6 deal with the entry you did make in the notes. But
7 again one of the other things you didn't do in
8 accordance with the NICE guidance for psychosis and
9 schizophrenia is the NICE guidance also recommends that
10 once a patient is well, who's had a psychotic episode,
11 you ask the patient to write down the thoughts, what
12 happened, what they were thinking; would you agree?
- 13 And that's something that's recommended in NICE as
14 the most easy thing to ask a patient to do when you've
15 stabilised them on medication:
- 16 "VC, please now write down how you experienced what
17 you experience when you are unwell."
- 18 So you can understand the thing you raise about
19 today: what is it in his thoughts? What are his beliefs
20 when he's unwell?
- 21 A. And that could have been easily done within the
22 community teams and the EIP services would do that work
23 with him.
- 24 Q. Well, let's come on to the second thing, then, that you
25 didn't do: this highly relevant information as to risk

74

- 1 A. It indicated a man who was experiencing psychotic
2 symptoms which were then impacting on having belief
3 systems, that inferred risk. However, at no point had
4 VC acted or intended to act on any of these, hence
5 specifically things that I did ask him, whether he had
6 intentions of harming anyone.
- 7 Q. But you never asked him about that linked to the Feven
8 incident. So he's describing in those messages he's
9 getting so angry about those that live nearby to him,
10 and that's what he's wanting to do: to hurt their heads.
- 11 So you never asked him in the context of what
12 happened to Feven --
- 13 A. He did say those things but they were not then followed
14 up with behaviour.
- 15 Q. But you didn't challenge him. You had another
16 contemporaneous, collateral piece of information that
17 completely contradicted and undermined what VC said, and
18 it was central for you as the Responsible Clinician
19 assessing risk, to challenge and ask VC about that.
- 20 A. I did challenge VC in terms of in general. He also
21 acknowledged that these difficulties were causing him
22 anguish, they were causing him distress, and on what
23 basis were or were there any intentions to harm or hurt
24 anyone? So I did try and help make, or help make
25 connection between that and whether there was still

76

1 ongoing risk in terms of him actually acting or carrying
 2 out any behaviours of risk.
 3 **Q.** But that had happened on 24 May to Feven. So -- and
 4 that's what I want to understand, because throughout
 5 your risk assessments and your analysis in the notes,
 6 and on discharge, you're saying there's no evidence yet
 7 of violence. How could that possibly be the case,
 8 Dr Seedat, when VC --
 9 **A.** Because --
 10 **Q.** Let me finish my question, please -- when VC has kicked
 11 the door in of a member of the public's home, forced his
 12 entry in and made noises and such outside so that she
 13 was so terrified that as a direct result she has jumped
 14 out of a window and fractured her back. How is that not
 15 violence and aggression by VC to his neighbour?
 16 **A.** Because the information I had at the time was that VC
 17 had damaged the door, but there was no information in
 18 the records which suggested that he had gained entry,
 19 and that the person in that flat had fled because VC had
 20 gained entry into the flat.
 21 **Q.** Okay. So let's then be absolutely clear when we look at
 22 your evidence and what's in the notes, your
 23 understanding of the Feven incident is he kicked a door,
 24 but did not gain entry?
 25 **A.** No. And that's also recorded in the notes, to suggest

77

1 **Q.** So let me just be clear then, you've given your
 2 analysis. If you had been told by the police that he
 3 had broken down that door, and that then Feven had
 4 jumped out of the window, would that have completely
 5 changed your risk assessment and involvement with VC
 6 regarding --
 7 **A.** It would have.
 8 **Q.** It would have?
 9 **A.** Yes. On the understanding that VC was presenting in
 10 a way that Feven feared for, or VC led to the person in
 11 that flat doing what they did.
 12 **Q.** But then additionally, we've heard evidence from Feven,
 13 so this was not her account that he simply kicked the
 14 door and got entry, she has also described that when she
 15 was in the courtyard waiting for the ambulance and the
 16 police brought VC down, he was staring at her and trying
 17 to get at her. Did you know about that?
 18 **A.** No I didn't.
 19 **Q.** Would you agree that that further account as to how VC
 20 was behaving towards Feven raises even more the
 21 significance of his violence and what he was doing on
 22 24 May 2020?
 23 **A.** It would have related to his potential risk of violence,
 24 yes.
 25 **Q.** Because that almost looks like it is something else

79

1 that that was the case.
 2 **Q.** But how in any event, even if that was the case, that
 3 violence and aggression has caused a member of the
 4 public to fear so much for their personal safety, even
 5 on your analysis, that she's jumped out of a window?
 6 That's a direct result of his violence and aggression.
 7 It's violence.
 8 **A.** I accept that he was aggressive. He did not do anything
 9 by his own hand to be violent to the individual. The
 10 individual took the decision to escape from a situation
 11 where someone was being aggressive. He hadn't been
 12 violent to her, and that was the assessment I made,
 13 based on information I had at the time.
 14 **Q.** Do you know that the police assess that what VC did to
 15 Feven amounted to grievous bodily harm?
 16 **A.** They did not bring the charge at the time --
 17 (*overspeaking*) --
 18 **Q.** Well, that's a different question. They don't make the
 19 charge, and that's in part due to your involvement as
 20 well, Dr Seedat, which we'll come on to. But did you
 21 know that the police considered this grievous bodily
 22 harm?
 23 **A.** I didn't.
 24 **Q.** You didn't?
 25 **A.** No.

78

1 again, isn't it: that VC is actually targeting this
 2 young student, first of all in her home and then when
 3 she's sat outside injured waiting for medical attention?
 4 **A.** Whether it was specifically targeting her --
 5 **Q.** Well, that's her evidence. He looked at her and was
 6 desperately trying to get to her and was restrained by
 7 the police.
 8 **A.** Yeah.
 9 **Q.** Now, let's just then briefly look at some concepts,
 10 because I'm going to suggest to you that you've
 11 completely underestimated VC's risk throughout your
 12 involvement, and the risk assessments you've completed
 13 in the notes suggest that you, in fact, are not properly
 14 applying criteria of violence, because you're
 15 underestimating risk.
 16 So the statutory principles you have to apply is,
 17 first of all, that someone has a mental disorder, and
 18 I think the guidance that's issued is you don't get too
 19 tied up of where it sits on the ICD or DSM; what you're
 20 essentially doing is ensuring that those who present
 21 a danger are not let free; would you agree?
 22 **A.** Are not at?
 23 **Q.** Not let free.
 24 **A.** Yes.
 25 **Q.** There needs to be a mental disorder in nature and

80

1 degree, and I think we've already agreed that for both
 2 nature and degree, insight needs to be considered and if
 3 it's not there, that again tips the balance away from
 4 discharge; would you agree?
 5 **A.** Yeah, it would have to be an important consideration to
 6 address.
 7 **Q.** In respect of, then, the other factor, there has to be
 8 medical treatment that can be delivered and that's not
 9 just medication; would you agree it includes nursing,
 10 psychological intervention, specialist mental health,
 11 habilitation, rehabilitation and care. So it's not
 12 simply giving him some medication; it's that whole
 13 package that has to be considered for an acutely unwell
 14 patient in detention?
 15 **A.** And that is something that we consider in all patients.
 16 **Q.** I think you've already said that you had no -- would you
 17 agree again, the NICE guidance recommends that
 18 psychologists are involved in the assessments?
 19 **A.** Yes.
 20 **Q.** Again, you've already told us that this -- you did not
 21 have a psychologist available on the ward at the time;
 22 is that correct?
 23 **A.** Yes.
 24 **Q.** Again, what had you done as clinical lead to ensure that
 25 there was psychological support and provision of them

81

1 **A.** Yes.
 2 **Q.** How was that dealt with in internal audit from your
 3 clinical lead about the significance of the absence of
 4 a key member of the Multi-Disciplinary Team?
 5 **A.** I think this is always thought about. I guess it's if
 6 one -- if we are having difficulties in terms of
 7 recruiting, it's a difficult way to -- it's a difficult
 8 thing to completely address.
 9 I think efforts are put in place to try and recruit
 10 psychologists to work on wards. I think we also need
 11 the specific expertise around psychologists working with
 12 patients with schizophrenia or psychotic illnesses which
 13 I think we still need to improve on.
 14 **Q.** Time does not allow me to deal with the wider systemic
 15 issues for patients beyond VC, and --
 16 **THE CHAIR:** You're out of time now, Ms Cartwright.
 17 **MS CARTWRIGHT:** Can I just ask the final question about
 18 appropriate medical treatment?
 19 **THE CHAIR:** Yes.
 20 **MS CARTWRIGHT:** Appropriate medical treatment of
 21 a mentally -- of a detained mentally ill person must
 22 have a therapeutic purpose, would you agree, aimed
 23 specifically insofar as possible as curing or
 24 alleviating a mental health condition including bringing
 25 about a reduction in or control over their

83

1 being involved, particularly with patients with
 2 psychosis and schizophrenia?
 3 **A.** I think there's been a general difficulty in terms of
 4 recruiting people to psychological posts. I think, in
 5 recent times, there has been improvement. I believe
 6 that we still have clinical psychology assistants.
 7 I believe that if you're going to provide NICE guidance
 8 specific interventions, particularly with psychosis, you
 9 need psychologists who are experienced in delivering CBT
 10 for psychosis, which we currently do not have on wards.
 11 **Q.** Just for some clarity because the psychosocial
 12 interventions is part of the -- in hospital as well, and
 13 we see it in VC's plan. How long had you not had
 14 psychological availability input at the Trust?
 15 **A.** It varies. We have periods when we don't have
 16 psychology and there are periods where we do have
 17 psychology. For the last, I would say, maybe two or
 18 three years, we have had consistent psychology input
 19 from psychology assistants.
 20 **Q.** But in the period of time when VC was receiving
 21 treatment from the Trust from 2020 to 2023, was there
 22 any psychologist available?
 23 **A.** No, there wasn't.
 24 **Q.** So that would have been the same for all patients with
 25 psychosis and schizophrenia?

82

1 dangerousness.
 2 **A.** Yes.
 3 **Q.** I'm going to suggest to you, Dr Seedat, when one does an
 4 analysis, what sits in your notes at page 21 of the
 5 things you asked VC about, apart from one entry that
 6 related to his thoughts, all of the other relevant
 7 information of risk is completely omitted and that
 8 includes -- and we've not dealt with it in evidence --
 9 that he had disclosed that he was wandering around at
 10 night on 18 May shadow boxing. So again, further highly
 11 relevant information as to risk and what VC was doing in
 12 the community when he was mentally unwell. Would you
 13 agree, Dr Seedat?
 14 **A.** Yes.
 15 **Q.** So, Dr Seedat, would you agree that you have failed in
 16 your assessment of risk for VC?
 17 **A.** I don't agree with that.
 18 **Q.** You don't agree even today?
 19 That's my time, unfortunately.
 20 **THE CHAIR:** Are there any other points, Ms Cartwright?
 21 **MS CARTWRIGHT:** No.
 22 **THE CHAIR:** You can pick them up in the future.
 23 **MS CARTWRIGHT:** All right. I'm very grateful.
 24 **THE CHAIR:** Yes, Mr Straw.

Questioned by MR STRAW

84

1 **MR STRAW:** Dr Seedat, I represent VC's family. I have
 2 a number of different topics, and I am sorry to jump
 3 around.
 4 On 11 July 2020, you have already been referred to
 5 concerns raised by Celeste to the Community Team about
 6 VC's mental state deteriorating, he wasn't making much
 7 sense, query whether he was taking medication.
 8 Do you agree that that should have led to a
 9 face-to-face assessment of his mental state?
 10 **A.** In terms of Celeste's concerns?
 11 **Q.** Yes.
 12 **A.** Yes, I directed her to say that it's important that she
 13 contact the -- was that the email with regards to the
 14 Crisis Team?
 15 **Q.** Sorry, yes.
 16 **A.** Sorry.
 17 **Q.** There should have been an assessment, a face-to-face
 18 assessment --
 19 **A.** Yes.
 20 **Q.** -- of VC by the Crisis Team --
 21 **A.** So when VC was discharged, he was meant to be seen by
 22 the Crisis Team and Celeste made me aware that the
 23 contact that had been made was not face-to-face; it was
 24 via a telephone conversation.
 25 **Q.** Sorry to jump in, but a slightly later time, which is
 85

1 schizophrenia?
 2 **A.** Yes, he was.
 3 **Q.** Now, at the time VC was living independently, apart from
 4 when he came into hospital, and somewhat -- in August,
 5 at least, 2020, he began working part-time in basic
 6 warehouse sorting roles for relatively short periods now
 7 do those two facts --
 8 **A.** August 2020.
 9 **Q.** August 2020, yeah. Now, do those two facts show that he
 10 did not have paranoid schizophrenia?
 11 **A.** The fact that he was working?
 12 **Q.** Yes, in basic warehouse sorting roles?
 13 **A.** Not necessarily.
 14 **Q.** -- (*overspeaking*) --
 15 **A.** No, it wouldn't. People who have schizophrenia, when
 16 they are stable, can function normally.
 17 **Q.** So it's not right to say it's very unusual for that to
 18 happen?
 19 **A.** No. I guess maybe one could argue what could be unusual
 20 is that somebody who has reached that level of education
 21 would be looking for better jobs than that, but I guess
 22 if obtaining jobs are difficult, then I guess people
 23 will take what they get in order to earn a living.
 24 **Q.** Okay. Thank you.
 25 In your witness statement you explain there's no
 87

1 11 July 2020, she phones the Community Team. I don't
 2 think you were made aware of it at the time --
 3 **A.** Oh, I see what you mean, yeah.
 4 **Q.** -- but she phones the Community Team, raised those
 5 concerns --
 6 **A.** Yes.
 7 **Q.** -- it should have led to a face-to-face assessment by
 8 the Community Team?
 9 **A.** Yes, I think it should have, yes, in view of if it would
 10 be good practice when concerns are raised about
 11 somebody's mental health that somebody checks and
 12 confirms whether those concerns are realistic or not.
 13 **Q.** Thank you. The next issue is about diagnosis. You
 14 diagnosed VC with paranoid schizophrenia on
 15 31 July 2020.
 16 **A.** Yes.
 17 **Q.** Now, were the messages that Elias had put together and
 18 been sent in, did those inform your diagnosis?
 19 **A.** They did.
 20 **Q.** Those were private messages between Elias and his
 21 brother. Was there any reason to doubt that VC was
 22 telling the truth to his brother in those messages?
 23 **A.** No, there wasn't -- (*overspeaking*) --
 24 **Q.** Then, going back to your diagnosis of paranoid
 25 schizophrenia, was VC exhibiting classic symptoms of
 86

1 history of antisocial personality factors. That's
 2 paragraph 433. Paragraph 248 you say:
 3 "It was my consistent view that VC was not
 4 aggressive or violent by nature/personality."
 5 You didn't diagnosis him with a personality
 6 disorder.
 7 **A.** No.
 8 **Q.** Why was it that you didn't consider that he had
 9 personality disorder?
 10 **A.** I think for personality disorder diagnosis, there tends
 11 to be aspects in the earlier life which then shape
 12 personality and lead to disordered personality. From
 13 the history that VC gave and confirmation from the
 14 family, there were no factors within his earlier life
 15 that would have impacted in developing a personality
 16 disorder and hence the diagnosis of personality disorder
 17 was not something that was considered to be present.
 18 **Q.** Understood. You explain that in some more detail in
 19 your witness statement, the type of factors that might
 20 indicate a personality disorder?
 21 **A.** That's correct.
 22 **Q.** Thank you. Now, after the 31 July diagnosis, is it
 23 right that you didn't speak to VC's family after that?
 24 **A.** Yes, you mean once he was discharged?
 25 **Q.** Yes.
 88

1 A. Yes, that's correct.
 2 Q. So you personally didn't pass on the paranoid
 3 schizophrenia diagnosis to the family?
 4 A. I did speak to the family and I think Mum was present
 5 prior to VC being discharged and during that meeting
 6 I did openly discuss what was now my opinion, initially
 7 on the first admission, the diagnosis of first episode
 8 psychosis. On this occasion, I discussed with VC, and
 9 I think his mum was present, that it's now my view that
 10 his difficulties are more indicative of schizophrenia.
 11 Q. Well, there's no note of that in the records, is there?
 12 A. I think there's a record which says that I discussed
 13 with the family diagnosis, assessment, treatment,
 14 et cetera. I may not have been explicit in terms of
 15 what exactly was discussed.
 16 Q. No. Okay. So the notes are along the lines of that
 17 he's got psychosis, that he's tending towards --
 18 A. Yes.
 19 Q. -- an illness?
 20 A. Yes.
 21 Q. But there's no note of you saying that he had paranoid
 22 schizophrenia?
 23 A. I don't recall correctly, but I have a feeling that I
 24 probably did, because I did communicate that to VC.
 25 Q. I ask because the family is very clear that they weren't

89

1 A. It could be that at that time he may have been having
 2 some more experiences from whatever was documented.
 3 It's only speculation that I can make. And when he went
 4 to Birmingham, I think subsequent to that, things could
 5 have settled down, in which case he was presenting or
 6 having -- wasn't experiencing those difficulties. So
 7 mental state can vary from period, and stresses and
 8 conflicts can have an impact and bearing on that.
 9 Q. As to your diagnosis in particular, paranoid
 10 schizophrenia, does it alter your diagnosis?
 11 A. No, it doesn't.
 12 Q. Okay. And a note by Dr Ibrahim in page 11 of the RiOs,
 13 I think, was read out earlier, which states that:
 14 "Dr Seedat explained that the most likely cause of
 15 the psychotic breakdown is sleep deprivation or stress."
 16 *(As read)*
 17 Firstly, is Dr Ibrahim right that that's what you
 18 explained?
 19 A. No, I think what I was trying to explain was that the --
 20 the likely rationale to understanding why he has had
 21 a psychotic breakdown, factors responsible, not the
 22 actual cause, but factors responsible could be the
 23 social isolation and the sleep deprivation which were
 24 quite evident and the stresses that he was experiencing
 25 at the time.

91

1 told that. Is your evidence now you don't recall
 2 whether or not you did tell them?
 3 A. I'm not certain.
 4 Q. Not certain. Okay. Thank you.
 5 Pre-morbid state. So before 2020. You were asked
 6 about a statement from a housemate in 2014 and 2015
 7 earlier on today --
 8 A. That's correct, yes.
 9 Q. -- and she was someone who described VC in that period.
 10 A. Yes.
 11 Q. There was also, just to give you a fuller picture,
 12 there's also been a statement disclosed to the Inquiry
 13 from Birmingham Metropolitan College where VC was
 14 a student from 2015 to 2016 and they say that the
 15 college records indicate no behavioural concerns or
 16 safeguarding concerns in that period.
 17 Now, if you'd had that information taken as a whole,
 18 so the housemate and the college, alongside everything
 19 else you had, would that have made any difference to
 20 your conclusions or to your approach to care?
 21 A. I would say that the mental state varies. It all
 22 depends on point in time. It could be that when he was
 23 in the 2014/2015 situation, I think it was
 24 Pembrokeshire, I think.
 25 Q. That's right, yeah.

90

1 Q. So it's a trigger rather than the underlying cause?
 2 A. That's correct, yeah. I mean, there are situations
 3 where stresses, sleep deprivation can cause short
 4 periods of psychotic episodes which then tend to then
 5 resolve spontaneously, and I've seen this on a number of
 6 occasions. But on this occasion, my view was more that
 7 they were more factors that were precipitating illness
 8 rather than them being actual causes of illness.
 9 Q. Okay. But nevertheless, the fact that you considered
 10 that a trigger of this episode included stress; would
 11 you agree it would have been better to tell the
 12 University that?
 13 A. Yes, I agree with that. As I said, it was my
 14 understanding that, having contacted somebody from the
 15 University and having had a conversation with
 16 University, the rationale and purpose of that was around
 17 VC's ability to deal with his studies, what impacts this
 18 would have in terms of him completing his studies which
 19 would infer that VC probably would have needed help in
 20 terms of completing his studies, and as the studies were
 21 potentially a factor in his clinical picture.
 22 Q. But it sounds like, if I'm not being fair please do tell
 23 me, but it sounds like you didn't clearly say to them:
 24 "I think stress was one of the triggers of this
 25 episode." -- *(overspeaking)* --

92

1 A. On reflection I probably would have been more -- I
2 should have been more explicit because it was something
3 that was clearly identified as a factor in his
4 presentation.

5 Q. The next issue is drugs. In the MDT discussion on
6 25 May 2020, it's noted that there's no indication that
7 his illness was drug-induced. And you've already
8 explained about the urine test which came back negative.

9 A. Yes.

10 Q. Was another reason why you concluded that this wasn't
11 drug-induced, the course of the psychosis and its
12 response to medication? And if I can clarify, in the
13 first admission, he had a bit of olanzapine and he
14 seemed to settle. He then had a drug-free trial and
15 psychotic symptoms emerged, and then he had aripiprazole
16 and seemed to get better. Was that another supporting
17 factor for that conclusion?

18 A. That would be difficult to say. I think the treatment
19 with the olanzapine, I think the response was more due
20 to the rapid tranquilisation he received rather than the
21 effects of the olanzapine because it was just too early
22 to see any beneficial effect from the olanzapine at that
23 point. It was more the sedation from the rapid
24 tranquilisation medication, which were benzodiazepines
25 that led to him settling down.

93

1 to be his mother. I believe that was his main driving
2 rationale and reason, in terms of damaging the two
3 doors.

4 Q. And how about the 14th July incident? So the next one
5 when -- later when he then again breaks into a flat. Do
6 you know what the motive for that --

7 A. Yeah, on this occasion I think the reasoning was
8 different, because on this occasion VC had stated that
9 he had gone there in order to confront this individual
10 as to why they were -- or he was affecting his mind.
11 And he wanted the individual to admit to what they were
12 doing.

13 Q. The RiOs at page 58, it's an entry of the MDT again,
14 indicate that prior to that incident, so before the 14th
15 July incident, VC stopped medication in the community
16 because he believed here was not ill; do you recall
17 that?

18 A. Yes.

19 Q. Now the belief that he was not ill. Is that itself
20 a feature of the illness? So it's a delusion which
21 arises from the illness?

22 A. I would say that it could be due to a variety of -- VC
23 found the rationale that he -- he could be
24 experiencing -- he was experiencing an illness
25 difficult, as did the family. And VC, I think, at that

95

1 It is very difficult to say whether, just by
2 response to medication, one can eliminate whether there
3 was an impact of substances on someone's presentation.

4 Q. So it was more the collateral information, the urine
5 test, the background history.

6 A. That's correct.

7 Q. That sort of thing that led you to the conclusion that
8 it wasn't drug-induced.

9 A. Yes.

10 Q. Okay. You are -- I'm sorry, I'm dotting around again,
11 going to another issue. You were asked what was it that
12 VC said drew him to break into flats twice on 24 May --

13 A. It was the belief that somebody was in trouble,
14 particularly a female who was being raped, and he
15 believed that person to be his mother.

16 Q. Do you remember there was an exchange between you and
17 Ms Langdale about whether there was an additional
18 factor. You were VC's Responsible Clinician for several
19 weeks. You spoke to him a number of times. What do you
20 say, in light of all of that contact with him, was the
21 motive for him to break into those flats? Was it the
22 one you've just said or was there something else?

23 A. I think his motive was that he was driven by his false
24 beliefs that somebody was in danger and risk and he
25 needed to go and rescue this individual, who he believed

94

1 time still somehow believed that somehow he could do
2 this without it being an illness and something that he
3 could control. And I think it's on that basis that he
4 stopped his medication, rather than on the basis that he
5 had experienced any specific side effects, and that was
6 not my belief, that he had stopped them because of side
7 effects, despite VC indicating that he stopped it
8 because he read -- and that was the important bit --
9 that he said he read. He never confirmed, and when
10 asked, he never stated that he actually felt slowing of
11 his brain.

12 Q. But the hallucinations he was suffering, some of them
13 might be described as quite extreme: hearing people
14 screaming, hearing his mother being raped and so on.
15 And he believed that that wasn't an illness. Was that,
16 that belief that even those very serious hallucinations
17 weren't an illness, itself a delusion?

18 A. It may well be, but I think based on the discharge and
19 the discussions we had it was made very clear to VC that
20 he did actually have illness and it was important to be
21 medicated. I guess it's a decision he made not to
22 continue with that, I think, on the more predication
23 that he wanted to see whether he could be well without
24 taking medication.

25 Q. Moving on, I'm afraid, another topic: risk. You say

96

1 three things in your witness statement --

2 **THE CHAIR:** Mr Straw, you're also running out of time. How

3 long are you going to be?

4 **MR STRAW:** As I understand it, I've got 20 minutes until 20

5 past and I'll stop there.

6 **THE CHAIR:** -- (*overspeaking*) -- if it's actually before

7 then, but all right.

8 **MR STRAW:** If I may. Thank you.

9 **THE CHAIR:** (*Unclear*).

10 **MR STRAW:** So three things in your witness statement: the

11 first one is you say it's clear that his risks were

12 dependent on the presence of acute psychotic symptoms;

13 secondly, you say to minimise risk you needed effective

14 control of the psychosis; and thirdly, you appear to

15 accept that when acutely unwell he was at high risk of

16 aggression.

17 Would you agree that in light of all those factors

18 it's very important that his psychosis is properly

19 treated?

20 **A.** Yes, it is.

21 **Q.** So two final topics, then. In that context, oral

22 medication, he was started on aripiprazole at the end of

23 the first admission -- sorry, during the first

24 admission, and then discharged at the end on

25 5 milligrams; would you agree that's a subtherapeutic

97

1 therapeutic level; would you agree with that?

2 **A.** I wouldn't. In view that he had been taking

3 a therapeutic dose, I wouldn't see the rationale as to

4 why one would then want to give him more medication to

5 achieve if the symptoms are controlled on that dose,

6 which on this occasion was increased to double what he

7 had taken on the first admission, I wouldn't understand

8 what the rationale would have been to try and increase

9 his medication.

10 **Q.** Well, the rationale is by this stage, or at least by the

11 end of the second admission, you've diagnosed him with

12 paranoid schizophrenia, and there was the very quick

13 failure in the community, after the first admission;

14 those two factors would indicate, wouldn't they, that

15 you needed to give him more?

16 **A.** Not necessarily. I think the dose of medication depends

17 on the control of symptoms. If the symptoms are

18 controlled at a specific dose, that is a therapeutic

19 dose. I don't think there is -- there's any benefit in

20 terms of increasing medication just for the sake of it.

21 There has to be some sort of clinical reason. There has

22 to be ongoing evidence of symptoms that would suggest

23 that they need further addressing, and on that basis you

24 would increase medication. But not just looking at the

25 situation saying: okay, we need to give more medication.

99

1 dose?

2 **A.** I think one needs to judge by in terms of what evidence

3 you have when you start medication. These medications

4 are quite strong. People can develop side effects which

5 would then be a reason where patients may not take them.

6 So it is a clinical judgement. I think it's not correct

7 to say whether a dose is the subtherapeutic or not. If

8 he was on that dose and he was still exhibiting some

9 features of his illness, then one would say yes, that

10 would be subtherapeutic.

11 But it was clear to us that in the time that he was

12 with us, there was an improvement in his mental state.

13 He denied any ongoing psychotic symptoms. There were no

14 behaviours observed during the post-treatment when he

15 was on the ward that would suggest that there was

16 evidence of psychosis, and so I would say that at that

17 point, 5 milligrams was therapeutic as opposed to

18 subtherapeutic.

19 **Q.** I'm going to suggest there were three benefits of

20 keeping him in hospital longer on the second admission.

21 I'm going to do this quickly because of the time, and

22 see if you agree with this.

23 So the first benefit is that one can then see

24 whether he suffered side effects from aripiprazole and,

25 if not, increase the dose so that it's at a more

98

1 **Q.** I would suggest -- and this is going to be my last point

2 because I'm going to run out of time -- but another

3 important reason why he should have been kept in

4 hospital longer at that point is that aripiprazole

5 takes, or can take, some time to come to full

6 therapeutic effect, and it was important, especially

7 given what happened in the first admission, that he was

8 carefully monitored to ensure that it had come to full

9 therapeutic effect; would you agree with that?

10 **A.** I wouldn't. I think the -- it's important to remember

11 that in order to continue monitoring medication, it

12 doesn't necessarily need to be within -- this can only

13 be done within an inpatient setting.

14 If someone has responded to medication and they then

15 meet the criteria that they can now be safely managed in

16 the community, that monitoring and supervision can be

17 carried on, which is what we did on this occasion,

18 within the community.

19 **MR STRAW:** Thank you very much.

20 **THE CHAIR:** Thank you.

21 Yes, Mr Beggs.

22 **Questioned by MR BEGGS**

23 **MR BEGGS:** Doctor, first quick points. Ms Langdale and

24 Mr Moloney took you through the content of the troubling

25 text messages; you recall?

100

1 A. I do.
 2 Q. You agree they're troubling?
 3 A. Yes.
 4 Q. Did you notify the police of the content and tone of
 5 those messages?
 6 A. No, I did not.
 7 Q. Do you agree, with hindsight, it might have been a good
 8 thing to do so?
 9 A. I think in hindsight, what would have been good to do is
 10 then request a forensic opinion and that may have led to
 11 involvement with the police, et cetera.
 12 Q. Because the context was of a man who is highly
 13 intelligent, physically strong, capable of deceit, and
 14 lacking insight. I think you've agreed all four points?
 15 A. Yeah, and that's something that's come about in terms of
 16 the assessment of his care, yes.
 17 Q. So going from the particular to the general, do you
 18 think on reflection, that better briefings from
 19 consultant psychiatrists, senior clinicians such as
 20 yourself, to the police, in respect of people who are
 21 potentially violent, would be a good thing?
 22 A. That would be a good thing in all situations, yes.
 23 Q. Yes. Might I suggest, finally, on that point, it would
 24 be a good thing if the clinician put that briefing into
 25 writing, let me suggest why, so that nothing is lost in

101

1 Q. Was your reason for not contacting the police for those
 2 two admissions because you considered you already knew
 3 what the information was?
 4 A. That's correct.
 5 Q. Yes, third point. When a potentially dangerous or
 6 violent patient is discharged into the community, it's
 7 obvious, isn't it, doctor, that it will be the police
 8 who will be the first responders to any materialisation
 9 of the risk?
 10 A. Yes.
 11 Q. But if we look, please, at your witness statement
 12 WITN0163001, and go first of all to paragraph 92 on
 13 page 37, and if we look at what would be the bottom hole
 14 punch, when you talk about discharge planning, you say:
 15 "... will be formally talked about. This will be
 16 a collective process between the inpatient team and
 17 involving the community team, carers, any involved
 18 agencies and the patient".
 19 Do you see that?
 20 A. Yes.
 21 Q. You don't mention the police there, do you?
 22 A. No, this -- and at the time of my involvement, I made
 23 the conclusion that yes, the text messages were
 24 worrying. I collected the information that was within
 25 the text messages to be closely linked and related to

103

1 translation?
 2 A. I would say that I think the interaction and link should
 3 be both ways rather than one way. I think the police
 4 can also be more helpful in terms of --
 5 Q. I agree --
 6 A. -- sharing information, and helping.
 7 Q. Yes, but at the moment we're dealing with something that
 8 you knew about but didn't tell the police.
 9 A. *(Unclear)*.
 10 Q. Second point, I think you've just made it, is when
 11 considering the risk that a patient may pose to members
 12 of the public, the police may well themselves have
 13 valuable input; is that fair?
 14 A. They would.
 15 Q. Yes, but during the period of the first two admissions,
 16 did you at any stage contact Nottinghamshire Police for
 17 more information?
 18 A. No.
 19 Q. Was that because --
 20 A. Other than the -- other than the interaction I had with
 21 PC Marsden.
 22 Q. PC Marsden, yes.
 23 A. Yes.
 24 Q. But that was him contacting you, wasn't it?
 25 A. Yes.

102

1 his acute psychotic symptoms, and I formed the opinion
 2 in view of that that if the psychotic symptoms were
 3 controlled, the risks would also be managed and
 4 mitigated, and in view that in both occasions he had
 5 responded well to treatment, which in my opinion then
 6 mitigated the risk, I didn't feel that at the point of
 7 discharge that he was still an ongoing risk of, or high
 8 risk of aggression or violence. If I did feel that, on
 9 that occasion I would have involved other agencies,
 10 including the police.
 11 Q. I'm inviting you to reflect on a slightly different
 12 point, which is in paragraph 92, you don't mention the
 13 police in respect of discharge.
 14 If we go to page 39 of your statement and
 15 paragraph 97, where again you speak of the decision to
 16 discharge being a collective approach, and then you list
 17 out the stakeholders, again not mentioning the police.
 18 Just to speed things up, if you go to paragraph 105 on
 19 page 42, the same there at the very bottom of that page:
 20 "It will involve obtaining collaborative information
 21 from the patient's medical records ... family/carers,
 22 community teams and any involved agencies."
 23 The one agency that three times running you don't
 24 mention is the police and I wonder whether that's
 25 a reflection of a Consultant Psychiatrist's mindset

104

1 which is we'll think of everyone else, but not the very
 2 people who will be first responders; do you see?
 3 **A.** I think the reason why the police are not mentioned is
 4 twofold. One is that at the time of VC being discharged
 5 on both occasions, I did not form the opinion or hold
 6 the opinion that his risks were such that the police
 7 needed to be informed or involved.
 8 **Q.** Doctor, may I intervene, politely I hope, the
 9 three paragraphs that I referred to were generic,
 10 talking about the discharge process, not confined to VC.
 11 **A.** Yes.
 12 **Q.** So I'm wondering whether they reflect a mindset which is
 13 "We don't consider the police to be part of the
 14 stakeholder group we should consult"?
 15 **A.** I think there is a mindset that we do involve police
 16 when the need or requirement is there. Having said
 17 that, it is also important to recognise that getting
 18 police involvement information is generally very
 19 difficult, and has been difficult.
 20 **Q.** I understand.
 21 **A.** And I think there needs to be agreed processes that
 22 would facilitate and make this easier going forward.
 23 **Q.** Yes. You can see, can't you, why, to take the example
 24 of the troubling texts, that if you had sent a short
 25 briefing to the police about those texts, which they

105

1 **A.** No.
 2 **MR BEGGS:** Thank you, Dr Seedat.
 3 **THE CHAIR:** Mr Beer.
 4 **Questioned by MR BEER**
 5 **MR BEER:** Just three topics, Dr Seedat. Firstly, I'm going
 6 to ask you some questions about where in the spectrum of
 7 risk did VC sit by the end of his first admission in May
 8 and June 2020; do you understand?
 9 **A.** Yes.
 10 **Q.** So I think by May and June 2020, you had been practising
 11 in psychiatry for many years.
 12 **A.** That's correct.
 13 **Q.** You'd taken up your first post in psychiatry in,
 14 I think, 1999; is that right?
 15 **A.** In training in psychiatry, yes.
 16 **Q.** Yes. So you'd been practising in the field for
 17 21 years?
 18 **A.** That's correct.
 19 **Q.** In that time, am I right to assume that you had seen
 20 hundreds or thousands of patients by the time we get to
 21 May and June 2020?
 22 **A.** Yes.
 23 **Q.** And assessed those patients and the risks that they
 24 posed, either to themselves or to others?
 25 **A.** Yes.

107

1 could put on to NICHE, for example, when police officers
 2 attend on VC later in the chronology, they might be able
 3 to view some of his behaviours in a more informed light.
 4 Do you see that?
 5 **A.** Yes.
 6 **Q.** Yes, my fourth and final point. I read from your
 7 paragraph 179 on page 72 of your statement, from the
 8 third line there, where you say:
 9 "... I made the impression that VC posed the
 10 likelihood of repeating his behaviours ..."
 11 Which you parenthetically summarise, and you say:
 12 "... could then potentially lead to a risk of
 13 violence to others."
 14 So I read that as you acknowledging the potential
 15 risk of violence upon discharge.
 16 **A.** That was acknowledging the potential risk of violence --
 17 **Q.** Yes.
 18 **A.** -- if VC did not follow the -- (*overspeaking*) --
 19 **Q.** Did you tell the police about that potential risk of
 20 violence?
 21 **A.** The information was, it was not -- the police were not
 22 informed of that, as I said, because -- (*overspeaking*)
 23 --
 24 **Q.** Did you tell the police about that potential risk of
 25 violence from this patient?

106

1 **Q.** In the course of seeing such patients and assessing such
 2 risks, presumably many of them demonstrated that they
 3 presented a risk of harm to others?
 4 **A.** That's correct.
 5 **Q.** That might be through what they had done in the past,
 6 especially if they had convictions?
 7 **A.** That's correct.
 8 **Q.** It might be through what they had said to clinicians
 9 about their thoughts and intentions?
 10 **A.** Correct.
 11 **Q.** It might be through their behaviour that they had
 12 demonstrated or displayed whilst an inpatient?
 13 **A.** That's correct.
 14 **Q.** It might be through what they had written down, whether
 15 in notes, scribbles, or drawings?
 16 **A.** That's correct.
 17 **Q.** It might be through what they had said online, in social
 18 media posts, or in messages to others?
 19 **A.** That's correct.
 20 **Q.** So through those various means that I've listed,
 21 doubtless there are more, would it be right that many,
 22 many patients disclose a risk of causing harm to others.
 23 **A.** That's correct.
 24 **Q.** Where in the spectrum of risk of causing harm to others
 25 did VC sit by the time of his discharge after his first

108

1 admission?

2 **A.** My assessment and opinion at the end of the first

3 admission was that VC risk, both in terms of aggression

4 and violence, had reduced and was graded as low. This

5 was in association of understanding the things which he

6 had said within his text messages.

7 **Q.** So do I understand your answer correctly as meaning that

8 many, many patients, hundreds or thousands, that you

9 have seen, expressed things in the variety of ways that

10 we've discussed that show a risk of causing harm to

11 others?

12 **A.** That's correct.

13 **Q.** But in the spectrum, his risk was assessed by you to be

14 low?

15 **A.** That's correct, at the end of treatment.

16 **Q.** You said in the course of your evidence this morning to

17 Ms Langdale that you would not have been able to justify

18 continued detention, having regard to the legal

19 framework and VC's presentation.

20 **A.** That's correct.

21 **Q.** I just want to ask you a little more about that, please.

22 Firstly, under the law, a person must be suffering from

23 a mental disorder of a nature or degree which makes it

24 appropriate for them to receive medical treatment in

25 a hospital. In your view, was that criterion fulfilled

109

1 occasions after he had left inpatient care on Rowan, to

2 speak to you, or to involve you in some way in his care

3 in the community. You said that it wouldn't be right or

4 appropriate for you to have acceded to VC's requests.

5 **A.** That's correct.

6 **Q.** Is one reason for that that patients, particularly those

7 suffering from mental disorders, should not be able to

8 select which clinicians they wish to speak to or get

9 involved in their care?

10 **A.** I agree.

11 **Q.** Is that because of, amongst other reasons, the risk of

12 the patient seeking to play one clinician off against

13 the next?

14 **A.** There is the risk of that, yes.

15 **Q.** And is that risk particularly acute in the context of

16 a patient suffering from a mental disorder?

17 **A.** Yes.

18 **Q.** Particularly paranoid schizophrenia?

19 **A.** That's correct.

20 **Q.** Is a second reason that the clinicians in this instance,

21 working in inpatient care, ie, you, will or may not be

22 familiar with the history, chronology, interactions,

23 treatment and care plan in the community?

24 **A.** Yes.

25 **Q.** Would it not be possible to obtain some or all of that

111

1 by the time of discharge?

2 **A.** No, it wasn't.

3 **Q.** And why not?

4 **A.** That's because VC had shown improvement and response to

5 his difficulties he had. He was no longer presenting

6 with any evidence of mental disorder. His risks had

7 reduced, hence he was not presenting with any particular

8 risk, and he had also been engaging with treatment.

9 **Q.** Secondly, under the law, the treatment of the patient in

10 detention must be necessary for their health or safety

11 or for the protection of others. In your view, was that

12 criterion fulfilled by the time of discharge?

13 **A.** No, it was no longer fulfilled.

14 **Q.** And why was that criterion not fulfilled?

15 **A.** Because the observations and the assessments we made did

16 not suggest that VC was presenting any significant risk

17 either to himself, to others.

18 **Q.** Thirdly, under the law, detention must be the least

19 restrictive option available in the circumstances. In

20 your view, was that criterion fulfilled by the time of

21 discharge?

22 **A.** No, because at this point it was now the position that

23 the least restrictive was not within an inpatient

24 setting but back into the community.

25 **Q.** The second topic, please, VC's requests, I think on two

110

1 background by reading the notes, or would that be

2 insufficient to get yourself involved in community care?

3 **A.** I think it would be insufficient because you have the

4 ideal in terms of what the ideal interventions or

5 interactions would be, but the ideals are not always

6 met, and if one is not fully aware of what resources are

7 available in the community, this would be very difficult

8 to address.

9 **Q.** And is all of this aside from the reason I think you've

10 already given, namely the importance of clear boundaries

11 and divisions of responsibilities?

12 **A.** That's correct.

13 **Q.** And is that, again, all aside from the issue I think

14 you've already mentioned of simple capacity and

15 resources, and your duties towards the other patients

16 that you were already treating in Rowan 1?

17 **A.** That's correct.

18 **Q.** The third topic, please, briefing the police about the

19 risks that a patient may pose. Is there an established

20 system to disclose information that is confidential to

21 a patient to the police where it is not assessed that

22 the patient exposes a risk of harm to others?

23 **A.** There is not, that I'm aware of.

24 **Q.** I think the paragraphs that were mentioned to you

25 a moment ago concerned the disclosure of information to

112

1 other agencies involved in the ongoing treatment and
 2 care of the discharged patient; is that right?
 3 **A.** That's correct.
 4 **Q.** Is the disclosure of information to third parties
 5 generally regulated by, among other things, the GMC
 6 guidelines?
 7 **A.** It is.
 8 **Q.** And those guidelines include, amongst other gateways: if
 9 disclosure is necessary to support a prosecution or the
 10 detection of a crime, in particular a serious criminal
 11 offence.
 12 **A.** That's correct.
 13 **Q.** Is there a gateway for disclosure back then, or even
 14 a gateway for disclosure now, a disclosure of
 15 information to the police about the risks that a patient
 16 may pose, even where it's not assessed that the patient
 17 poses a risk of harm to others?
 18 **A.** No, there isn't.
 19 **MR BEER:** Thank you very much, Dr Seedat.
 20 **THE WITNESS:** Thank you.
 21 **THE CHAIR:** Thank you.
 22 **Questioned by THE CHAIR**
 23 **THE CHAIR:** Yes, Dr Seedat, I just wanted to ask a few
 24 questions. If we can just have the exchange with
 25 PC Marsden up. So that's WITN0163012.

113

1 **THE CHAIR:** But that's exactly what you did do, wasn't it?
 2 **A.** Yes, I did and this is why I've reflected and said I'm
 3 unclear, I'm, I guess wondering as to why I did. In
 4 fact I should have insisted that he sends me the form,
 5 but I was trying to --
 6 **THE CHAIR:** Just a moment. He told you in that email, which
 7 we can see on the right there, that he kicked the door
 8 down "several times causing the young female victim
 9 inside to become extremely scared, so much so that she
 10 jumped out of her first floor window".
 11 **A.** Yes.
 12 **THE CHAIR:** So you knew that before you gave your response.
 13 **A.** Yes, I did.
 14 **THE CHAIR:** It wasn't something you didn't know.
 15 **A.** No, I did know.
 16 **THE CHAIR:** So when you gave your response about precisely
 17 those matters, effectively criminal responsibility, you
 18 knew the extent of the issue in relation to the young
 19 female, didn't you?
 20 **A.** I did know about that incident, yes.
 21 **THE CHAIR:** Did you not understand that what was being
 22 asked, effectively, as it says in the email:
 23 "... and the victim and [the] ... family to
 24 establish whether or not [VC] can be held accountable
 25 for his actions or not" that police were making that

115

1 Page 1. Then there's your response, which is where
 2 you reply to PC Marsden.
 3 **A.** Yes.
 4 **THE CHAIR:** We'll just put that next to each other. That's
 5 on WITN0163014. And that's also page 1.
 6 So just looking at that, because what you told the
 7 Inquiry is that you thought you were being asked about
 8 his fitness to be interviewed; is that correct?
 9 **A.** My initial thought, and this is why I asked for this
 10 specific form. If I see my first email to PC Marsden
 11 was --
 12 **THE CHAIR:** Yes.
 13 **A.** ~-- "Can you send me" or I referred to this specific
 14 form, because we have this specific form which we fill
 15 in around fitness to interview.
 16 **THE CHAIR:** But when you received this email, and the
 17 request, it doesn't mention anything to do with fitness
 18 to --
 19 **A.** No. So what I was trying to allude to is that the
 20 agreement that we had with the police was that we, as
 21 inpatient consultants, will only be commenting on
 22 whether a person is fit to be interviewed or not, we
 23 wouldn't get into the details around patient's capacity
 24 around crime, et cetera, because that's not within my
 25 expertise.

114

1 decision on the basis of what you were telling them?
 2 **A.** What I didn't understand at the time was that my -- what
 3 I was going to say was going to be used as a decision
 4 whether they do or they don't. What I was trying to
 5 convey was purely a capacity around his mental state,
 6 which was evident to me that when this incident
 7 happened, VC was being driven by his psychotic
 8 experiences.
 9 **THE CHAIR:** Well, what you've said is:
 10 "It's clear that his judgement and awareness of his
 11 environment and actions was impaired. It's more likely
 12 that he didn't have the capacity to be responsible for
 13 his actions." *(As read)*
 14 So that is something which is a criminal matter,
 15 isn't it?
 16 **A.** I did, yes. I did say that, because that was the
 17 opinion I held.
 18 **THE CHAIR:** Yes. And as far as that's concerned, you've
 19 also told us that the fact that there is a criminal
 20 conviction, or a referral, or through the criminal
 21 justice system, is something which is necessary for you
 22 to be able to call in forensic services, isn't it?
 23 **A.** Yes.
 24 **THE CHAIR:** So in doing this, were you not aware that you
 25 were, in effect, creating a situation in which these

116

1 incidents were not on the police computer because they
 2 weren't going to be pursued, and therefore this wouldn't
 3 be something which would be taken into account in
 4 deciding whether forensic psychiatry could be involved?
 5 **A.** I wouldn't agree that the conviction would have been the
 6 only factor that would have led to the referral to
 7 forensic services. If I did believe that, despite there
 8 being no conviction, that he did require forensic
 9 services, I would have still made the view or the
 10 referral.
 11 **THE CHAIR:** Because you gave this on 2 June, and it looks as
 12 if you received the notes from -- of all the emails and
 13 so on -- on the same day. The second you've put the
 14 note in RiO on 3 June, so assume you didn't read it on
 15 the same day. This is all the notes from
 16 Elias Calocane, that you received those in June.
 17 **A.** In June of 2020.
 18 **THE CHAIR:** Yes. Just looking at that.
 19 **MS LANGDALE:** Chair, they're sent, I think, 28 May to the
 20 doctor and he reads them on 3 June.
 21 **THE CHAIR:** Yes, 28 May and they're summarised on 3 June.
 22 **A.** Yes.
 23 **THE CHAIR:** So in the same period as you're communicating
 24 with PC Marsden.
 25 **A.** Yes.

117

1 **THE CHAIR:** It had obviously come into your head and you
 2 discussed it with him as being the worst-case scenario.
 3 **A.** Yes.
 4 **THE CHAIR:** But that is a risk, isn't it?
 5 **A.** I was trying to -- rather than making a risk assessment,
 6 I was clearly trying to drive the point home to VC that
 7 if, you know, it could be that one of the unintended
 8 consequences, as was the case with the lady who had
 9 jumped off the --
 10 **THE CHAIR:** I think we're at cross purposes, because
 11 I accept you weren't making a risk assessment in the
 12 forensic way, but it was your -- in making that comment,
 13 you had assessed that as a risk.
 14 **A.** I assessed that, if he continued that, it could be that
 15 one of the unintended consequences could be that she
 16 would -- that somebody would die from their injuries,
 17 yes.
 18 **THE CHAIR:** But if he'd broken down the door, or the young
 19 woman had broken her neck rather than her back, did you
 20 not take that into account as well?
 21 **A.** If --
 22 **THE CHAIR:** Particularly having seen the texts that you had.
 23 **A.** Yeah, at the time, as I said, I didn't have knowledge
 24 that VC had actually gained access or entry into the
 25 flat. The information I had was that on both occasions

119

1 **THE CHAIR:** Did it not occur to you, having read those, that
 2 what you had sent to Police Constable Marsden, and the
 3 fact that they were asking about these issues, that it
 4 was something that the police should have been aware of,
 5 or that you should have changed your view or given some
 6 caveat to your view?
 7 **A.** I do accept that in hindsight I shouldn't have made a
 8 comment on this and would have focused on just agreeing
 9 to comment on whether VC was fit for interview at the
 10 time. I, at the time, did not think, maybe, and which
 11 I should have, whether what I had said would be used to
 12 make decisions around whether to charge or not to
 13 charge.
 14 **THE CHAIR:** Yes.
 15 **A.** That's something I need to reflect on.
 16 **THE CHAIR:** Yes. Just, then, leading to the second
 17 admission, and the note that was made about your
 18 conversation with VC, and where you say that you
 19 challenged him.
 20 Just in relation to that, you said it wasn't a risk
 21 assessment in the sense that you didn't consider that he
 22 was likely to kill somebody.
 23 **A.** That's correct.
 24 **THE CHAIR:** But was it not your assessment of the risk?
 25 **A.** No, it wasn't.

118

1 he had caused damage to the doors to the flat.
 2 **THE CHAIR:** Well, but the door wasn't his object, was it?
 3 It was getting in from --
 4 **A.** Yeah, and his intention, what he told me on both
 5 occasions, was that he was going in to determine whether
 6 the person who was, that he was worried about, was safe
 7 or not.
 8 **THE CHAIR:** I think that by this stage he'd also told you
 9 that -- you were aware that he was trying to hurt the
 10 people who were mocking him or monitoring him who he
 11 believed to be in the other flat?
 12 **A.** Yes, I did know that from the text messages.
 13 **THE CHAIR:** Yes.
 14 **A.** Yes.
 15 **THE CHAIR:** So it was a risk and some --
 16 **A.** It was a risk.
 17 **THE CHAIR:** Yes, all right. Thank you.
 18 Yes, we'll start again on Monday. Thank you.
 19 (4.48 pm)
 20 (The hearing adjourned until 10.00 am on Monday, 27
 21 April 2026)
 22
 23
 24
 25

120

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

I N D E X

Page

Questioned by MR MOLONEY	49
Questioned by MS CARTWRIGHT	65
Questioned by MR STRAW	84
Questioned by MR BEGGS	100
Questioned by MR BEER	107
Questioned by THE CHAIR	113

<p>MR BEER: [2] 107/5 113/19</p> <p>MR BEGGs: [2] 100/23 107/2</p> <p>MR MOLONEY: [2] 49/7 49/10</p> <p>MR STRAW: [5] 85/1 97/4 97/8 97/10 100/19</p> <p>MS CARTWRIGHT: [5] 65/5 83/17 83/20 84/21 84/23</p> <p>MS LANGDALE: [3] 1/3 49/2 117/19</p> <p>THE CHAIR: [45] 49/5 49/8 64/23 83/16 83/19 84/20 84/22 84/24 97/2 97/6 97/9 100/20 107/3 113/21 113/23 114/4 114/12 114/16 115/1 115/6 115/12 115/14 115/16 115/21 116/9 116/18 116/24 117/11 117/18 117/21 117/23 118/1 118/14 118/16 118/24 119/1 119/4 119/10 119/18 119/22 120/2 120/8 120/13 120/15 120/17</p> <p>THE WITNESS: [1] 113/20</p> <hr/> <p>'it [1] 6/19</p> <p>'lack [1] 24/11</p> <p>'made [1] 5/2</p> <p>'murder' [1] 53/20</p> <p>'Okay [1] 62/14</p> <p>'slow [1] 5/1</p> <p>'strange [1] 24/6</p> <p>'Take [1] 55/12</p> <p>'that [1] 8/16</p> <p>'the [1] 25/5</p> <p>'there [1] 42/10</p> <hr/> <p>-</p> <hr/> <p>-- it [1] 48/6</p> <hr/> <p>.</p> <hr/> <p>...it [1] 8/12</p> <hr/> <p>/</p> <hr/> <p>/family/his [1] 24/15</p> <hr/> <p>1</p> <p>1.55 [1] 1/2</p> <p>10 November 2020 [1] 24/21</p> <p>10.00 [1] 120/20</p> <p>105 [1] 104/18</p> <p>106 [2] 20/7 20/11</p> <p>107 [2] 20/9 22/12</p> <p>11 [3] 70/18 85/4 91/12</p>	<p>11 July 2020 [1] 86/1 11.00 [1] 37/22 11.02 [1] 57/13 115 [1] 24/1 120 [4] 53/2 55/15 56/11 57/5 136 [1] 28/24 138 [1] 24/20 14:52 [2] 55/3 55/4 14th [2] 95/4 95/14 158 [2] 16/22 16/24 159 [2] 16/22 19/6 15:13 [1] 55/22 15:19 [1] 52/23 16 [1] 43/8 160 [1] 41/25 17 [3] 54/24 55/2 55/3 179 [1] 106/7 18 [3] 52/21 62/12 84/10 1999 [1] 107/14</p> <hr/> <p>2</p> <p>2 hours [1] 56/11</p> <p>20 [1] 97/4</p> <p>20 May 2020 [1] 57/11</p> <p>20 minutes [1] 97/4</p> <p>2014 [1] 90/6</p> <p>2014/2015 [1] 90/23</p> <p>2015 [3] 90/6 90/14 90/23</p> <p>2016 [1] 90/14</p> <p>2020 [17] 24/21 57/11 70/24 79/22 82/21 85/4 86/1 86/15 87/5 87/8 87/9 90/5 93/6 107/8 107/10 107/21 117/17</p> <p>2021 [2] 42/1 42/3</p> <p>2022 [3] 44/5 44/12 46/7</p> <p>2023 [1] 82/21</p> <p>2026 [3] 1/1 70/23 120/21</p> <p>21 [2] 59/10 84/4</p> <p>21 February 2022 [1] 44/5</p> <p>21 July [1] 13/11</p> <p>21 years [1] 107/17</p> <p>23 [1] 1/1</p> <p>24 May [2] 77/3 94/12</p> <p>24 May 2020 [1] 79/22</p> <p>248 [1] 88/2</p> <p>25 May 2020 [1] 93/6</p> <p>27 [1] 120/20</p> <p>28 [1] 15/9</p> <p>28 July [1] 20/7</p> <p>28 May [2] 117/19 117/21</p> <hr/> <p>3</p> <p>3.00 [1] 49/2</p>	<p>3.20 [2] 64/21 65/1</p> <p>3.35 [1] 65/3</p> <p>3.35 pm [1] 64/25</p> <p>30 [1] 24/2</p> <p>31 July [1] 88/22</p> <p>31 July 2020 [1] 86/15</p> <p>31st [1] 24/16</p> <p>37 [1] 103/13</p> <p>39 [1] 104/14</p> <p>3rd [2] 59/12 59/15</p> <hr/> <p>4</p> <p>4.48 [1] 120/19</p> <p>42 [1] 104/19</p> <p>433 [1] 88/2</p> <hr/> <p>5</p> <p>5 milligrams [2] 97/25 98/17</p> <p>58 [1] 95/13</p> <hr/> <p>6</p> <p>61 [2] 2/6 2/8</p> <p>64 [1] 4/22</p> <p>66 [1] 9/7</p> <hr/> <p>7</p> <p>7 am [1] 55/16</p> <p>72 [1] 106/7</p> <p>72-hour [3] 4/23 9/20 17/14</p> <p>75 [1] 10/14</p> <p>79 [2] 13/10 13/17</p> <hr/> <p>9</p> <p>92 [2] 103/12 104/12</p> <p>97 [1] 104/15</p> <hr/> <p>A</p> <p>abated [1] 73/13</p> <p>ability [2] 2/24 92/17</p> <p>able [13] 3/3 23/2 23/3 24/9 35/19 37/17 39/5 44/24 62/16 106/2 109/17 111/7 116/22</p> <p>about [138]</p> <p>above [1] 1/11</p> <p>absence [1] 83/3</p> <p>absolutely [3] 60/13 69/17 77/21</p> <p>academic [2] 5/7 32/7</p> <p>acceded [1] 111/4</p> <p>accept [13] 4/2 4/5 4/10 4/11 8/11 8/15 68/19 69/13 70/14 78/8 97/15 118/7 119/11</p> <p>acceptance [1] 8/20</p> <p>accepted [4] 4/19 69/24 70/14 71/18</p> <p>accepting [2] 18/17 48/13</p> <p>access [5] 29/14</p>	<p>30/15 34/1 38/16 119/24</p> <p>accommodation [10] 32/4 33/10 33/11 33/14 33/16 33/19 33/20 33/20 33/25 46/15</p> <p>accommodations [1] 33/7</p> <p>accordance [2] 66/23 74/8</p> <p>account [5] 2/25 79/13 79/19 117/3 119/20</p> <p>accountable [1] 115/24</p> <p>accounts [1] 75/20</p> <p>accuracy [1] 67/19</p> <p>accurate [5] 29/6 67/3 67/21 71/8 71/13</p> <p>accurately [2] 69/1 69/19</p> <p>achieve [2] 69/4 99/5</p> <p>achieved [5] 14/1 14/2 14/9 14/12 21/3</p> <p>acknowledge [1] 75/17</p> <p>acknowledged [1] 76/21</p> <p>acknowledging [2] 106/14 106/16</p> <p>across [2] 51/1 51/18</p> <p>act [4] 1/4 2/17 14/20 76/4</p> <p>acted [1] 76/4</p> <p>acting [1] 77/1</p> <p>actions [8] 6/10 8/3 8/5 40/15 67/9 115/25 116/11 116/13</p> <p>actual [4] 29/2 31/10 91/22 92/8</p> <p>actually [20] 4/11 5/12 12/14 29/23 33/21 36/2 36/4 36/4 47/20 51/2 60/23 64/9 64/9 69/14 77/1 80/1 96/10 96/20 97/6 119/24</p> <p>acute [9] 9/8 9/17 10/19 11/19 14/16 65/13 97/12 104/1 111/15</p> <p>acutely [3] 36/18 81/13 97/15</p> <p>additional [1] 94/17</p> <p>additionally [1] 79/12</p> <p>address [5] 32/1 34/11 81/6 83/8 112/8</p> <p>addressed [2] 34/10 49/25</p> <p>addressing [1] 99/23</p> <p>adequately [2] 36/19 36/24</p> <p>adjourned [1] 120/20</p> <p>admission [47] 3/14 4/6 4/9 4/25 5/11 5/16</p>	<p>7/5 9/3 9/5 10/1 10/4 10/21 10/23 10/25 12/6 13/9 13/21 13/24 14/3 15/8 20/25 22/7 22/16 23/13 24/20 25/14 34/6 35/14 35/25 42/7 44/18 57/12 61/24 71/21 89/7 93/13 97/23 97/24 98/20 99/7 99/11 99/13 100/7 107/7 109/1 109/3 118/17</p> <p>admissions [9] 41/11 44/9 44/19 50/1 61/25 65/10 65/12 102/15 103/2</p> <p>admit [2] 1/13 95/11</p> <p>admitted [5] 13/24 28/24 40/5 40/20 41/5</p> <p>adult [1] 33/1</p> <p>advice [1] 37/14</p> <p>advocate [1] 2/11</p> <p>affect [1] 73/21</p> <p>affected [1] 6/11</p> <p>affecting [1] 95/10</p> <p>afraid [1] 96/25</p> <p>after [19] 4/7 4/24 12/19 18/5 20/25 24/20 37/20 43/9 49/4 49/6 51/4 55/25 57/15 57/25 88/22 88/23 99/13 108/25 111/1</p> <p>afternoon [3] 49/10 65/5 65/6</p> <p>again [28] 2/23 6/18 14/3 14/6 16/4 34/15 34/16 42/2 42/19 46/24 62/5 71/10 72/23 74/7 75/3 80/1 81/3 81/17 81/20 81/24 84/10 94/10 95/5 95/13 104/15 104/17 112/13 120/18</p> <p>again' [1] 6/20</p> <p>against [4] 11/5 51/15 61/14 111/12</p> <p>agencies [4] 103/18 104/9 104/22 113/1</p> <p>agency [1] 104/23</p> <p>aggression [8] 9/18 10/12 77/15 78/3 78/6 97/16 104/8 109/3</p> <p>aggressive [3] 78/8 78/11 88/4</p> <p>ago [3] 53/2 56/11 112/25</p> <p>agree [39] 11/12 36/20 65/13 65/20 66/10 66/23 69/17 69/21 70/11 71/3 71/4 71/9 72/8 72/21 73/10 74/12 79/19 80/21 81/4 81/9 81/17 83/22 84/13 84/15 84/17 84/18 85/8 92/11</p>
--	--	---	---	---

<p>A</p> <p>agree... [11] 92/13 97/17 97/25 98/22 99/1 100/9 101/2 101/7 102/5 111/10 117/5</p> <p>agreed [5] 46/1 68/7 81/1 101/14 105/21</p> <p>agreeing [1] 118/8</p> <p>agreement [1] 114/20</p> <p>Ah [1] 41/3</p> <p>aid [1] 18/23</p> <p>aim [1] 3/4</p> <p>aimed [1] 83/22</p> <p>all [39] 1/21 2/12 9/1 9/1 10/20 13/24 14/6 14/9 25/13 26/2 26/24 27/16 27/24 29/9 29/20 32/8 49/2 64/10 68/13 71/15 80/2 80/17 81/15 82/24 84/6 84/23 90/21 94/20 97/7 97/17 101/14 101/22 103/12 111/25 112/9 112/13 117/12 117/15 120/17</p> <p>alleviating [1] 83/24</p> <p>allow [1] 83/14</p> <p>allowed [1] 15/9</p> <p>allows [1] 13/14</p> <p>allude [1] 114/19</p> <p>alluded [1] 31/13</p> <p>almost [1] 79/25</p> <p>along [1] 89/16</p> <p>alongside [2] 16/23 90/18</p> <p>already [13] 27/16 33/13 65/8 71/18 81/1 81/16 81/20 85/4 93/7 103/2 112/10 112/14 112/16</p> <p>also [40] 3/12 3/21 4/7 5/16 9/23 10/8 16/10 18/5 26/21 27/1 31/12 32/2 38/18 38/19 40/11 41/21 41/21 44/20 50/12 60/25 61/17 65/10 65/17 67/7 73/23 74/9 76/20 77/25 79/14 83/10 90/11 90/12 97/2 102/4 104/3 105/17 110/8 114/5 116/19 120/8</p> <p>alter [1] 91/10</p> <p>alternative [1] 42/9</p> <p>always [7] 40/15 51/1 51/18 61/2 69/1 83/5 112/5</p> <p>am [12] 32/2 37/11 37/12 43/14 45/8 47/1 55/16 55/17 61/23 85/2 107/19 120/20</p> <p>ambivalence [1] 18/6</p>	<p>ambulance [1] 79/15</p> <p>AMHP [1] 31/22</p> <p>among [1] 113/5</p> <p>amongst [2] 111/11 113/8</p> <p>amount [1] 14/21</p> <p>amounted [1] 78/15</p> <p>amounting [1] 69/24</p> <p>analysis [6] 2/15 75/25 77/5 78/5 79/2 84/4</p> <p>Angela [1] 10/15</p> <p>anger [3] 55/6 57/4 58/14</p> <p>angry [2] 73/19 76/9</p> <p>anguish [2] 55/5 76/22</p> <p>another [11] 33/10 44/12 46/23 48/7 56/18 76/15 93/10 93/16 94/11 96/25 100/2</p> <p>answer [3] 29/17 53/7 109/7</p> <p>antisocial [1] 88/1</p> <p>any [64] 5/12 6/3 6/23 6/23 9/17 9/24 10/4 10/20 10/22 11/8 12/4 12/16 12/24 13/1 13/22 15/9 18/6 18/7 19/17 21/24 24/6 25/22 26/6 27/1 27/7 27/8 28/11 28/25 29/10 30/14 31/7 31/10 38/2 38/11 40/16 52/13 56/20 61/8 61/8 62/6 63/6 64/5 67/19 70/12 70/20 76/4 76/23 77/2 78/2 82/22 84/20 86/21 90/19 93/22 96/5 98/13 99/19 102/16 103/8 103/17 104/22 110/6 110/7 110/16</p> <p>anyone [2] 76/6 76/24</p> <p>anything [12] 6/13 8/21 18/20 24/14 27/4 27/23 38/24 48/15 57/18 58/1 78/8 114/17</p> <p>anything/mock [1] 57/18</p> <p>anyway [1] 60/24</p> <p>apart [3] 27/23 84/5 87/3</p> <p>apologise [2] 36/2 36/6</p> <p>appeal [1] 2/14</p> <p>appealed [1] 15/11</p> <p>appear [3] 2/12 27/18 97/14</p> <p>appeared [1] 4/10</p> <p>appears [2] 8/14 28/8</p> <p>apply [4] 66/6 71/1</p>	<p>71/15 80/16</p> <p>applying [2] 66/3 80/14</p> <p>appointment [2] 24/2 25/5</p> <p>appreciate [5] 61/20 66/14 70/3 70/22 71/16</p> <p>appreciated [2] 8/22 37/8</p> <p>appreciation [2] 53/3 56/12</p> <p>approach [3] 37/20 90/20 104/16</p> <p>appropriate [9] 1/21 10/4 42/18 50/13 61/11 83/18 83/20 109/24 111/4</p> <p>April [2] 1/1 120/21</p> <p>April 2026 [1] 120/21</p> <p>are [64] 4/11 7/7 11/21 11/23 13/23 14/1 14/11 18/3 18/4 18/5 18/5 21/4 26/3 26/6 28/23 29/3 29/6 31/6 33/19 40/15 43/11 43/14 43/17 44/23 45/24 47/23 49/2 50/14 58/17 62/16 63/12 63/13 65/19 66/15 66/17 73/21 74/17 74/19 80/13 80/21 80/22 81/18 82/9 82/16 83/6 83/9 84/20 86/10 86/12 87/16 87/22 89/10 89/16 92/2 94/10 97/3 98/4 99/5 99/17 101/20 105/3 108/21 112/5 112/6</p> <p>area [5] 17/17 29/12 31/7 33/22 43/15</p> <p>argue [2] 69/6 87/19</p> <p>arguing [1] 19/20</p> <p>aripiprazole [5] 41/10 93/15 97/22 98/24 100/4</p> <p>arise [2] 6/21 24/14</p> <p>arises [1] 95/21</p> <p>arose [2] 6/22 22/1</p> <p>around [32] 2/2 3/23 3/25 4/7 9/24 11/24 13/4 13/9 17/20 17/22 21/9 21/24 22/7 32/3 41/22 62/21 63/20 64/10 64/13 64/13 72/9 74/4 83/11 84/9 85/3 92/16 94/10 114/15 114/23 114/24 116/5 118/12</p> <p>arrest [1] 28/21</p> <p>arrested [1] 22/2</p> <p>arrests [1] 27/12</p> <p>Artificial [1] 42/12</p> <p>as [106] 1/9 1/10 3/22 3/22 4/8 4/11</p>	<p>4/11 9/13 10/7 10/10 11/6 13/3 14/6 15/18 18/22 18/23 20/14 20/14 20/16 21/6 22/5 24/11 25/6 28/10 31/12 32/7 34/17 37/12 38/20 40/8 40/13 41/5 41/11 43/8 46/15 46/25 48/4 49/24 51/1 51/18 51/20 51/22 54/13 56/20 57/21 62/22 63/6 63/23 65/12 65/15 65/15 66/24 67/20 68/12 68/17 69/12 69/15 69/18 69/18 71/19 72/5 72/7 74/13 74/25 75/12 75/13 76/18 77/13 78/19 79/19 81/24 82/12 83/23 83/23 84/11 90/17 91/9 91/16 92/13 92/20 93/3 95/10 95/25 96/13 97/4 98/17 99/3 101/19 106/14 106/22 109/4 109/7 114/20 115/3 115/22 116/3 116/13 116/18 116/18 117/11 117/23 119/2 119/8 119/13 119/20 119/23</p> <p>aside [2] 112/9 112/13</p> <p>ask [35] 4/10 12/20 26/18 27/24 27/24 37/18 42/11 42/13 49/10 49/12 52/16 53/4 54/9 54/15 56/19 58/19 58/22 58/24 60/5 62/4 62/6 65/7 71/17 72/9 73/5 73/22 74/11 74/14 76/5 76/19 83/17 89/25 107/6 109/21 113/23</p> <p>asked [28] 27/22 28/20 34/22 37/4 38/7 38/12 42/9 44/7 44/9 44/17 48/18 48/25 52/18 52/22 58/17 59/1 59/25 70/20 72/19 76/7 76/11 84/5 90/5 94/11 96/10 114/7 114/9 115/22</p> <p>asking [8] 2/10 39/4 43/3 47/4 47/18 48/11 72/2 118/3</p> <p>asleep [1] 57/5</p> <p>aspects [1] 88/11</p> <p>assault [2] 30/8 46/11</p> <p>assaulted [3] 46/8 46/13 46/13</p> <p>assaults [1] 22/1</p> <p>assertion [2] 3/12 19/16</p>	<p>assess [2] 39/11 78/14</p> <p>assessed [7] 30/11 107/23 109/13 112/21 113/16 119/13 119/14</p> <p>assessing [5] 9/13 66/10 72/24 76/19 108/1</p> <p>assessment [34] 1/4 3/20 4/3 10/12 11/1 11/25 14/11 22/22 31/11 32/5 36/22 48/7 48/11 49/1 52/13 54/14 61/11 71/9 71/14 73/11 78/12 79/5 84/16 85/9 85/17 85/18 86/7 89/13 101/16 109/2 118/21 118/24 119/5 119/11</p> <p>assessments [5] 26/21 77/5 80/12 81/18 110/15</p> <p>assist [2] 17/7 26/15</p> <p>assistants [2] 82/6 82/19</p> <p>assisted [1] 43/23</p> <p>associated [1] 10/9</p> <p>association [2] 74/2 109/5</p> <p>assume [3] 53/21 107/19 117/14</p> <p>assumed [2] 41/20 54/7</p> <p>assumption [3] 53/11 54/18 54/20</p> <p>assurance [2] 13/8 63/22</p> <p>assured [2] 18/4 18/5</p> <p>at [161]</p> <p>attempt [1] 42/1</p> <p>Attempts [1] 40/10</p> <p>attend [1] 106/2</p> <p>attention [2] 53/23 80/3</p> <p>audit [2] 65/24 83/2</p> <p>August [5] 42/1 42/3 87/4 87/8 87/9</p> <p>August 2020 [2] 87/8 87/9</p> <p>August 2021 [1] 42/3</p> <p>availability [1] 82/14</p> <p>available [7] 27/15 29/20 43/12 81/21 82/22 110/19 112/7</p> <p>aware [15] 2/18 4/12 12/20 19/13 33/7 43/2 51/22 75/14 85/22 86/2 112/6 112/23 116/24 118/4 120/9</p> <p>awareness [1] 116/10</p> <p>away [4] 8/16 33/21 55/12 81/3</p> <p>away' [1] 55/13</p>
--	---	--	---	--

<p>B</p> <p>background [3] 63/10 94/5 112/1</p> <p>backgrounds [2] 62/23 63/24</p> <p>backwards [1] 53/20</p> <p>bad [1] 3/22</p> <p>balance [4] 22/14 51/3 73/3 81/3</p> <p>barged [1] 1/12</p> <p>based [8] 3/11 15/5 17/14 39/12 61/17 63/9 78/13 96/18</p> <p>basic [2] 87/5 87/12</p> <p>basically [1] 26/24</p> <p>basics [1] 18/18</p> <p>basis [5] 76/23 96/3 96/4 99/23 116/1</p> <p>baton [1] 75/13</p> <p>be [190]</p> <p>bearing [2] 19/17 91/8</p> <p>because [86] 4/25 5/8 6/3 6/7 7/7 9/20 10/22 10/24 11/13 12/11 14/19 16/8 18/3 19/25 19/25 20/1 25/2 25/5 25/12 29/3 29/14 33/9 33/20 34/15 35/14 37/19 38/15 38/16 39/17 39/21 40/4 41/8 41/10 43/13 43/18 47/12 48/13 51/4 51/5 53/16 54/4 54/24 55/7 60/7 61/8 62/22 63/23 70/4 71/8 72/23 73/25 75/14 77/4 77/9 77/16 77/19 79/25 80/10 80/14 82/11 89/24 89/25 93/2 93/21 95/8 95/16 96/6 96/8 98/21 100/2 101/12 102/19 103/2 106/22 110/4 110/15 110/22 111/11 112/3 114/6 114/14 114/24 116/16 117/1 117/11 119/10</p> <p>become [1] 115/9</p> <p>becomes [1] 25/24</p> <p>been [73] 1/20 3/24 9/16 11/9 11/21 14/9 14/12 14/16 18/14 18/15 18/25 24/18 28/11 28/13 28/23 28/24 28/25 30/25 31/9 31/9 31/12 33/4 33/8 36/17 36/20 37/5 40/8 40/10 40/11 40/11 41/9 41/17 44/22 45/4 47/3 47/16 52/22 61/2 61/3 68/4 68/6 70/3 70/15 70/16 74/21 75/17 78/11 79/2 82/3 82/5 82/24</p>	<p>85/4 85/17 85/23 86/18 89/14 90/12 91/1 92/11 93/1 93/2 99/2 99/8 100/3 101/7 101/9 105/19 107/10 107/16 109/17 110/8 117/5 118/4</p> <p>Beer [3] 107/3 107/4 121/7</p> <p>before [15] 1/3 10/17 24/24 37/19 41/9 43/22 45/19 49/3 49/5 57/12 58/10 90/5 95/14 97/6 115/12</p> <p>began [1] 87/5</p> <p>begged [1] 55/12</p> <p>Beggs [3] 100/21 100/22 121/6</p> <p>beginning [4] 12/13 26/16 31/21 35/25</p> <p>begins [1] 1/6</p> <p>behalf [2] 49/11 65/7</p> <p>behave [1] 40/14</p> <p>behaving [1] 79/20</p> <p>behaviour [9] 5/15 16/10 21/13 22/10 35/17 35/19 35/23 76/14 108/11</p> <p>behavioural [1] 90/15</p> <p>behaviours [14] 5/22 5/25 6/4 7/3 7/5 7/8 7/14 13/6 23/18 36/6 77/2 98/14 106/3 106/10</p> <p>being [39] 2/25 11/23 18/24 19/15 19/24 22/2 22/11 23/19 23/19 24/16 25/2 25/12 25/19 25/19 26/8 31/25 43/4 43/20 56/21 64/13 68/20 69/2 73/15 73/15 78/11 82/1 89/5 92/8 92/22 94/14 96/2 96/14 104/16 105/4 114/7 115/21 116/7 117/8 119/2</p> <p>belief [8] 17/1 72/2 72/10 76/2 94/13 95/19 96/6 96/16</p> <p>beliefs [6] 1/16 3/24 33/21 74/3 74/19 94/24</p> <p>believe [6] 9/4 23/9 82/5 82/7 95/1 117/7</p> <p>believed [8] 17/16 36/14 94/15 94/25 95/16 96/1 96/15 120/11</p> <p>below [1] 57/16</p> <p>beneficial [1] 93/22</p> <p>benefit [3] 26/3 98/23 99/19</p> <p>benefits [2] 22/24 98/19</p>	<p>benzodiazepines [1] 93/24</p> <p>bereaved [1] 49/11</p> <p>better [9] 1/21 36/21 37/16 49/3 70/16 87/21 92/11 93/16 101/18</p> <p>between [13] 13/6 21/13 35/16 37/2 50/5 52/7 54/4 57/21 74/2 76/25 86/20 94/16 103/16</p> <p>beyond [2] 26/14 83/15</p> <p>Bilal [1] 51/23</p> <p>Birmingham [2] 90/13 91/4</p> <p>bit [6] 35/5 39/24 52/19 57/5 93/13 96/8</p> <p>blood [2] 19/13 19/20</p> <p>blue [1] 59/14</p> <p>board [4] 7/7 8/6 11/23 17/14</p> <p>bodily [2] 78/15 78/21</p> <p>both [13] 11/13 17/25 26/25 32/19 50/17 65/11 81/1 102/3 104/4 105/5 109/3 119/25 120/4</p> <p>bother [1] 64/21</p> <p>bottom [9] 2/9 16/1 16/24 24/3 44/14 47/7 59/14 103/13 104/19</p> <p>boundaries [5] 46/25 50/13 51/6 51/7 112/10</p> <p>box [2] 24/3 42/2</p> <p>boxes [2] 2/9 30/4</p> <p>boxing [1] 84/10</p> <p>brain [1] 96/11</p> <p>breach [1] 38/17</p> <p>breached [1] 51/6</p> <p>break [9] 1/3 49/4 49/4 49/6 58/10 64/24 65/2 94/12 94/21</p> <p>breakdown [2] 91/15 91/21</p> <p>breaks [1] 95/5</p> <p>briefing [3] 101/24 105/25 112/18</p> <p>briefings [1] 101/18</p> <p>briefly [2] 74/5 80/9</p> <p>bring [1] 78/16</p> <p>bringing [1] 83/24</p> <p>broadly [1] 71/5</p> <p>broken [4] 36/15 79/3 119/18 119/19</p> <p>brother [7] 52/24 55/20 56/18 57/23 75/21 86/21 86/22</p> <p>brought [1] 79/16</p> <p>build [1] 12/14</p> <p>building [1] 39/22</p> <p>built [1] 50/10</p> <p>Burri [3] 51/22 51/23</p>	<p>51/25</p> <p>Burri's [1] 24/22</p> <p>busy [1] 44/23</p> <p>but [88] 2/16 8/3 8/6 9/23 11/7 11/11 23/12 25/1 25/16 26/21 28/22 29/10 31/4 32/1 32/8 35/2 36/8 36/17 38/17 40/10 44/10 44/22 44/24 47/7 47/9 47/13 48/18 50/12 52/18 55/21 56/20 60/10 61/25 65/10 66/15 67/7 67/11 68/1 70/10 72/13 72/14 73/22 74/6 75/10 75/19 76/7 76/13 76/15 77/3 77/17 77/24 78/2 78/20 79/12 82/20 85/25 86/4 87/21 89/21 89/23 91/22 92/6 92/9 92/22 92/23 96/12 96/18 97/7 98/11 99/24 100/2 102/7 102/8 102/15 102/24 103/11 105/1 109/13 110/24 112/5 114/16 115/1 115/5 118/24 119/4 119/12 119/18 120/2</p>	<p>13/17 18/6 26/23 28/11 32/25 39/18 43/8 43/9 55/19 105/23</p> <p>candid [1] 49/22</p> <p>cannot [1] 32/13</p> <p>capable [1] 101/13</p> <p>capacity [11] 17/4 18/20 22/12 22/15 22/16 22/22 23/5 112/14 114/23 116/5 116/12</p> <p>capital [2] 70/9 70/12</p> <p>care [28] 1/6 1/23 11/5 12/9 37/12 37/13 38/1 38/9 39/3 39/5 46/25 52/9 53/3 56/12 67/2 67/5 75/11 75/13 81/11 90/20 101/16 111/1 111/2 111/9 111/21 111/23 112/2 113/2</p> <p>carefully [1] 100/8</p> <p>Carer's [1] 16/17</p> <p>carers [2] 103/17 104/21</p> <p>carried [1] 100/17</p> <p>carries [1] 55/21</p> <p>carrying [2] 32/5 77/1</p> <p>Carter [1] 40/12</p> <p>CARTWRIGHT [4] 65/4 83/16 84/20 121/4</p> <p>case [14] 7/2 10/1 10/3 25/1 25/21 34/14 44/11 52/6 77/7 78/1 78/2 91/5 119/2 119/8</p> <p>cases [1] 28/17</p> <p>catchphrase [1] 53/19</p> <p>cause [4] 91/14 91/22 92/1 92/3</p> <p>caused [2] 78/3 120/1</p> <p>causes [2] 8/14 92/8</p> <p>causing [7] 1/16 76/21 76/22 108/22 108/24 109/10 115/8</p> <p>cautious [1] 21/1</p> <p>caveat [1] 118/6</p> <p>CBT [2] 12/4 82/9</p> <p>ceasing [1] 73/8</p> <p>Celeste [2] 85/5 85/22</p> <p>Celeste's [1] 85/10</p> <p>central [1] 76/18</p> <p>certain [4] 1/11 35/3 90/3 90/4</p> <p>certainly [1] 27/11</p> <p>certainty [1] 62/1</p> <p>cetera [7] 11/25 30/13 31/10 33/23 89/14 101/11 114/24</p> <p>chain [1] 31/21</p> <p>Chair [4] 49/2 113/22</p>
--	--	--	--	---

<p>C</p> <p>Chair... [2] 117/19 121/8</p> <p>challenge [4] 69/1 76/15 76/19 76/20</p> <p>challenged [1] 118/19</p> <p>chance [2] 10/4 44/23</p> <p>change [1] 58/3</p> <p>changed [6] 34/8 48/15 61/22 61/23 79/5 118/5</p> <p>changes [3] 12/24 56/1 69/16</p> <p>changing [1] 43/14</p> <p>chaotic [2] 10/2 11/21</p> <p>chap [1] 44/19</p> <p>charge [4] 78/16 78/19 118/12 118/13</p> <p>chat [2] 12/21 45/12</p> <p>check [8] 27/4 28/6 28/9 28/9 67/19 69/7 69/8 69/11</p> <p>checked [1] 38/15</p> <p>checking [1] 69/9</p> <p>checks [2] 27/20 86/11</p> <p>choose [1] 18/21</p> <p>chosen [1] 8/13</p> <p>chronological [1] 75/20</p> <p>chronology [2] 106/2 111/22</p> <p>circumstances [3] 15/19 29/9 110/19</p> <p>citing [1] 32/7</p> <p>clarify [4] 45/12 45/20 58/22 93/12</p> <p>clarity [2] 56/20 82/11</p> <p>classic [1] 86/25</p> <p>clear [16] 17/10 26/7 29/3 41/8 45/24 62/17 74/2 75/22 77/21 79/1 89/25 96/19 97/11 98/11 112/10 116/10</p> <p>clearly [9] 2/1 6/25 10/11 14/20 41/22 42/21 92/23 93/3 119/6</p> <p>clinic [1] 39/20</p> <p>clinical [12] 15/5 24/17 65/12 65/22 65/24 68/12 81/24 82/6 83/3 92/21 98/6 99/21</p> <p>clinically [1] 40/21</p> <p>clinician [9] 41/12 52/6 65/9 66/15 72/17 76/18 94/18 101/24 111/12</p> <p>clinicians [5] 30/14 101/19 108/8 111/8</p>	<p>111/20</p> <p>close [6] 27/10 32/22 39/13 40/17 47/23 55/17</p> <p>closely [2] 73/25 103/25</p> <p>clue [1] 55/15</p> <p>collaborative [1] 104/20</p> <p>collateral [2] 76/16 94/4</p> <p>colleague's [1] 10/15</p> <p>collected [1] 103/24</p> <p>collective [2] 103/16 104/16</p> <p>college [4] 26/12 90/13 90/15 90/18</p> <p>come [18] 20/6 30/19 33/5 47/3 47/5 47/21 48/4 48/25 51/5 64/24 67/11 74/5 74/24 78/20 100/5 100/8 101/15 119/1</p> <p>comes [4] 20/8 53/18 56/5 64/12</p> <p>comfort [2] 12/16 40/16</p> <p>comfortable [1] 34/2</p> <p>coming [5] 11/4 27/10 33/12 60/10 60/18</p> <p>comment [8] 7/25 9/19 21/10 25/15 59/1 118/8 118/9 119/12</p> <p>commented [1] 51/21</p> <p>commenting [1] 114/21</p> <p>comments [2] 4/23 16/1</p> <p>common [2] 62/23 63/23</p> <p>communicate [2] 42/12 89/24</p> <p>communicated [1] 34/17</p> <p>communicating [2] 68/13 117/23</p> <p>communications [1] 52/12</p> <p>community [42] 3/11 9/14 10/6 14/13 14/18 21/4 21/17 21/19 30/25 38/11 38/19 43/5 43/6 43/10 43/25 44/2 45/1 47/16 60/25 61/6 61/19 61/22 73/16 74/22 75/14 84/12 85/5 86/1 86/4 86/8 95/15 99/13 100/16 100/18 103/6 103/17 104/22 110/24 111/3 111/23 112/2 112/7</p> <p>complete [1] 67/21</p> <p>completed [1] 80/12</p>	<p>completely [6] 11/12 76/17 79/4 80/11 83/8 84/7</p> <p>completeness [1] 67/20</p> <p>completing [2] 92/18 92/20</p> <p>compliance [2] 13/5 21/24</p> <p>compliant [3] 18/24 22/11 23/8</p> <p>complicated [1] 43/16</p> <p>complicates [1] 43/18</p> <p>comply [1] 62/18</p> <p>comprehensive [1] 73/11</p> <p>computer [1] 117/1</p> <p>concedes [1] 5/1</p> <p>concepts [2] 71/25 80/9</p> <p>concern [10] 5/5 5/8 6/12 18/7 33/13 36/18 39/15 40/17 60/10 72/7</p> <p>concerned [8] 32/1 32/2 34/12 38/24 39/16 39/17 112/25 116/18</p> <p>concerning [2] 70/8 71/19</p> <p>concerns [14] 5/22 21/24 22/1 23/8 34/9 40/23 41/22 85/5 85/10 86/5 86/10 86/12 90/15 90/16</p> <p>concerted [1] 40/9</p> <p>conclude [1] 6/2</p> <p>concluded [2] 49/14 93/10</p> <p>conclusion [5] 5/23 10/11 93/17 94/7 103/23</p> <p>conclusions [1] 90/20</p> <p>concordance [3] 9/8 10/7 20/16</p> <p>concordant [1] 22/3</p> <p>concrete [1] 29/1</p> <p>concur [1] 11/9</p> <p>condition [2] 11/14 83/24</p> <p>confer [1] 3/17</p> <p>confidence [1] 12/14</p> <p>confidential [1] 112/20</p> <p>confidentiality [1] 72/16</p> <p>confined [1] 105/10</p> <p>confirm [2] 42/14 60/16</p> <p>confirmation [1] 88/13</p> <p>confirmed [3] 3/13 61/12 96/9</p>	<p>confirming [1] 51/11</p> <p>confirms [1] 86/12</p> <p>conflicts [1] 91/8</p> <p>confront [4] 1/9 1/17 36/16 95/9</p> <p>confronted [1] 5/14</p> <p>confronting [1] 36/6</p> <p>connection [3] 13/6 54/18 76/25</p> <p>connotation [1] 54/19</p> <p>consequence [1] 8/2</p> <p>consequences [4] 7/24 8/3 119/8 119/15</p> <p>consequent [1] 74/3</p> <p>consider [8] 3/19 14/25 18/10 53/5 81/15 88/8 105/13 118/21</p> <p>considerable [1] 49/24</p> <p>consideration [3] 20/24 52/11 81/5</p> <p>considered [9] 75/2 75/4 75/5 78/21 81/2 81/13 88/17 92/9 103/2</p> <p>considering [5] 2/25 40/4 54/13 72/17 102/11</p> <p>consistent [3] 61/2 82/18 88/3</p> <p>conspiracy [1] 51/15</p> <p>Constable [1] 118/2</p> <p>constantly [1] 43/14</p> <p>consult [1] 105/14</p> <p>consultant [7] 39/1 44/15 47/1 47/14 69/18 101/19 104/25</p> <p>consultants [4] 68/13 69/6 69/9 114/21</p> <p>contact [14] 24/15 31/14 34/5 38/19 38/20 39/8 39/9 39/23 43/13 49/23 85/13 85/23 94/20 102/16</p> <p>contacted [5] 34/6 38/11 40/12 44/3 92/14</p> <p>contacting [5] 38/7 39/18 39/24 102/24 103/1</p> <p>contained [1] 71/20</p> <p>contains [1] 67/1</p> <p>contemporaneous [1] 76/16</p> <p>content [2] 100/24 101/4</p> <p>contentious [2] 66/22 67/7</p> <p>contest [1] 51/2</p> <p>context [13] 7/11 46/10 52/13 53/8 53/9 53/11 54/16 54/23 56/21 76/11 97/21</p>	<p>101/12 111/15</p> <p>continue [14] 3/10 7/10 14/16 15/2 15/11 18/12 19/11 21/15 21/20 44/13 62/21 63/19 96/22 100/11</p> <p>continued [6] 7/3 19/23 21/4 42/13 109/18 119/14</p> <p>continues [1] 7/6</p> <p>continuing [2] 25/9 73/12</p> <p>continuity [2] 12/9 67/2</p> <p>contradicted [1] 76/17</p> <p>control [9] 16/10 17/16 22/9 35/19 36/14 83/25 96/3 97/14 99/17</p> <p>control' [1] 24/11</p> <p>controlled [8] 16/9 16/10 35/18 61/14 73/24 99/5 99/18 104/3</p> <p>controlling [3] 19/9 23/25 36/7</p> <p>conversation [22] 4/19 5/17 5/19 6/25 17/20 23/17 23/23 33/17 38/10 38/21 38/23 42/20 42/25 44/2 44/7 48/9 48/12 48/14 57/25 85/24 92/15 118/18</p> <p>conversations [7] 11/13 12/15 23/7 23/12 23/20 49/23 50/12</p> <p>convey [4] 33/6 40/22 63/10 116/5</p> <p>conveyed [1] 40/25</p> <p>conviction [5] 28/11 28/22 116/20 117/5 117/8</p> <p>convictions [2] 28/8 108/6</p> <p>convince [1] 22/7</p> <p>convinced [2] 4/15 61/23</p> <p>coordinator [1] 75/11</p> <p>copy [1] 44/9</p> <p>core [1] 72/23</p> <p>correct [37] 1/18 22/19 29/7 42/8 60/12 64/12 65/14 66/7 73/4 81/22 88/21 89/1 90/8 92/2 94/6 98/6 103/4 107/12 107/18 108/4 108/7 108/10 108/13 108/16 108/19 108/23 109/12 109/15 109/20 111/5 111/19 112/12 112/17 113/3 113/12 114/8 118/23</p> <p>correctly [2] 89/23</p>
--	---	--	---	--

<p>C</p> <p>correctly... [1] 109/7</p> <p>corridor [1] 42/25</p> <p>could [69] 5/1 5/4 7/2 7/9 7/17 7/24 8/3 10/5 14/2 15/13 17/16 17/23 17/24 25/4 25/15 29/19 29/21 30/1 31/14 31/15 31/16 33/4 34/6 35/13 36/20 37/9 38/13 42/4 42/5 42/14 43/23 44/7 44/25 44/25 47/8 47/24 48/14 49/20 50/21 50/23 52/1 54/23 55/8 56/3 60/14 61/22 64/18 70/15 71/10 73/18 74/21 77/7 87/19 87/19 90/22 91/1 91/4 91/22 95/22 95/23 96/1 96/3 96/23 106/1 106/12 117/4 119/7 119/14 119/15</p> <p>couldn't [3] 43/24 55/8 57/7</p> <p>Council [1] 66/25</p> <p>couple [3] 37/7 53/4 55/16</p> <p>course [4] 50/15 93/11 108/1 109/16</p> <p>courtyard [1] 79/15</p> <p>Covid [1] 19/13</p> <p>CPN [2] 40/12 40/19</p> <p>CQC [1] 10/25</p> <p>create [2] 63/2 64/2</p> <p>creating [1] 116/25</p> <p>crime [2] 113/10 114/24</p> <p>criminal [5] 113/10 115/17 116/14 116/19 116/20</p> <p>crisis [8] 20/13 21/22 24/15 35/8 75/11 85/14 85/20 85/22</p> <p>criteria [6] 15/6 15/8 61/19 72/24 80/14 100/15</p> <p>criterion [4] 109/25 110/12 110/14 110/20</p> <p>criticisms [1] 10/24</p> <p>cross [1] 119/10</p> <p>crucial [1] 43/19</p> <p>crush [1] 73/18</p> <p>Culpin [6] 31/22 32/11 32/12 34/8 35/6 35/10</p> <p>curing [1] 83/23</p> <p>curiosity [1] 26/25</p> <p>curious [3] 26/14 26/18 26/20</p> <p>current [2] 37/12 37/15</p> <p>currently [2] 37/12 82/10</p>	<p>D</p> <p>damage [1] 120/1</p> <p>damaged [1] 77/17</p> <p>damaging [1] 95/2</p> <p>danger [3] 6/17 80/21 94/24</p> <p>dangerous [2] 75/22 103/5</p> <p>dangerousness [6] 71/20 72/19 75/1 75/12 75/15 84/1</p> <p>dare [2] 57/17 57/25</p> <p>darkest [2] 55/8 57/4</p> <p>data [1] 38/17</p> <p>date [3] 35/2 37/15 55/4</p> <p>dated [1] 75/20</p> <p>day [5] 56/16 57/13 58/11 117/13 117/15</p> <p>days [1] 33/12</p> <p>days' [1] 15/9</p> <p>deal [5] 51/25 62/3 74/6 83/14 92/17</p> <p>dealing [4] 2/21 2/23 10/16 102/7</p> <p>deals [3] 16/20 67/15 68/8</p> <p>dealt [3] 62/4 83/2 84/8</p> <p>Dear [1] 37/3</p> <p>deceit [1] 101/13</p> <p>deciding [1] 117/4</p> <p>decision [19] 15/4 15/8 17/5 19/7 19/17 36/23 62/7 62/20 63/6 63/8 63/19 64/6 64/13 66/17 78/10 96/21 104/15 116/1 116/3</p> <p>decision-making [2] 64/6 64/13</p> <p>decisions [5] 22/16 40/24 67/4 67/9 118/12</p> <p>deductions [1] 13/22</p> <p>defend [1] 15/16</p> <p>definitely [1] 27/12</p> <p>degree [4] 72/25 81/1 81/2 109/23</p> <p>deliver [1] 12/5</p> <p>delivered [2] 12/8 81/8</p> <p>delivering [2] 11/20 82/9</p> <p>delusion [2] 95/20 96/17</p> <p>delusionary [1] 1/16</p> <p>demonstrate [2] 5/24 36/1</p> <p>demonstrated [5] 33/4 35/11 35/13 108/2 108/12</p> <p>demonstrating [3] 6/8 6/23 27/6</p> <p>denied [1] 98/13</p> <p>dependent [1] 97/12</p>	<p>depends [4] 13/24 14/6 90/22 99/16</p> <p>depot [25] 16/18 16/19 17/1 17/2 17/19 17/20 17/24 18/11 18/13 18/19 18/21 18/22 18/22 18/22 19/8 19/18 19/18 22/23 35/7 49/18 62/5 62/8 62/22 63/7 63/20</p> <p>deprivation [3] 91/15 91/23 92/3</p> <p>describe [2] 6/4 57/7</p> <p>described [6] 5/18 46/15 72/11 79/14 90/9 96/13</p> <p>describes [1] 4/24</p> <p>describing [1] 76/8</p> <p>desperately [1] 80/6</p> <p>despite [4] 11/3 63/14 96/7 117/7</p> <p>detail [2] 29/1 88/18</p> <p>detailed [2] 32/5 36/21</p> <p>details [8] 27/17 27/17 29/2 29/3 29/4 34/5 38/21 114/23</p> <p>detain [1] 15/2</p> <p>detained [3] 15/20 73/3 83/21</p> <p>detection [1] 113/10</p> <p>detention [12] 1/4 14/21 14/24 15/7 15/9 64/13 72/18 73/8 81/14 109/18 110/10 110/18</p> <p>deteriorating [1] 85/6</p> <p>deterioration [1] 24/9</p> <p>determine [7] 5/11 10/3 26/1 27/3 28/4 61/1 120/5</p> <p>determined [1] 6/22</p> <p>determining [2] 25/23 26/7</p> <p>develop [5] 4/8 7/15 7/15 43/6 98/4</p> <p>developed [1] 4/16</p> <p>developing [2] 12/13 88/15</p> <p>diagnosed [3] 10/8 86/14 99/11</p> <p>diagnosis [14] 4/18 11/3 86/13 86/18 86/24 88/5 88/10 88/16 88/22 89/3 89/7 89/13 91/9 91/10</p> <p>dialogue [1] 54/4</p> <p>dictate [1] 32/13</p> <p>dictates [1] 14/8</p> <p>dictionary [1] 53/18</p> <p>did [153]</p> <p>didn't [74] 2/19 3/21 4/1 4/10 6/14 7/18 8/23 10/22 11/8 17/13 19/25 20/3 21/12 23/8 23/13 23/15 26/16</p>	<p>26/19 27/7 27/13 34/7 38/1 41/3 41/14 47/17 47/25 48/22 50/15 51/16 53/1 53/12 53/14 53/15 54/11 54/12 54/14 54/15 55/14 56/10 56/19 59/18 59/22 59/22 60/7 60/8 61/5 61/8 64/7 65/17 71/2 71/3 72/3 72/10 72/11 74/7 74/25 76/15 78/23 78/24 79/18 88/5 88/8 88/23 89/2 92/23 102/8 104/6 115/14 115/19 116/2 116/12 117/14 118/21 119/23</p> <p>die [1] 119/16</p> <p>died [1] 8/5</p> <p>difference [1] 90/19</p> <p>different [9] 7/24 15/10 45/14 45/22 49/1 78/18 85/2 95/8 104/11</p> <p>difficult [22] 11/19 15/23 18/2 25/24 26/8 28/13 40/21 48/6 69/4 69/7 69/11 70/3 71/17 83/7 83/7 87/22 93/18 94/1 95/25 105/19 105/19 112/7</p> <p>difficulties [8] 11/4 21/10 38/12 76/21 83/6 89/10 91/6 110/5</p> <p>difficulty [2] 29/14 82/3</p> <p>direct [3] 27/13 77/13 78/6</p> <p>directed [1] 85/12</p> <p>directly [2] 34/7 34/17</p> <p>discharge [27] 4/25 12/19 14/19 15/4 15/5 15/13 24/24 27/10 34/11 34/25 36/13 36/23 37/20 73/8 77/6 81/4 96/18 103/14 104/7 104/13 104/16 105/10 106/15 108/25 110/1 110/12 110/21</p> <p>discharged [15] 12/24 20/15 24/16 31/25 34/15 40/20 51/4 73/15 85/21 88/24 89/5 97/24 103/6 105/4 113/2</p> <p>discharging [4] 14/14 65/11 66/17 75/10</p> <p>Disciplinary [4] 66/14 66/19 67/22 83/4</p> <p>disclose [4] 60/3 71/24 108/22 112/20</p> <p>disclosed [10] 59/12 59/15 59/17 59/19</p>	<p>59/19 59/20 60/7 70/9 84/9 90/12</p> <p>disclosing [1] 72/1</p> <p>disclosure [6] 112/25 113/4 113/9 113/13 113/14 113/14</p> <p>discovered [1] 22/3</p> <p>discuss [7] 37/14 37/17 39/5 49/25 50/4 71/12 89/6</p> <p>discussed [14] 18/23 34/18 59/18 59/19 69/2 70/5 70/7 70/8 71/22 89/8 89/12 89/15 109/10 119/2</p> <p>discussing [1] 1/10</p> <p>discussion [11] 7/1 8/10 13/12 16/16 17/19 17/21 17/22 18/9 20/8 20/12 93/5</p> <p>discussions [5] 11/16 12/15 26/22 70/24 96/19</p> <p>disorder [12] 72/25 80/17 80/25 88/6 88/9 88/10 88/16 88/16 88/20 109/23 110/6 111/16</p> <p>disordered [1] 88/12</p> <p>disorders [1] 111/7</p> <p>displayed [1] 108/12</p> <p>distance [1] 63/4</p> <p>distinction [1] 57/21</p> <p>distress [1] 76/22</p> <p>distrust [2] 63/1 64/1</p> <p>Diversification [1] 27/16</p> <p>divisions [1] 112/11</p> <p>do [84] 3/5 6/1 9/15 9/24 10/15 11/11 13/1 14/5 15/1 15/17 17/11 17/22 18/20 18/20 19/19 20/2 21/7 21/19 22/22 23/13 24/10 26/9 27/22 28/1 28/1 31/5 32/16 33/2 33/18 36/19 36/23 42/21 48/14 48/25 49/5 49/8 50/3 51/4 52/25 53/3 56/3 56/9 56/12 62/24 63/24 65/17 69/13 72/11 73/11 74/7 74/14 74/22 74/25 76/10 78/8 78/14 82/10 82/16 85/8 87/7 87/9 92/22 94/16 94/19 95/5 95/16 96/1 98/21 101/1 101/7 101/8 101/9 101/17 103/19 103/21 105/2 105/15 106/4 107/8 109/7 114/17 115/1 116/4 118/7</p> <p>doctor [10] 24/25 29/23 44/15 47/14 67/16 70/10 100/23 103/7 105/8 117/20</p>
---	--	---	--	--

<p>D</p> <p>doctors [2] 68/14 68/17</p> <p>document [6] 50/18 50/19 57/10 62/12 69/14 75/6</p> <p>documentation [3] 36/20 68/18 70/15</p> <p>documented [5] 6/25 41/23 68/20 75/18 91/2</p> <p>documents [2] 41/1 41/23</p> <p>does [20] 8/11 8/15 15/15 15/18 19/5 20/9 21/7 22/15 23/22 24/4 24/14 33/16 56/7 56/23 56/24 73/20 73/20 83/14 84/3 91/10</p> <p>doesn't [12] 10/19 14/14 20/18 25/7 28/9 29/15 41/8 56/22 73/2 91/11 100/12 114/17</p> <p>doing [12] 1/13 1/25 5/1 66/9 68/14 72/14 79/11 79/21 80/20 84/11 95/12 116/24</p> <p>don't [40] 2/16 12/5 15/10 20/22 20/23 23/14 25/22 29/10 29/11 29/11 29/16 30/20 30/22 30/23 31/3 38/16 39/23 45/16 48/14 48/20 48/21 49/3 50/7 61/20 68/1 68/15 78/18 80/18 82/15 84/17 84/18 86/1 89/23 90/1 99/19 103/21 104/12 104/23 105/13 116/4</p> <p>done [13] 2/16 4/7 13/3 20/15 21/9 34/13 34/19 43/2 47/24 74/21 81/24 100/13 108/5</p> <p>door [9] 1/9 77/11 77/17 77/23 79/3 79/14 115/7 119/18 120/2</p> <p>doors [2] 95/3 120/1</p> <p>dose [9] 98/1 98/7 98/8 98/25 99/3 99/5 99/16 99/18 99/19</p> <p>dotting [1] 94/10</p> <p>double [1] 99/6</p> <p>doubt [1] 86/21</p> <p>doubtless [1] 108/21</p> <p>down [16] 20/6 30/19 44/16 50/25 57/14 59/14 71/3 74/11 74/16 79/3 79/16 91/5 93/25 108/14 115/8 119/18</p> <p>dozed [1] 55/16</p>	<p>Dr [53] 1/3 6/16 8/12 13/13 16/2 20/11 20/13 24/22 26/11 34/22 37/3 40/7 41/21 42/5 42/6 42/13 44/4 44/8 44/14 45/10 47/2 47/20 49/10 51/22 51/23 51/25 52/2 53/6 54/12 58/18 59/25 60/19 64/20 65/5 70/3 70/17 72/4 73/7 73/17 75/19 77/8 78/20 84/3 84/13 84/15 85/1 91/12 91/14 91/17 107/2 107/5 113/19 113/23</p> <p>Dr Bilal [1] 51/23</p> <p>Dr Burri [2] 51/22 51/25</p> <p>Dr Burri's [1] 24/22</p> <p>Dr Gibson [4] 44/14 45/10 47/2 47/20</p> <p>Dr Ibrahim [2] 91/12 91/17</p> <p>Dr Lloyd [2] 40/7 41/21</p> <p>Dr Lomas [1] 44/4</p> <p>Dr Ludvigsen [1] 70/17</p> <p>Dr Seedat [38] 1/3 6/16 8/12 13/13 16/2 20/11 20/13 26/11 34/22 37/3 42/5 42/6 44/8 49/10 52/2 53/6 54/12 58/18 59/25 60/19 64/20 65/5 70/3 72/4 73/7 73/17 75/19 77/8 78/20 84/3 84/13 84/15 85/1 91/14 107/2 107/5 113/19 113/23</p> <p>dramatic [1] 58/2</p> <p>dramatically [2] 57/19 58/2</p> <p>drawings [1] 108/15</p> <p>dreams [1] 58/8</p> <p>drew [1] 94/12</p> <p>drive [1] 119/6</p> <p>driven [3] 57/9 94/23 116/7</p> <p>driving [1] 95/1</p> <p>drug [4] 93/7 93/11 93/14 94/8</p> <p>drug-induced [3] 93/7 93/11 94/8</p> <p>drugs [2] 24/4 93/5</p> <p>DSM [1] 80/19</p> <p>due [5] 7/5 9/8 78/19 93/19 95/22</p> <p>dunno [1] 56/4</p> <p>during [20] 3/14 5/11 5/15 7/4 10/4 10/23 23/13 27/5 34/5 38/23 42/7 44/7 65/10 65/18 68/2 68/4 89/5 97/23 98/14 102/15</p>	<p>duties [2] 48/25 112/15</p> <p>E</p> <p>each [3] 16/23 72/19 114/4</p> <p>earlier [7] 10/10 42/15 55/3 88/11 88/14 90/7 91/13</p> <p>early [3] 10/2 50/11 93/21</p> <p>earn [1] 87/23</p> <p>easier [2] 18/11 105/22</p> <p>easily [3] 25/4 29/14 74/21</p> <p>easy [1] 74/14</p> <p>ed [1] 25/4</p> <p>education [1] 87/20</p> <p>educational [1] 31/16</p> <p>effect [7] 1/10 49/14 71/11 93/22 100/6 100/9 116/25</p> <p>effective [4] 5/24 12/4 14/8 97/13</p> <p>effectively [2] 115/17 115/22</p> <p>effects [6] 5/14 93/21 96/5 96/7 98/4 98/24</p> <p>effort [1] 40/9</p> <p>efforts [1] 83/9</p> <p>EIP [2] 12/8 74/22</p> <p>either [3] 19/15 107/24 110/17</p> <p>elaborate [1] 51/13</p> <p>Eleanor [2] 31/21 32/16</p> <p>Elias [3] 86/17 86/20 117/16</p> <p>Elias Calocane [1] 117/16</p> <p>eliminate [1] 94/2</p> <p>else [11] 8/21 27/22 27/23 32/22 53/12 55/12 68/14 79/25 90/19 94/22 105/1</p> <p>email [17] 29/16 31/21 32/12 33/3 34/5 41/1 44/11 46/17 46/21 48/2 75/17 75/19 85/13 114/10 114/16 115/6 115/22</p> <p>emails [3] 44/5 45/4 117/12</p> <p>emerged [1] 93/15</p> <p>emerging [1] 2/1</p> <p>emotional [1] 58/2</p> <p>employers [1] 31/16</p> <p>encounters [1] 67/21</p> <p>end [17] 4/6 4/9 6/18 7/10 7/17 9/3 9/5 13/8 33/12 35/14 39/14 97/22 97/24 99/11 107/7 109/2 109/15</p> <p>ended [1] 38/21</p> <p>enduring [5] 8/11</p>	<p>8/20 17/15 18/17 46/4</p> <p>engaged [2] 63/3 64/3</p> <p>engaging [6] 40/10 41/9 41/9 44/20 45/1 110/8</p> <p>engine [1] 53/17</p> <p>enough [1] 14/5</p> <p>ensure [10] 3/15 21/2 31/5 46/24 66/8 66/25 67/2 69/19 81/24 100/8</p> <p>ensuring [3] 22/7 66/3 80/20</p> <p>entails [1] 18/19</p> <p>entire [1] 61/22</p> <p>entitled [1] 30/3</p> <p>entries [1] 67/12</p> <p>entry [12] 38/18 52/17 59/11 74/6 77/12 77/18 77/20 77/24 79/14 84/5 95/13 119/24</p> <p>environment [2] 34/3 116/11</p> <p>episode [5] 11/6 74/10 89/7 92/10 92/25</p> <p>episodes [2] 1/20 92/4</p> <p>equated [1] 4/18</p> <p>erratic [1] 40/14</p> <p>escalate [1] 28/3</p> <p>escape [1] 78/10</p> <p>especially [2] 100/6 108/6</p> <p>essential [3] 41/13 67/8 69/18</p> <p>essentially [10] 50/17 51/9 54/4 60/10 60/19 64/19 68/12 69/23 71/6 80/20</p> <p>establish [2] 42/16 115/24</p> <p>established [1] 112/19</p> <p>establishments [1] 31/16</p> <p>estate [1] 33/25</p> <p>et [7] 11/25 30/13 31/10 33/23 89/14 101/11 114/24</p> <p>et cetera [7] 11/25 30/13 31/10 33/23 89/14 101/11 114/24</p> <p>ethnic [3] 62/23 63/12 63/24</p> <p>ethnicity [3] 62/6 63/6 64/12</p> <p>even [17] 18/16 36/2 43/4 45/25 47/16 51/4 55/14 56/19 58/12 67/15 78/2 78/4 79/20 84/18 96/16 113/13 113/16</p> <p>event [1] 78/2</p>	<p>events [7] 1/21 23/16 27/14 28/16 47/17 61/17 68/4</p> <p>eventual [1] 34/11</p> <p>ever [13] 4/5 4/11 8/23 27/22 28/14 28/16 31/3 31/8 39/18 54/9 55/18 57/7 64/16</p> <p>every [4] 45/2 69/4 69/7 69/11</p> <p>everyone [5] 53/20 66/3 69/10 75/18 105/1</p> <p>everything [3] 40/3 68/25 90/18</p> <p>evidence [34] 3/12 15/6 15/13 15/14 19/2 24/23 27/2 27/7 29/22 29/23 31/10 45/20 52/4 63/11 63/15 65/8 70/2 70/4 70/7 70/11 70/23 71/11 72/14 77/6 77/22 79/12 80/5 84/8 90/1 98/2 98/16 99/22 109/16 110/6</p> <p>evident [3] 73/14 91/24 116/6</p> <p>evocative [1] 54/1</p> <p>exact [1] 27/17</p> <p>exactly [5] 5/9 29/15 48/1 89/15 115/1</p> <p>example [9] 9/17 28/23 51/15 53/14 54/2 64/19 70/6 105/23 106/1</p> <p>exchange [7] 6/21 6/22 33/2 37/2 67/3 94/16 113/24</p> <p>exhibit [1] 6/3</p> <p>exhibiting [4] 27/9 72/18 86/25 98/8</p> <p>existing [1] 22/14</p> <p>expectation [1] 68/9</p> <p>expecting [1] 42/23</p> <p>experience [6] 2/21 11/21 27/18 51/17 61/1 74/17</p> <p>experienced [4] 5/10 74/16 82/9 96/5</p> <p>experiences [6] 33/10 57/9 73/25 74/1 91/2 116/8</p> <p>experiences' [1] 24/6</p> <p>experiencing [8] 5/4 5/12 74/2 76/1 91/6 91/24 95/24 95/24</p> <p>expertise [3] 12/3 83/11 114/25</p> <p>explain [5] 44/25 67/8 87/25 88/18 91/19</p> <p>explained [11] 13/13 16/2 17/25 18/13 20/13 20/15 44/23 45/1 91/14 91/18 93/8</p> <p>explanation [1] 42/9</p>
--	--	--	---	--

<p>E</p> <p>explicit [2] 89/14 93/2</p> <p>explore [1] 63/16</p> <p>explored [1] 70/21</p> <p>exploring [1] 8/9</p> <p>exposes [1] 112/22</p> <p>express [1] 38/23</p> <p>expressed [1] 109/9</p> <p>expressing [2] 11/4 31/1</p> <p>extent [2] 43/23 115/18</p> <p>extreme [1] 96/13</p> <p>extremely [2] 56/21 115/9</p>	<p>fears [1] 32/3</p> <p>feature [1] 95/20</p> <p>features [1] 98/9</p> <p>February [3] 44/5 44/12 46/7</p> <p>February 2022 [2] 44/12 46/7</p> <p>feel [16] 3/21 3/21 13/7 20/14 39/12 48/22 50/3 52/25 53/3 56/9 56/12 62/24 63/24 73/19 104/6 104/8</p> <p>feeling [7] 24/10 24/11 24/12 51/13 51/14 57/3 89/23</p> <p>fell [1] 57/5</p> <p>felt [11] 21/21 44/1 47/21 55/5 55/17 55/18 55/24 57/6 57/7 60/7 96/10</p> <p>female [3] 94/14 115/8 115/19</p> <p>Feven [9] 76/7 76/12 77/3 77/23 78/15 79/3 79/10 79/12 79/20</p> <p>few [4] 33/12 44/21 52/5 113/23</p> <p>field [1] 107/16</p> <p>fill [1] 114/14</p> <p>final [4] 64/17 83/17 97/21 106/6</p> <p>finally [2] 55/16 101/23</p> <p>find [4] 18/1 18/2 27/7 69/14</p> <p>finish [1] 77/10</p> <p>first [54] 3/22 4/6 7/5 9/3 9/3 10/1 10/21 10/23 10/25 11/6 15/8 20/25 27/11 31/20 34/6 34/15 34/25 35/2 36/3 36/3 42/6 50/24 52/1 52/20 55/24 57/12 61/24 65/10 69/22 71/21 75/20 80/2 80/17 89/7 89/7 93/13 97/11 97/23 97/23 98/23 99/7 99/13 100/7 100/23 102/15 103/8 103/12 105/2 107/7 107/13 108/25 109/2 114/10 115/10</p> <p>first-episode [1] 11/6</p> <p>first-hand [1] 75/20</p> <p>Firstly [5] 49/13 49/21 91/17 107/5 109/22</p> <p>fit [2] 114/22 118/9</p> <p>fitness [3] 114/8 114/15 114/17</p> <p>five [1] 50/24</p> <p>flat [15] 1/8 1/12 1/12 32/20 33/22 34/1 36/3 36/3 77/19 77/20</p>	<p>79/11 95/5 119/25 120/1 120/11</p> <p>flatmate [1] 46/14</p> <p>flats [4] 36/16 58/11 94/12 94/21</p> <p>fled [1] 77/19</p> <p>floor [2] 7/24 115/10</p> <p>fluctuate [1] 11/22</p> <p>focus [4] 5/10 11/24 12/3 22/6</p> <p>focused [3] 43/14 48/24 118/8</p> <p>follow [4] 32/22 40/9 70/3 106/18</p> <p>followed [4] 29/22 46/21 60/24 76/13</p> <p>following [4] 24/12 31/24 35/8 43/1</p> <p>fond [3] 19/10 19/15 19/16</p> <p>forced [1] 77/11</p> <p>forensic [12] 49/17 60/13 60/25 61/5 61/19 61/21 101/10 116/22 117/4 117/7 117/8 119/12</p> <p>form [11] 3/7 3/8 29/22 29/25 30/14 75/25 105/5 114/10 114/14 114/14 115/4</p> <p>formally [1] 103/15</p> <p>formed [4] 18/16 51/3 61/10 104/1</p> <p>former [2] 37/24 39/19</p> <p>formulation [2] 11/25 69/24</p> <p>forward [1] 105/22</p> <p>forwards [1] 32/11</p> <p>found [2] 61/3 95/23</p> <p>four [3] 49/11 50/21 101/14</p> <p>fourth [2] 62/3 106/6</p> <p>fourthly [1] 49/18</p> <p>fractured [1] 77/14</p> <p>framework [1] 109/19</p> <p>frank [13] 6/24 7/1 8/10 23/6 23/11 23/12 23/15 23/17 23/19 23/19 23/20 23/23 25/13</p> <p>frankness [1] 23/22</p> <p>free [3] 80/21 80/23 93/14</p> <p>friendly [2] 51/1 51/19</p> <p>front [3] 19/6 26/22 26/23</p> <p>frustration [1] 33/4</p> <p>fulfil [1] 61/18</p> <p>fulfilled [6] 15/6 109/25 110/12 110/13 110/14 110/20</p> <p>full [2] 100/5 100/8</p> <p>fuller [2] 31/18 90/11</p>	<p>fully [9] 7/7 8/15 12/18 17/13 18/17 18/17 69/7 71/16 112/6</p> <p>function [1] 87/16</p> <p>further [6] 24/17 25/21 40/12 79/19 84/10 99/23</p> <p>future [6] 19/4 43/22 44/18 61/3 67/5 84/22</p> <p>G</p> <p>gain [1] 77/24</p> <p>gained [3] 77/18 77/20 119/24</p> <p>Gary [2] 40/12 40/19</p> <p>gateway [2] 113/13 113/14</p> <p>gateways [1] 113/8</p> <p>gather [1] 29/2</p> <p>gave [7] 29/23 40/1 75/21 88/13 115/12 115/16 117/11</p> <p>general [9] 9/9 43/16 60/22 61/8 66/24 72/7 76/20 82/3 101/17</p> <p>generally [3] 2/23 105/18 113/5</p> <p>generic [2] 29/16 105/9</p> <p>Geoff [5] 31/22 32/11 34/8 35/6 35/10</p> <p>Geoff Culpin [5] 31/22 32/11 34/8 35/6 35/10</p> <p>get [34] 3/4 3/8 5/20 8/23 9/5 9/21 12/14 13/1 21/22 25/7 27/19 28/4 28/5 28/6 28/11 28/13 29/18 29/19 31/13 31/18 34/21 40/7 40/12 43/8 60/25 79/17 80/6 80/18 87/23 93/16 107/20 111/8 112/2 114/23</p> <p>gets [1] 40/20</p> <p>getting [4] 48/23 76/9 105/17 120/3</p> <p>Gibson [4] 44/14 45/10 47/2 47/20</p> <p>give [17] 19/18 19/18 23/3 28/20 29/4 29/11 29/11 30/12 32/14 37/9 38/1 55/15 70/5 90/11 99/4 99/15 99/25</p> <p>given [11] 2/12 12/16 17/23 19/24 68/16 70/4 71/11 79/1 100/7 112/10 118/5</p> <p>gives [1] 41/19</p> <p>giving [7] 11/25 23/3 24/22 45/20 63/22 70/23 81/12</p> <p>GMC [1] 113/5</p> <p>go [43] 1/6 4/13 8/16</p>	<p>9/7 16/17 20/6 23/6 26/12 29/15 30/5 31/20 32/11 32/13 33/1 33/25 35/9 36/2 36/4 36/5 37/1 37/21 41/14 41/25 43/12 44/1 44/4 44/5 44/12 49/5 50/19 54/23 55/2 55/21 57/10 62/12 62/17 68/6 72/13 75/9 94/25 103/12 104/14 104/18</p> <p>goal [6] 15/22 15/25 16/6 16/12 16/14 41/12</p> <p>goals [2] 13/25 14/10</p> <p>God [1] 55/24</p> <p>goes [4] 11/5 21/17 21/19 58/5</p> <p>going [43] 5/21 13/21 13/23 18/11 21/16 21/18 24/22 29/17 29/17 34/2 34/7 34/8 34/11 34/13 34/21 37/16 39/8 43/21 45/4 52/16 58/24 60/14 62/3 69/1 71/13 73/6 80/10 82/7 84/3 86/24 94/11 97/3 98/19 98/21 100/1 100/2 101/17 105/22 107/5 116/3 116/3 117/2 120/5</p> <p>gone [1] 95/9</p> <p>good [17] 19/4 26/11 35/11 35/13 44/23 49/10 50/10 51/3 65/5 65/6 71/1 86/10 101/7 101/9 101/21 101/22 101/24</p> <p>got [13] 22/25 28/14 30/14 30/23 41/2 45/15 49/11 51/13 51/14 75/7 79/14 89/17 97/4</p> <p>governance [1] 65/22</p> <p>GP [2] 12/23 24/15</p> <p>graded [1] 109/4</p> <p>gradually [1] 56/17</p> <p>grateful [2] 50/21 84/23</p> <p>gravity [2] 3/16 7/16</p> <p>greatest [2] 55/17 57/6</p> <p>grievous [2] 78/15 78/21</p> <p>grounds [1] 14/23</p> <p>group [1] 105/14</p> <p>guarded [1] 44/20</p> <p>guess [18] 5/24 6/6 7/15 23/24 31/18 33/3 33/5 39/17 40/23 54/17 62/20 63/19 83/5 87/19 87/21 87/22 96/21 115/3</p>
--	--	--	---	---

<p>G</p> <p>guessing [1] 45/8 guidance [9] 22/15 30/21 66/24 68/16 74/8 74/9 80/18 81/17 82/7 Guide [1] 26/11 guidelines [3] 11/6 113/6 113/8</p>	<p>69/13 70/10 71/24 73/24 76/2 83/6 91/1 91/6 92/14 92/15 105/16 109/18 118/1 119/22 he [397] he'd [8] 10/20 19/13 45/11 57/7 58/13 62/16 119/18 120/8 he'll [1] 45/20 he's [30] 24/22 37/5 44/5 44/19 44/19 44/22 45/14 45/19 45/20 45/22 45/25 47/13 47/13 48/1 48/18 48/18 57/1 57/1 57/20 57/20 58/2 58/6 58/17 59/3 74/20 76/8 76/8 76/10 89/17 89/17 head [1] 119/1 headlock [1] 46/14 heads [2] 73/19 76/10 health [19] 1/4 2/17 3/20 12/22 14/20 24/9 24/14 32/4 38/13 40/1 43/13 45/13 45/21 65/13 66/9 81/10 83/24 86/11 110/10 hear [3] 25/1 25/6 42/11 heard [3] 1/10 8/21 79/12 hearing [8] 42/7 57/20 58/6 58/6 59/3 96/13 96/14 120/20 heart [1] 72/16 held [3] 72/3 115/24 116/17 help [13] 7/14 15/4 31/11 42/5 43/12 47/5 47/19 47/19 47/20 48/8 76/24 76/24 92/19 helpful [16] 11/10 18/2 18/23 29/18 30/17 31/9 31/12 44/25 45/15 47/3 47/5 47/7 47/8 47/13 47/15 102/4 helping [3] 11/24 13/5 102/6 helps [2] 16/20 67/8 hence [4] 33/12 76/4 88/16 110/7 her [19] 34/18 34/23 35/3 41/1 41/19 77/14 78/12 79/13 79/16 79/17 80/2 80/4 80/5 80/5 80/6 85/12 115/10 119/19 119/19 here [17] 2/1 6/15 8/8 13/19 16/4 17/19 20/19 21/1 26/13 31/3 40/22 60/16 60/21</p>	<p>63/1 64/2 69/18 95/16 herself [1] 70/17 Hi [2] 37/23 40/8 high [3] 10/11 97/15 104/7 Highbury [2] 24/24 25/11 higher [3] 7/23 44/14 47/14 highest [1] 72/7 highlight [2] 7/13 39/25 highlighted [2] 33/15 41/23 highlighting [1] 23/17 highly [7] 71/2 71/19 74/25 75/12 75/15 84/10 101/12 him [109] 1/9 1/10 1/17 1/17 2/2 2/13 2/21 3/25 5/17 7/1 7/4 7/15 7/19 8/21 8/24 13/5 16/25 17/7 17/25 19/18 19/18 22/2 22/8 23/4 23/7 23/18 23/23 23/24 24/12 24/13 25/4 31/6 32/6 32/9 32/14 36/15 36/15 38/6 38/7 38/8 38/10 38/12 38/20 39/4 39/5 39/6 39/8 39/8 39/10 39/18 40/2 40/11 40/13 40/19 41/2 41/11 41/13 42/19 42/19 43/6 45/24 46/3 46/14 46/19 48/12 48/16 49/23 50/15 51/3 51/15 57/18 57/24 58/1 58/19 58/22 58/24 59/1 59/23 60/7 63/22 70/10 72/11 73/5 74/23 76/5 76/7 76/9 76/11 76/15 76/21 76/22 77/1 81/12 88/5 92/18 93/25 94/12 94/19 94/20 94/21 98/20 99/4 99/11 99/15 102/24 118/19 119/2 120/10 120/10 him/spy [1] 36/15 him/torment [1] 36/15 himself [6] 8/6 14/25 15/1 24/11 63/4 110/17 hindsight [5] 25/15 61/21 101/7 101/9 118/7 his [202] history [4] 88/1 88/13 94/5 111/22 hold [2] 62/15 105/5 holding [1] 46/14 hole [3] 57/15 57/16</p>	<p>103/13 hole punches [1] 57/15 home [4] 24/21 77/11 80/2 119/6 honest [2] 3/1 25/19 hope [3] 37/4 66/21 105/8 hoped [1] 12/7 hoping [1] 8/16 hospital [17] 3/5 3/8 12/25 13/14 15/20 19/14 24/25 25/3 25/12 35/20 39/14 40/6 82/12 87/4 98/20 100/4 109/25 hostage [1] 46/15 hostage-style [1] 46/15 hostility [1] 9/18 hour [3] 4/23 9/20 17/14 hours [3] 55/16 56/11 57/6 housemate [2] 90/6 90/18 how [39] 2/11 4/17 5/21 6/10 6/21 9/13 9/16 13/22 13/24 14/1 15/17 19/9 22/2 22/9 23/6 26/6 28/1 32/17 34/7 35/13 44/18 48/14 49/22 52/16 57/23 57/23 59/17 69/14 73/17 73/20 74/16 77/7 77/14 78/2 79/19 82/13 83/2 95/4 97/2 however [4] 13/18 68/21 71/24 76/3 human [1] 56/21 hundreds [2] 107/20 109/8 hurt [5] 7/6 55/10 76/10 76/23 120/9 hurting [1] 58/14</p> <hr/> <p>I</p> <p>I accept [4] 68/19 70/14 78/8 119/11 I actually [2] 51/2 69/14 I agree [5] 36/20 69/21 71/4 102/5 111/10 I also [4] 26/21 27/1 38/18 61/17 I am [3] 32/2 43/14 47/1 I appreciate [1] 66/14 I ask [4] 49/10 62/4 65/7 89/25 I asked [6] 38/7 38/12 42/9 59/1 59/25 114/9</p>	<p>I assessed [1] 119/14 I be [1] 53/24 I believe [3] 9/4 23/9 82/7 I came [1] 46/20 I can [5] 4/13 25/6 60/6 60/18 93/12 I can't [5] 13/16 26/23 39/18 43/8 55/19 I cannot [1] 32/13 I clarify [1] 58/22 I collected [1] 103/24 I come [1] 74/5 I concur [1] 11/9 I confirmed [1] 61/12 I could [3] 49/20 60/14 64/18 I did [32] 3/7 3/8 13/7 13/22 19/23 39/7 53/7 58/19 61/10 67/23 67/25 68/5 69/8 71/25 72/9 72/9 76/20 76/24 89/4 89/6 89/24 101/6 104/8 105/5 115/2 115/3 115/15 115/20 116/16 116/16 117/7 120/12 I didn't [22] 4/10 7/18 17/13 27/7 34/7 48/22 51/16 53/1 53/12 53/15 54/11 55/14 56/10 59/18 59/22 72/10 72/11 78/23 79/18 104/6 116/2 119/23 I discussed [2] 89/8 89/12 I do [5] 42/21 51/4 69/13 101/1 118/7 I don't [13] 12/5 23/14 29/10 38/16 45/16 48/14 48/20 48/21 49/3 50/7 84/17 86/1 99/19 I even [1] 55/14 I explained [2] 17/25 44/23 I feel [4] 39/12 52/25 56/9 56/12 I felt [3] 21/21 55/5 55/24 I focused [1] 48/24 I followed [1] 46/21 I formed [2] 18/16 104/1 I gave [1] 40/1 I go [1] 23/6 I gradually [1] 56/17 I guess [17] 5/24 6/6 7/15 23/24 31/18 33/3 33/5 40/23 54/17 62/20 63/19 83/5 87/19 87/21 87/22 96/21 115/3</p>
---	---	---	---	--

I	I had [11] 4/14 23/4 34/5 47/2 48/4 48/24 60/9 77/16 78/13 118/11 119/25 I hadn't [1] 48/16 I happen [1] 39/20 I have [17] 28/17 40/25 41/5 43/8 44/2 46/12 47/1 61/3 63/17 68/21 68/22 68/22 68/23 68/24 69/3 69/16 89/23 I held [1] 116/17 I hope [2] 37/4 105/8 I intervene [1] 105/8 I just [8] 39/25 52/18 53/4 60/18 63/16 83/17 109/21 113/23 I know [3] 31/3 52/25 56/9 I look [1] 26/25 I love [1] 56/13 I made [8] 7/1 10/11 61/10 62/20 63/19 78/12 103/22 106/9 I maintained [1] 50/13 I may [9] 49/12 50/19 52/19 53/16 54/23 60/13 64/17 89/14 97/8 I mean [4] 11/16 23/23 53/13 92/2 I meant [1] 21/14 I need [3] 9/24 53/22 118/15 I needed [1] 9/20 I never [1] 64/16 I not [2] 53/3 56/12 I painted [1] 7/2 I pass [1] 75/13 I please [1] 39/10 I probably [1] 93/1 I quickly [1] 38/15 I raised [1] 16/25 I read [1] 106/6 I recall [1] 42/24 I recognise [1] 70/25 I referred [1] 114/13 I reiterated [1] 5/19 I remain [1] 32/1 I remind [1] 38/20 I reminded [2] 7/4 38/8 I represent [1] 85/1 I right [1] 107/19 I said [16] 7/20 13/3 14/6 22/5 25/3 34/17 38/10 41/5 44/10 47/1 48/4 62/22 63/23 92/13 106/22 119/23 I say [1] 68/25 I see [4] 44/22 63/16 86/3 114/10	I should [3] 41/5 115/4 118/11 I shouldn't [1] 118/7 I suggest [1] 101/23 I take [1] 50/15 I think [82] 2/3 3/21 4/6 9/15 11/19 12/10 14/6 14/19 20/24 22/5 22/25 23/17 25/22 26/2 26/20 29/12 29/12 30/18 31/8 36/25 43/4 45/11 50/11 51/2 51/21 54/21 60/9 62/22 63/1 63/23 64/2 68/8 68/16 71/15 71/18 72/5 80/18 81/1 81/16 82/3 82/4 83/5 83/9 83/10 83/13 86/9 88/10 89/4 89/9 89/12 90/23 90/24 91/4 91/13 91/19 93/18 93/19 94/23 95/7 96/3 96/18 98/2 98/6 99/16 100/10 101/9 101/14 102/2 102/3 102/10 105/3 105/15 105/21 107/10 107/14 110/25 112/3 112/9 112/13 112/24 117/19 120/8 I thought [2] 52/25 56/9 I told [1] 39/8 I took [1] 47/10 I understand [4] 73/22 97/4 105/20 109/7 I want [4] 54/22 56/13 68/11 77/4 I wanted [1] 6/24 I was [35] 4/16 5/19 5/20 7/20 10/3 20/24 21/1 21/8 21/16 23/3 23/4 27/2 31/24 33/5 39/3 39/8 39/17 40/4 43/2 46/20 48/10 48/25 53/1 55/25 56/10 63/8 63/10 63/13 91/19 114/19 115/5 116/3 116/4 119/5 119/6 I wasn't [1] 25/16 I will [2] 26/6 72/4 I wonder [2] 44/24 104/24 I would [21] 11/11 26/20 31/12 34/18 41/20 41/20 43/10 43/12 43/13 50/6 50/6 68/16 73/14 73/23 82/17 90/21 95/22 98/16 102/2 104/9 117/9 I wouldn't [9] 45/17 51/7 62/1 73/10 99/2 99/3 99/7 100/10	117/5 I'd [5] 37/4 48/4 50/18 52/20 60/5 I'll [4] 51/25 64/20 70/5 97/5 I'm [27] 15/3 34/21 41/24 43/9 50/21 52/16 55/14 60/14 62/3 73/6 80/10 84/3 84/23 90/3 92/22 94/10 94/10 96/25 98/19 98/21 100/2 104/11 105/12 107/5 112/23 115/2 115/3 I've [10] 37/24 49/11 54/25 55/18 64/9 70/14 92/5 97/4 108/20 115/2 I, [1] 118/10 I, at [1] 118/10 Ibrahim [2] 91/12 91/17 ICD [1] 80/19 ideal [2] 112/4 112/4 ideals [1] 112/5 ideas [2] 45/14 45/22 identified [3] 10/7 16/6 93/3 ie [3] 2/10 7/21 111/21 if [161] ill [10] 4/1 4/2 20/1 45/25 48/12 48/12 48/13 83/21 95/16 95/19 illness [27] 7/8 8/10 8/12 8/20 13/7 17/11 17/12 17/16 18/18 22/8 23/2 23/25 27/5 35/15 46/4 89/19 92/7 92/8 93/7 95/20 95/21 95/24 96/2 96/15 96/17 96/20 98/9 illnesses [2] 12/2 83/12 imagine [4] 40/13 55/9 57/5 57/15 immediate [1] 15/1 immense [1] 55/5 impact [7] 5/25 6/12 22/10 23/10 62/7 91/8 94/3 impacted [2] 23/2 88/15 impacting [1] 76/2 impacts [1] 92/17 impaired [1] 116/11 implement [1] 62/7 implication [1] 61/13 implications [3] 7/8 7/14 11/15 importance [11] 7/13 11/15 13/4 20/19 22/8 22/11 23/18 23/24 35/17 44/25 112/10 important [37] 3/14	5/10 12/10 12/12 16/8 17/8 17/17 19/9 21/21 22/6 23/6 25/3 27/2 30/22 35/5 38/10 40/2 40/4 43/5 44/2 50/12 52/13 54/13 62/15 63/1 64/2 67/2 68/18 81/5 85/12 96/8 96/20 97/18 100/3 100/6 100/10 105/17 impress [1] 23/24 impression [3] 9/7 25/17 106/9 improve [2] 29/13 83/13 improvement [3] 82/5 98/12 110/4 improvements [1] 21/3 incidence [1] 32/19 incidences [1] 28/9 incident [12] 5/15 5/20 27/18 31/24 33/11 76/8 77/23 95/4 95/14 95/15 115/20 116/6 incidents [5] 2/4 28/16 36/17 72/20 117/1 include [1] 113/8 included [1] 92/10 includes [2] 81/9 84/8 including [2] 83/24 104/10 income [1] 32/15 increase [3] 98/25 99/8 99/24 increased [1] 99/6 increasing [1] 99/20 increasingly [2] 8/14 32/2 independently [1] 87/3 indicate [4] 88/20 90/15 95/14 99/14 indicated [2] 75/24 76/1 indicating [1] 96/7 indication [1] 93/6 indicative [1] 89/10 individual [12] 7/5 27/25 30/3 31/17 31/18 63/2 64/3 78/9 78/10 94/25 95/9 95/11 induced [3] 93/7 93/11 94/8 infer [3] 21/11 21/11 92/19 inferred [1] 76/3 influence [1] 63/14 inform [4] 31/11 38/19 60/22 86/18 informal [1] 12/21 information [62] 2/12	3/23 23/3 23/9 27/13 27/15 27/17 27/19 27/24 28/4 28/5 28/12 28/21 29/2 29/5 29/11 29/12 29/17 29/19 30/2 30/6 30/15 31/17 38/2 40/25 41/19 43/19 46/18 59/12 59/15 60/9 67/1 67/3 69/18 70/8 71/19 71/24 72/5 72/6 73/6 74/25 75/12 76/16 77/16 77/17 78/13 84/7 84/11 90/17 94/4 102/6 102/17 103/3 103/24 104/20 105/18 106/21 112/20 112/25 113/4 113/15 119/25 informed [6] 17/5 43/25 66/18 105/7 106/3 106/22 informs [1] 67/4 initial [1] 114/9 initially [1] 89/6 injection [10] 18/3 18/3 18/8 18/14 19/8 19/24 19/25 20/3 62/22 63/21 injections [1] 62/18 injured [1] 80/3 injuries [1] 119/16 inpatient [13] 21/3 21/17 43/8 51/8 62/25 63/25 100/13 103/16 108/12 110/23 111/1 111/21 114/21 input [4] 24/17 82/14 82/18 102/13 INQ [1] 35/9 Inquiry [4] 29/23 46/10 90/12 114/7 insertion [1] 53/8 inside [1] 115/9 insight [19] 3/15 4/8 4/16 6/10 6/17 8/9 13/4 20/16 20/18 25/20 26/17 35/12 35/13 72/21 72/23 73/2 75/22 81/2 101/14 insisted [1] 115/4 insofar [1] 83/23 instance [2] 42/6 111/20 insufficient [2] 112/2 112/3 intelligence [2] 2/23 42/13 intelligent [1] 101/13 intended [2] 21/11 76/4 intending [1] 8/7 intent [1] 8/7 intention [4] 40/22 42/23 60/24 120/4 intentions [4] 50/7
----------	---	--	--	---	---

I	issued [2] 66/24 80/18 issues [5] 43/23 71/7 71/13 83/15 118/3 it [311] it not [1] 42/18 it' [1] 8/17 it's [72] 2/8 8/23 11/19 12/10 14/3 14/5 14/16 15/22 16/12 16/14 26/11 28/5 29/23 35/5 36/9 39/18 42/1 43/14 47/11 47/11 47/19 48/6 49/2 50/24 57/1 57/11 57/12 57/16 60/18 61/1 61/20 62/4 62/22 63/23 64/21 66/17 68/22 68/25 69/6 69/17 69/19 70/3 70/18 75/25 78/7 81/3 81/11 81/12 83/5 83/7 83/7 85/12 87/17 87/17 89/9 91/3 92/1 93/6 95/13 95/20 96/3 96/21 97/6 97/11 97/18 98/6 98/25 100/10 103/6 113/16 116/10 116/11 it, [1] 30/22 it, in [1] 30/22 its [1] 93/11 itself [4] 48/20 72/2 95/19 96/17	51/13 52/18 53/4 53/4 53/13 53/16 53/19 54/3 54/22 54/25 55/12 56/3 56/6 56/8 57/11 57/12 57/16 57/21 58/13 59/7 59/8 59/9 59/25 60/14 60/16 60/18 62/4 63/16 64/7 64/9 64/9 64/15 64/17 64/18 64/18 68/11 71/5 79/1 80/9 81/9 82/11 83/17 90/11 93/21 94/1 94/22 99/20 99/24 102/10 104/18 107/5 109/21 113/23 113/24 114/4 114/6 115/6 117/18 118/8 118/16 118/20 justice [1] 116/21 Justified [1] 30/10 justify [4] 15/23 30/11 67/9 109/17 justifying [1] 15/11	knows [1] 57/17	52/12 52/20 52/25 56/9 56/15 60/5 79/25 92/22 92/23 likelihood [1] 106/10 likely [10] 8/14 9/10 10/8 32/6 45/14 45/22 91/14 91/20 116/11 118/22 line [2] 44/16 106/8 lines [3] 16/1 50/24 89/16 link [4] 21/13 35/16 35/19 102/2 linked [3] 73/25 76/7 103/25 list [1] 104/16 listed [1] 108/20 listen [1] 48/16 listening [2] 25/10 48/15 little [4] 5/2 11/22 43/11 109/21 live [2] 32/13 76/9 living [6] 1/11 31/15 33/8 34/2 87/3 87/23 Lloyd [2] 40/7 41/21 LMHT [1] 12/23 located [1] 32/9 Lomas [1] 44/4 long [6] 2/11 13/22 14/5 48/17 82/13 97/3 longer [8] 15/21 25/1 38/8 47/10 98/20 100/4 110/5 110/13 look [31] 4/22 10/14 10/19 15/25 19/6 22/12 26/14 26/25 27/1 29/25 33/25 35/4 36/12 38/25 39/6 40/7 45/19 53/13 59/9 60/14 65/17 65/18 67/11 68/5 71/5 72/13 74/5 77/21 80/9 103/11 103/13 looked [6] 1/3 2/17 27/3 66/18 72/6 80/5 looking [10] 14/19 15/3 18/5 43/9 51/5 64/6 87/21 99/24 114/6 117/18 looks [3] 40/8 79/25 117/11 loses [1] 1/25 lost [2] 11/12 101/25 lot [7] 3/23 4/7 13/3 21/9 47/1 48/5 51/21 lots [1] 50/9 love [1] 56/13 low [3] 10/13 109/4 109/14 Ludvigsen [1] 70/17 lying [1] 26/24
intentions... [3] 76/6 76/23 108/9 interact [1] 51/17 interacted [1] 38/18 interaction [4] 39/12 40/22 102/2 102/20 interactions [8] 4/13 4/14 25/16 31/7 68/24 69/15 111/22 112/5 interesting [1] 45/15 interesting/helpful [1] 45/15 internal [1] 83/2 intervene [1] 105/8 intervention [2] 12/11 81/10 interventions [12] 9/17 10/5 10/19 10/20 11/1 11/20 11/23 12/1 14/8 82/8 82/12 112/4 interview [3] 50/16 114/15 118/9 interviewed [3] 64/8 114/8 114/22 into [34] 1/12 2/24 6/10 14/12 20/24 21/19 25/7 26/17 34/21 36/15 39/6 40/6 53/1 53/13 53/17 55/19 56/10 58/10 64/12 73/15 75/22 77/20 87/4 94/12 94/21 95/5 101/24 103/6 110/24 114/23 117/3 119/1 119/20 119/24 introduced [1] 64/8 inviting [1] 104/11 involve [3] 104/20 105/15 111/2 involved [20] 17/3 22/1 37/13 38/8 40/21 43/8 43/17 47/16 48/23 67/22 81/18 82/1 103/17 104/9 104/22 105/7 111/9 112/2 113/1 117/4 involvement [10] 16/18 28/25 45/13 45/22 78/19 79/5 80/12 101/11 103/22 105/18 involving [1] 103/17 irritable [1] 24/13 is [232] isn't [14] 14/3 29/10 30/22 37/20 48/2 57/8 57/24 58/3 80/1 103/7 113/18 116/15 116/22 119/4 isolation [1] 91/23 issue [8] 10/8 10/8 70/13 86/13 93/5 94/11 112/13 115/18	J Jesus [1] 56/2 job [1] 69/5 jobs [2] 87/21 87/22 joint [4] 48/25 66/11 66/13 66/14 judge [1] 98/2 judgement [2] 98/6 116/10 July [11] 13/11 20/7 24/2 24/16 24/25 85/4 86/1 86/15 88/22 95/4 95/15 jump [2] 85/2 85/25 jumped [7] 7/6 7/22 77/13 78/5 79/4 115/10 119/9 June [9] 107/8 107/10 107/21 117/11 117/14 117/16 117/17 117/20 117/21 June 2020 [3] 107/8 107/10 107/21 just [86] 4/13 5/7 6/24 14/16 18/2 19/19 22/18 24/24 29/8 29/15 29/25 32/23 32/25 37/4 37/24 39/25 40/2 40/22 41/18 45/4 45/11 48/4 49/11 49/24 51/9	K KC [1] 65/9 keep [2] 14/23 58/13 keeping [3] 15/20 15/23 98/20 key [2] 20/2 100/3 key [4] 10/8 16/14 67/1 83/4 kicked [4] 77/10 77/23 79/13 115/7 kill [4] 7/20 8/1 53/19 118/22 killing [5] 6/18 7/10 7/17 8/3 8/7 knew [12] 27/11 34/4 34/24 38/12 41/9 41/10 46/16 66/9 102/8 103/2 115/12 115/18 knocked [1] 1/9 know [58] 2/14 2/15 2/16 6/6 10/16 18/1 20/22 23/16 24/19 27/14 29/5 29/15 29/16 29/18 30/22 30/23 30/24 30/25 31/3 31/9 33/18 37/7 39/7 39/8 41/14 45/9 45/16 46/3 46/6 46/7 46/8 46/17 47/15 47/17 48/20 48/22 49/3 50/7 51/4 52/25 53/12 54/12 54/14 56/9 56/13 62/23 63/23 67/11 75/16 78/14 78/21 79/17 95/6 115/14 115/15 115/20 119/7 120/12 knowing [1] 63/14 knowledge [2] 41/24 119/23	L lacking [1] 101/14 lady [1] 119/8 lan [1] 12/20 landlords [2] 32/14 32/17 Langdale [7] 49/14 49/24 52/18 65/9 94/17 100/23 109/17 large [1] 43/22 last [5] 4/25 34/25 37/7 82/17 100/1 lasted [1] 56/16 later [6] 47/17 57/11 64/6 85/25 95/5 106/2 law [3] 109/22 110/9 110/18 lead [6] 65/12 68/12 81/24 83/3 88/12 106/12 leading [2] 67/4 118/16 learn [1] 31/25 learning [2] 25/18 26/5 least [9] 2/4 14/21 15/17 18/18 21/23 87/5 99/10 110/18 110/23 leave [4] 45/5 46/20 48/4 64/20 leaving [3] 40/23 46/15 69/15 led [8] 6/7 79/10 85/8 86/7 93/25 94/7 101/10 117/6 Leeds [1] 29/24 left [4] 25/16 56/15 63/17 111/1 legal [3] 14/23 15/16 109/18 length [1] 14/8 lengthy [1] 50/11 lens [1] 65/19 less [3] 13/19 57/5 58/10 let [9] 2/14 39/6 39/8 45/9 77/10 79/1 80/21 80/23 101/25 let's [6] 15/25 58/13 66/21 74/24 77/21 80/9 level [8] 2/23 6/4 6/5 6/5 26/25 50/6 87/20 99/1 levels [1] 61/1 Liaison [1] 27/16 life [4] 55/18 57/7 88/11 88/14 light [3] 94/20 97/17 106/3 like [17] 6/13 8/23 10/19 37/4 39/16 39/20 45/11 50/18	M Ma'am [1] 70/18 made [44] 2/7 5/23

M	42/16 45/19 45/19 49/12 50/19 52/19 53/16 54/23 57/11 60/13 64/17 68/4 71/16 77/3 79/22 84/10 89/14 91/1 93/6 94/12 96/18 97/8 98/5 101/10 102/11 102/12 105/8 107/7 107/10 107/21 111/21 112/19 113/16 117/19 117/21 maybe [14] 7/13 7/23 31/14 32/16 41/5 42/5 51/2 53/22 54/17 61/24 61/25 82/17 87/19 118/10 maybe: [1] 41/6 maybe: I should [1] 41/6 MDT [8] 20/7 20/12 52/7 67/17 68/14 70/18 93/5 95/13 me [57] 2/10 3/8 4/13 5/2 5/8 15/4 23/4 25/16 26/22 26/22 26/24 26/24 29/11 29/11 34/4 34/6 34/18 37/9 38/7 38/14 38/18 38/24 38/24 39/4 39/4 39/18 39/23 39/24 40/21 42/22 42/23 43/3 43/18 44/3 45/6 45/9 46/18 47/21 48/6 48/16 48/21 50/8 51/5 55/12 56/2 56/15 63/14 77/10 79/1 83/14 85/22 92/23 101/25 114/13 115/4 116/6 120/4 mean [11] 11/16 14/15 23/22 23/23 53/13 53/14 73/20 75/8 86/3 88/24 92/2 meaning [1] 109/7 meaningful [1] 12/15 means [6] 20/22 28/24 45/16 48/20 53/20 108/20 meant [9] 4/17 11/14 21/14 32/24 53/5 54/9 54/15 54/15 85/21 media [1] 108/18 medical [12] 44/9 51/18 51/19 66/24 69/9 71/1 80/3 81/8 83/18 83/20 104/21 109/24 medicated [1] 96/21 medicating [1] 21/23 medication [63] 3/1 3/6 3/10 4/24 9/9 10/7 12/19 12/22 12/24 13/5 16/3 16/5 17/1 17/2 17/24 17/25 18/4 18/6 18/7 18/8 18/12 18/15 18/19 18/24	19/9 19/12 20/1 20/4 20/5 21/20 21/25 22/3 22/9 22/11 23/9 23/15 35/18 35/21 41/13 43/21 49/18 62/5 62/8 74/15 81/9 81/12 85/7 93/12 93/24 94/2 95/15 96/4 96/24 97/22 98/3 99/4 99/9 99/16 99/20 99/24 99/25 100/11 100/14 medications [5] 3/13 17/22 21/16 62/19 98/3 meds [4] 32/21 35/7 35/11 35/11 meet [1] 100/15 meeting [3] 16/16 39/19 89/5 member [6] 33/24 36/5 36/10 77/11 78/3 83/4 members [1] 102/11 memory [3] 37/6 37/18 41/17 men [1] 10/10 mental [43] 1/4 2/17 3/20 8/10 8/11 8/20 12/22 14/20 17/11 17/12 17/15 18/17 22/12 24/8 24/14 32/3 38/13 39/11 40/1 43/13 45/13 45/21 46/4 61/12 61/12 65/13 66/9 72/25 80/17 80/25 81/10 83/24 85/6 85/9 86/11 90/21 91/7 98/12 109/23 110/6 111/7 111/16 116/5 mentally [8] 3/19 4/1 4/2 17/6 45/25 83/21 83/21 84/12 mention [4] 103/21 104/12 104/24 114/17 mentioned [3] 105/3 112/14 112/24 mentioning [1] 104/17 message [13] 34/23 52/20 52/22 52/23 54/23 54/25 56/18 56/20 58/19 59/7 59/7 59/8 59/8 messages [32] 41/6 49/15 52/1 52/11 52/16 52/19 54/13 55/1 57/2 58/18 58/23 59/4 59/23 60/1 60/3 71/25 72/1 72/12 74/1 74/5 75/8 76/8 86/17 86/20 86/22 100/25 101/5 103/23 103/25 108/18 109/6 120/12 met [2] 55/24 112/6 Metropolitan [1]	90/13 microphone [1] 49/7 middle [1] 20/10 might [16] 9/13 24/12 43/19 45/15 53/14 60/11 88/19 96/13 101/7 101/23 106/2 108/5 108/8 108/11 108/14 108/17 milligrams [2] 97/25 98/17 mind [12] 3/24 5/3 5/4 15/18 25/10 26/17 33/23 36/7 36/15 53/1 56/10 95/10 mind' [1] 5/1 mindset [3] 104/25 105/12 105/15 minimise [1] 97/13 minorities [1] 63/12 minority [3] 62/23 63/9 63/24 minute [1] 63/16 minutes [6] 53/2 55/3 55/15 56/11 57/6 97/4 missed [1] 11/5 mitigate [1] 61/14 mitigated [2] 104/4 104/6 mock [2] 57/18 58/1 mocking [1] 120/10 Moloney [7] 49/3 49/5 49/9 64/23 71/18 100/24 121/3 moment [7] 24/5 44/22 72/13 75/10 102/7 112/25 115/6 Monday [2] 120/18 120/20 money [1] 32/15 monitor [1] 21/22 monitored [1] 100/8 monitoring [6] 39/13 40/17 55/7 100/11 100/16 120/10 month [1] 57/11 months [3] 13/15 13/18 37/7 morbid [1] 90/5 more [42] 1/21 5/2 5/8 9/15 9/19 20/2 20/14 26/18 26/18 36/21 38/2 39/13 41/19 52/19 53/23 60/23 62/24 63/12 63/25 71/5 79/20 88/18 89/10 91/2 92/6 92/7 93/1 93/2 93/19 93/23 94/4 96/22 98/25 99/4 99/15 99/25 102/4 102/17 106/3 108/21 109/21 116/11 morning [1] 109/16 most [5] 31/24 74/14 75/12 75/22 91/14	mother [8] 11/3 11/14 13/13 16/17 37/2 94/15 95/1 96/14 motive [3] 94/21 94/23 95/6 move [3] 14/12 52/1 60/5 moved [2] 33/9 33/21 Moving [1] 96/25 Mr [18] 32/12 49/3 49/5 49/9 64/23 71/18 84/24 84/25 97/2 100/21 100/22 100/24 107/3 107/4 121/3 121/5 121/6 121/7 Mr Beer [3] 107/3 107/4 121/7 Mr Beggs [3] 100/21 100/22 121/6 Mr Culpin [1] 32/12 Mr Moloney [5] 49/3 49/5 64/23 71/18 100/24 Mr Straw [4] 84/24 84/25 97/2 121/5 Mrs [2] 10/15 10/16 Mrs Angela [1] 10/15 Mrs Purdue [1] 10/16 Ms [12] 34/4 49/14 49/24 52/18 65/4 65/9 83/16 84/20 94/17 100/23 109/17 121/4 Ms Cartwright [2] 83/16 84/20 Ms Langdale [7] 49/14 49/24 52/18 65/9 94/17 100/23 109/17 Ms Turner [1] 34/4 much [7] 10/16 64/22 78/4 85/6 100/19 113/19 115/9 Multi [4] 66/14 66/19 67/22 83/4 Multi-Disciplinary [4] 66/14 66/19 67/22 83/4 Multidisciplinary [1] 52/8 multiple [1] 36/16 mum [6] 17/25 33/15 40/11 51/2 89/4 89/9 murder [3] 57/1 57/2 58/12 must [8] 16/5 16/6 41/24 42/10 83/21 109/22 110/10 110/18 my [71] 2/4 8/16 10/12 11/21 17/1 19/8 19/17 21/10 22/25 23/23 27/18 28/7 33/3 33/6 34/4 34/5 35/14 37/14 39/21 40/20 40/22 40/22 40/23 43/15 43/16 43/17 45/4 47/2 48/5 48/14
----------	---	--	---	--

<p>M</p> <p>my... [41] 48/23 48/24 48/24 49/2 51/5 51/6 51/6 51/7 55/18 55/23 56/1 60/18 60/24 61/1 62/3 63/8 64/12 68/2 68/4 68/17 69/14 69/16 70/15 73/10 77/10 84/19 88/3 89/6 89/9 92/6 92/13 96/6 100/1 103/22 104/5 106/6 109/2 114/9 114/10 114/24 116/2</p> <p>myself [7] 38/20 43/7 50/13 53/1 56/10 56/17 68/6</p>	<p>neighbours' [1] 36/16</p> <p>never [16] 8/21 28/15 43/21 51/6 51/13 51/14 56/3 64/12 64/16 71/8 71/13 73/7 76/7 76/11 96/9 96/10</p> <p>nevertheless [1] 92/9</p> <p>new [1] 11/3</p> <p>next [8] 7/9 20/9 33/12 86/13 93/5 95/4 111/13 114/4</p> <p>NGPF0002527 [1] 52/21</p> <p>NHFT0000168 [10] 2/6 2/8 4/22 10/14 20/7 24/1 24/20 41/25 59/10 70/19</p> <p>NHFT0000203 [1] 1/5</p> <p>NHFT0000222 [1] 36/12</p> <p>NHFT0015099 [1] 26/10</p> <p>NHFT0019071 [1] 44/4</p> <p>NICE [6] 11/6 74/8 74/9 74/13 81/17 82/7</p> <p>NICHE [1] 106/1</p> <p>night [2] 55/5 84/10</p> <p>no [83] 6/10 6/12 6/12 6/16 7/18 8/20 9/9 9/11 9/12 10/18 10/22 11/1 24/16 24/25 27/7 30/16 30/17 32/9 32/15 35/2 35/23 36/1 36/17 36/20 38/8 41/3 41/16 46/9 46/18 46/18 47/10 51/16 51/24 53/15 54/11 60/4 60/5 61/7 61/10 63/8 64/20 70/11 71/21 72/14 72/15 73/18 76/3 77/6 77/17 77/25 78/25 79/18 81/16 82/23 84/21 86/23 87/15 87/19 87/25 88/7 88/14 89/11 89/16 89/21 90/15 91/11 91/19 93/6 98/13 101/6 102/18 103/22 107/1 110/2 110/5 110/13 110/13 110/22 113/18 114/19 115/15 117/8 118/25</p> <p>nodded [1] 50/2</p> <p>noises [1] 77/12</p> <p>non [6] 9/8 10/7 21/24 22/3 66/22 67/7</p> <p>non-compliance [1] 21/24</p> <p>non-concordance [2] 9/8 10/7</p> <p>non-concordant [1] 22/3</p>	<p>non-contentious [2] 66/22 67/7</p> <p>None [3] 62/9 62/10 62/11</p> <p>nonplussed [1] 5/14</p> <p>normal [1] 37/8</p> <p>normally [2] 39/23 87/16</p> <p>not [217]</p> <p>note [10] 2/6 6/15 24/22 70/18 72/14 89/11 89/21 91/12 117/14 118/17</p> <p>noted [2] 10/1 93/6</p> <p>notes [18] 10/15 36/8 68/10 68/14 71/20 72/6 74/6 75/9 77/5 77/22 77/25 80/13 84/4 89/16 108/15 112/1 117/12 117/15</p> <p>nothing [6] 25/21 39/15 55/12 57/2 70/19 101/25</p> <p>notify [1] 101/4</p> <p>Nottingham [3] 28/18 28/19 31/22</p> <p>Nottinghamshire [2] 28/20 102/16</p> <p>November [1] 24/21</p> <p>now [50] 3/23 13/2 14/17 19/8 23/11 24/19 32/8 36/12 40/13 40/19 43/4 48/19 49/8 51/9 52/1 52/12 52/25 53/2 54/22 55/2 56/9 56/12 56/18 57/23 58/13 59/25 60/5 60/13 61/20 64/21 64/24 65/8 68/12 69/17 74/16 80/9 83/16 86/17 87/3 87/6 87/9 88/22 89/6 89/9 90/1 90/17 95/19 100/15 110/22 113/14</p> <p>number [10] 23/11 26/13 35/9 37/19 38/3 48/18 67/12 85/2 92/5 94/19</p> <p>nurse [1] 39/7</p> <p>nursing [1] 81/9</p>	<p>51/5 52/12 119/1</p> <p>occasion [10] 8/25 21/21 34/25 89/8 92/6 95/7 95/8 99/6 100/17 104/9</p> <p>occasions [11] 9/1 32/19 35/3 48/19 50/1 92/6 104/4 105/5 111/1 119/25 120/5</p> <p>occur [2] 28/9 118/1</p> <p>occurred [1] 37/6</p> <p>off [5] 49/7 55/16 67/20 111/12 119/9</p> <p>offence [1] 113/11</p> <p>offered [2] 11/2 18/22</p> <p>office [1] 39/21</p> <p>officer [2] 46/8 46/13</p> <p>officers [1] 106/1</p> <p>offices [1] 47/23</p> <p>oh [2] 60/6 86/3</p> <p>okay [15] 36/10 39/12 40/3 54/22 55/3 61/16 62/3 77/21 87/24 89/16 90/4 91/12 92/9 94/10 99/25</p> <p>olanzapine [4] 93/13 93/19 93/21 93/22</p> <p>old [1] 33/16</p> <p>omitted [1] 84/7</p> <p>on [200]</p> <p>once [4] 14/18 40/19 74/10 88/24</p> <p>one [54] 1/19 3/22 6/6 6/6 9/21 9/22 10/15 10/24 12/11 14/18 17/23 26/5 26/13 29/15 31/7 32/20 33/7 33/9 37/24 40/4 42/16 42/17 46/24 52/10 61/2 64/15 64/17 64/19 69/8 70/2 70/5 72/20 74/7 83/6 84/3 84/5 87/19 92/24 94/2 94/22 95/4 97/11 98/2 98/9 98/23 99/4 102/3 104/23 105/4 111/6 111/12 112/6 119/7 119/15</p> <p>ongoing [8] 12/19 45/13 45/21 77/1 98/13 99/22 104/7 113/1</p> <p>online [3] 32/8 53/14 108/17</p> <p>only [18] 15/8 21/7 21/16 25/2 27/19 28/6 28/8 53/3 55/3 56/12 67/12 75/2 75/4 75/6 91/3 100/12 114/21 117/6</p> <p>onset [1] 8/23</p> <p>onto [2] 42/11 52/1</p> <p>onwards [1] 17/12</p>	<p>open [1] 49/22</p> <p>openly [2] 48/21 89/6</p> <p>operating [1] 66/8</p> <p>opinion [19] 3/7 3/9 4/16 8/14 9/4 18/16 21/8 23/4 35/14 60/25 61/11 89/6 101/10 104/1 104/5 105/5 105/6 109/2 116/17</p> <p>opportunity [5] 11/5 11/12 44/8 45/2 47/22</p> <p>opposed [2] 69/15 98/17</p> <p>option [6] 15/17 16/25 17/24 18/10 19/11 110/19</p> <p>options [1] 64/14</p> <p>or [137]</p> <p>oral [9] 17/23 18/24 19/7 19/11 20/5 35/7 35/11 62/18 97/21</p> <p>order [5] 7/14 71/15 87/23 95/9 100/11</p> <p>other [36] 1/13 4/15 16/23 17/24 22/18 25/6 25/7 28/11 28/17 29/10 29/14 30/24 31/6 32/3 32/20 39/19 43/10 46/19 51/17 51/19 52/8 69/8 74/7 81/7 84/6 84/20 102/20 102/20 104/9 111/11 112/15 113/1 113/5 113/8 114/4 120/11</p> <p>others [20] 3/18 5/25 6/11 15/1 22/2 31/13 34/16 36/14 69/15 106/13 107/24 108/3 108/18 108/22 108/24 109/11 110/11 110/17 112/22 113/17</p> <p>otherwise [3] 8/21 38/16 39/13</p> <p>our [2] 46/24 47/23</p> <p>out [22] 3/4 3/8 5/17 7/23 30/2 32/5 33/5 49/25 50/4 50/8 51/22 58/13 77/2 77/14 78/5 79/4 83/16 91/13 97/2 100/2 104/17 115/10</p> <p>outcome [1] 27/20</p> <p>outpatient [1] 39/22</p> <p>outpatients [1] 39/20</p> <p>outside [3] 51/7 77/12 80/3</p> <p>over [9] 3/25 24/11 25/10 30/5 44/5 55/21 55/21 57/11 83/25</p> <p>overspeaking [18] 15/19 35/1 53/23 54/6 54/19 56/25 58/21 60/2 60/2 60/17 75/24 78/17 86/23 87/14 92/25 97/6 106/18 106/22</p>
---	---	--	---	---

<p>O</p> <p>overwhelming [1] 55/11</p> <p>own [9] 3/12 17/17 23/22 23/23 47/2 48/5 67/13 69/14 78/9</p>	<p>paid [1] 32/14</p> <p>paint [1] 7/20</p> <p>painted [1] 7/2</p> <p>paragraph [11] 12/17 13/11 19/7 24/23 88/2 88/2 103/12 104/12 104/15 104/18 106/7</p>	<p>40/10 45/7 47/15 48/3 48/7 48/23 51/7 59/13 59/16 66/17 66/25 67/4 69/22 72/16 73/15 74/10 74/11 74/14 81/14 102/11 103/6 103/18 106/25 110/9 111/12 111/16 112/19 112/21 112/22 113/2 113/15 113/16</p>	<p>120/6</p> <p>personal [2] 65/15 78/4</p> <p>personality [10] 88/1 88/4 88/5 88/9 88/10 88/12 88/12 88/15 88/16 88/20</p>	<p>24/18 35/20 40/2 40/5 41/4 44/15 46/16 46/17 48/22 55/11 55/23 56/1 67/19 69/6 70/12 70/20 71/21 73/18 76/3 90/22 93/23 98/17 100/1 100/4 101/23 102/10 103/5 104/6 104/12 106/6 110/22 119/6</p>
<p>P</p> <p>package [1] 81/13</p> <p>page [60] 1/5 1/6 1/7 2/6 2/8 4/22 9/7 10/14 13/10 13/17 16/22 16/24 19/6 20/7 20/10 22/12 24/1 26/10 26/12 29/21 30/1 30/5 31/20 32/11 35/9 36/12 37/1 37/21 38/25 41/25 44/4 44/13 44/14 50/23 52/21 52/23 54/24 55/2 55/21 55/22 57/10 57/14 59/10 60/15 60/16 60/20 62/12 62/13 70/18 84/4 91/12 95/13 103/13 104/14 104/19 104/19 106/7 114/1 114/5 121/2</p> <p>page 1 [12] 1/6 26/10 29/21 30/1 35/9 37/1 37/21 38/25 44/4 44/13 114/1 114/5</p> <p>page 106 [1] 20/7</p> <p>page 107 [1] 22/12</p> <p>page 11 [2] 70/18 91/12</p> <p>page 115 [1] 24/1</p> <p>page 158 [2] 16/22 16/24</p> <p>page 160 [1] 41/25</p> <p>page 17 [2] 54/24 55/2</p> <p>page 18 [2] 52/21 62/12</p> <p>page 2 [1] 32/11</p> <p>page 21 [2] 59/10 84/4</p> <p>page 3 [4] 1/5 1/7 31/20 36/12</p> <p>page 37 [1] 103/13</p> <p>page 39 [1] 104/14</p> <p>page 42 [1] 104/19</p> <p>page 58 [1] 95/13</p> <p>page 6 [1] 57/10</p> <p>page 61 [2] 2/6 2/8</p> <p>page 64 [1] 4/22</p> <p>page 66 [1] 9/7</p> <p>page 7 [2] 26/12 50/23</p> <p>page 72 [1] 106/7</p> <p>page 75 [1] 10/14</p> <p>page 79 [2] 13/10 13/17</p> <p>page 8 [2] 60/15 60/16</p>	<p>paragraph 105 [1] 104/18</p> <p>paragraph 179 [1] 106/7</p> <p>Paragraph 248 [1] 88/2</p> <p>paragraph 433 [1] 88/2</p> <p>paragraph 92 [2] 103/12 104/12</p> <p>paragraph 97 [1] 104/15</p> <p>paragraphs [3] 5/18 105/9 112/24</p> <p>paranoia [1] 55/6</p> <p>paranoid [9] 24/10 86/14 86/24 87/10 89/2 89/21 91/9 99/12 111/18</p> <p>paranoid' [1] 5/2</p> <p>paraphrasing [1] 57/13</p> <p>Pardon [2] 66/12 67/24</p> <p>parenthetically [1] 106/11</p> <p>part [10] 51/15 54/13 54/24 54/25 63/6 64/5 78/19 82/12 87/5 105/13</p> <p>part-time [1] 87/5</p> <p>particular [7] 12/3 30/3 55/23 91/9 101/17 110/7 113/10</p> <p>particularly [9] 10/10 12/2 82/1 82/8 94/14 111/6 111/15 111/18 119/22</p> <p>parties [1] 113/4</p> <p>Partnership [1] 29/24</p> <p>party [3] 59/12 59/15 60/9</p> <p>pass [3] 75/13 75/23 89/2</p> <p>passage [1] 50/16</p> <p>passed [1] 46/18</p> <p>passing [1] 39/20</p> <p>past [7] 19/4 39/21 43/22 44/22 61/3 97/5 108/5</p> <p>pathway [2] 43/16 61/22</p> <p>pathways [1] 28/3</p> <p>patient [49] 4/23 14/7 14/17 14/25 15/11 15/20 15/24 16/1 26/4 26/4 26/22 26/23 27/1 29/4 29/8 39/3 40/9</p>	<p>107/23 108/1 108/22 109/8 111/6 112/15</p> <p>pattern [1] 1/25</p> <p>Pausing [2] 5/3 17/4</p> <p>pay [1] 53/22</p> <p>PC [6] 102/21 102/22 113/25 114/2 114/10 117/24</p> <p>PC Marsden [6] 102/21 102/22 113/25 114/2 114/10 117/24</p> <p>peace [2] 55/18 57/6</p> <p>Pembrokeshire [1] 90/24</p> <p>penultimate [1] 12/17</p> <p>people [43] 3/25 18/1 18/4 24/12 25/6 25/7 25/10 30/24 31/6 31/15 32/13 32/23 32/25 33/22 36/3 37/20 51/21 52/8 53/19 56/13 57/17 57/19 57/21 58/5 58/6 58/7 58/12 58/20 58/23 58/25 59/2 62/23 63/11 63/24 71/2 82/4 87/15 87/22 96/13 98/4 101/20 105/2 120/10</p> <p>people's [1] 38/16</p> <p>perhaps [1] 6/18</p> <p>period [14] 12/7 13/20 14/20 14/21 15/21 21/23 27/5 65/18 82/20 90/9 90/16 91/7 102/15 117/23</p> <p>periods [4] 82/15 82/16 87/6 92/4</p> <p>permanently [3] 55/10 57/3 58/14</p> <p>person [16] 1/11 1/13 8/5 22/15 25/25 37/11 55/25 75/2 75/4 77/19 79/10 83/21 94/15 109/22 114/22</p>	<p>personally [2] 47/20 89/2</p> <p>persons [1] 1/12</p> <p>perspective [3] 31/13 42/18 65/19</p> <p>perused [1] 2/17</p> <p>phase [1] 14/16</p> <p>phases [1] 10/2</p> <p>phone [4] 2/15 37/25 38/3 39/23</p> <p>phoned [1] 34/22</p> <p>phones [2] 86/1 86/4</p> <p>phrase [1] 53/21</p> <p>physically [2] 8/1 101/13</p> <p>pick [1] 84/22</p> <p>picking [1] 43/9</p> <p>picture [4] 31/18 67/21 90/11 92/21</p> <p>piece [1] 76/16</p> <p>pivotal [1] 55/23</p> <p>place [8] 5/20 9/25 10/5 11/16 11/17 34/20 61/18 83/9</p> <p>placed [1] 37/16</p> <p>plan [7] 1/6 1/7 1/19 1/23 69/5 82/13 111/23</p> <p>planning [2] 17/22 103/14</p> <p>plans [2] 21/2 40/24</p> <p>play [4] 15/18 63/6 64/5 111/12</p> <p>please [53] 1/5 2/6 4/22 5/18 9/7 10/14 13/10 16/23 20/6 24/1 24/19 26/10 26/12 29/21 31/20 36/12 37/1 37/21 38/13 38/25 39/10 41/25 44/4 44/13 49/12 49/20 50/19 50/23 52/2 52/20 52/22 54/23 54/24 57/10 59/9 59/10 59/10 60/6 60/14 60/15 60/15 60/19 62/5 62/12 62/12 64/18 74/16 77/10 92/22 103/11 109/21 110/25 112/18</p> <p>pm [5] 1/2 64/25 65/1 65/3 120/19</p> <p>PNC [4] 27/20 28/6 28/9 28/9</p> <p>point [49] 1/22 3/14 5/23 6/3 7/9 9/6 13/20 13/23 14/18 16/19 17/6 17/8 17/9 17/10 17/12 17/13 21/8</p>	<p>points [3] 84/20 100/23 101/14</p> <p>police [55] 1/14 2/17 27/12 27/13 27/19 27/20 27/24 28/12 28/20 28/25 29/11 29/16 29/25 30/5 31/8 46/8 46/13 60/23 78/14 78/21 79/2 79/16 80/7 101/4 101/11 101/20 102/3 102/8 102/12 102/16 103/1 103/7 103/21 104/10 104/13 104/17 104/24 105/3 105/6 105/13 105/15 105/18 105/25 106/1 106/19 106/21 106/24 112/18 112/21 113/15 114/20 115/25 117/1 118/2 118/4</p> <p>polite [2] 51/1 51/19</p> <p>politely [1] 105/8</p> <p>poor [1] 44/20</p> <p>popping [1] 48/1</p> <p>pose [3] 102/11 112/19 113/16</p> <p>posed [2] 106/9 107/24</p> <p>poses [1] 113/17</p> <p>posing [1] 73/12</p> <p>position [3] 15/16 43/20 110/22</p> <p>possible [5] 8/9 8/13 44/10 83/23 111/25</p> <p>possibly [2] 73/17 77/7</p> <p>post [2] 98/14 107/13</p> <p>post-treatment [1] 98/14</p> <p>posts [2] 82/4 108/18</p> <p>postulate [1] 50/9</p> <p>potential [9] 3/17 11/15 36/18 49/17 79/23 106/14 106/16 106/19 106/24</p> <p>potentially [5] 3/17 92/21 101/21 103/5 106/12</p> <p>power [1] 8/17</p> <p>powers [3] 2/18 14/23 15/3</p> <p>practical [1] 26/7</p> <p>practice [3] 26/11 71/2 86/10</p> <p>practising [2] 107/10</p>

<p>P</p> <p>practising... [1] 107/16</p> <p>Pre [1] 90/5</p> <p>Pre-morbid [1] 90/5</p> <p>precipitating [1] 92/7</p> <p>precisely [2] 2/16 115/16</p> <p>precluded [1] 54/20</p> <p>predicated [1] 54/17</p> <p>predication [1] 96/22</p> <p>predictable [1] 40/15</p> <p>predictor [1] 19/4</p> <p>predicts [2] 43/22 61/3</p> <p>prefer [1] 19/23</p> <p>preferred [1] 19/11</p> <p>premise [3] 21/21 26/2 26/23</p> <p>presence [1] 97/12</p> <p>present [5] 44/21 80/20 88/17 89/4 89/9</p> <p>presentation [5] 46/19 61/18 93/4 94/3 109/19</p> <p>presentations [1] 11/22</p> <p>presented [2] 42/25 108/3</p> <p>presenting [7] 69/22 69/23 79/9 91/5 110/5 110/7 110/16</p> <p>presents [1] 57/24</p> <p>press [1] 53/24</p> <p>pressing [2] 62/21 63/20</p> <p>presumably [2] 32/24 108/2</p> <p>prevent [1] 44/18</p> <p>previous [5] 5/16 44/9 44/18 50/1 55/5</p> <p>previously [2] 45/12 58/11</p> <p>pride [2] 57/18 58/1</p> <p>primary [1] 3/4</p> <p>principle [2] 26/3 43/17</p> <p>principles [2] 71/1 80/16</p> <p>prior [2] 89/5 95/14</p> <p>prioritise [2] 45/16 45/18</p> <p>private [1] 86/20</p> <p>probabilities [1] 22/14</p> <p>probably [7] 16/4 20/23 57/15 69/13 89/24 92/19 93/1</p> <p>problem [1] 1/17</p> <p>problems [3] 9/10 9/11 37/5</p> <p>process [5] 9/23 60/24 68/16 103/16 105/10</p> <p>processes [1] 105/21</p>	<p>productive [1] 38/9</p> <p>professional [2] 65/15 66/24</p> <p>progress [3] 12/9 14/7 25/20</p> <p>progresses [1] 13/24</p> <p>prolonged [2] 12/6 38/9</p> <p>prompt [1] 50/22</p> <p>properly [2] 80/13 97/18</p> <p>prosecution [2] 28/22 113/9</p> <p>protected [1] 31/6</p> <p>protection [1] 110/11</p> <p>protocols [1] 9/25</p> <p>proven [1] 34/14</p> <p>provide [2] 46/25 82/7</p> <p>provided [6] 11/24 38/3 43/19 52/11 71/21 75/21</p> <p>provision [1] 81/25</p> <p>Psychiatrist's [1] 104/25</p> <p>psychiatrists [3] 26/13 30/21 101/19</p> <p>psychiatry [7] 25/22 49/17 60/13 107/11 107/13 107/15 117/4</p> <p>psychoeducation [1] 11/2</p> <p>psychological [15] 10/19 10/20 10/22 11/1 11/8 11/10 11/17 11/18 11/20 12/10 24/2 81/10 81/25 82/4 82/14</p> <p>psychologist [4] 11/8 24/3 81/21 82/22</p> <p>psychologists [4] 81/18 82/9 83/10 83/11</p> <p>psychology [6] 24/17 82/6 82/16 82/17 82/18 82/19</p> <p>psychosis [19] 4/18 4/20 8/13 8/22 11/6 12/4 40/14 69/22 74/8 82/2 82/8 82/10 82/25 89/8 89/17 93/11 97/14 97/18 98/16</p> <p>psychosocial [1] 82/11</p> <p>psychotic [19] 12/2 27/9 44/21 73/20 73/23 74/1 74/3 74/10 76/1 83/12 91/15 91/21 92/4 93/15 97/12 98/13 104/1 104/2 116/7</p> <p>public [6] 31/6 65/16 72/8 75/1 78/4 102/12</p> <p>public's [1] 77/11</p> <p>pulled [1] 22/18</p> <p>punch [2] 57/16</p>	<p>103/14</p> <p>punches [1] 57/15</p> <p>punishment [2] 70/9 70/13</p> <p>Purdue [2] 10/15 10/16</p> <p>purely [1] 116/5</p> <p>purported [1] 31/10</p> <p>purpose [4] 2/10 2/11 83/22 92/16</p> <p>purposes [1] 119/10</p> <p>pursue [1] 63/7</p> <p>pursued [1] 117/2</p> <p>put [18] 1/21 9/1 10/5 21/2 27/16 30/20 34/20 41/6 53/16 54/22 55/19 69/5 83/9 86/17 101/24 106/1 114/4 117/13</p> <p>putting [1] 6/6</p> <hr/> <p>Q</p> <p>quality [1] 50/5</p> <p>queries [1] 16/18</p> <p>query [1] 85/7</p> <p>question [13] 3/3 19/21 31/19 37/5 37/17 53/7 53/24 54/20 56/5 58/22 77/10 78/18 83/17</p> <p>Questioned [12] 49/9 65/4 84/25 100/22 107/4 113/22 121/3 121/4 121/5 121/6 121/7 121/8</p> <p>questions [11] 2/10 49/2 49/10 53/4 65/7 66/18 71/17 72/9 73/5 107/6 113/24</p> <p>quick [3] 29/25 99/12 100/23</p> <p>quickly [3] 14/1 38/15 98/21</p> <p>quite [12] 4/7 13/3 21/9 40/14 50/11 51/1 51/18 52/5 55/19 91/24 96/13 98/4</p> <hr/> <p>R</p> <p>race [1] 64/16</p> <p>raise [1] 74/18</p> <p>raised [4] 16/25 85/5 86/4 86/10</p> <p>raises [1] 79/20</p> <p>raising [1] 70/17</p> <p>rang [1] 39/3</p> <p>raped [2] 94/14 96/14</p> <p>rapid [3] 9/24 93/20 93/23</p> <p>rapport [1] 50/10</p> <p>rather [19] 5/4 5/9 5/12 11/25 15/21 17/20 20/3 20/22 43/7 62/21 63/3 63/20 92/1 92/8 93/20 96/4 102/3 119/5 119/19</p>	<p>rationale [8] 32/8 91/20 92/16 95/2 95/23 99/3 99/8 99/10</p> <p>rawest [1] 75/25</p> <p>reached [4] 13/8 15/22 21/8 87/20</p> <p>reaches [1] 14/18</p> <p>react [1] 5/21</p> <p>read [16] 2/8 4/25 5/3 5/9 5/13 8/13 11/6 91/13 91/16 96/8 96/9 106/6 106/14 116/13 117/14 118/1</p> <p>readily [1] 29/20</p> <p>reading [2] 33/22 112/1</p> <p>readmission [1] 35/20</p> <p>reads [1] 117/20</p> <p>real [2] 9/12 73/6</p> <p>realistic [1] 86/12</p> <p>reality [1] 21/6</p> <p>really [7] 12/9 29/16 37/8 48/20 50/7 52/7 71/1</p> <p>reappearing [1] 35/22</p> <p>reason [13] 11/7 67/7 86/21 93/10 95/2 98/5 99/21 100/3 103/1 105/3 111/6 111/20 112/9</p> <p>reasoning [2] 56/3 95/7</p> <p>reasons [1] 111/11</p> <p>reassurance [2] 8/24 13/1</p> <p>recall [8] 7/4 33/18 42/21 42/24 89/23 90/1 95/16 100/25</p> <p>receive [1] 109/24</p> <p>received [5] 49/15 93/20 114/16 117/12 117/16</p> <p>receiving [1] 82/20</p> <p>recent [3] 24/7 31/24 82/5</p> <p>recently [1] 60/23</p> <p>recognise [5] 13/6 45/25 70/25 72/9 105/17</p> <p>recognised [4] 21/12 35/17 58/20 70/14</p> <p>recognising [2] 24/8 24/10</p> <p>recognition [3] 5/24 6/5 23/1</p> <p>recommendation [1] 24/17</p> <p>recommended [1] 74/13</p> <p>recommends [2] 74/9 81/17</p> <p>record [10] 8/8 59/10 66/25 67/3 67/4 69/4 69/7 69/11 70/19</p>	<p>89/12</p> <p>recorded [6] 34/23 35/23 36/8 46/6 72/14 77/25</p> <p>recording [2] 67/17 69/2</p> <p>records [25] 2/15 6/15 27/3 27/15 36/9 38/15 38/16 39/6 41/7 41/14 44/10 67/11 67/12 67/16 68/5 68/19 68/23 69/9 69/20 70/11 75/18 77/18 89/11 90/15 104/21</p> <p>recourse [2] 29/10 43/11</p> <p>recovery [1] 27/6</p> <p>recruit [1] 83/9</p> <p>recruiting [2] 82/4 83/7</p> <p>red [17] 53/2 53/5 53/5 53/17 53/18 53/20 54/1 54/7 54/10 54/14 54/15 56/11 56/20 58/12 58/13 59/7 59/8</p> <p>reduced [2] 109/4 110/7</p> <p>reduction [1] 83/25</p> <p>reference [7] 42/1 58/23 59/4 60/1 60/2 61/5 61/21</p> <p>references [1] 22/20</p> <p>referral [3] 116/20 117/6 117/10</p> <p>referred [5] 23/11 23/20 85/4 105/9 114/13</p> <p>referring [1] 14/23</p> <p>refers [1] 1/19</p> <p>reflect [5] 50/17 53/22 104/11 105/12 118/15</p> <p>reflected [7] 8/12 33/3 36/24 52/17 69/13 69/19 115/2</p> <p>reflecting [2] 2/7 67/20</p> <p>reflection [5] 50/4 69/16 93/1 101/18 104/25</p> <p>refused [1] 62/8</p> <p>regard [1] 109/18</p> <p>regarding [2] 71/6 79/6</p> <p>regards [2] 37/12 85/13</p> <p>regrading [1] 37/6</p> <p>regular [4] 9/22 21/18 39/13 40/18</p> <p>regularly [2] 16/5 16/7</p> <p>regulated [1] 113/5</p> <p>rehabilitation [1] 81/11</p>
--	--	---	---	--

<p>R</p> <p>reiterated [1] 5/19 reiterates [1] 41/18 relapse [2] 9/8 11/2 relate [1] 73/14 related [4] 11/2 79/23 84/6 103/25 relating [2] 30/6 57/23 relation [5] 9/19 52/9 54/3 115/18 118/20 relationship [7] 12/13 42/15 43/6 49/13 49/21 50/5 51/3 relatively [1] 87/6 relayed [1] 5/8 relevance [2] 9/13 9/15 relevant [5] 74/25 75/12 75/15 84/6 84/11 religions [1] 53/8 religious [6] 53/9 53/11 53/21 54/1 54/5 54/19 remain [2] 23/8 32/1 remains [2] 63/3 64/3 remark [3] 50/24 57/19 59/2 remember [7] 18/12 30/12 36/8 39/19 70/23 94/16 100/10 remembered [1] 48/18 remind [2] 38/20 68/6 reminded [3] 7/4 33/15 38/8 remorse [7] 6/10 6/12 6/17 6/23 35/23 36/1 36/2 reneged [1] 3/9 repeatedly [1] 72/6 repeating [1] 106/10 reply [3] 40/7 55/20 114/2 report [1] 10/25 reported [2] 42/5 42/6 represent [2] 14/25 85/1 request [9] 27/20 27/22 28/2 29/22 44/12 46/19 46/20 101/10 114/17 requested [2] 28/16 71/23 requests [3] 44/13 110/25 111/4 require [1] 117/8 required [4] 9/17 43/13 45/6 47/24 requirement [8] 45/11 46/22 47/9 47/10 47/11 47/12</p>	<p>47/19 105/16 requires [1] 73/3 rescue [2] 1/14 94/25 research [4] 53/14 53/16 63/11 64/10 Resident [1] 68/17 residents [2] 32/1 32/3 resolve [1] 92/5 resources [3] 43/11 112/6 112/15 respect [3] 81/7 101/20 104/13 respond [5] 5/22 35/10 37/10 37/19 45/3 responded [2] 100/14 104/5 responders [2] 103/8 105/2 responds [1] 6/19 response [10] 5/7 40/16 56/5 93/12 93/19 94/2 110/4 114/1 115/12 115/16 responsibilities [6] 47/2 48/24 52/9 65/16 68/22 112/11 responsibility [5] 52/6 52/10 62/14 65/22 115/17 responsible [11] 1/12 3/25 41/12 52/6 65/9 72/17 76/18 91/21 91/22 94/18 116/12 responsible.' [1] 62/16 rest [1] 40/23 restrained [1] 80/6 restrictive [3] 15/17 110/19 110/23 result [3] 69/12 77/13 78/6 resulted [1] 28/21 return [1] 32/6 returned [2] 45/5 56/17 returning [2] 32/20 33/19 reveals [1] 56/21 review [9] 4/23 9/20 13/11 17/14 20/7 67/16 68/4 68/10 68/15 reviewed [2] 68/19 75/6 reviewing [1] 69/3 right [23] 3/7 20/17 20/20 21/15 26/15 37/11 54/22 59/6 61/20 64/5 84/23 87/17 88/23 90/25 91/17 97/7 107/14 107/19 108/21 111/3 113/2 115/7 120/17</p>	<p>rights [2] 2/7 2/18 ring [1] 37/9 RiO [13] 2/6 27/3 27/15 27/17 36/9 38/15 41/7 41/23 52/17 59/9 68/5 75/18 117/14 RiOs [2] 91/12 95/13 risk [99] 2/1 3/17 10/6 10/11 10/12 14/25 15/1 16/11 19/10 30/11 30/24 31/4 31/5 31/11 32/5 34/12 34/16 34/18 36/19 36/21 36/24 41/19 47/18 52/14 54/14 60/21 61/1 61/3 61/4 61/8 61/9 61/10 61/13 61/15 66/10 69/19 70/8 71/6 71/9 71/13 71/14 71/19 72/5 72/7 72/9 72/20 73/12 74/4 74/25 75/1 76/3 76/19 77/1 77/2 77/5 79/5 79/23 80/11 80/12 80/15 84/7 84/11 84/16 94/24 96/25 97/13 97/15 102/11 103/9 104/6 104/7 104/8 106/12 106/15 106/16 106/19 106/24 107/7 108/3 108/22 108/24 109/3 109/10 109/13 110/8 110/16 111/11 111/14 111/15 112/22 113/17 118/20 118/24 119/4 119/5 119/11 119/13 120/15 120/16 risks [12] 10/9 23/7 71/16 73/13 97/11 104/3 105/6 107/23 108/2 110/6 112/19 113/15 risky [1] 22/10 role [8] 30/23 49/17 65/11 66/11 66/13 66/14 68/21 72/17 roles [3] 51/6 87/6 87/12 rooms [1] 58/7 Rowan [2] 111/1 112/16 Royal [1] 26/12 rum [17] 53/2 53/5 53/5 53/17 53/18 53/20 54/1 54/7 54/10 54/14 54/15 56/11 56/20 58/13 58/13 59/7 59/8 run [1] 100/2 running [2] 97/2 104/23</p>	<p>safeguarding [1] 90/16 safely [2] 14/17 100/15 safety [4] 1/7 1/19 78/4 110/10 said [72] 2/13 3/7 4/13 4/19 7/20 13/3 14/6 17/9 19/10 22/5 23/4 24/9 24/14 24/24 25/1 25/2 25/3 25/5 25/11 34/17 37/25 38/10 38/13 39/6 40/19 41/5 42/6 43/1 43/22 44/10 45/19 46/22 47/1 47/3 47/9 47/11 48/1 48/4 51/9 52/4 52/5 56/6 56/8 59/1 60/1 60/16 60/19 62/22 63/23 69/2 71/6 71/24 73/18 73/18 76/17 81/16 92/13 94/12 94/22 96/9 105/16 106/22 108/8 108/17 109/6 109/16 111/3 115/2 116/9 118/11 118/20 119/23 sake [1] 99/20 same [21] 7/22 12/11 18/14 26/21 32/1 35/9 43/20 45/2 51/19 55/4 55/25 58/11 65/11 66/6 69/6 73/22 82/24 104/19 117/13 117/15 117/23 sample [1] 64/21 sat [1] 80/3 satisfactory [2] 15/14 29/9 say [64] 6/1 6/1 6/7 6/9 7/19 11/7 11/11 15/17 15/25 16/24 17/25 18/6 20/4 26/20 33/2 33/18 35/13 38/6 38/23 39/15 46/21 50/18 50/24 51/18 53/7 55/14 57/18 57/25 59/23 62/1 63/8 63/13 64/9 68/25 71/10 73/17 73/23 75/3 75/6 76/13 82/17 85/12 87/17 88/2 90/14 90/21 92/23 93/18 94/1 94/20 95/22 96/25 97/11 97/13 98/7 98/9 98/16 102/2 103/14 106/8 106/11 116/3 116/16 118/18 saying [19] 1/15 6/19 19/20 20/2 20/16 20/18 20/19 20/20 21/14 21/14 27/1 47/13 55/4 62/13 64/11 70/23 75/11 77/6 89/21</p>	<p>saying: [1] 99/25 saying: okay [1] 99/25 says [15] 14/20 22/13 25/11 29/8 31/23 35/6 47/7 52/24 55/22 56/6 57/14 57/17 57/25 89/12 115/22 scared [1] 115/9 scenario [2] 7/2 119/2 sceptical [1] 71/2 scepticism [1] 70/22 schizophrenia [19] 8/15 9/10 10/9 69/25 74/9 82/2 82/25 83/12 86/14 86/25 87/1 87/10 87/15 89/3 89/10 89/22 91/10 99/12 111/18 screaming [1] 96/14 screen [6] 13/10 20/8 24/19 26/10 30/1 30/20 scribbles [1] 108/15 search [1] 53/17 second [25] 1/5 3/14 4/9 5/11 9/5 13/11 13/21 22/7 24/20 24/23 25/13 27/11 42/2 55/23 57/16 61/24 62/8 74/24 98/20 99/11 102/10 110/25 111/20 117/13 118/16 secondly [4] 49/14 69/23 97/13 110/9 secretly [1] 53/19 section [4] 2/7 13/13 15/10 15/12 section 3 [2] 2/7 13/13 sedation [1] 93/23 see [47] 2/9 13/11 13/16 13/17 20/10 21/23 22/23 24/5 25/6 30/1 32/12 32/17 34/1 36/4 40/2 40/11 42/2 44/1 44/6 44/14 44/22 46/19 47/4 48/2 48/5 48/14 50/15 51/7 55/2 55/4 63/16 68/1 70/17 75/18 82/13 86/3 93/22 96/23 98/22 98/23 99/3 103/19 105/2 105/23 106/4 114/10 115/7 Seedat [39] 1/3 6/16 8/12 13/13 16/2 20/11 20/13 26/11 34/22 37/3 42/5 42/6 42/13 44/8 49/10 52/2 53/6 54/12 58/18 59/25 60/19 64/20 65/5 70/3 72/4 73/7 73/17 75/19</p>
		<p>S</p> <p>safe [2] 73/7 120/6</p>		

<p>S</p> <p>Seedat... [11] 77/8 78/20 84/3 84/13 84/15 85/1 91/14 107/2 107/5 113/19 113/23</p> <p>seeing [3] 34/13 56/20 108/1</p> <p>seek [4] 12/23 29/1 53/13 61/5</p> <p>seeking [3] 30/2 50/8 111/12</p> <p>seemed [3] 8/12 93/14 93/16</p> <p>seems [5] 5/14 6/16 9/9 20/16 44/21</p> <p>seen [10] 31/2 40/13 40/19 46/10 48/16 85/21 92/5 107/19 109/9 119/22</p> <p>select [1] 111/8</p> <p>self [2] 57/1 57/3</p> <p>self-harm [2] 57/1 57/3</p> <p>send [3] 29/15 41/18 114/13</p> <p>sending [1] 30/5</p> <p>sends [1] 115/4</p> <p>senior [3] 28/3 65/20 101/19</p> <p>sense [3] 56/4 85/7 118/21</p> <p>sent [6] 30/25 41/2 86/18 105/24 117/19 118/2</p> <p>September [1] 33/17</p> <p>sequence [2] 54/25 55/3</p> <p>serious [7] 2/1 8/10 31/4 47/17 47/18 96/16 113/10</p> <p>service [3] 27/16 45/13 45/21</p> <p>services [16] 12/8 21/5 44/20 61/19 62/25 63/1 63/3 63/4 64/1 64/1 64/4 65/13 74/22 116/22 117/7 117/9</p> <p>Set [1] 5/17</p> <p>sets [1] 30/2</p> <p>setting [5] 11/19 21/4 66/1 100/13 110/24</p> <p>settle [1] 93/14</p> <p>settled [1] 91/5</p> <p>settling [1] 93/25</p> <p>seven [1] 16/1</p> <p>several [2] 94/18 115/8</p> <p>shadow [1] 84/10</p> <p>shape [1] 88/11</p> <p>share [2] 31/16 72/5</p> <p>shared [3] 34/5 52/7 75/21</p> <p>sharing [1] 102/6</p>	<p>she [26] 31/22 32/22 34/6 34/9 34/12 34/12 34/17 34/22 34/22 34/24 35/2 38/3 41/8 41/8 41/24 43/1 77/12 77/13 79/14 79/14 85/12 86/1 86/4 90/9 115/9 119/15</p> <p>she's [3] 70/19 78/5 80/3</p> <p>she's sat [1] 80/3</p> <p>shock [1] 7/13</p> <p>short [7] 14/3 57/12 65/2 75/19 87/6 92/3 105/24</p> <p>should [30] 14/21 18/21 21/11 32/25 33/4 39/6 41/5 41/6 43/25 44/1 44/3 48/22 68/19 70/15 72/19 72/23 75/17 85/8 85/17 86/7 86/9 93/2 100/3 102/2 105/14 111/7 115/4 118/4 118/5 118/11</p> <p>shouldn't [1] 118/7</p> <p>show [4] 6/4 62/16 87/9 109/10</p> <p>showed [1] 56/25</p> <p>shown [2] 56/2 110/4</p> <p>side [4] 96/5 96/6 98/4 98/24</p> <p>sign [2] 24/13 67/20</p> <p>significance [6] 1/25 2/5 11/18 19/14 79/21 83/3</p> <p>significant [3] 31/14 73/6 110/16</p> <p>significantly [1] 72/20</p> <p>signs [4] 6/10 6/12 24/8 72/18</p> <p>similar [2] 4/15 69/10</p> <p>simple [1] 112/14</p> <p>simply [5] 6/19 58/24 64/6 79/13 81/12</p> <p>single [3] 69/4 69/7 69/11</p> <p>sit [4] 28/10 31/3 107/7 108/25</p> <p>sits [2] 80/19 84/4</p> <p>situation [8] 7/16 26/19 39/19 46/16 78/10 90/23 99/25 116/25</p> <p>situations [6] 29/20 32/18 37/6 50/14 92/2 101/22</p> <p>slang [1] 53/17</p> <p>sleep [4] 55/8 91/15 91/23 92/3</p> <p>slightly [3] 53/24 85/25 104/11</p> <p>slow [2] 5/3 5/4</p> <p>slowing [1] 96/10</p> <p>so [133]</p>	<p>social [2] 91/23 108/17</p> <p>sole [1] 47/1</p> <p>solution [1] 70/10</p> <p>some [36] 6/4 6/5 6/5 7/15 11/11 13/7 20/15 28/24 29/13 34/10 47/18 47/19 50/6 53/8 55/11 62/14 67/11 67/23 67/25 69/16 70/2 80/9 81/12 82/11 88/18 91/2 96/12 98/8 99/21 100/5 106/3 107/6 111/2 111/25 118/5 120/15</p> <p>somebody [19] 1/16 7/21 7/22 12/3 13/23 25/23 26/7 28/7 28/7 29/19 30/24 68/23 86/11 87/20 92/14 94/13 94/24 118/22 119/16</p> <p>somebody's [1] 86/11</p> <p>somehow [4] 62/24 63/25 96/1 96/1</p> <p>someone [18] 6/19 7/10 7/17 7/21 8/1 8/4 8/7 14/14 15/5 15/22 21/7 40/20 68/14 72/18 78/11 80/17 90/9 100/14</p> <p>someone's [1] 94/3</p> <p>something [30] 12/7 17/21 21/7 21/7 28/21 31/8 41/18 53/22 55/11 55/19 56/15 62/15 66/21 71/23 72/3 74/13 79/25 81/15 88/17 93/2 94/22 96/2 101/15 102/7 115/14 116/14 116/21 117/3 118/4 118/15</p> <p>sometimes [4] 18/1 28/5 29/3 40/14</p> <p>somewhat [1] 87/4</p> <p>sorry [8] 13/17 68/3 85/2 85/15 85/16 85/25 94/10 97/23</p> <p>sort [5] 7/15 29/13 53/8 94/7 99/21</p> <p>sorting [2] 87/6 87/12</p> <p>sorts [1] 31/17</p> <p>sought [4] 30/6 49/25 50/3 51/22</p> <p>sounds [3] 39/15 92/22 92/23</p> <p>space [2] 11/17 11/18</p> <p>speak [20] 34/23 34/24 38/1 42/2 42/4 42/17 42/19 42/23 43/3 44/8 44/17 47/25 47/25 48/21 71/7</p>	<p>88/23 89/4 104/15 111/2 111/8</p> <p>speaking [1] 37/11</p> <p>specialist [1] 81/10</p> <p>specific [9] 12/1 29/19 82/8 83/11 96/5 99/18 114/10 114/13 114/14</p> <p>specifically [6] 50/8 59/23 72/11 76/5 80/4 83/23</p> <p>specifics [1] 30/12</p> <p>spectrum [3] 107/6 108/24 109/13</p> <p>speculating [1] 50/6</p> <p>speculation [1] 91/3</p> <p>speed [1] 104/18</p> <p>spend [1] 52/19</p> <p>spikes [2] 57/18 58/1</p> <p>spoke [6] 10/10 24/8 42/4 42/15 70/12 94/19</p> <p>spoken [3] 47/21 49/21 63/22</p> <p>spontaneously [1] 92/5</p> <p>spy [1] 36/15</p> <p>spying [1] 55/7</p> <p>stabilised [1] 74/15</p> <p>stability [1] 33/14</p> <p>stable [2] 9/12 87/16</p> <p>staff [7] 2/14 33/25 36/5 36/10 42/11 51/18 51/20</p> <p>stage [5] 17/9 22/4 99/10 102/16 120/8</p> <p>stakeholder [1] 105/14</p> <p>stakeholders [1] 104/17</p> <p>standard [1] 67/8</p> <p>standards [2] 66/1 66/3</p> <p>staring [1] 79/16</p> <p>start [8] 7/15 11/20 14/19 17/19 52/4 66/21 98/3 120/18</p> <p>started [1] 97/22</p> <p>starting [3] 17/5 17/8 17/9</p> <p>starts [1] 55/3</p> <p>state [13] 39/11 53/1 56/10 56/16 61/12 61/13 85/6 85/9 90/5 90/21 91/7 98/12 116/5</p> <p>stated [4] 3/21 12/18 95/8 96/10</p> <p>statement [14] 9/15 16/20 60/22 67/15 68/8 87/25 88/19 90/6 90/12 97/1 97/10 103/11 104/14 106/7</p> <p>states [1] 91/13</p> <p>statutory [3] 66/18 72/24 80/16</p>	<p>stay [1] 13/23</p> <p>steps [1] 31/5</p> <p>still [17] 14/15 15/6 15/23 33/16 45/6 45/8 47/4 72/3 73/3 73/14 76/25 82/6 83/13 96/1 98/8 104/7 117/9</p> <p>stop [1] 97/5</p> <p>stopped [6] 16/3 41/10 95/15 96/4 96/6 96/7</p> <p>stopping [3] 4/24 35/21 46/14</p> <p>stops [1] 14/15</p> <p>straight [1] 1/7</p> <p>strange [1] 8/12</p> <p>Straw [4] 84/24 84/25 97/2 121/5</p> <p>stress [3] 91/15 92/10 92/24</p> <p>stresses [3] 91/7 91/24 92/3</p> <p>strong [2] 98/4 101/13</p> <p>strongly [1] 47/21</p> <p>struggles [1] 46/3</p> <p>struggling [3] 18/23 24/13 45/24</p> <p>student [2] 80/2 90/14</p> <p>students [1] 32/18</p> <p>studies [4] 92/17 92/18 92/20 92/20</p> <p>style [1] 46/15</p> <p>subsequent [2] 23/16 91/4</p> <p>subsequently [2] 36/1 61/25</p> <p>substances [1] 94/3</p> <p>subtherapeutic [4] 97/25 98/7 98/10 98/18</p> <p>such [9] 14/17 30/15 31/4 32/18 77/12 101/19 105/6 108/1 108/1</p> <p>suffered [1] 98/24</p> <p>suffering [4] 96/12 109/22 111/7 111/16</p> <p>sufficient [1] 15/13</p> <p>suggest [15] 8/21 14/9 70/20 73/7 77/25 80/10 80/13 84/3 98/15 98/19 99/22 100/1 101/23 101/25 110/16</p> <p>suggested [2] 63/11 77/18</p> <p>suggestion [4] 19/22 27/8 37/14 40/1</p> <p>suggestive [1] 27/4</p> <p>suggests [1] 20/22</p> <p>summarise [1] 106/11</p> <p>summarised [1] 117/21</p>
---	---	--	---	--

<p>S</p> <p>summary [5] 1/6 1/22 36/13 75/9 75/9</p> <p>sums [1] 36/19</p> <p>supervision [2] 21/18 100/16</p> <p>support [12] 10/22 11/8 11/10 12/20 12/22 12/23 20/14 32/17 40/12 43/12 81/25 113/9</p> <p>supporting [2] 32/6 93/16</p> <p>sure [9] 32/22 39/11 39/25 40/3 41/24 44/10 55/14 58/17 62/4</p> <p>surprise [3] 34/4 39/17 39/24</p> <p>surprised [2] 31/24 39/3</p> <p>survivors [1] 65/7</p> <p>symptoms [32] 3/16 4/17 5/12 13/7 16/9 16/9 19/9 21/13 22/9 23/18 27/5 27/9 35/16 35/18 35/21 44/21 61/14 73/11 73/13 73/23 74/3 76/2 86/25 93/15 97/12 98/13 99/5 99/17 99/17 99/22 104/1 104/2</p> <p>system [4] 68/12 68/23 112/20 116/21</p> <p>systemic [1] 83/14</p> <p>systems [3] 72/2 72/10 76/3</p>	<p>talk [2] 58/5 103/14</p> <p>talked [3] 58/11 58/14 103/15</p> <p>talking [5] 58/2 58/7 58/17 60/21 105/10</p> <p>targeting [2] 80/1 80/4</p> <p>TCLT0000754 [1] 62/5</p> <p>TCLT0000758 [3] 50/19 50/20 60/15</p> <p>team [34] 20/13 21/22 24/15 35/8 37/15 38/11 38/13 38/19 38/20 39/7 40/1 40/8 40/24 43/5 43/25 44/2 45/1 49/1 52/8 61/6 61/22 66/15 66/19 75/11 83/4 85/5 85/14 85/20 85/22 86/1 86/4 86/8 103/16 103/17</p> <p>teams [4] 43/14 67/22 74/22 104/22</p> <p>telephone [2] 57/24 85/24</p> <p>tell [13] 25/4 32/23 32/25 38/14 48/1 48/12 57/20 90/2 92/11 92/22 102/8 106/19 106/24</p> <p>telling [5] 3/5 23/13 25/24 86/22 116/1</p> <p>tells [2] 24/2 53/18</p> <p>tenancy [1] 32/14</p> <p>tend [3] 62/25 64/1 92/4</p> <p>tending [1] 89/17</p> <p>tends [2] 11/24 88/10</p> <p>term [1] 53/16</p> <p>terms [52] 1/15 1/19 3/9 5/9 5/22 6/9 7/2 10/6 10/12 11/4 11/23 13/22 13/25 15/3 17/4 19/17 21/9 25/11 25/16 32/2 34/10 35/21 38/7 40/16 43/11 46/18 46/25 47/5 48/7 50/7 50/12 68/17 68/20 68/21 68/25 69/1 69/3 76/20 77/1 82/3 83/6 85/10 89/14 92/18 92/20 95/2 98/2 99/20 101/15 102/4 109/3 112/4</p> <p>terrified [1] 77/13</p> <p>test [5] 21/16 21/18 29/5 93/8 94/5</p> <p>tests [2] 19/13 19/20</p> <p>text [10] 41/6 72/1 72/12 74/1 75/8 100/25 103/23 103/25 109/6 120/12</p> <p>texts [7] 26/16 30/25 31/2 41/1 105/24</p>	<p>105/25 119/22</p> <p>than [30] 5/4 5/9 5/12 11/25 15/21 15/21 17/20 20/4 36/21 39/19 43/7 46/19 56/19 57/5 58/10 62/21 63/3 63/12 63/20 70/16 87/21 92/1 92/8 93/20 96/4 102/3 102/20 102/20 119/5 119/19</p> <p>thank [24] 1/7 2/8 20/9 30/19 49/8 49/8 60/5 64/17 64/21 64/23 64/25 86/13 87/24 88/22 90/4 97/8 100/19 100/20 107/2 113/19 113/20 113/21 120/17 120/18</p> <p>that [901]</p> <p>that that [1] 9/19</p> <p>that's [78] 1/18 5/18 16/22 18/11 22/2 22/19 22/22 28/8 29/7 29/9 36/8 47/9 50/20 51/25 53/22 57/8 58/10 60/12 62/15 64/6 64/10 64/12 65/14 66/7 68/11 73/2 73/4 74/13 74/13 76/10 77/4 77/25 78/6 78/18 78/19 80/5 80/18 81/8 84/19 88/1 88/21 89/1 90/8 90/25 91/17 92/2 94/6 97/25 101/15 101/15 103/4 104/24 107/12 107/18 108/4 108/7 108/13 108/16 108/19 108/23 109/12 109/15 109/20 110/4 111/5 111/19 112/12 112/17 113/3 113/12 113/25 114/4 114/5 114/24 115/1 116/18 118/15 118/23</p> <p>Theemis [2] 50/16 64/8</p> <p>their [15] 11/22 15/12 32/3 32/17 40/15 48/7 73/19 76/10 78/4 83/25 108/9 108/11 110/10 111/9 119/16</p> <p>them [35] 1/17 2/19 15/2 15/13 19/21 29/5 34/10 36/5 36/6 36/7 36/16 48/16 50/18 54/4 56/13 56/14 66/4 67/20 67/23 67/25 68/15 68/17 74/15 81/25 84/22 90/2 92/8 92/23 96/6 96/12 98/5 108/2 109/24 116/1 117/20</p> <p>theme [3] 54/2 55/21 60/6</p> <p>themes [1] 50/17</p>	<p>themselves [3] 7/6 102/12 107/24</p> <p>then [65] 7/19 21/4 22/10 25/18 31/11 33/17 35/19 38/4 39/1 40/21 42/10 48/6 51/25 55/15 55/20 56/6 56/16 57/5 57/10 58/5 59/9 59/14 62/25 64/1 64/15 64/17 69/23 70/19 70/20 71/5 73/2 73/14 74/24 76/2 76/13 77/21 79/1 79/3 79/12 80/2 80/9 81/7 86/24 87/22 88/11 92/4 92/4 93/14 93/15 95/5 97/7 97/21 97/24 98/5 98/9 98/23 99/4 100/14 101/10 104/5 104/16 106/12 113/13 114/1 118/16</p> <p>therapeutic [10] 12/13 42/15 43/6 83/22 98/17 99/1 99/3 99/18 100/6 100/9</p> <p>therapist [1] 12/11</p> <p>there [113] 2/3 5/3 6/16 6/25 9/11 9/16 9/21 9/23 11/13 13/7 13/21 15/13 16/16 17/4 18/6 18/10 21/10 21/24 26/6 27/4 27/7 28/10 28/23 28/24 28/25 29/13 29/18 31/9 32/8 33/12 33/24 34/24 35/25 36/16 37/21 38/21 39/15 41/22 42/8 42/10 42/17 45/6 46/21 46/22 50/8 50/13 53/5 56/5 56/5 56/14 60/10 60/20 61/8 61/10 63/8 63/10 64/20 67/1 67/2 68/8 72/15 73/7 74/1 75/11 76/23 76/25 77/17 80/25 81/3 81/7 81/25 82/5 82/16 82/21 82/23 84/20 85/17 86/21 86/23 88/10 88/14 89/11 90/11 92/2 94/2 94/16 94/17 94/22 95/9 97/5 98/12 98/13 98/15 98/19 99/12 99/19 99/21 99/21 103/21 104/19 105/15 105/16 105/21 106/8 108/21 111/14 112/19 112/23 113/13 113/18 115/7 116/19 117/7</p> <p>there's [20] 28/11 37/19 44/23 45/11 55/20 64/10 70/11 70/19 71/12 72/14 77/6 82/3 87/25 89/11 89/12 89/21 90/12</p>	<p>93/6 99/19 114/1</p> <p>therefore [3] 73/5 75/23 117/2</p> <p>these [23] 5/18 5/22 11/11 15/18 31/17 43/23 54/13 56/1 57/2 58/18 58/23 59/23 60/3 60/15 72/1 72/2 72/12 73/5 76/4 76/21 98/3 116/25 118/3</p> <p>they [78] 3/17 3/24 4/18 7/23 8/6 11/17 11/22 13/23 14/11 15/12 15/21 22/1 22/9 23/12 23/12 29/6 29/11 32/17 32/25 37/15 42/12 43/2 43/19 43/20 44/1 44/1 45/24 47/21 47/22 47/24 48/11 48/14 52/14 56/2 57/25 60/7 60/8 62/25 64/1 66/9 66/9 69/9 73/25 74/12 76/13 76/22 78/16 78/18 79/11 86/19 87/16 87/23 89/25 90/14 92/7 95/10 95/11 99/14 99/23 100/14 100/15 102/14 105/12 105/25 106/2 107/23 108/2 108/5 108/6 108/8 108/11 108/14 108/17 111/8 116/4 116/4 117/1 118/3</p> <p>they're [6] 47/18 62/24 63/25 101/2 117/19 117/21</p> <p>thing [16] 7/22 28/6 28/8 55/7 56/8 63/13 64/17 74/14 74/18 74/24 83/8 94/7 101/8 101/21 101/22 101/24</p> <p>things [36] 3/8 11/11 12/12 14/12 20/17 20/20 21/6 21/15 23/1 34/7 34/8 34/19 34/19 40/4 43/2 45/12 50/4 50/9 50/18 52/10 60/7 60/10 68/6 70/2 70/4 74/7 76/5 76/13 84/5 91/4 97/1 97/10 104/18 109/5 109/9 113/5</p> <p>think [124]</p> <p>thinking [10] 22/4 26/17 53/2 54/9 56/11 57/1 57/2 59/2 61/17 74/12</p> <p>third [10] 26/13 27/12 33/8 44/16 60/9 62/3 103/5 106/8 112/18 113/4</p> <p>third-party [1] 60/9</p> <p>thirdly [3] 49/17 97/14 110/18</p>
--	---	--	--	---

<p>T</p> <p>this [193]</p> <p>those [54] 1/21 2/2 11/16 27/14 29/8 31/2 34/9 41/6 41/11 49/2 49/20 50/17 51/6 52/16 63/12 65/11 66/3 66/8 67/19 69/20 71/7 71/12 71/22 72/6 72/10 72/20 73/24 74/5 76/8 76/9 76/13 80/20 86/4 86/12 86/18 86/20 86/22 87/7 87/9 91/6 94/21 96/16 97/17 99/14 101/5 103/1 105/25 107/23 108/20 111/6 113/8 115/17 117/16 118/1</p> <p>though [5] 18/16 20/14 20/16 24/11 69/17</p> <p>thought [13] 9/23 25/19 34/9 42/10 51/14 52/25 55/14 56/9 64/9 64/16 83/5 114/7 114/9</p> <p>thoughts [7] 31/1 55/8 57/4 74/11 74/19 84/6 108/9</p> <p>thousands [2] 107/20 109/8</p> <p>three [12] 1/20 2/4 2/9 12/6 27/12 82/18 97/1 97/10 98/19 104/23 105/9 107/5</p> <p>three paragraphs [1] 105/9</p> <p>three weeks [1] 12/6</p> <p>three years [1] 82/18</p> <p>through [17] 8/17 22/18 28/3 42/25 45/4 46/17 65/19 68/6 72/13 100/24 108/5 108/8 108/11 108/14 108/17 108/20 116/20</p> <p>throughout [2] 77/4 80/11</p> <p>Thursday [2] 1/1 25/5</p> <p>Ticking [1] 30/4</p> <p>tied [1] 80/19</p> <p>till [1] 25/5</p> <p>time [78] 1/5 3/20 4/3 6/8 6/14 7/9 12/5 12/7 12/19 13/1 13/8 13/20 14/8 14/11 14/22 15/16 15/22 18/9 21/23 22/25 25/25 26/21 26/24 34/15 35/2 35/20 36/23 38/24 41/17 41/21 42/16 42/21 43/2 45/15 48/17 49/24 52/19 53/12 55/24</p>	<p>60/18 61/9 64/7 65/11 65/18 73/23 77/16 78/13 78/16 81/21 82/20 83/14 83/16 84/19 85/25 86/2 87/3 87/5 90/22 91/1 91/25 96/1 97/2 98/11 98/21 100/2 100/5 103/22 105/4 107/19 107/20 108/25 110/1 110/12 110/20 116/2 118/10 118/10 119/23</p> <p>timed [1] 75/20</p> <p>timeframe [1] 69/3</p> <p>times [9] 23/11 28/17 28/23 36/16 52/5 82/5 94/19 104/23 115/8</p> <p>tipping [1] 73/2</p> <p>tips [4] 26/12 26/13 30/20 81/3</p> <p>tired [2] 25/2 25/12</p> <p>today [9] 28/10 49/22 68/17 70/7 71/6 71/11 74/19 84/18 90/7</p> <p>together [5] 1/22 6/6 9/2 26/3 86/17</p> <p>told [15] 24/25 39/5 39/8 42/22 42/24 43/20 65/8 79/2 81/20 90/1 114/6 115/6 116/19 120/4 120/8</p> <p>tomorrow [1] 31/25</p> <p>tone [2] 33/3 101/4</p> <p>too [2] 80/18 93/21</p> <p>took [4] 8/6 47/10 78/10 100/24</p> <p>top [8] 1/8 13/12 13/17 19/7 35/4 59/14 60/20 62/13</p> <p>topic [5] 52/1 62/3 96/25 110/25 112/18</p> <p>topics [4] 49/12 85/2 97/21 107/5</p> <p>torment [1] 36/15</p> <p>towards [6] 4/6 23/23 27/10 79/20 89/17 112/15</p> <p>tracking [1] 1/15</p> <p>trainee [2] 44/15 47/14</p> <p>training [1] 107/15</p> <p>tranquilisation [3] 9/25 93/20 93/24</p> <p>translation [1] 102/1</p> <p>transpired [1] 68/5</p> <p>treated [6] 13/14 42/19 62/24 63/12 63/25 97/19</p> <p>treating [3] 40/24 73/9 112/16</p> <p>treatment [37] 9/22 10/2 11/16 14/10 14/15 14/15 15/22 15/25 16/6 16/7 16/8 16/8 16/16 17/5 17/7 22/17 22/23 23/5 23/6</p>	<p>41/12 43/16 63/7 64/14 81/8 82/21 83/18 83/20 89/13 93/18 98/14 104/5 109/15 109/24 110/8 110/9 111/23 113/1</p> <p>treatments [1] 9/25</p> <p>trial [1] 93/14</p> <p>tribunal [3] 2/11 15/12 15/12</p> <p>tricky [1] 44/19</p> <p>tried [1] 33/5</p> <p>tries [1] 58/10</p> <p>trigger [2] 92/1 92/10</p> <p>triggers [1] 92/24</p> <p>trouble [1] 94/13</p> <p>trouble' [1] 25/8</p> <p>troubling [3] 100/24 101/2 105/24</p> <p>true [3] 6/23 19/19 56/2</p> <p>trust [14] 12/14 21/12 28/4 30/4 46/7 60/8 60/11 63/2 64/3 65/12 65/20 66/8 82/14 82/21</p> <p>truth [2] 25/24 86/22</p> <p>truthful [1] 26/8</p> <p>try [22] 5/11 7/11 7/14 11/10 21/2 21/22 27/3 27/3 28/4 29/1 31/13 31/17 36/4 36/5 40/2 54/22 60/25 63/2 64/2 76/24 83/9 99/8</p> <p>trying [22] 5/20 7/20 9/20 10/3 21/1 21/1 23/23 33/5 36/14 63/8 63/10 63/13 73/22 79/16 80/6 91/19 114/19 115/5 116/4 119/5 119/6 120/9</p> <p>turn [1] 49/20</p> <p>Turner [2] 31/21 34/4</p> <p>twice [2] 42/19 94/12</p> <p>two [23] 4/24 5/18 12/5 14/5 17/23 33/7 41/11 46/14 50/1 57/15 58/11 61/25 65/10 65/12 82/17 87/7 87/9 95/2 97/21 99/14 102/15 103/2 110/25</p> <p>two paragraphs [1] 5/18</p> <p>twofold [1] 105/4</p> <p>type [1] 88/19</p>	<p>underestimating [1] 80/15</p> <p>underlying [1] 92/1</p> <p>undermine [2] 60/8 60/11</p> <p>undermined [1] 76/17</p> <p>understand [22] 2/12 13/5 17/6 21/6 23/2 23/5 23/14 34/7 68/11 71/7 72/4 72/20 73/22 74/18 77/4 97/4 99/7 105/20 107/8 109/7 115/21 116/2</p> <p>understanding [21] 2/3 2/4 3/16 4/17 4/20 5/21 6/5 6/23 7/16 9/21 14/24 21/10 23/1 28/7 28/10 33/6 77/23 79/9 91/20 92/14 109/5</p> <p>understands [4] 12/18 16/4 20/19 26/4</p> <p>understood [16] 2/18 8/22 17/2 17/3 17/10 17/11 17/13 18/18 19/8 21/12 22/23 35/15 35/16 41/21 66/4 88/18</p> <p>unfortunately [1] 84/19</p> <p>uni [1] 55/24</p> <p>unintended [3] 8/2 119/7 119/15</p> <p>unintendedly [1] 7/21</p> <p>university [8] 31/22 32/4 32/10 33/6 33/8 92/12 92/15 92/16</p> <p>unless [6] 15/11 28/6 28/7 68/22 69/5 71/11</p> <p>unquantifiable [1] 31/4</p> <p>until [4] 20/9 33/16 97/4 120/20</p> <p>unusual [2] 87/17 87/19</p> <p>unwell [10] 3/19 17/7 36/18 44/22 73/21 74/17 74/20 81/13 84/12 97/15</p> <p>up [29] 2/9 2/17 6/18 7/10 7/17 8/13 13/14 16/1 16/17 29/22 32/14 32/22 35/8 36/19 37/15 39/14 40/9 43/10 46/21 53/18 55/17 57/6 60/18 76/14 80/19 84/22 104/18 107/13 113/25</p> <p>upon [2] 69/16 106/15</p> <p>urban [1] 53/17</p> <p>urge [1] 39/10</p> <p>urine [2] 93/8 94/4</p>	<p>us [14] 5/17 19/6 25/4 25/24 33/15 45/14 45/23 47/5 62/16 65/8 81/20 98/11 98/12 116/19</p> <p>use [5] 8/16 16/18 24/4 30/9 60/18</p> <p>used [4] 5/8 42/16 116/3 118/11</p>
V				
<p>vaccines [1] 19/13</p> <p>Valdo [1] 43/3</p> <p>validity [1] 19/21</p> <p>valuable [1] 102/13</p> <p>value [1] 26/14</p> <p>varies [2] 82/15 90/21</p> <p>variety [2] 95/22 109/9</p> <p>various [3] 11/13 30/4 108/20</p> <p>vary [1] 91/7</p> <p>VC [170]</p> <p>VC's [25] 3/15 8/9 11/5 13/13 16/17 33/14 37/2 46/18 49/15 50/7 52/6 52/12 57/23 62/6 65/9 80/11 82/13 85/1 85/6 88/23 92/17 94/18 109/19 110/25 111/4</p> <p>verbatim [1] 68/25</p> <p>version [1] 17/1</p> <p>versus [1] 19/7</p> <p>very [47] 2/18 4/14 6/24 7/1 7/24 8/10 11/19 11/22 12/12 14/3 24/12 25/24 30/22 38/9 40/21 42/21 44/19 44/22 47/23 48/6 49/22 50/11 50/21 56/8 57/8 62/17 64/22 69/4 69/7 69/10 70/8 73/6 74/5 84/23 87/17 89/25 94/1 96/16 96/19 97/18 99/12 100/19 104/19 105/1 105/18 112/7 113/19</p> <p>via [2] 39/23 85/24</p> <p>victim [3] 6/12 115/8 115/23</p> <p>video [1] 46/10</p> <p>view [33] 4/8 5/21 16/2 16/19 17/15 19/8 20/25 23/1 25/22 33/21 38/17 43/4 47/15 58/20 58/20 67/23 67/25 69/10 73/10 86/9 88/3 89/9 92/6 99/2 104/2 104/4 106/3 109/25 110/11 110/20 117/9 118/5 118/6</p> <p>views [4] 6/4 31/1</p>				

<p>V</p> <p>views... [2] 33/19 66/19</p> <p>vigorously [1] 27/2</p> <p>violence [24] 1/20 9/18 10/9 10/12 30/7 31/10 36/17 47/16 47/18 77/7 77/15 78/3 78/6 78/7 79/21 79/23 80/14 104/8 106/13 106/15 106/16 106/20 106/25 109/4</p> <p>violent [5] 78/9 78/12 88/4 101/21 103/6</p> <p>visit [4] 24/21 33/24 39/10 40/9</p> <p>visits [2] 39/13 40/18</p> <p>voices [9] 1/10 24/6 25/1 25/6 42/7 42/11 57/17 57/21 57/22</p> <p>voices/people [1] 57/17</p> <p>volatile [2] 56/21 57/8</p>	<p>was' [1] 42/10</p> <p>wasn't [32] 4/1 10/24 15/13 18/25 20/1 23/15 25/16 25/17 34/12 34/16 40/3 41/9 44/10 47/12 48/13 48/15 63/9 68/9 82/23 85/6 86/23 91/6 93/10 94/8 96/15 102/24 110/2 115/1 115/14 118/20 118/25 120/2</p> <p>way [15] 6/3 19/15 21/16 29/13 30/2 30/14 30/15 33/15 57/16 59/18 79/10 83/7 102/3 111/2 119/12</p> <p>ways [11] 17/23 22/7 25/23 26/7 34/10 40/14 56/1 56/3 69/14 102/3 109/9</p> <p>we [149]</p> <p>we'll [12] 20/8 24/5 64/24 64/24 67/11 72/13 74/5 75/9 78/20 105/1 114/4 120/18</p> <p>we're [4] 29/17 60/21 102/7 119/10</p> <p>we've [8] 31/2 45/1 72/5 75/7 79/12 81/1 84/8 109/10</p> <p>weapons [1] 30/9</p> <p>weeds [1] 34/21</p> <p>week [2] 57/12 58/10</p> <p>weekly [2] 40/11 68/4</p> <p>weeks [6] 4/24 12/6 14/5 24/7 28/5 94/19</p> <p>well [39] 4/8 8/5 15/25 18/10 23/19 25/6 29/10 31/1 32/21 34/12 34/21 35/5 37/4 40/7 47/11 51/17 51/20 51/23 64/20 65/15 66/4 72/4 72/4 73/15 74/10 74/24 78/18 78/20 80/5 82/12 89/11 96/18 96/23 99/10 102/12 104/5 116/9 119/20 120/2</p> <p>went [7] 1/8 7/22 15/12 36/10 42/11 72/16 91/3</p> <p>were [104] 1/15 2/5 2/8 2/25 3/24 3/24 3/25 7/23 9/11 9/17 11/2 11/13 11/15 16/9 19/13 21/24 23/12 25/20 27/9 29/2 33/22 36/14 38/13 39/16 41/22 43/20 43/20 43/20 43/25 48/11 50/7 50/9 51/15 51/22 52/5 52/11 52/17 54/13 58/6 58/7 59/23 60/3 62/13 64/8 64/11</p>	<p>65/9 65/10 65/17 66/9 66/9 67/16 67/22 68/13 69/9 72/1 72/2 72/12 73/8 73/13 73/24 73/25 74/12 75/1 75/4 75/10 76/2 76/13 76/21 76/22 76/23 76/23 86/2 86/17 86/20 88/14 90/5 91/23 92/7 92/7 92/20 93/24 94/11 94/18 95/10 95/11 97/11 98/13 98/19 103/23 104/2 105/6 105/9 106/21 112/16 112/24 114/7 115/25 116/1 116/24 116/25 117/1 118/3 120/9 120/10</p> <p>were making [1] 25/20</p> <p>weren't [6] 17/10 23/12 89/25 96/17 117/2 119/11</p> <p>West [1] 29/24</p> <p>what [142]</p> <p>what's [5] 11/18 14/24 16/19 25/18 77/22</p> <p>whatever [6] 14/10 21/2 62/9 62/11 68/25 91/2</p> <p>whatsoever [1] 62/10</p> <p>when [73] 2/7 2/16 2/25 3/5 5/14 7/20 9/1 12/24 20/8 20/14 21/7 21/19 22/1 22/3 25/3 25/4 27/9 27/11 27/20 28/23 33/8 34/14 41/9 43/21 46/17 46/20 55/17 57/20 62/8 64/8 66/9 66/17 70/17 70/22 72/13 73/17 73/19 73/19 73/21 74/5 74/14 74/17 74/20 75/10 77/8 77/10 77/21 79/14 80/2 82/15 82/20 84/3 84/12 85/21 86/10 87/4 87/15 90/22 91/3 95/5 95/5 96/9 97/15 98/3 98/14 102/10 103/5 103/14 105/16 106/1 114/16 115/16 116/6</p> <p>where [39] 10/1 12/20 13/16 21/9 22/25 27/5 29/14 29/15 32/13 32/25 33/9 33/11 43/10 43/12 50/14 50/16 50/23 52/24 55/24 59/1 68/23 69/24 70/2 70/16 71/1 78/11 80/19 82/16 90/13 92/3 98/5 104/15</p>	<p>106/8 107/6 108/24 112/21 113/16 114/1 118/18</p> <p>whereas [1] 15/9</p> <p>whether [75] 2/13 2/25 3/3 3/9 4/10 5/11 9/16 9/21 10/3 12/21 13/25 14/8 15/4 15/6 18/21 18/21 19/17 20/22 21/12 21/15 21/24 25/23 26/6 26/7 27/4 29/5 29/18 31/7 31/9 34/1 34/1 38/12 42/4 42/9 42/11 42/12 42/13 42/22 44/24 47/7 48/12 48/21 50/8 50/9 58/24 59/25 61/20 61/23 62/7 63/7 69/9 72/2 76/5 76/25 80/4 85/7 86/12 90/2 94/1 94/2 94/17 96/23 98/7 98/24 104/24 105/12 108/14 114/22 115/24 116/4 117/4 118/9 118/11 118/12 120/5</p> <p>which [61] 1/25 2/1 3/4 4/14 6/25 28/24 31/11 34/5 35/18 35/18 35/25 39/7 41/24 48/20 48/24 49/13 52/23 59/10 60/9 62/5 63/11 67/1 69/6 74/3 76/2 77/18 78/20 82/10 83/12 85/25 88/11 89/12 91/5 91/13 91/23 92/4 92/18 93/8 93/24 95/20 98/4 99/6 100/17 104/5 104/12 105/1 105/12 105/25 106/11 109/5 109/23 111/8 114/1 114/14 115/6 116/6 116/14 116/21 116/25 117/3 118/10</p> <p>whilst [5] 3/10 46/20 52/5 73/8 108/12</p> <p>who [34] 12/3 18/1 18/4 21/22 28/2 29/17 29/23 30/24 31/14 38/12 39/7 43/13 58/7 63/13 66/3 67/16 68/23 72/17 76/1 80/20 82/9 87/15 87/20 90/9 94/14 94/25 101/12 101/20 103/8 105/2 119/8 120/6 120/10 120/10</p> <p>who's [1] 74/10</p> <p>whole [2] 81/12 90/17</p> <p>whom [1] 40/25</p> <p>why [40] 1/9 3/13 5/10 6/1 7/19 15/17 15/23 22/6 25/3 27/2</p>	<p>27/11 30/3 38/7 41/4 41/18 42/18 48/16 52/25 53/21 54/1 54/12 54/15 56/9 67/7 68/11 75/23 88/8 91/20 93/10 95/10 99/4 100/3 101/25 105/3 105/23 110/3 110/14 114/9 115/2 115/3</p> <p>wider [2] 65/16 83/14</p> <p>will [40] 2/13 2/14 6/17 6/18 6/19 8/16 8/16 8/17 12/22 17/17 21/6 21/19 21/20 24/9 24/15 26/5 26/6 26/8 28/2 28/3 29/4 32/14 32/21 35/8 37/15 37/16 39/13 49/8 51/2 55/15 72/4 87/23 103/7 103/8 103/15 103/15 104/20 105/2 111/21 114/21</p> <p>willingness [1] 71/12</p> <p>window [5] 7/23 77/14 78/5 79/4 115/10</p> <p>wish [1] 111/8</p> <p>within [27] 10/2 11/19 12/5 12/8 21/3 21/4 28/3 33/12 36/21 41/6 41/23 43/15 61/24 62/25 63/25 66/8 69/5 74/21 75/18 88/14 100/12 100/13 100/18 103/24 109/6 110/23 114/24</p> <p>without [6] 19/20 58/12 71/8 75/25 96/2 96/23</p> <p>WITN0163001 [2] 16/22 103/12</p> <p>WITN0163006 [1] 37/21</p> <p>WITN0163008 [1] 31/20</p> <p>WITN0163009 [1] 38/25</p> <p>WITN0163011 [1] 37/1</p> <p>WITN0163012 [1] 113/25</p> <p>WITN0163014 [1] 114/5</p> <p>WITN0163017 [1] 44/13</p> <p>WITN0412015 [1] 29/21</p> <p>witness [6] 50/2 87/25 88/19 97/1 97/10 103/11</p> <p>woke [2] 55/17 57/6</p> <p>woman [1] 119/19</p> <p>won't [1] 64/20</p> <p>wonder [2] 44/24 104/24</p>
--	--	---	---	--

<p>W</p> <p>wondered [1] 42/8</p> <p>wondering [2] 105/12 115/3</p> <p>word [1] 3/9</p> <p>words [2] 55/19 57/7</p> <p>work [19] 4/7 11/10 13/4 17/18 20/15 21/9 26/2 26/23 29/8 32/7 32/8 32/16 32/17 43/15 51/8 53/1 56/10 74/22 83/10</p> <p>worked [1] 3/15</p> <p>working [6] 26/3 51/3 83/11 87/5 87/11 111/21</p> <p>worried [2] 72/15 120/6</p> <p>worrying [1] 103/24</p> <p>worst [2] 7/2 119/2</p> <p>worst-case [1] 119/2</p> <p>would [174]</p> <p>wouldn't [23] 1/22 8/6 40/5 44/24 45/17 45/18 51/7 52/14 57/17 57/25 62/1 73/10 73/24 87/15 99/2 99/3 99/7 99/14 100/10 111/3 114/23 117/2 117/5</p> <p>write [4] 38/25 71/3 74/11 74/16</p> <p>writing [1] 101/25</p> <p>written [2] 72/12 108/14</p> <p>wrote [1] 56/2</p>	<p>30/23 30/25 45/14 46/6 49/21 51/9 52/4 52/4 52/22 65/8 70/4 70/7 71/5 71/11 71/18 73/17 74/14 79/1 80/10 80/12 81/16 81/20 93/7 94/22 99/11 101/14 102/10 112/9 112/14 116/9 116/18 117/13</p> <p>young [5] 56/19 80/2 115/8 115/18 119/18</p> <p>younger [2] 10/10 56/19</p> <p>your [96] 1/4 2/19 4/23 7/4 7/5 7/8 7/8 8/3 10/15 14/24 15/18 16/19 16/20 18/8 18/8 18/12 22/4 23/22 25/18 28/10 30/11 30/22 32/12 33/19 37/24 39/3 40/17 41/17 42/16 45/8 47/12 47/15 49/13 49/21 50/16 51/17 59/11 62/7 63/6 64/5 66/17 66/23 67/9 67/11 67/12 67/15 68/8 70/2 70/18 72/24 73/19 75/25 77/5 77/5 77/22 77/22 78/5 78/19 79/1 79/5 80/11 83/2 84/4 84/16 86/18 86/24 87/25 88/19 90/1 90/20 90/20 91/9 91/10 97/1 97/10 103/1 103/11 104/14 106/6 106/7 107/13 109/7 109/16 109/25 110/11 110/20 112/15 114/1 115/12 115/16 118/5 118/6 118/17 118/24 119/1 119/12</p> <p>yours [1] 50/24</p> <p>yourself [4] 2/7 27/14 101/20 112/2</p>			
<p>Y</p> <p>yeah [18] 15/3 33/3 36/9 46/2 50/3 53/25 54/6 59/22 80/8 81/5 86/3 87/9 90/25 92/2 95/7 101/15 119/23 120/4</p> <p>year [2] 33/9 55/23</p> <p>years [3] 82/18 107/11 107/17</p> <p>yes [170]</p> <p>yet [2] 36/17 77/6</p> <p>York [1] 29/24</p> <p>Yorkshire [1] 29/24</p> <p>you [530]</p> <p>you'd [9] 10/7 10/8 35/23 41/2 41/11 73/18 90/17 107/13 107/16</p> <p>you're [22] 18/4 18/7 20/18 20/19 23/19 25/25 30/3 30/4 37/4 44/15 47/14 70/22 71/13 73/20 73/22 77/6 80/14 80/19 82/7 83/16 97/2 117/23</p> <p>you've [37] 18/8 18/8 23/11 23/19 28/20</p>	<p>Z</p> <p>zeros [1] 50/21</p>			