1 **Wednesday, 15 April 2026**
2 **(9.59 am)**
3 **MR BLAKE:** Good morning, Chair. Can I please call
4 Rachel Watson.
5 **THE CHAIR:** Yes.
6 **RACHEL WATSON (affirmed)**
7 **Questioned by MR BLAKE**
8 **THE CHAIR:** Yes.
9 **MR BLAKE:** Thank you. You should have in front of you two
10 witness statements. The first is dated 11 December 2025
11 and has a URN of WITN0339001, and the second is dated
12 7 April 2026 and has a URN of WITN0339015.
13 Is that correct?
14 **A.** It is correct.
15 **Q.** Can you please confirm that those are both true to the
16 best of your knowledge and belief?
17 **A.** They are both true to the best of my knowledge, yes.
18 **Q.** Thank you. You are the Director General of the IOPC; is
19 that correct?
20 **A.** That is.
21 **Q.** You've been in that position since 22 April 2024.
22 **A.** That's right.
23 **Q.** Prior to taking up that role you've held a number of
24 different positions in the Civil Service, all of which
25 are outlined in your witness statement.

1 **A.** They are. There's a summary in the witness statement.
2 I don't list every single role but there's a summary.
3 **Q.** Thank you. I'm going to make clear at the very outset,
4 that our Terms of Reference prohibit us from doing
5 anything that would prejudice a misconduct
6 investigation --
7 **A.** Yes.
8 **Q.** -- so I'm not going to ask you to comment on the
9 substance of any ongoing investigation, and nor will any
10 core participant. But what our Terms of Reference do
11 require is for us to look at whether your reviews
12 sufficiently address matters relevant to the Inquiry.
13 I'm just going to begin by outlining a little bit of
14 detail about the IOPC. If we could bring up on to
15 screen, please, WITN0339003, and this is the IOPC
16 framework document. At page 3 it sets out the purpose
17 and aims. At the bottom of the page there it says:
18 "The Independent Office for Police Conduct ...
19 investigates serious and sensitive matters involving the
20 police, including conduct matters and deaths and serious
21 injuries ... involving the police.
22 "It oversees the police complaints system in England
23 and Wales and sets the standards by which the police
24 should handle complaints."
25 Does that accurately set out the principal purpose

1 of the IOPC?
2 **A.** Yes, it does.
3 **Q.** Is part of the IOPC's function to reassure the public
4 that effective action is being taken against the police,
5 where appropriate?
6 **A.** Yes, it is.
7 **Q.** Also I think under section 10B of the Police Reform Act,
8 you and the IOPC are required to carry out your
9 functions efficiently and effectively.
10 **A.** That's right, yes.
11 **Q.** You've set out at paragraph 12 onwards in your first
12 statement the statutory framework underpinning the IOPC,
13 and I won't repeat that.
14 You've explained that there are three main matters
15 over which the IOPC exercises jurisdiction: complaints,
16 conduct matters and death or serious injury matters.
17 **A.** Mm-hm.
18 **Q.** I just want to take each of those separately. If we
19 start, then, with complaints; briefly, what are
20 complaints?
21 **A.** It's when a member of the public expresses
22 dissatisfaction with the service they've received from
23 the police and they themselves or someone they know was
24 affected by that.
25 **Q.** Conduct matters; how are they different?

1 **A.** They're different because a complaint may not involve
2 police conduct, but the conduct matter is when if
3 there's indication that a police officer may have
4 behaved in a way such that disciplinary proceedings
5 could be brought against them, or indeed also -- sorry,
6 I should have added -- or potentially a criminal way as
7 well.
8 **Q.** Am I right to understand, then, that in theory,
9 a complaint can involve the same kind of issue as
10 a conduct matter, but a complaint is something that is
11 made proactively by a member of the public?
12 **A.** That is right. It may, if we are arrested in a conduct
13 matter and then someone made a complaint about it, then
14 we would define that as a complaint investigation, but
15 fundamentally there's much overlap between the two, yes.
16 **Q.** Then death or serious injury matters, what are they and
17 how are they different?
18 **A.** That is when someone dies or is seriously injured either
19 while they're in police custody or following contact,
20 either directly or indirectly, with police and there's
21 a possibility that that conduct could have caused or
22 contributed to the death or the serious injury.
23 **Q.** We'll also hear about an appropriate authority?
24 **A.** Yes.
25 **Q.** What is an appropriate authority and what part do they

1 play?
2 **A.** That is the decision-making body. So that would be the
3 police force in the case of an officer whose conduct is
4 called into question. If it's the Chief Constable whose
5 conduct is called into question, then that would be the
6 PCC or the mayor in the case of there's a mayoral system
7 in that force area.
8 **Q.** Is the usual system for there to be an investigation at
9 that local level before it reaches the IOPC?
10 **A.** Not necessarily. There would be -- there has to be
11 a referral. Complaints can't come directly first, they
12 have to be referred by the force, but a force will make
13 a decision as to whether or not they should refer
14 something to the IOPC.
15 The IOPC, if they then believe it meets the
16 criteria, if it's sufficiently serious that it should be
17 referred to the IOPC, there are criteria set out in
18 legislation, the IOPC will then make a determination as
19 to whether the IOPC itself should undertake that
20 investigation, whether they -- we should direct a local
21 force to undertake the investigation, or whether, in
22 some cases, the force should undertake the investigation
23 under the direction of the IOPC.
24 For some, we'll simply return it to force and say,
25 "This isn't a valid referral, there's no action needed",

5

1 but that's a fairly small proportion.
2 **Q.** I want to move on to the topic of interested persons.
3 If we could please bring up on the screen WITN0339008.
4 This is the Statutory Guidance, and there's a definition
5 of interested persons at page 178. I won't read the
6 whole thing out, but it starts as follows, it says:
7 "Someone who has an interest in being kept properly
8 informed about the handling of a complaint, recordable
9 conduct matter or DSI matter. An interested person is
10 not a complainant.
11 "In the case of a complaint or recordable conduct
12 matter, a person will have an interest in being kept
13 properly informed if it appears to the IOPC or to an
14 appropriate authority that the person: ... "
15 The first example is:
16 "Is a relative of the person whose death is alleged
17 to be the result of the conduct complained of or to
18 which the recordable conduct relates."
19 The third bullet point is:
20 "Is a person who has suffered serious injury that is
21 alleged to be the result of the conduct complained of or
22 to which the recordable conduct relates."
23 It then goes on to address the definition in the
24 respect of a DSI matter. Then there's a catch-all,
25 really, paragraph below which says:

6

1 "A person who does not fall into any of the
2 categories above may still be an interested person if
3 the IOPC or the appropriate authority considers that
4 they have an interest in the handling of the complaint,
5 conduct matter or DSI matter that is sufficient to make
6 it appropriate for information to be provided to them in
7 accordance with this section. For example, this may
8 include coroners."
9 So that's quite a broad definition, that final
10 paragraph.
11 **A.** It is, although they would have to be a very legitimate
12 interest so it's a coroner also, of course, the Inquiry,
13 for example, but it's not sort of anyone who might take
14 an interest, if you like.
15 **Q.** Can you assist us, what happens when somebody -- let's
16 say a family member of a bereaved or a survivor in an
17 attack like this present case -- what happens when they
18 don't know that a local policing authority, the
19 appropriate authority, is or has been investigating
20 something? How do they become interested persons or
21 even find out about it?
22 **A.** The investigating body should be considering who could
23 count as interesting persons *(sic)* particularly focusing
24 on the top six bullet points we have and they should be
25 practically giving them the opportunity to become

7

1 interested persons.
2 **Q.** Does that mean the burden essentially falls on the
3 police force?
4 **A.** Or the IOPC, if they're investigating, yes.
5 **Q.** There may be a complaint by somebody else, there may be
6 a conduct matter. Does the IOPC take proactive steps to
7 identify people?
8 **A.** We have improved our guidance. I know that we --
9 unfortunately, I'm very sorry that we did not clearly
10 take the practice steps we should have done in the case
11 of Operation Penhallow in particular and some of our
12 other investigations. So we have actually revised our
13 guidance to make sure our initial meetings about any
14 investigation, we think very broadly about who the
15 interested persons could be and then gives them the
16 opportunity to become interested person. Of course
17 someone may not want that, but they need to be offered
18 the opportunity in a sensitive way.
19 **Q.** I think you've reflected on that in relation to
20 Operation Penhallow --
21 **A.** Yes.
22 **Q.** -- and we'll get on to that in due course.
23 To take a slightly different example, there was
24 a complaint by Elias Calocane.
25 **A.** Yes.

8

1 **Q.** That, I think, reached the IOPC in August 2024 and the
2 bereaved weren't notified until May 2025. How does the
3 process work there and has it worked there?
4 **A.** I think what happened there is that there is at the
5 moment a backlog we're working through of complaints, so
6 it was at the back of the queue of complaints. When it
7 came to the attention of -- was being actively -- when
8 it was being considered, rather, at that point then it
9 was determined that it was appropriate to give the
10 families the opportunity to become interested persons.
11 It was in a queue, I understand, because I have asked
12 that question because it does seem an awfully long time
13 ago.
14 **Q.** So essentially in that case it's not a question of a
15 problem with the definition of an interest person; it's
16 actually just an issue with the time it takes --
17 **A.** Yes.
18 **Q.** -- to reach that decision or to even reach the
19 appropriate person to make that decision.
20 **A.** That's right. That was in that case, yes.
21 **Q.** Do you think the width of the definition is sufficiently
22 understood within the IOPC?
23 **A.** I don't think it always has been. I think with the
24 revised guidance and training that we're doing, I think
25 that it is going forwards. I think it is fairly -- it

1 can -- it's not particularly complex but it is
2 reasonably broad, so I don't think it's fully understood
3 across policing and certainly we are doing work at the
4 moment to ensure that it is properly understood and
5 considered in the IOPC.
6 **Q.** In your experience, and not looking at this particular
7 case, but do appropriate authorities sufficiently
8 understand that definition?
9 **A.** I don't think -- I suspect they don't. It's not -- of
10 course we wouldn't audit every investigation they do
11 that we're not involved in, so I wouldn't like to look
12 at -- condemn them all for not doing, but given the
13 experience and given what I've seen, particularly in
14 relation to the events leading up to this Inquiry,
15 I think it's safe to say that it isn't a term that's as
16 well understood as it should be, particularly as
17 understood as broad as it actually is.
18 **Q.** What do you think could be done to improve that?
19 **A.** I think improve the guidance is probably -- is the key
20 and it's about prioritising, so within the IOPC we're
21 undertaking a major transformation programme so we're
22 focusing on the experience of those people who come into
23 contact with our services and improving that. So within
24 the IOPC, we are very much on the case. More broadly,
25 we do -- we set standards for dealing with complaints so

1 I suspect there is more that we can do to promote the
2 need to do this for appropriate authorities, but
3 ultimately it's for the leadership of police forces to
4 make sure their Professional Standards departments are
5 implementing this properly.
6 **Q.** Thank you. I'm going to take you through now each of
7 the individual investigations in this case. There are
8 five principal investigations and we'll start with
9 Operation Gosemore.
10 **A.** Yes.
11 **Q.** Could we please bring on to screen IOPC0000004. This is
12 what was the final report, we'll get on to whether it
13 still is, it says there it is:
14 "[An] Investigation into Nottinghamshire Police's
15 contact with a white van prior to two members of the
16 public sustaining injuries in Nottingham city centre on
17 13 June 2023".
18 If we turn over, please, to page 3 it sets out the
19 key issues to be addressed in that report, and they
20 relate to the actions and decisions of the police
21 officer driving the prior to the collision; "the
22 officer's dynamic risk assessment prior to the
23 collision; and whether the actions of the officer were
24 in line with local and national policies and
25 procedures."

1 This investigation is the first in time, having been
2 brought to the IOPC's attention on 13 June, and formally
3 referred, I think, it was the next day, to the IOPC.
4 **A.** Yes.
5 **Q.** Is that because this was considered to potentially be
6 a DSI?
7 **A.** That is correct, and I should say of course these events
8 all took place before I took up post at the IOPC, so I'm
9 very much reliant on the accounts of others and the
10 investigator report itself, but it was indeed considered
11 a DSI, yes.
12 **Q.** This investigation concluded on 27 September 2023, and
13 we can see on page 19, please, the conclusions. There's
14 a summary of investigation, the second paragraph of that
15 second box says:
16 "The investigation concluded there was no indication
17 [and] any police officer may have behaved in a manner
18 that would justify the bringing of disciplinary
19 proceedings or committed a criminal offence."
20 And also that there is no learning. That's the next
21 box.
22 The essential finding in this particular case was
23 that the officer couldn't have foreseen that VC would
24 veer sharply and hit members of the public; is that
25 right?

1 **A.** The essential -- not so much about foreseen, but that he
2 wasn't doing anything outside training and guidance, so
3 that he had behaved properly as you'd expect an officer
4 to behave in that situation.
5 **Q.** That investigation was concluded within three months.
6 Is that considered by the IOPC to be a reasonable
7 timeframe?
8 **A.** It is, yes.
9 **Q.** Yes. On 19 March, you've explained in your second
10 witness statement, the solicitors acting for two of the
11 survivors have asked you to reopen the investigation.
12 Is there anything further that you can say in that
13 respect? If not, you don't have to, but are there any
14 developments?
15 **A.** I -- perhaps if the Chair would permit me, I can provide
16 a summary that I hope won't prejudice the investigation
17 which is that --
18 **THE CHAIR:** Thank you.
19 **A.** Thank you. Which is that our -- paragraph 59 I think of
20 the final report assesses that there was authorisation
21 for the officer in question to be pursuing the van.
22 Now, that is based, I have been told, on a witness
23 statement rather than any audio or visual footage. It
24 does appear that during the course of the Inquiry, the
25 potential audio footage has come to light which could

1 potentially -- and we don't know yet, we need to go
2 through our reinvestigation policy -- but there's
3 a possibility that could affect the outcome so we do
4 need to evaluate that. The solicitors of the survivors
5 have written to us and we are considering at the moment
6 the -- whether or not we do need to reinvestigate in
7 light of this.
8 **MR BLAKE:** Subject to that being reinvestigated or reopened,
9 this is the only one of the investigations that has
10 reached the conclusion.
11 **A.** That's right, yes.
12 **Q.** Yes. If we move on then, to Operation Astwell, and
13 please could we bring up on to screen IOPC0000050. It
14 sets out there, this is the Terms of Reference, it says:
15 "Investigation into the actions and responses by
16 Nottinghamshire Police in relation to Mr [VC] prior to,
17 during and after 13 June ..."
18 If we go over the page, please, on the second page
19 it sets out the Terms of Reference. In very broad terms
20 are you able to summarise for us what this investigation
21 concerns?
22 **A.** Yes, of course. This is about what the police actions
23 up to 13th June and also in the aftermath, and the
24 extent to which they were appropriate, and the extent to
25 which the police could or should have known more about

1 VC. It also covers other police forces, not just
2 Nottinghamshire, so it covers all police contact with VC
3 up to the events of 13th June, so it's very broad
4 ranging.
5 **Q.** This is a complaint investigation.
6 **A.** That's right, yes. It follows the meeting that the IOPC
7 had -- again, before I arrived -- with the families of
8 Barnaby, Grace and Ian.
9 **Q.** I think the complaint was referred to the IOPC on
10 5 February 2024.
11 **A.** *(The witness nodded)*.
12 **Q.** There were additional complaints, I think you've
13 complained in your witness statement --
14 **A.** Yes.
15 **Q.** -- made on 3 May 2024.
16 You've said in your witness statement -- it's
17 paragraph 66, we don't need to bring it up -- but if it
18 assists, you've said the original Terms of Reference
19 were not of sufficient quality and had not been reviewed
20 by a sufficiently senior staff.
21 Briefly can you tell us what the issue was there?
22 **A.** The Terms of Reference have been drafted too broadly,
23 and more broadly than the IOPC would be able to add
24 value to. Again, this does -- I should say now the
25 families did not receive the service they deserved from

1 the IOPC. I've been very clear about that from the
2 outset, and this is one of the examples where the IOPC
3 clearly let them down. There was not sufficient senior
4 supervision which meant that when the Terms of
5 Reference, as drafted, came to the sight of more senior
6 staff within the IOPC, they realised that that would not
7 be a realisable investigation. They were then narrowed
8 down and I finally ended up meeting with the family
9 solicitor myself in October I think it was -- I've
10 forgotten the date, but in October -- and at that point
11 we were able to finalise the Terms of Reference.
12 **Q.** I think it took eight months to finalise those Terms of
13 Reference --
14 **A.** Mm, yeah.
15 **Q.** -- from when the case was first referred, finalised on
16 22 October of 2024; is that right?
17 **A.** That would be right, yes.
18 **Q.** It is now well over two years since that matter was
19 first referred. A decision was taken on 10 February
20 this year that this and the other investigations I think
21 await evidence arising from the Inquiry; is that right?
22 **A.** That is right, yes.
23 **Q.** If we were to stop the clock at that 10 February
24 decision, two years after the initial referral, to use
25 the language of the Terms of Reference that I drew your

1 attention to at the very beginning of your evidence, do
2 you think it's fair to say that the IOPC has not -- had
3 not yet sufficiently addressed the complaints?
4 **A.** It had not yet sufficiently addressed them. We were
5 waiting for outstanding witness statements in
6 particular, so they had not been sufficiently addressed,
7 no.
8 **Q.** Do you acknowledge that that is a significant amount of
9 delay?
10 **A.** I'm very clear, the investigations should have -- I wish
11 they had happened and taken place a lot more quickly.
12 They have been too slow. I do know now we have -- and
13 I'm very confident we have -- the right team in place
14 and the right supervision and the right capabilities in
15 the team, and they are moving at pace. I would say
16 there are issues of -- not to excuse, but to perhaps
17 give some context -- there are issues of the complexity.
18 There are a lot of interactions between VC and policing,
19 for example, in each force -- not each force, but more
20 than one force -- over a number of years. There are a
21 lot of witnesses, assessments have been undertaken for
22 57 officers, special procedures decisions undertaken for
23 33, just in relation to Operation Astwell.
24 So a lot of work has gone into this, and there have
25 also been some issues in accessing witnesses who have

1 been needed, but that is just to give some context.
2 They should have. It was our hope and intention that
3 they would have been concluded by the Inquiry. That
4 said, we are getting very useful evidence from the
5 Inquiry which will doubtless add to our ability to come
6 up with robust findings at the end.
7 **Q.** Moving on, then, to Operation Longdale, can we please
8 bring up on to screen IOPC0000046. Sets out there at
9 the top of the Terms of Reference a summary of the
10 investigation. It's an:
11 "Investigation into the actions of Nottinghamshire
12 Police regarding a non-reportable media briefing with
13 various media organisations on 22 February 2024
14 following the conviction of [VC]."
15 Again, if we turn over to page 2, it sets out the
16 background to the non-reportable briefing. Briefly, are
17 you able to summarise the nature of this investigation?
18 **A.** Yes. It is a complaint about a non-reportable briefing
19 undertaken by Nottinghamshire Police following the
20 verdict. And, in addition, the complaint that they
21 subsequently made to IPSO about the reporting of that
22 non-attributable briefing.
23 **Q.** Thank you. If we turn over to page 3, you can see there
24 the Terms of Reference.
25 **A.** Yes.

1 **Q.** You've highlighted in your witness statement that the
2 Head of Communications had expressed opinions that
3 weren't for them to decide --
4 **A.** Yes.
5 **Q.** -- and/or on which the IOPC should remain neutral. Can
6 you briefly assist us with what that is about, please?
7 **A.** I can, of course, and I should say that is the former
8 Head of Communications. He left the IOPC at the end of
9 June of that year.
10 But it is normal for forces to engage with the IOPC.
11 Indeed, it's set out in the protocol we have with the
12 National Chiefs' Police Council, that forces should,
13 when it's an IOPC investigation, as was the case here,
14 they should be deferring to us in terms of what they can
15 say.
16 However, they did not seek any agreement or tell the
17 IOPC about the briefing before it had taken place. So
18 the first communication with the force is the Head of
19 Comms quite understandably expressing dissatisfaction
20 with that and asking them what they were doing.
21 There is, unfortunately, a point at which he was
22 consulted on whether or not it was appropriate to make
23 a complaint to IPSO, and he opined, personally, that he
24 thought that was appropriate, and very clear he should
25 not have done that. We have no place in advising forces

1 in that way on how to handle media, and because of that
2 we realised that it would doubtlessly make the families
3 even less confident in us, which is why we took two
4 measures: first of all, to ensure that there was an
5 email chain in which he informed a few people about
6 this. None of those individuals were involved in the
7 decision making -- or will be involved in the decision
8 making, of course, as it stays open -- and also that we
9 asked an external KC to review the Special Procedures
10 Decision that was taken in light of that and we will do
11 that for any further decisions in relation to this.
12 We've been clear, we've reminded the Press Office of
13 their absolute -- the fundamental importance of
14 impartiality at all times and in not overstepping our
15 boundaries and we're also in the process of working with
16 the National Police Chiefs' Council to review the
17 protocol because it's clear it's not clear enough,
18 things have gone wrong, so I want to make it as
19 watertight as possible to avoid any recurrences.
20 **Q.** I think the underlying email, the issue occurred in
21 June 2024.
22 **A.** Mm-hm.
23 **Q.** Are you able to assist us with how quickly it was
24 brought to your attention?
25 **A.** I -- it wasn't brought to my attention for quite a long

1 time. I think I was aware of an email in the summer of
2 last year, but again, not really the extent to which it
3 had impact or impacted on the Terms of Reference of the
4 investigation. Once I was aware and I appreciated that
5 in the autumn, that's when I instructed my staff that we
6 needed to have an external KC to review our decision
7 making because I thought there was no way the families
8 would be able to trust us on the basis of having seen
9 that, even though it wouldn't -- I do know my staff
10 would not have been biased because of it, but the
11 appearance was, frankly, not good. So it was important
12 that we had an external scrutiny.
13 **Q.** Is there any learning there in respect of the amount of
14 time it took to reach you?
15 **A.** Well, in general, I -- it's an interesting one. I've
16 certainly, since then, and since sort of early autumn of
17 last year, am now getting bi-weekly updates on this, on
18 the progress of these investigations, partly to ensure
19 that we inject pace, and partly to ensure that when
20 there's issues like this when there's miscommunication
21 don't arise, and we're putting in place actually case
22 conferences on key investigations every other week and
23 that will help us keep a more senior grip.
24 We have already, we have moved to a new operating
25 model in the autumn of last year and that means there's

21

1 a much better senior oversight of the progress of all
2 investigations, so I think that --
3 **THE CHAIR:** Can you just slow down a bit?
4 **THE WITNESS:** Oh sorry, of course.
5 Of course. That will ensure that we have better
6 oversight at a senior level of progress of all the
7 different investigations, and I think that will ensure
8 that things are escalated to me at the right time.
9 I suspect that people didn't appreciate the significance
10 of this at that point but I'm speculating there, I don't
11 really know.
12 **MR BLAKE:** If we focus once again on the Terms of Reference
13 and the amount of time that that has taken in respect of
14 this particular investigation, I think the Terms of
15 Reference weren't finalised until 27 January 2025.
16 **A.** *(The witness nodded)*.
17 **Q.** So I think it took ten months to finalise those Terms of
18 Reference.
19 **A.** I think they were added to. I think one of the issues,
20 is my understanding, is that the complaint was added
21 that was of the further complaint. We started off
22 investigating about the press briefing itself, and then
23 the complaint to IPSO was added at a point. I think
24 that is -- and we do continually review Terms of
25 Reference, as we come up, perhaps as we find something

22

1 else that is relevant. So it is not unusual for them to
2 be adjusted during the course of an investigation. That
3 doesn't mean that we haven't already got started though.
4 **Q.** Once again this is an investigation that's taken over
5 two years from its instigation.
6 **A.** Mm.
7 **Q.** Again, if we stop the clock at that 10 February
8 decision, to use the language of our Terms of Reference,
9 would you say that the IOPC had not yet sufficiently
10 addressed those complaints?
11 **A.** No, in part because we were awaiting a statement from
12 Chief Constable Meynell who, as the Inquiry has heard,
13 was unwell and therefore was unable to give a statement
14 for quite a period of time. When she became well enough
15 she completely understandably prioritised the Inquiry.
16 And so now the Inquiry -- now her part of the Inquiry is
17 finished, I'm hoping that we'll be able to obtain one
18 very soon.
19 **Q.** So are you still awaiting that witness statement --
20 **A.** We are.
21 **Q.** -- from the Chief Constable?
22 **A.** We are.
23 **Q.** When do you hope to condition include that
24 investigation?
25 **A.** Well, once we have that, that should then be very swift

23

1 because I believe we have, unless -- of course we're
2 also monitoring the Inquiry to see if anything else
3 comes out and we've heard from officers from
4 Nottinghamshire force, so we do need to review that as
5 well. But I should think very swiftly, once we have
6 former Chief Constable Meynell's statement.
7 **Q.** If we move on then to Operation Copthorne. Can we
8 please bring up on to screen IOPC0000064. This is
9 an investigation into the complaints against the Chief
10 Constable of Nottinghamshire Police raised by the
11 families of VC's victims. This is again another
12 complaint that was first raised on 26 March 2024.
13 If we go over, please, to page 2, you see there the
14 Terms of Reference. Again, briefly, are you able to
15 summarise the nature of this investigation?
16 **A.** Yes, and this concerns Chief Constable Meynell and what
17 she knew or ought to have known about VC, in the run-up
18 to attacks, also about the investigation itself, the
19 engagement with the families and communication with the
20 families following that.
21 **Q.** I think again this is a case where the Terms of
22 Reference took eight months to finalise, I think they
23 were finalised on 18 November 2024. It's now been
24 two years since this investigation began. Is this again
25 one that you would say lies at the door of the Chief

24

1 Constable and her statement, or is this one that you
2 would accept has not yet been sufficiently addressed?
3 A. I think that certainly would be part of it. We have
4 been awaiting her statement. So we haven't been able to
5 conclude. We've also seen issues come up during the
6 course of the Inquiry that we needed to fully establish,
7 particularly around the -- some of the -- how the
8 WhatsApp group was dealt with, for example. It seems
9 some assurances that we thought we had from the force
10 seemed to have been called into question, so we've
11 written to the force urgently to try to seek clarity on
12 exactly what audits, for example, that they undertook.
13 So there are I think some still new lines that we
14 will be following, but until that point I think the key
15 issue was ensuring that we did have the former Chief
16 Constable's statement.
17 Q. The Inquiry obviously only started in February of this
18 year. It is still a considerable amount of time between
19 the instigation and even the beginning of the Inquiry.
20 A. I agree and as I said at the beginning, I'm very clear
21 these investigations have taken longer than I would like
22 them to have done and longer than they should have done.
23 There are some reasons behind this but that isn't to
24 excuse the length of time which must have been
25 inordinately painful to the families and I'm sure added

25

1 to their suffering, which the IOPC should not be doing.
2 Q. Thank you. If we move on, then, to Operation Penhallow.
3 That can be found at IOPC0000043. This is the
4 investigation into the conduct of three Leicestershire
5 police officers in relation to their investigation of
6 assault on 5 May 2023. So this relates to the Arvato
7 warehouse incident, does it?
8 A. That's right. That is a conduct referral from
9 Leicestershire Police about two officers who attended
10 an incident, an alleged assault by VC at a factory,
11 while a warrant was out for his arrest, and yet no
12 arrest was made so it's an investigation into that.
13 Q. Thank you. I think it started as a DSI referral on
14 29 January 2024, but then was replaced by a conduct
15 referral on 1 February 2024; is that right?
16 A. Yes, that's right. There was some interaction and
17 discussion between our assessment unit that deal with
18 the referrals and the police force to understand whether
19 or not it should be a DSI. I think the IOPC -- and
20 again, this is before I arrived -- knew it had to
21 investigate but because it didn't completely clearly
22 meet the DSI definition, it was agreed that it would be
23 taken forward as conduct.
24 Q. The Terms of Reference were first approved on
25 20 February 2024. I think they went through some

26

1 changes. You've noted in your witness statement, it's
2 paragraph 88, but again we don't need to bring it up,
3 that the families were first informed on 26 March 2024,
4 and offered IP status. You've accepted -- it's
5 paragraph 123 of your statement -- that that was not the
6 earliest opportunity.
7 A. No.
8 Q. Can you assist us with what went wrong there?
9 A. It simply -- it wasn't. It wasn't thought of, clearly.
10 It should have been. It's that we didn't -- at that
11 time the IOPC did not have as clear standards in place
12 or supervision as it needed, and the systems and
13 processes were not as effective. So that meant things
14 like that did slip, and I'm very sorry that this was one
15 of those occasions. That's why, as I think I said
16 earlier, we've put in place measures to make sure that
17 now exactly who could be considered an interested person
18 is absolutely part of the outset of an investigation.
19 Q. Thank you. If we could please bring up on to screen
20 IOPC0000031. Operation Penhallow reported on
21 25 September 2024, and if we please turn to page 3.
22 I think it sets out the background to the investigation.
23 And if we go to the final page, essentially there was,
24 I think, no learning identified from this particular
25 incident; is that right?

27

1 A. Yes.
2 Q. Then if we go on to IOPC0000090, there was an addendum
3 report. Can you assist us with why an addendum report
4 was required?
5 A. I'm afraid actually I can't remember why there was
6 an addendum report. I can assist with why the Operation
7 Penhallow was reopened, certainly, which I think this
8 relates to.
9 Q. We'll get to that in a moment. We can scroll over to
10 the next page and it sets it out but it doesn't matter;
11 the evidence is before the Inquiry in any event.
12 This investigation, again, it took eight months or
13 so to conclude. Again, reflecting on that, is that too
14 long?
15 A. Eight months is fairly typical. We're not unusual in --
16 I am very clear I want all our investigations to be
17 quicker. We are fairly typical with the longer end
18 compared to police force Professional Standards
19 departments, but we're not desperately out of line.
20 Nonetheless, they often do go on too long.
21 Eight months would be not unusual for this type of
22 investigation. It can -- sometimes delay can seem built
23 in, it can take it quite a while to get witness
24 statements. There are other -- not the case with this
25 but quite often it can take a while, for example, to get

28

1 forensic reports. So in general, eight months would not
2 be unusual but I am keen that we focus -- or make our
3 investigations as quick as possible. I can't say for
4 sure whether this could have been quicker without really
5 going through exactly all the actions that the
6 individuals undertook.
7 **Q.** Thank you. That document can come down.
8 You've said at paragraphs 90-91 of your statement
9 that the investigation has reopened.
10 **A.** Yes.
11 **Q.** Can you briefly summarise for us why that has reopened?
12 **A.** Absolutely, and that is entirely thanks to the
13 representations made by the families through their
14 solicitors. The final report was shared with them
15 towards the end of 2024, and it was -- it became clear
16 that they made representations that we should make
17 further enquiries into what potential other intelligence
18 databases we -- the officers might have accessed in
19 addition to the Police National Database and the Police
20 National Computer.
21 We -- there was -- we did this. There was some
22 resistance still within the IOPC to reopening the
23 investigation. I think at the investigator level there
24 was a belief that this would be -- could be dealt with,
25 the extra evidence, through a misconduct hearing. The

1 families emailed me personally, or at my work email
2 address, in late February and we took -- we then of
3 course met about the issue, and it was clear that there
4 was additional information available from Leicestershire
5 Police about what could have been seen and accessed by
6 one of the officers that would -- could potentially make
7 a material difference to the level of misconduct,
8 because the original investigation had judged a case to
9 answer for misconduct.
10 Had a warrant been seen and ignored, that would
11 elevate the potential misconduct level so it was
12 important then to reopen the investigation. Clearly
13 this was not -- the family should not have had to make
14 those representations. It is to my deep regret that
15 they had to. I am glad that they did, because it meant
16 we reopened the investigation, we have a new Lead
17 Investigator and new supervision and I commissioned
18 a report by one of our most experienced decision makers
19 into what went wrong there and there are some clear
20 lessons which have been incorporated, not just into the
21 reopened investigation, but into investigations going
22 forward through our transformation programme.
23 **Q.** So this is essentially the NICHE system and what can be
24 seen, the audit of the NICHE system --
25 **A.** Yes.

1 **Q.** -- the rebuilding of the NICHE system. In your view,
2 should that have been obvious to the investigator as
3 a line to pursue?
4 **A.** Certainly in the review that I commissioned, the
5 reviewer thought this should have been something that
6 was pursued and there should have been more active
7 questioning of what other potential databases, whatever
8 other potential systems could have been seen. So there
9 were clearly mistakes made in the initial investigation.
10 **Q.** You've talked about learning lessons learnt. Briefly,
11 what are the key lessons from that?
12 **A.** There's quite a few. A key one is around interviewing
13 because there was a perception separately raised about
14 bias, the interviewers of the police officers came
15 across as too almost friendly, pally with them, which
16 was undermining our really important independence.
17 There is also not simply taking at face value that
18 a check of the system has been done. It's really
19 important that when we're asking police forces what
20 systems have been interrogated that we make absolutely
21 clear we mean every single system that we get forces to
22 look at that and don't make assumptions.
23 So those are couple that are quite -- there are
24 quite a few more -- one of the key measures we have now
25 is around better supervision and a sort of requirement

1 of supervisors to dip sample investigative interviews,
2 for example, and to do more check-ins on how interviews
3 are going to ensure we're monitoring the quality of
4 those.
5 **Q.** It's been reopened, still no final decision, again, over
6 two years on. Again, to use the language of our Terms
7 of Reference, has that not yet been sufficiently
8 addressed?
9 **A.** I'm -- again it's taken far too long. I absolutely
10 agree. It has -- what was decided was needed to get to
11 the absolute bottom of what was seen when the officer
12 accessed NICHE, it became clear that NICHE could be
13 rebuilt, so we could actually see clearly what that
14 officer would have seen on the page.
15 The rebuilding, unfortunately, took, by a different
16 police force who had the capacity and technological
17 capability to do this, took much longer than was
18 envisaged and that really only concluded, if I remember,
19 just at the beginning of this year.
20 So we've had -- we also need to wait for the kind of
21 final responses from the officers as well, and again,
22 I think my understanding -- I think I'm right here --
23 that they prioritised the Inquiry, so we should be
24 hopefully getting those soon.
25 **Q.** Putting all of those investigations to one side there's

1 also a further separate investigation relating to IOPC
2 staff. You've said in your witness statement that on 5
3 February 2025 you were informed about allegations
4 regarding inappropriate assurances provided by IOPC
5 staff.
6 **A.** Mm.
7 **Q.** Are you able to briefly summarise that issue?
8 **A.** Yes, that is the one I think I just mentioned, that
9 in -- while interviewing the subject officers in
10 Penhallow, the investigator made remarks that were
11 clearly intended to put -- or came across as too
12 friendly and came across as almost apologetic, and that
13 was the issue. Clearly the families were concerned that
14 that did not give them assurance that the police were
15 being held to account in a really fair and impartial
16 way.
17 I -- that was subject to the review as well that I
18 commissioned and the review concurred with that
19 conclusion. We did, on the basis of the complaints,
20 there were a few complaints about IOPC staff, to ensure
21 that we could be really clear that we weren't being
22 biased in our assessment of our own staff,
23 I commissioned an external investigator, Womble Bond
24 Dickinson to undertake these investigations. We have
25 had the results of some but not all. There are two

1 parts. They were put into two parts to try to get them
2 done more quickly because it has again taken longer than
3 anyone would wish, and part one has been communicated to
4 the families along with our next steps, but we still
5 await part two.
6 **Q.** Is there anything in addition to that you're able to say
7 today or you feel able to say? If you can't, then
8 don't.
9 **A.** I think what I would say is the -- a conduct
10 investigation even into IOPC staff looks at whether
11 there's been a breach of the disciplinary policy. Just
12 because there hasn't been a breach doesn't mean the
13 service was good enough, doesn't mean things happened as
14 they should have happened, and doesn't mean that robust
15 feedback wouldn't be given and doesn't mean that
16 performance conversations wouldn't happen.
17 **Q.** In terms, again, of the time that everything seems to
18 take, I think you found out about the allegations on 5
19 February 2025. The external law firm wasn't instructed
20 until 22 July 2025. Can you assist us with why that
21 took so long?
22 **A.** Yes, the IOPC found out about them. These were
23 statements in regulation 30 notices. They were
24 basically the officers' statements that would be used at
25 a Misconduct Panel hearing.

1 They contained -- quite often they'll contain what
2 I understand are termed abuse arguments, so it's not
3 that unusual for officers, perhaps, to make "Well, that
4 wasn't a very fair investigation, you might expect
5 that", I'm not saying that's the case in this, that's
6 a generalisation. So it doesn't seem the team thought
7 there was anything particularly concerning in that, and
8 it only came to my attention in the second half of May,
9 I think, that these had been made. Obviously that was
10 deeply concerning.
11 There were other complaints at that time, so that
12 had already been made by the families, partly when they
13 met with me in April of that year. These complaints
14 were put together and it was agreed that we'd actually
15 ask an external firm to investigate every single one of
16 the complaints and not just the two that had -- they --
17 the kind of the issue that had come through in the
18 statements provided by the officers.
19 **Q.** This Inquiry is going on for another few months. Are
20 you able to commit to sharing an update in respect of
21 those investigations, should they be completed in that
22 time?
23 **A.** Yes, of course. I will happily share an update.
24 **Q.** Thank you.
25 A totally separate topic to finish, and that's the

1 use of WhatsApp.
2 **A.** Yes.
3 **Q.** If we could please bring onto screen IOPC0000027, the
4 IOPC has conducted an independent review into the use of
5 WhatsApp and other instant messaging applications within
6 the police service. This is a 2021 review, so it
7 happened quite a long time before you joined.
8 **A.** Yes.
9 **Q.** If we turn over, please, to page 4 we can see there an
10 executive summary. The second paragraph there it says:
11 "This review was initiated when an IOPC
12 investigation revealed specialist unit officers in the
13 Police Service were using WhatsApp operationally. Over
14 a billion people worldwide use WhatsApp and IOPC
15 referrals containing WhatsApp-related issues are
16 increasing. Some relate to operational use and
17 subsequent dissemination to non-police staff, others to
18 the exchange of inappropriate work-related information
19 with non-police friends. This review explored WhatsApp
20 in police work and the associated benefits and risks of
21 using this private, non-accredited system."
22 Are you able to briefly summarise the concerns that
23 the IOPC had?
24 **A.** I think we continued to have concerns around the use of
25 WhatsApp. We don't use it ourselves, operationally.

1 They -- what we find is officers will send
2 police-related things or photographs potentially to
3 non-police officers. They will share sometimes --
4 I mean not all officers, but we see lots of examples of
5 inappropriate messaging, inappropriate chat groups,
6 sometimes with offensive or discriminatory remarks
7 within them. And we see, and of course there might be
8 a legitimate reason to use WhatsApp for policing, but it
9 does tend -- there is a risk it crosses the boundary and
10 we end up with police documents that have no place
11 outside policing being shared with friends or family.
12 **Q.** I'm not going to ask you about this particular case
13 because it may be that you're investigating or going to
14 be investigating matters. Can you just assist us with
15 what the IOPC is able to do in that respect now, whether
16 there's any ongoing work or whether you're working with
17 any partners to try to address that?
18 **A.** Well, we did, following this review, a working group was
19 established with policing, the National Police Chiefs'
20 Council, to take forward recommendations and to -- but
21 ultimately it is for police forces to ensure that
22 WhatsApp is being used effectively. We can shine
23 a light on it and we can make recommendations but it is
24 for police chiefs themselves and the senior leadership
25 of forces to make sure that recommendations are taken on

37

1 board and that they are being very robust in their
2 policies when it comes to using WhatsApp.
3 **Q.** So if we go over the page, please, we can see there
4 "organisational learning recommendations".
5 **A.** Mm.
6 **Q.** You've recommended that police forces review their
7 practices, policies and guidance on WhatsApp; that they
8 ensure all guidance on WhatsApp and other instant
9 messaging applications is easily accessible. There's
10 other recommendations about dual use, monitoring of
11 WhatsApp use, et cetera.
12 Is there any way for the IOPC to, or another body,
13 to look at police forces nationwide and to see whether
14 actually those recommendations you made in 2021 are
15 being followed through?
16 **A.** It wouldn't be for the IOPC to do that; it's not our
17 function, we're part of an incredibly complex system of
18 policing bodies. HMICFRS monitors and inspects police
19 forces. At the moment they don't tend to inspect those
20 forces against IOPC recommendations and we certainly --
21 we could do a dip sample but for us we're not kind of
22 resourced, if you like, or geared up to do overview of
23 inspection of policing.
24 One of the measures announced in the recent police
25 reform White Paper was to ensure that HMICFRS kept

38

1 a database not just of their own recommendations, but
2 also those of other bodies, including us. So I'm hoping
3 going forward that will mean a slicker system when it
4 comes to following up on recommendations such as this.
5 **MR BLAKE:** Thank you, Ms Watson. I don't have any further
6 questions. There are some questions from Core
7 Participants.
8 **THE CHAIR:** Yes, Mr Moloney.
9 **Questioned by MR MOLONEY**
10 **MR MOLONEY:** Ms Watson, just Operation Penhallow, please.
11 **A.** Yes.
12 **Q.** The IOPC investigations, as Mr Blake has pointed out,
13 began shortly after the sentencing of VC in
14 February 2024.
15 You have to say it into the microphone so it will
16 be -- you have to say either yes, or no.
17 **THE CHAIR:** Yes, sorry, did you nod?
18 **A.** Sorry, I was just moving my --
19 **THE CHAIR:** Please just say "yes" or "no" --
20 **A.** I didn't realise there was a question. Sorry, I just
21 moved my head. Was that a question?
22 **MR MOLONEY:** Yes, it was. Sorry if it wasn't clear that it
23 was a question.
24 **A.** Sorry, can you repeat the question then? I didn't
25 catch it.

39

1 **Q.** Will do. The IOPC investigations began shortly after
2 the sentencing of VC in February 2024.
3 **A.** Yes, that's true, certainly in the case of Penhallow.
4 **Q.** Thank you. In your first statement you confirmed that
5 the intention was for all four investigations to be
6 completed by January 2026.
7 **A.** That's correct, yes.
8 **Q.** In your second statement, dated 7 April, disclosed to
9 Core Participants last week and Mr Blake has just asked
10 you about it, that they're still continuing.
11 **A.** They are.
12 **Q.** Now, Penhallow was completed, wasn't it?
13 **A.** It was, before it was reopened, yes.
14 **Q.** As you've acknowledged, the families, through their
15 lawyers, pressed and pressed that more could be done,
16 didn't they?
17 **A.** They did and they shouldn't have had to. I apologise,
18 I will apologise again. They should not have had to do
19 that.
20 **Q.** And "some resistance" to reopening the investigation is
21 an understatement of the resistance that the families
22 faced in terms of Penhallow, isn't it?
23 **A.** There was resistance. Once I got involved the
24 resistance stopped, but there was resistance up to that
25 point, yes.

40

1 **Q.** Quite overt resistance to reopening, wasn't there?
2 **A.** There was definitely resistance. I know the -- I think
3 the correspondence that was sent back wasn't appropriate
4 and there was not enough active listening to perfectly
5 sensible points that the families were making through
6 their solicitor, yes.
7 **Q.** Yeah, and it was quite literally at the 11th hour that
8 it was reopened, wasn't it?
9 **A.** It was, I think the misconduct hearing had at that point
10 been called off, it was, so it was very close to the
11 line. Dr Kumar had felt necessary to email me directly
12 on behalf of the families.
13 **Q.** The conduct hearing was fixed, it was about to happen
14 and then was adjourned at the last moment, and then the
15 investigation was reopened.
16 **A.** Yes, that's right.
17 **Q.** Your team sent the latest update to the families last
18 week on that investigation.
19 **A.** We would have done. That would have been the regular
20 28 day update, so yes, I believe so.
21 **Q.** You've spoken about part one and part two of a staff
22 complaint related to Penhallow.
23 **A.** That's right.
24 **Q.** Now I'm not, and I'm deliberately not going to go into
25 the relationship between part one and part two, because

1 to do so would potentially do what we're all trying to
2 avoid, which is to prejudice any consideration of these
3 issues before the IOPC and other bodies; do you
4 understand?
5 **A.** I do understand, yes.
6 **Q.** But they are not -- just to make clear, you've spoken,
7 albeit in oblique terms, about part one; part one and
8 part two are not unconnected, are they?
9 **A.** They are indeed connected, yes.
10 **Q.** Thank you very much, Ms Watson.
11 **A.** I did not mean to imply they weren't, either. We just
12 split them off in order to try to progress things more
13 quickly; clearly not as quickly as anyone would have
14 liked.
15 **MR MOLONEY:** Thank you very much, Ms Watson.
16 **THE CHAIR:** Ms Cartwright.
17 **Questioned by MS CARTWRIGHT**
18 **MS CARTWRIGHT:** Good morning, Ms Watson.
19 **A.** Hello.
20 **Q.** Ms Watson, I just want to deal with one topic with you,
21 please, as to whether there's a need for greater
22 guidance and training in respect of death and serious
23 injury.
24 Now you've already dealt with with Mr Blake the
25 definition of a death and serious injury, but perhaps

1 for completeness can we display your WITN0339001 at
2 page 4 of your statement, please. Thank you. And can
3 we move to page 4. Thank you.
4 You've helpfully set out there the guidance from
5 the -- the Statutory Guidance and the definition, and
6 I think perhaps most significantly the last section:
7 "at or before the time of death or serious injury
8 the person had contact of any kind -- whether direct or
9 indirect -- with a person serving with the police who
10 was acting in the execution of their duties and there is
11 an indication that the contact may have caused --
12 whether directly or indirectly -- or contributed to the
13 death or serious injury."
14 And I think you've already confirmed that in respect
15 of the collision with Sharon Miller and Marcin that
16 you're absolutely clear that that meets the
17 categorisation of a DSI; would you agree?
18 **A.** I do agree, yes.
19 **Q.** So can I then just ask you briefly just to
20 contextualise. If we could have displayed, please,
21 INQT0000037 at page 17. So INQT0000037 at page 17.
22 Thank you. If we could just expand, it's the top right,
23 so it's what's page 66.
24 **A.** Oh yes.
25 **Q.** This is in the context of questions that were being

1 asked of Officer Griffin about the contact by Officer
2 Reynolds when he was in pursuit of VC, and the answer
3 that was given by Officer Griffin was:
4 **"Answer:** ... I think there was and actually still
5 is a level of confusion about the definition of DSI."
6 And he's then talking about a conversation in the
7 control room, and he says:
8 **"Answer:** ... actually having studied it since and
9 reflected on that discussion particularly, it's not
10 a DSI, plainly not."
11 Now, you looked exasperated on your face then. So
12 what's your view about the senior officer categorising
13 the collision with VC when an officer is pursued as
14 plainly not a DSI?
15 **A.** Sorry, I didn't mean to look frustrated. Forgive me.
16 I'm a little -- I'm surprised. It seems fairly
17 straightforward that it would be. Police van -- police
18 vehicle was following the van driven by VC. If a police
19 vehicle is following, clearly following a car that then
20 crashes, injures people, we would routinely have that
21 referred to us as a DSI. We get -- many forces tend to
22 err on the side of caution and refer to us even if they
23 are not quite sure rather than not do so.
24 I'm slightly surprised. I do think the concept of
25 indirect contact can be confusing for people, but in

1 general we get quite -- we get a very high number of DSI
2 referrals from forces.
3 **Q.** Thank you. So would you suggest, therefore, that that
4 indicates in this senior officer, still in Nottingham
5 Police, a serious misunderstanding about what
6 categorised as an indirect DSI?
7 **A.** I can't say what's in his mind. I think I --
8 **THE CHAIR:** I think we're straying into the wrong territory,
9 Ms Cartwright.
10 **MS CARTWRIGHT:** Thank you.
11 Can I then, please, just picking up on the issue of
12 referrals you receive, could we then just look again
13 under the definitions. Can we have displayed, please,
14 IOPC0000055. So IOPC0000055, page 4 of this document,
15 please.
16 I just want to look in the far column, please. This
17 is dealing with an incident the Inquiry has been looking
18 at linking to the incident with Feven, and what's been
19 recorded on this IOPC document again is -- references
20 the injuries and it goes on:
21 "... [the] victim had received a fracture to back
22 and been operated on, ...she should have considered and
23 provided rationale as to why crime should ... not be
24 a sec[tion] 18 GBH. Given severity of injury and police
25 contact earlier in the day, there should have been an

1 IOPC [death serious injury] referral."
2 **THE CHAIR:** Sorry, Ms Cartwright, can you just go back to
3 the beginning so we're clear what this document is?
4 **MS CARTWRIGHT:** Of course.
5 **THE CHAIR:** It's not come up -- it's just come up.
6 **MS CARTWRIGHT:** Thank you. Go back to page 1, please, this
7 is obviously the investigator's report for Operation
8 Astwell.
9 **THE CHAIR:** That's still ongoing?
10 **A.** It is, yes.
11 **THE CHAIR:** I think, therefore, if you're going to go into
12 this, it is something which is still an ongoing
13 investigation, Ms Cartwright.
14 **MS CARTWRIGHT:** No, it's not about the detail, but it's
15 about, again, the categorisation of a DSI.
16 **THE CHAIR:** Well, I think you -- all right, well that is
17 something which is being dealt with, isn't it?
18 **A.** It is being dealt with as part of Operation Astwell,
19 yes.
20 **MS CARTWRIGHT:** Well, we'll perhaps then -- but in the
21 categorisation, just not the details, is that being
22 treated as an indirect DSI?
23 **A.** Again, this is something we're looking at in the context
24 of Operation Astwell.
25 **Q.** Finally, then, could we just go back to your witness

1 statement, please, just under whether there's a need for
2 greater guidance. WITN0339001, at page 5. Thank you.
3 Paragraph 18. One of the matters that I think you set
4 out about the indirect contact definition is that
5 there's no settled case law.
6 **A.** No.
7 **Q.** So do you think that there is a need for greater
8 guidance or advice to be provided to forces about what
9 categorises as a DSI on the indirect contact basis to
10 ensure that there's proper investigation where a matter
11 could fall into that categorisation?
12 **A.** I think it might be difficult to provide further advice
13 when the law itself isn't clear because that would give
14 a false clarity. There's no doubt it's very complex and
15 indeed the entire system of police accountability is
16 very complex because I was -- written to the Government
17 about this. I was very pleased they are planning to
18 review the overall accountability system as part of the
19 White Paper announced a couple of months ago. It is, so
20 any further guidance that gave the clarity where
21 actually the clarity isn't there in law would be
22 potentially problematic.
23 What we tend to find is that forces will -- and
24 ultimately, there will be a matter of judgement about
25 the causation. There inevitably is. It would be

1 impossible to completely cast that out, so there was
2 kind of a line down the middle.
3 What forces tend to do is speak to our assessment
4 unit and get feedback and discuss, and we would
5 generally say: if in doubt, refer it in, and then we can
6 consider it. And then they've done their duty by the
7 law.
8 **Q.** Thank you. I think perhaps you have given us an example
9 of that today about Leicester, they referred it as
10 a query DSI, and then you treated it as a conduct issue.
11 **A.** That's right, yes.
12 **MS CARTWRIGHT:** Thank you very much.
13 **THE WITNESS:** Thank you.
14 **Questioned by THE CHAIR**
15 **THE CHAIR:** Can I just ask about the timing of this, because
16 obviously you've come into post, as it were, halfway
17 through the currency of all of these investigations, but
18 this Inquiry was -- part of our Terms of Reference were
19 to consider and build on the findings of the IOPC, but
20 also not to undermine any investigations, and what in
21 fact happened is, I think it must have been anticipated
22 at that stage, that they would be complete --
23 **A.** Yes.
24 **THE CHAIR:** -- by the time that the Inquiry comes to it,
25 they'd hear evidence and also to report. It's, as it

1 were, gone the other way round, hasn't it?
2 **A.** It has, and I'm sorry, I wish that we had been able to
3 complete them earlier. It was certainly -- it was our
4 intention. The -- as I've set out before, they -- we
5 should have been quicker, fundamentally. We have a --
6 we have a better resourced team now and we have the
7 right people on it. The complexity, I think, was also
8 perhaps underestimated in terms of -- underestimated in
9 terms of some of the number of incidents that would need
10 to be addressed.
11 **THE CHAIR:** I know it may be difficult, but when are you
12 likely to complete?
13 **A.** As soon as possible after the policing evidence. We are
14 now approaching witnesses who have given their evidence
15 to the Inquiry so we can get their final statements.
16 We'll need to review, there is fresh evidence, as I've
17 mentioned before, that's come to light as part of the
18 Inquiry. But I would want to be concluding very soon
19 afterwards as the vast majority of work is now done.
20 **THE CHAIR:** So as far as the Inquiry is concerned, is it not
21 going to be in a position where, as it were, we can't
22 not prejudice your outcomes, but at the same time can in
23 fact take into account your findings which is the
24 requirement of the terms of reference of this Inquiry.
25 **A.** I would hope by the time the Inquiry eventually

1 concludes I'd hope we'd be able to have these
2 investigations finished because we can start as soon as
3 the policing -- sort of the policing hearings have taken
4 place. Then I'd hope we can finalise.
5 **THE CHAIR:** Thank you.
6 **A.** I'm sorry it's taken so long.
7 **THE CHAIR:** Yes, we'll take a break now. Thank you.
8 11.20, thank you.
9 **(11.05 am)**
10 **(A short break)**
11 **(11.20 am)**
12 **MS LANGDALE:** Chair, may I call the next witness, please.
13 Dr Dissayanaka.
14 **DR NUWAN DISSAYANAKA (affirmed)**
15 **THE CHAIR:** Yes, Ms Langdale.
16 **Questioned by MS LANGDALE**
17 **MS LANGDALE:** You have prepared a statement for the Inquiry
18 dated 23 February 2026. Can you confirm that the
19 contents are true and accurate as far as you're
20 concerned?
21 **A.** I can.
22 **Q.** Can you tell us, please, about your qualifications and
23 your role?
24 **A.** So I'm a Consultant Psychiatrist so my medical degree is
25 from Newcastle University. I am a member of the Royal

1 College of Psychiatrists, I have a special endorsement
2 in rehabilitation psychiatry which means I have special
3 experience and expertise in the treatment of people with
4 complex psychosis, and I've worked as a frontline
5 clinician in Assertive Outreach for 24 years as
6 a consultant now.
7 The other bit that may be relevant to the Inquiry in
8 terms of working with disengaged patients with psychosis
9 is that I have expertise in the use of Community
10 Treatment Orders and I was on the topic group for the
11 Mental Health Act review for that.
12 **Q.** Thank you. You are aware, as is everyone else, we
13 haven't asked you to comment specifically on VC's case,
14 but you have prepared a statement that addresses the
15 Assertive Outreach model and you have by your experience
16 a lot of information that you can share with us that
17 will assist the Inquiry.
18 So can I start, please, by the Assertive Outreach
19 model and paragraph 4 of your -- sorry, paragraph 6 of
20 your statement. It might help you, because it's not
21 a memory test, to have that near to you, but can you set
22 out, please, what the Assertive Outreach Model involves
23 and which patients are suitable for that model and why?
24 **A.** So the Assertive Outreach Model is a very specific model
25 designed for looking after patients who have severe

1 mental illness, who are disengaged from services, who
2 don't take their medication reliably, who repeatedly
3 become unwell. There are risks usually associated with
4 those relapses, and who are then repeatedly detained in
5 hospital for treatment.
6 That is the pattern of the patient that we see.
7 That's also what was set out in the Policy
8 Implementation Guidance from 2001, I think it was. They
9 have complex needs. So in addition to those features,
10 they are patients who may have concurrent substance
11 misuse issues. They have social instability, they're
12 often homeless or have had periods of homelessness, and
13 they have high risks, and many have offending behaviour
14 histories as well.
15 **Q.** You refer in paragraph 8 to those complex needs,
16 including a history of violence or persistent offending.
17 Does that have a particular definition for you? Does it
18 require, for example, convictions, or can it be matters
19 that haven't been progressed to prosecution but are
20 still evidence of offending?
21 **A.** It's the behaviour. So in contrast to -- sometimes
22 people who are accepted by forensic services, it's the
23 behaviour, because many people who commit offences are
24 diverted away from the criminal justice system. So it
25 is the risk rather than whether they've been convicted

1 or whether anything is pending.
2 **Q.** So how would you expect, in your current role, in
3 relation to any of your patients, to know about those
4 cases where the police or the behaviour has drawn the
5 attention of the police to them but there isn't, in
6 effect, criminal proceedings that follow? How would you
7 find out about those situations?
8 **A.** That will be captured in the medical notes, because the
9 people we're seeing are not brand new, so they've been
10 in services, so there will be some history in terms of
11 how they ended up in hospital. But we would also seek
12 out that information because it's often incomplete, the
13 records are not comprehensive, and we do that directly
14 with the police by filling out an information request,
15 and they share with us relevant information.
16 It's not the best system, and we don't get all of
17 the information that we need and it can be quite
18 difficult because if people have moved around, then
19 there may be history from other areas which one police
20 force doesn't necessarily hold all of.
21 **Q.** Can I ask you to speak up a little or pull a microphone
22 nearer to you? I anticipate it might be difficult to
23 pick up. I can hear you.
24 But in terms of that, would a psychiatrist or a care
25 coordinator or anyone in the team invite that

1 information from the police by filling in that form?
2 Does it have to be a particular person that does that to
3 request the information?
4 **A.** Our team members can fill the form out, but our team
5 manager is the one who sends it off.
6 **Q.** So you have a system that's set up, so someone in the
7 team, a clinician in the team --
8 **A.** *(The witness nodded)*.
9 **Q.** -- then via the team manager gets the information from
10 the police, the relevant police service?
11 **A.** Yes, but it's not restricted to use by our service.
12 Other services within the trust could do that.
13 Sometimes it doesn't happen, and it is us that looks for
14 the information.
15 **Q.** Right. Any other information sharing, would you request
16 information for other organisations? For example,
17 probation, if you're dealing with somebody that's been
18 on probation, have you ever had a situation where you've
19 requested information there?
20 **A.** Yes, from probation, we liaise with probation officers.
21 We also liaise with prisons if people have been in
22 prison. Wherever we can get the information from, we'll
23 seek it out if -- *(overspeaking)* --
24 **Q.** Local authority, Social Services?
25 **A.** Absolutely.

1 **Q.** Do you get any pushback when, as an organisation, you
2 ask for that information or a service?
3 **A.** There is more bureaucracy in the system than there used
4 to be. It used to be much more readily available.
5 I think people are more conscious now of prejudicing
6 ongoing investigations, so are more reluctant to share
7 -- *(overspeaking)* --
8 **Q.** So the police might not want to give you information
9 about something --
10 **A.** *(The witness nodded)*.
11 **Q.** -- where they're investigating criminal proceedings?
12 **A.** Yeah, and they also might be quite restrictive about
13 which -- you have to be very specific about what you
14 want and why you want it, so they might not share
15 everything, even though it might be very pertinent, but
16 you have to explain that.
17 **Q.** Why would you want it? Is it related to risk assessment
18 and management? Why would you request this kind of
19 information?
20 **A.** It's to do with risk management and management,
21 absolutely. Well, one, we're sending our staff into
22 these situations so we need to know what the risks are,
23 but it's trying to also look at risks that are
24 correlated with the mental illness and deterioration of
25 that, and really mapping that quite closely so that we

1 know what the risks are when people become unwell.
2 **Q.** Where there is multi-agency sharing of information, do
3 you think it would be helpful to have a more formal
4 structure for that with the patients you're dealing
5 with, some kind of multi-agency working format that's
6 specifically directed to adults who are at risk of
7 violence to the public?
8 **A.** I can see the logic in that but at the same time I think
9 that people's histories are often not very well known.
10 So it's how would you identify that, that group?
11 I think just better systems generally of information
12 sharing would be a better way forward.
13 **Q.** Way forward. So as you say, Trusts, not just ones that
14 specialise as you do with your case load, but Trusts
15 should be able to get the same information that you're
16 getting --
17 **A.** Yes.
18 **Q.** -- making risk assessments if they request it?
19 **A.** They should.
20 **Q.** Do you think Trusts should have systems like you have,
21 whether it's via management forms, relevant forms you
22 fill in that everybody understands whether they're
23 sending or receiving those requests?
24 **A.** I think other services do the same thing sometimes.
25 It's the same system for everybody in our Trust.

1 **Q.** Could you, pursuant to giving evidence, let us have
2 a blank copy of the information, the type of form you
3 fill in, please, to send and request for information**?**
4 **A.** *(The witness nodded).*
5 **Q.** Do you have to set out GDPR, why you are asking for
6 information in that kind of detail? Perhaps the form
7 will tell us.
8 **A.** We can certainly look at providing you with a form,
9 yeah.
10 **Q.** Thank you. Paragraph 9 of your statement you say:
11 "The model is underpinned by assertive engagement in
12 the community, a whole team approach with shared
13 caseload rather than individual case management ..."
14 **A.** Yes.
15 **Q.** Can you tell us what you mean by "a whole team approach"
16 and why is that the approach?
17 **A.** So this is one of the features of the Fidelity Scale,
18 which comes later in my statement.
19 **Q.** It does.
20 **A.** The whole-team approach is the team having a shared
21 understanding of all of the patients on the caseload and
22 that's all members of the team because it could be any
23 one of them that might be having to deal with
24 a situation, as opposed to a single worker in
25 a Community Mental Health Team who, if they're not

1 available or away for some reason, you know, that
2 information is lost.
3 We need that because we have different skills within
4 the team and all team members, so we have psychology, we
5 have social work, we have occupational therapy, so all
6 of the people involved need to understand the patient,
7 and their background and their history and the risks in
8 order to work effectively with them.
9 We run an extended hours service so we're there on
10 the evenings and weekends as well, so those staff would
11 need to know all of those things as well. There are
12 lots of good reasons why, for the benefit of the
13 patient, sharing that information is essential. But
14 it's also for the benefit of the staff, because dealing
15 with really complicated, high-risk patients can be very
16 taxing, both on resources and on stress, so to prevent
17 burnout, sharing with colleagues is really important as
18 well.
19 **Q.** Looking at, and as we go through your statement it's
20 very intense, isn't it? You refer to having to have the
21 ability as a team to flex, presumably adapt to the needs
22 of the patient.
23 **A.** Yeah.
24 **Q.** Do you find it difficult to attract the best candidates
25 into this work, given the demands you're going to

1 explain?
2 **A.** The best candidates for this work are people who like
3 this kind of work and this patient group. I really like
4 working with this group of patients, and I interview
5 most of the nurses that we get as well, and it really is
6 that passion for working with people who are very
7 psychotic, very unwell, where the rewards might not be
8 so obvious, but you see this recovery, often over a long
9 period of time, and there are staff who, you know, are
10 very enthusiastic, passionate about that, and those are
11 the people we want in a service like ours.
12 **Q.** So do you think for you it's twofold: one, for the
13 patients, to support them through illness. And just on
14 that point, how distressing is it for patients to have
15 psychotic symptoms and psychosis?
16 **A.** Incredibly, and actually I think this speaks directly to
17 the violence risk. Most people I know who have
18 committed violent acts are very scared when they're
19 doing it, they're very fearful, they're very persecuted,
20 so it is incredibly distressing for the patient to have
21 psychotic experiences. That's on the cases that I have.
22 I think there are other people who might have less
23 intense or slightly different content of their psychotic
24 experiences who are able to engage with psychological
25 therapies better than the patients I see who find ways

1 round that, and working with their psychotic
2 experiences, which may not be quite so distressing and
3 uncomfortable for them.
4 **THE CHAIR:** Sorry, can I just ask you to speak up? You're
5 very softly spoken. It's quite difficult to hear you so
6 it's not simply the microphone, if you can try and
7 project a bit more. Thank you.
8 **THE WITNESS:** No problem.
9 **MS LANGDALE:** So motivational rewards, working with patients
10 facing those distressing symptoms. What about with the
11 Assertive Outreach work and all that you do, the value
12 that that provides to the public, keeping people safe
13 from people doing psychotic episodes and violence, is
14 that also a motivating factor, do you think, to work in
15 this area?
16 **A.** I think it is. But if we -- to me, I think it's very
17 difficult to separate violence risk management from good
18 clinical care. So if you provide the good clinical
19 care, then if it's due to illness, the violence risk,
20 that is something you're going to mitigate against.
21 It's just much broader than that. It's not -- it's
22 about dealing with the other problems that people have.
23 People have premature mortality or morbidity. They
24 are socially very isolated, so it's all those other
25 things, as well. But I mean it comes into it, but

1 I don't think that's a main motivating factor,
2 protecting the public. Do I think it's important?
3 I think it's incredibly important, but it's part of what
4 we do.
5 Q. Do you say -- it's practical support, effectively, a lot
6 of practical support around issues such as housing and
7 finances; day-to-day management with people?
8 A. It is. It's also the psychological support as well. So
9 typically the people we see come to us with a deep
10 mistrust of services. They don't think they're ill, to
11 start off with. They don't think they need medication.
12 They feel that we are part of the conspiracy against
13 them quite often.
14 Q. What, you as in mental health services?
15 A. Mental health services, absolutely.
16 Q. Because you're falsely telling them they're ill, or
17 why --
18 A. Absolutely. And it takes -- there are the more
19 restrictive things that we need to do in terms of
20 ensuring treatment and managing risk, but it takes quite
21 a long time sometimes to get in and build trust with
22 people in that situation, as you can imagine.
23 So it will be practical matters. So, you know, if
24 somebody has really unstable housing, or if they have --
25 don't have access to benefits because the psychosis

1 spills out into all areas of functioning. So addressing
2 those things builds trust.
3 They then get to know us and they realise that our
4 intention is not to be admitting them to hospital if we
5 don't have to, and that we are there to support them
6 with the practical day-to-day things that they need.
7 And that can take a long time. And that collaboration
8 with people building to a point where we're working on
9 their strengths and more independence for them is where
10 we ultimately get to.
11 I talk about sort of constructive relationships with
12 patients, and that's what I mean by that. Does that
13 make sense?
14 Q. It does. Building trust and rapport with a patient.
15 How do you balance that with where you need to challenge
16 them about the fact that they're ill and they need
17 medication?
18 A. I think it's necessary. I think there are psychiatrists
19 who take different views on this about patient autonomy
20 and where the balance lies.
21 My view is that sometimes medication is absolutely
22 necessary and that isn't just for the public good
23 because they pose a violence risk, it's for their good
24 because the consequences for them when they commit
25 violent acts is severe as well. So in my view, it is

1 for them, it's for their care as well as for people who
2 are potentially affected by their actions.
3 Q. Do you talk to your patients about the violence they
4 have committed and what it represents for other people
5 such as their victims and why that can't happen?
6 I mean, do you have those kinds of discussions with
7 patients?
8 A. Yes, and I think you have to get to a position where you
9 can have those conversations, and that's through the
10 relationship. That it's really important to have that.
11 And if somebody doesn't appreciate the effect that it
12 has on victims, that matters. It matters as part of
13 your risk assessment, and, you know, the need
14 potentially for restrictive practice. If they really
15 don't get that part of it, then the potential for that
16 happening again might be higher.
17 Q. What's the importance of having, you say you seek
18 information from the police, but having a police account
19 of events? Because presumably you have situations where
20 the patient has a different account, and you might
21 obtain something from the police that makes that clear.
22 Would you confront the patient about the differences in
23 those accounts and what you knew, or how do you manage
24 that kind of situation?
25 A. We'd have a conversation with them, whether it's -- how

1 confrontational it is I guess is a question. It's more
2 an enquiry to see what they have to say about what
3 happened and what their explanation is. It's often very
4 clear from accounts that that's not what happened
5 because other people witnessed what happened. And I do
6 think that patients' memories, their understanding of
7 what happens when they're very unwell can be very
8 distorted.
9 Q. Do you think, or do you express understanding for the
10 view that someone might not want to upset the patient
11 with the reality of what had occurred, or the account
12 that you had from the police? Would you do that or
13 would you make it clear to them so they did understand,
14 even though it was difficult, how they were behaving
15 when psychotic?
16 A. I believe in honesty. I think it's really important to
17 have honest conversations, and if you're looking at risk
18 management then collaboration in risk management is
19 really important. Not everybody is going to engage with
20 that but management of risk, you know, has to involve
21 the person who might be the risk to other people.
22 Q. Does that mean honesty, truth, collaboration is finding
23 the ways -- I'm not suggesting it has to be
24 confrontational but certainly challenge and discussion
25 about facts where recollections vary?

1 **A.** Absolutely and we do that very regularly.
2 **Q.** Do you?
3 **A.** We have to, to assess the ongoing risk.
4 **Q.** Do you have training amongst you as a team and as
5 a group of different professions about how you do that?
6 Because it's clear people approach those issues in
7 different ways in terms of what they say to the patient,
8 isn't it?
9 **A.** I think it is, but I think there's something about being
10 in a service like ours that, you know, you get to
11 norms(?), so other services take a different approach.
12 So early intervention services dealing with, for
13 example, a group of people who are newer to services who
14 might be presenting with, you know, present with
15 first-episode psychosis, and their approach may be less,
16 might be lighter touch, if you like, in how they deal
17 with things. Their approach to treatment might be the
18 same. I think there is something about culture. You
19 can maintain the respect but you can have really honest
20 conversations because it really matters.
21 **Q.** You're a multi-disciplinary team, you've said
22 psychiatrists, psychologists, occupational therapists.
23 Can you just tell us the difference between psychiatric
24 role and psychological role?
25 **A.** So psychiatrists are medically qualified.

1 Traditionally, we would be the ones who would be dealing
2 with diagnosis and with physical treatment, so
3 medication. I would say that most psychiatrists I know
4 don't just do that; they take a biopsychosocial view,
5 I certainly do. Psychologists would be more involved
6 with understanding the meaning and using psychological
7 therapies, and we have psychologists within our team who
8 do that.
9 **Q.** Do you think they are important -- they have an
10 important role to play?
11 **A.** They certainly are but they see a minority of our
12 patients because the difficulty with patients *(unclear)*
13 because of the engagement is that the consistency that
14 you need, that reflective attitude, the openness to
15 challenging or looking at alternative explanations for
16 experiences, specifically talking about cognitive
17 behavioural therapy here -- some of our patients really
18 aren't at that stage of being able to do that.
19 So yeah, they see -- but they -- psychologists in
20 our team, in addition to direct care, they facilitate
21 our formulations and team supervision, reflective
22 practice, that kind of thing. So they're very much
23 there for the team and helping us to understand, even if
24 they're not seeing the patient directly.
25 **Q.** Just tell us what you mean by formulation.

1 **A.** So formulation is looking at whatever area you're
2 looking at, so it might be you're feeling very stuck
3 with a patient -- sorry, I should say there's lots of
4 different models of formulation -- and trying to
5 understand that better. And the way that we would do
6 that is look at it in the context of a person's life
7 history, and what the meaning might be behind the
8 behaviours that they're exhibiting, so just trying to
9 understand more why --
10 **Q.** Why.
11 **A.** -- things are happening, and the way they're happening.
12 **Q.** That's the point, isn't it: understanding whatever the
13 illness, why? Why is it happening? Why is the violence
14 happening or the behaviour, and how can you address
15 that?
16 **A.** I think it's really important and I think that knowledge
17 of the person is really important as well. These things
18 get lost in the mists of time and that continuity we
19 have in our service is really important. So I might get
20 a call from, you know, the team that says that one of
21 our patients has been out scratching cars, and to some
22 people that without seem like a really innocuous thing
23 for that person to be doing, but within the team, what
24 we know, because we have this much more longitudinal
25 in-depth approach, is that that happened before. That

1 happened because of the number plates of the cars and
2 the meaning that those number plates had for that
3 patient. It also happened in the context of increased
4 drug use. It was also associated with the sharp
5 escalation and significant violence that followed. It
6 also happened because that person was carrying a bladed
7 instrument with them that they used to scratch the car.
8 So all of that comes in to understanding. It
9 doesn't necessarily understand why he had the idea, you
10 know, he might have had the idea that, you know, that
11 meaning was there, but it does help us to understand
12 what the risks might be.
13 **Q.** Risk and escalation?
14 **A.** Exactly.
15 **Q.** You tell us at paragraph 11 of your statement that:
16 "Assertive Community Treatment is one of the most
17 extensively evaluated mental health interventions, with
18 15 systematic reviews and over 75 randomised controlled
19 trials, showing good evidence for its efficacy."
20 **A.** Yes.
21 **Q.** So when you say "efficacy", what are you referring to
22 there?
23 **A.** So previously, so right back to the original research on
24 this, this is by Leonard Stein and Mary Test, so that
25 is -- the landmark paper was in 1980, but the work

1 happened in the 1970s, and they introduced what became
2 Assertive Outreach with a group of patients who were
3 frequently hospitalised and it was part of the
4 deinstitutionalisation that was happening in America at
5 the time.
6 What they found was that those patients who received
7 this level of support and this team approach of way of
8 working, they were in hospital less, they had less
9 symptoms, they were more compliant with their
10 medication, they had more stable housing, their social
11 functioning improved, and some of them were working, so
12 their employment stability was maintained.
13 There's been lots of other studies that came after
14 that, which have -- has looked at all of that and those
15 are the things. Offending behaviour is something that's
16 also been in amongst.
17 So the observation, I think, from the original study
18 is not admitting to hospital didn't spill over into the
19 criminal justice system, but after that it was more
20 about the offending behaviour reducing with the
21 Assertive Outreach Team involved, but it's called
22 Assertive Community Treatment in the States.
23 **Q.** You say at paragraph 14:
24 "Standard community teams cannot offer this and
25 hybrid approaches, as well as lacking a positive

1 evidence base, have been shown to lose the benefits such
2 as decreased hospitalisation rates."
3 **A.** Yes.
4 **Q.** Why is it that you say the standard, if it's not obvious
5 from what you've said before, standard community teams
6 can't provide this?
7 **A.** If -- I don't mind if we go to paragraph 45 in my
8 report, I think it's worth talking about Fidelity there.
9 **Q.** Shall we have that on the screen?
10 **A.** If you don't mind.
11 **Q.** Of course. WITN0412001, page 24, please.
12 **A.** So these are the -- this is not an exhaustive list, by
13 the way, but these --
14 **Q.** It goes on to the next page as well.
15 **A.** It does.
16 **Q.** We can probably put two on the same screen, 24 and 25.
17 **A.** So even this is not the exhaustive list. The Fidelity
18 Scale has either 26 or 28 items, depending on the
19 version. But what it does reflect is what Assertive
20 Outreach teams can do and do do that Community Mental
21 Health Teams can't manage. That's not a criticism of
22 Community Mental Health Teams, by the way, I think
23 they're very good, by and large.
24 So we have small caseloads. We have a small -- so
25 individual caseloads for care coordinators. We have

1 a small team caseload. We have the range of staff
2 involved in the team itself who can offer this assertive
3 approach to care within the team in-house, rather than
4 brokering out the different needs to different agencies
5 which people are not going to engage with.
6 We have a high intensity of contact as a standard.
7 We have a weekly multi-disciplinary team meeting in
8 which we review all of the patients on the caseload, no
9 matter what their situation, and a daily planning
10 meeting in which care is planned in addition to the
11 planned visits, so things changed during the course of
12 the week. That still doesn't capture how much work is
13 needed because there are missed visits where people
14 aren't there, we go back and there are --
15 **Q.** Do you go back the same day --
16 **A.** Yes.
17 **Q.** -- if they're not there? How many times when you stop
18 going back the same day?
19 **A.** People can go a couple of times, two or three times to
20 try to get contact with the same person in a day, and
21 that's not because they're deteriorating, that's because
22 they weren't there and they're hard to engage. We have
23 some patients that are homeless, for example, and it's,
24 you know, trawling around where they might be begging
25 might be the place where we try to find them, so it's

1 not something that can be offered by --
2 **Q.** And not engaging or dropping out isn't an option for
3 you, is it?
4 **A.** No. So I mean we operate a "no drop-out" policy. We
5 won't discharge people because they're seen as hard to
6 engage or not engaging. We would keep trying and
7 exploring other avenues, looking at social networks. So
8 actually working with social networks is one of the
9 features of the Fidelity Scale. So we would be very
10 much on to whichever social networks there'd be family
11 immediately if we couldn't find somebody and we were
12 concerned that there was deterioration.
13 **Q.** On the subject of family, if a patient did not want you
14 to contact the family or told you that --
15 **A.** Yes.
16 **Q.** -- does that prevent you from receiving information from
17 the family? Not necessarily providing information about
18 the patient, but checking in and finding out what they
19 know? Would you do that?
20 **A.** Yeah, we can't share information about the patient. If
21 they -- I mean that's -- actually we can, depends on
22 what the information is. But receiving information,
23 absolutely.
24 **Q.** So everybody would understand that in your team. You
25 can still contact and effectively say, "Do you know

1 where they are? Can you check in with them? How did
2 they sound to you? Where are we going to find them?"
3 **A.** Yeah.
4 **Q.** If they're being helpful about where they think they are
5 or where they are not where they are and pointing that
6 out to you, that would be useful.
7 **A.** Yeah, or if they're saying they're away or are giving
8 false addresses as might be pertinent. Those would be
9 red flags with somebody who is very psychotic and
10 disengaged, and we'd be looking to other people to
11 confirm that and try and find the person.
12 **Q.** In terms of the limitations of what you shared with
13 family members, you said it depends what it is. What
14 could you share in those circumstances where a patient
15 didn't want you to communicate with the family?
16 **A.** I think if we're talking about violence risk and other
17 people being harmed, then I think that would be
18 a circumstance where we might need to share information.
19 **Q.** Well, it might be directed at the family, mightn't it --
20 **A.** Exactly.
21 **Q.** -- or anyone else, if they're a risk. So anyone you
22 thought might be adversely affected by the risk, or
23 impacted, you would consider you were able to share --
24 **A.** Yes.
25 **Q.** -- information about escalation of a risk. So if they

1 were at a school or an adult at university, if you
2 thought they were a risk to other people you would feel
3 able to share that.
4 **A.** I think it would depend on the case --
5 **Q.** Of course.
6 **A.** -- but we would have to look at that very carefully and
7 if we felt there was a tangible risk then we would
8 pursue that.
9 **Q.** Would that be a whole-team consideration? You set out
10 how you're always at the meetings as the consultant.
11 **A.** Yes.
12 **Q.** Would that be sufficiently serious to have that
13 discussed across and between you?
14 **A.** These things are discussed together. I'm very much part
15 of the team. I mean one of the other things that --
16 I don't know if --
17 **Q.** Yes, do you want to go back to this? Sorry, I've taken
18 you off the Fidelity list.
19 **A.** I don't know whether it's sort of the access to the
20 doctor is really important, so I regularly through the
21 course of the week say, "We've been to see so and so and
22 we're not happy about, you know, we think they're
23 deteriorating, can you come and see them?" And I would
24 go and see them. I keep my diary as flexible as I'm
25 able to in order to accommodate that, which again, in

1 a standard Community Mental Health Team, they've got
2 high caseloads, you know, they work very more
3 clinic-based, they're dealing with far more engaged
4 patients. It's just quite different. They can't just
5 suddenly change to this way of working because the
6 system is in some ways structurally incompatible with
7 this way of working.
8 **Q.** You're critical, aren't you, of the Theemis Report for
9 not referring to this Assertive Outreach model and how
10 this can assist. Do you want to say something about
11 that as well?
12 **A.** I don't think the Theemis Report is on its own.
13 Assertive Outreach. There is a phrase "Assertive
14 Outreach approach" which I don't really understand, and
15 I think it just means trying to be more proactive with
16 people who might be disengaging.
17 **Q.** Just pausing there, can we finish with this sheet?
18 **A.** Yes, of course.
19 **Q.** This can come down, and while you're talking about that
20 can we have NHFT0015099, page 12. You've just referred
21 to the fact that you don't find the terminology helpful
22 in Theemis --
23 **A.** Yes.
24 **Q.** -- and there's references to "outreach approach". This
25 is actually "Assessment and management of risk to

1 others", the Royal College of Psychiatrists guidance,
2 and if we look at NHFT0015099, page 12, we see
3 in "management plan", three or four bulletin points from
4 the bottom:
5 "Has an assertive outreach approach been
6 considered?"
7 Now it's clear, as you've said, units aren't set up
8 like you are and resourced -- and we'll come to that in
9 a moment -- like you are. This seems very much to
10 suggest there's an approach, in other words you don't
11 have the unit but try and think about some of the things
12 they do.
13 Is that broadly how this is used? And do you think
14 it's a safe expression, is it possible?
15 **A.** I don't really understand what it means. Assertive
16 Outreach is a very clearly defined model, it has
17 a Fidelity Scale which most services don't have anything
18 like that, it's a standalone model. But it is not just
19 Theemis, it's not just the Royal College
20 of Psychiatrists. I think in NICE guidance the bipolar
21 guidance refers to an Assertive Outreach approach.
22 I think the homelessness one does as well. I don't
23 really know what it means because it isn't a thing.
24 **Q.** That can come down, please. Do you tell us in the
25 statement and, indeed, in its opening the Inquiry made

1 reference to the Ritchie Inquiry, the report, the
2 recommendations subsequently and --
3 A. Yes.
4 Q. -- the investment around mental health, and you set out
5 at paragraph 18 of your statement -- we can have that
6 back, WITN0412001, page 9 -- you set out at paragraph 18
7 the ten-year strategy by the government and
8 subsequently -- Well, tell us what "The National
9 Reduction in Assertive Outreach Provision" outcome
10 involved. What was that?
11 A. So if you indulge me, I'll just go back a little bit
12 because you mentioned the Ritchie report. The Ritchie
13 report comes from a case in 1992 from a case of
14 Christopher Clunis, who killed a chap called Jonathan,
15 Zito at Finsbury Park station. There are striking
16 similarities in terms of systemic failure with lots of
17 cases. I'm not mentioning -- not specific to this -- in
18 terms of lack of oversight, risk management, various
19 things. And the Ritchie report looked at all of these
20 and it recommended -- it made some really good
21 recommendations, it talked about strengthening care
22 planning through the care programme approach, it talked
23 about aftercare, through section 117 aftercare. It
24 talked about the forerunner to community treatment
25 orders, Section 25, or supervised discharge, and it also

1 led to the national roll-out of Assertive Outreach
2 teams.
3 So that came through via the National Service
4 Framework along with Early Intervention Services and
5 crisis services, and it was quite centrally prescribed
6 by the Policy Implementation Guidance, which is a very
7 good document.
8 After that, however, there was a decline. So this
9 is bringing me on to where we are here. One of the
10 metrics linked to the roll-out of Assertive Outreach
11 teams was hospital use, and one of the things that
12 people wanted to see was a reduction in hospital use.
13 I personally don't see the logic in that because
14 this was never about hospital bed use, it was about
15 violence risk management. And there were a number of
16 studies, a few studies, which conflicted with the
17 earlier American and other studies, which said that
18 hospital use was not reduced by the use of Assertive
19 Outreach. The most prominent of which was the REACT
20 study in 2006.
21 There are various reasons and explanations why that
22 might be the case and I've laid those out in my
23 statement. But what I think that was a catalyst for is
24 the reduction of Assertive Outreach Team provision
25 across the country to the point now where I think we've

1 got about a third of areas have got some form of
2 Assertive Outreach, although I would suspect that a lot
3 of it is very low Fidelity.
4 Q. We see at paragraph 20 of your statement you say:
5 "... the current position ... in England ... now
6 estimated at 32% coverage and a significant variation in
7 the fidelity of the remaining teams."
8 Was that all about financial cuts, do you know, or
9 as opposed to misplaced faith in the capacity of
10 Assertive Outreach?
11 A. I think things are often about money. So I think
12 finances definitely played a part. Health is very
13 political, so it depends on what the priorities of the
14 day might be. And I think there are some sort of
15 ideological differences within the profession about
16 Assertive Outreach as well. Some consultants may -- not
17 consultants -- some psychiatrists may be very wedded to
18 the idea of broader community teams and not specialist
19 services. This provided an opportunity, I suppose, to
20 be looking at reducing the number of Assertive Outreach
21 teams.
22 So there's probably lots of factors that led to it,
23 but finance is a big one, I would say.
24 Q. In terms of belief in community teams, this is
25 a specialist cohort, isn't it, identified in the Ritchie

1 Inquiry and identified through your evidence.
2 A. Yeah.
3 Q. A specialist cohort that require particular management
4 and assessment of risk on an ongoing basis; is that
5 right?
6 A. That's my view.
7 Q. At paragraph 21, you say:
8 "The subject of violence risk is fraught with
9 misinformation, fear and stigma and one that is largely
10 still avoided."
11 What did you mean by that?
12 A. I think, when talking about mental illness, people are
13 quite squeamish about talking about violence risk
14 because it's stigmatising, and drawing that association
15 where most people who have -- the vast majority of
16 people who have mental illnesses don't commit any
17 violence, I think is found to be unhelpful and
18 demonising.
19 My personal view is that we should just be a bit
20 more honest about this, just because patient
21 homicides -- and that's obviously the most extreme end
22 of violence risk -- just because that's rare, or just
23 because patients may be more the victims of violence
24 than the perpetrators of violence in general, doesn't
25 mean that patient homicides and violent risk towards

others is insignificant, read as not meaning significant.

My own experience of seeing the consequences of patient homicide, it's absolutely devastating, and I don't think that's appreciated sometimes within the profession. So what's happened over time is that people have said because it's rare, we take a public health approach. It's not something that we should focus on too much.

And so if you look at the anti-stigma campaigns, they're always around more palatable aspects of mental health, mental illness, and more things that people can identify with better, and actually the stigma hasn't changed when it comes to violence risk. It's still the same.

I think we should just be honest about it so that this is something that happens, this is something that might not happen very often, but it is something that we need to take seriously for the sake of the people affected, including victims, including patients. And I think that that's --

So what's happened is we've had more of a focus on suicide when it comes to deaths, as opposed to homicide. I think this was -- it's kind of illustrated by the change from the National Confidential Inquiry to not

81

looking at homicides, I think it was 2018, I'm not sure of the date, which I think is coming back now the other way.

Q. Yes.

A. Also, a lot of the work, when we have training, it's all about suicide, there's very little about violence risk now. So I think it's something, it's an area we need to focus on far more and take far more seriously.

Q. In terms of the issue of stigma, it's the case, isn't it, that the majority of those people with paranoid schizophrenia or psychosis won't commit violent offences?

A. Yes.

Q. But you've referred and -- indeed, we'll be hearing from them -- Professor Fazel about work surrounding whether there is a significant association between schizophrenia, psychosis and violent offending. So your evidence is that needs to be confronted, addressed, and patients treated, you'd say, through a proper programme?

A. I think Professor Fazel is far more qualified than me to talk about the academic aspects of this. There is certainly an association with violence risk in schizophrenia. There are other areas around substance use, around antisocial personality, around childhood experiences, around social factors, which are all

82

relevant and all things that we should be looking to try to impact upon. But he would be more qualified to talk about the statistics and the associations than me.

Q. So are you describing co-morbidities there, personality factors or disorders, with schizophrenia?

A. I wasn't, no. I think he talked about -- well, I'd let him speak to his own research, but I think it's about antisocial personality disorder specifically itself without necessarily psychosis, but he'll be able to explain that better than me.

Q. Understood. Paragraph 25, please, you describe your case load, and halfway down say:

"On my caseload approximately two thirds of patients have history of keeping or using weapons as part of their previous relapses and they often have a poor appreciation of the risks they present when unwell."

A. Yes.

Q. Do you routinely and are you able, in your position, to understand what your patients are viewing on phones or what they're accessing and seeing? I mean, there's a lot out there now, isn't there, live streams, videos, mass killings, information that people can access. Do you have any way of understanding what people are seeing and how that might be influencing them?

A. An omission from my statement is that almost everybody

83

I see has a history of violence in the past, in the context of being unwell. In addition to that, that's the two-thirds have a history of -- sometimes it's just keeping for self-protection at home, but because they think they're going to be attacked. Sometimes it's more than that, taking out or using weapons. So it's quite broad.

In answer to your question, a lot of my patients are digitally excluded. So they're not looking on their phones at things like this or on the Internet. They don't have phones is part of the problem in terms of keeping up with them. But we do -- we don't have access to what they're looking at but we do ask them about what they're looking at. Particularly that's been the case with people who we consider to be groomed or vulnerable to terrorist activity. So if people have been with Prevent -- well, they don't usually engage very well with them, but if that's been flagged as a risk, then that's something we would obviously keep asking about, you know, what they're viewing and what they think of it.

Q. So you can't compel them to show you their phone but in best-case scenario they might let you have a look at it. Does anyone let you have a look at a device?

A. They do, yeah, yeah.

84

1 Q. Would you keep going back to that? Because our phones
2 do tell us a lot, don't they, about people, what they're
3 seeing, viewing, how they're communicating, which is
4 highly relevant presumably to dynamic risk assessment,
5 but it's difficult to understand how you would access
6 that where somebody says they don't want to give it you.
7 In those circumstances you couldn't persist with that.
8 A. Not that I'm aware of, no.
9 Q. No. Paragraph 29, please. In fact, it's page 16, the
10 end of that paragraph. You say:
11 "Assertive Outreach Team members do inreach into the
12 wards in their efforts to be included in and to inform
13 discharge plans. There is scope for improvement in this
14 aspect of communication."
15 So these are people who have been hospitalised and
16 moved from hospital to living in the community with your
17 support and management. How do you or your team work to
18 support the hospitalisation?
19 A. So we -- one of the aspects in the Fidelity Scale is
20 about having responsibility for not just the kind of
21 social support and the aspects I've talked about before,
22 but also the hospital stuff. So we would -- well, we'd
23 manage the crisis if we can ourselves. We don't refer
24 to crisis teams, so there's no fragmentation there. But
25 if they need to be admitted we would organise that. We

1 would be the ones who'd be organising; it wouldn't
2 happen through our crisis team, we'd do it directly.
3 Q. So are there times, whether it's lack of insight, lack
4 of ability to accept the use of medication, you will
5 initiate that?
6 A. Sorry, can you --
7 Q. You will initiate a period of detention or being in
8 hospital.
9 A. Oh yes. Yeah, and that might be for that reason. It
10 could be because of deterioration. It could be because
11 they're on a Community Treatment Order and they're
12 not -- they're either deteriorating or they're not
13 sticking to the conditions which are felt necessary. So
14 they may be recalled to hospital for their treatment
15 under that framework as well.
16 But absolutely, and with the Community Treatment
17 Orders it would be the team that managed that in terms
18 of getting the necessary warrants, organising the secure
19 transport if that's needed. All of those practical
20 aspects are done by the team to admit the person to
21 hospital.
22 Once they're in the hospital, as with every patient,
23 as I've said, every patient on the caseload is reviewed
24 every week, so we would be having a very in-depth
25 conversation about what's happening with that patient

1 week by week, if they're in for a longer period than
2 a week, to see what's happening with their treatment, to
3 see what's happening with leave arrangements, to see
4 what's directly in reaching, going and seeing a person
5 on the ward in preparation for discharge.
6 If they're on leave, supporting the leave so we see
7 them at home before discharge if that's feasible, as
8 well as planning what their treatment is going to look
9 like, or where they might live if that's something
10 that's come up whilst they've been in.
11 So all of those aspects are things that we'd be
12 doing very directly with the wards.
13 There's enormous pressure on beds across the country
14 and I think that sometimes people do get discharged
15 quicker than we would like them to be.
16 Q. From hospital?
17 A. From hospitals.
18 Q. But not from you as a team in the community?
19 A. No, no, no, no. So we would be picking that up in
20 a more urgent way if that was -- if that's what the ward
21 felt they needed to do.
22 Q. So it sounds like you have procedures and protocols
23 that, despite paying respect to the patient's autonomy,
24 where you're concerned, and there is non-engagement or
25 not taking a medication where it's necessitated, you

1 will initiate a different route?
2 A. Yeah, and it's all captured. I think it's not in my
3 documents but I think it's captured in some of the other
4 documents about a RAG system, so red, amber, green, sort
5 of a zoning system that we have. We have that. So we
6 have a red zone where people -- where we're more
7 concerned, we need to have much more frequent
8 conversations about them, see them daily or see them
9 more than daily. We have people who are less of
10 a concern. We have -- I mean ours isn't a RAG system,
11 we've got more boxes. So we have people on Community
12 Treatment Orders to make sure we're doing everything we
13 need to do within that framework, and we have a hospital
14 zone. So we have those people specifically in there so
15 we're reviewing those people very regularly as well, so
16 everything is very systematic.
17 Q. You say in paragraph 30:
18 "During COVID full face to face contact was
19 essential rather than remote working for this group."
20 A. Yes.
21 Q. Why do you say that, and were you able to achieve that?
22 A. We had to limit slightly in terms of visits because of
23 the restrictions, but by and large, visits continued as
24 normal during Covid with us going with protective gear
25 on and everything. There's two reasons for that. One

1 is a lot of our people are hard to contact. So we
2 wouldn't have been able to do telephone calls or video
3 calls or anything else, because that just doesn't work
4 for them. So going and going repeatedly to see people
5 still had to happen.
6 There is also something about seeing a person in the
7 community, seeing them in their environment, that tells
8 you an awful lot about how well they're doing. Somebody
9 can come to the clinic and seem okay but when you go to
10 their house and you see, you know, that they're really
11 not managing and things are declining, then that can
12 tell you a lot. And actually it's more comfortable for
13 some people who are in this situation not to come to
14 a healthcare setting as well. So, you know, going and
15 seeing somebody where they're more comfortable is better
16 all round, really.
17 And I say it -- I haven't said but I don't do any
18 clinics; all of my work is visits.
19 **Q.** Paragraph 34, please. You refer to bed use in Leeds.
20 **A.** Yes.
21 **Q.** Can you just expand upon that: "the use of acute beds
22 ... calculated for patients accepted by the Assertive
23 Outreach Team"?
24 **A.** So the REACT study, what that did was it looked at
25 patients who were with the Community Mental Health Team,

1 and they either stayed with the Community Mental Health
2 Team or they went to a fairly newly established,
3 I think, Assertive Outreach team, and then they looked
4 at their bed days' difference.
5 We did the reverse of that -- sorry, we did the same
6 as that, so we looked at people who'd come from
7 Community Mental Health Teams to our service. We've
8 done it twice. The first time was in 2010, and there's
9 a very lengthy report in my bundle from one of my
10 previous trainees who wrote that up. And what that
11 showed was conversely, with regard to the REACT study,
12 there was an 80% reduction in bed days in people coming
13 to our team, and that was looking at the 12 months
14 before and after coming to our team.
15 Our infomatics department looked at this again in
16 around 2020, and it looked at all of the patients we
17 took on over a five-year period, in the 18 months before
18 and after coming to our service, and what that showed
19 was a reduction from around 27,500 bed days to around
20 9,500 bed days, which is a reduction of 18,000 bed days
21 which I think is around 65%. So these findings are
22 quite different to what the very limited research that
23 says it doesn't reduce bed days with the high fidelity
24 model, our experience is very different to that.
25 The important thing, in terms of cost, is that that

1 number of bed days over that five-year period equates to
2 ten beds, ten adult acute beds. So really a significant
3 saving.
4 **Q.** Paragraph 35. You set out that:
5 "Patients with the Assertive Outreach Team
6 invariably have a history of poor medication
7 concordance."
8 Can you just give us a very brief overview of the
9 available medications, the antipsychotics, and you refer
10 to when clozapine may be used and the safeguards around
11 that treatment?
12 **A.** So there are various oral antipsychotic medications.
13 They vary not so much in terms of how well they work,
14 but more terms of their side effects profiles and
15 tolerability for different patients. People are very
16 individual in terms of what they tolerate or don't
17 tolerate. And that might determine the choice.
18 There are depot medications. They're all older
19 actually now but we used to talk about the older style
20 ones and the newer atypical ones, but they're all quite
21 old. Again, the older ones tend to be -- have more side
22 effects and problems but some of the newer ones have
23 different side effects and problems. Again, there isn't
24 a lot to choose in terms of difference in terms of how
25 well they work.

1 Clozapine is the antipsychotic that stands out and
2 is much more effective for treatment-resistant
3 schizophrenia, psychosis. It does have restrictions on
4 it because it causes drops in your white blood cell
5 count so it needs very close monitoring, and that's the
6 difficulty, in a community setting, with patients who
7 are refusing that or not engaging is getting the blood
8 tests to make sure that it's safe treatment because you
9 can't do it without the blood monitoring; it's
10 a requirement.
11 So those treatments, we do have quite a lot of
12 people on clozapine, or have had over the years, but
13 it's one we can't use if someone is not going to comply
14 with the conditions of that use in the community.
15 **Q.** In your patient cohort, is there a distinction for you
16 between recognising where someone is treatment-resistant
17 as opposed to simply resistant to treatment and not
18 wanting to take anything because they don't think
19 they're unwell?
20 **A.** I think, yeah, in the community setting, it's quite
21 complicated with my patient group, because there are
22 other destabilisers in the mix, not least of which is
23 their illicit drug use. When people go to hospital
24 sometimes they're treated with medication and they do
25 very well, and then they come out and then everything

1 destabilises again. That, as with risk, is very
2 dynamic. But there are certainly a group of people who
3 don't respond to anything apart from clozapine, and
4 that's what you need to use with that group.
5 **Q.** Paragraph 44, you make reference to:
6 "... the Theemis Report ... recommendation that
7 across the Trust ..."
8 There should have been:
9 "... robust peer support offer for those under
10 community mental health services with access to
11 culturally appropriate groups with lived experience. "
12 You say that whilst that may be helpful, the
13 evidence base is that it's limited for patients such as
14 yours. Why is it limited in that cohort of patients?
15 **A.** So in an earlier part of my statement, what I've said is
16 that there was felt -- what it implies is that that
17 sharing of understanding is the thing that would be more
18 helpful in terms of the relationship with this patient
19 group, and that might be achieved with a peer support
20 worker, who might be very paranoid, and it specifically
21 talks about people being paranoid.
22 I mean, that's all the people that we see, have a --
23 are very paranoid and we're very used to dealing with
24 them, collaborating with them, advocating for them,
25 working with them in a very constructive way. So

1 I think that was initial objection to that is that we do
2 that anyway.
3 The more sort of -- the other part of this is that
4 the patients I see don't think they're ill at all, a lot
5 of them. So if you were to mention you might meet with
6 this person who's had similar experiences to you, that
7 isn't something that they'd want to do. They will say,
8 "Why would you want me to do that?" And we've asked
9 people many times whether that's something they would
10 want, and they've said no.
11 It is something that we will continue to explore
12 because I think there is some merit in it if we can, but
13 I think if it's being framed as a peer support offer
14 instead of Assertive Outreach or instead of a different
15 route, I think that would just be dangerous, because to
16 expose somebody who is unqualified, who isn't versed in
17 risk management to somebody who is very paranoid,
18 dangerous to other people in the way that he was,
19 I think would be really reckless. I think that really
20 would. It wouldn't be instead of what we do, I think
21 that would not be sensible.
22 **Q.** In terms of you refer to the paranoia, there's much more
23 material available on the Internet now, isn't there,
24 that supports those who have conspiracy theories, views,
25 that can be to amplified in certain sites. So again, is

1 psychiatry up to date with that, or that information
2 that's available on the Internet and how that might be
3 impacting thinking?
4 **A.** I think there's emerging talk about AI psychosis,
5 I think, I don't know if that's what you mean. And
6 about how, because of the way it affirms the things that
7 you're saying, it can worsen these things. I don't
8 think that necessarily represents a change in terms of
9 cause, but it certainly may represent a change in terms
10 of course. So --
11 **Q.** And risk?
12 **A.** -- accessing that is very isolated -- and risk, yes --
13 who is accessing that who might be very isolated and is
14 having their beliefs confirmed by AI, I think that
15 potentially could be a dangerous thing. Again, it's
16 through conversations, trying to understand. I don't
17 think there's enough research there to be up to date
18 with it in meaningfully changing things, but talking to
19 people about whether they are using that to make sense
20 of what's going on for them is -- I think it's something
21 that's -- it's something we're going to need to learn to
22 do more of.
23 **Q.** Paragraph 50 onwards, page 26, you were invited to
24 suggest recommendations in this area.
25 **A.** Yeah.

1 **Q.** You set out at the beginning criteria for Assertive
2 Outreach and explain how it works, and you say on
3 page 27, the last bullet point:
4 "They have high risks which may include significant
5 violence risks. They require a team led by a consultant
6 psychiatrist dedicated to and experienced in the
7 assessment and management of higher risk thresholds.
8 They require close monitoring of these risks with robust
9 longitudinal risk assessment and regular review."
10 Again, would you just like to summarise for us why
11 you say that's necessary in a particular cohort of
12 patients, as the Ritchie Inquiry, of course, said and
13 found before?
14 **A.** Do you mean consultant psychiatrists in general, or do
15 you mean --
16 **Q.** Just the whole approach of the whole team and the role
17 of the psychiatrist consultant is only one person in
18 that, from what you've expressed, but why do you think
19 that is so important for this cohort of patients?
20 **A.** Well, this section what I tried to do was lay out the
21 different areas which the team approach is needed for,
22 and the specific expertise in this patient group. So
23 there are things in there about their sort of
24 occupation/social needs, their physical health needs and
25 risk is one of those needs.

1 I think that having -- this is -- it's what we're
2 used to, we're dealing with this every day. I've spent
3 the last 20 plus years every day dealing with people who
4 are at high risk of violence. So me, I carry a lot of
5 that responsibility, but the team also share that, so
6 it's something we develop a culture around in terms of
7 how to deal with those things. So that's why I've set
8 out dedicated service is important.
9 Because the people -- the sequence of events if you
10 don't have this is that people who aren't asking for
11 services, in fact don't want services, disengage.
12 That's not picked up on quickly enough. As they
13 disengage, they start to become unwell because they're
14 not having treatment. The warning signs are not picked
15 up on. By the time they are picked up on, things have
16 escalated to the point where the risks are going up. So
17 having a systemic team approach to considering this,
18 monitoring this, and intervening in a timely fashion, is
19 really important. That's why it couldn't be managed in
20 a system where these people are scattered, where they're
21 easily missed.
22 **Q.** If we can go to paragraph 53, please, on page 30, you
23 refer to the training there, specifically the principle
24 of qualified care coordination should remain, you
25 suggest and you refer to "qualified community

1 psychiatric nurses or social workers".
2 What do you say about the qualification of mental
3 health workforce and the importance of qualification?
4 **A.** I think it's something that isn't taken seriously
5 enough. I think that we have an increasingly
6 unqualified mental health workforce which we probably
7 wouldn't tolerate if we were talking about parity of
8 esteem with physical health care.
9 I think that there are specific things that people
10 learn during their training in different disciplines in
11 mental health care to get those qualifications. That
12 includes knowing about illness, knowing about risk,
13 knowing about the use of the Mental Health Act, knowing
14 about safeguarding, there are lots of areas where these
15 things are specifically covered in training, and an
16 induction into that is not the same thing.
17 The other part of it is accountability. If you have
18 a PIN, if you have, you know -- a nurse would have a PIN
19 with the NMC, or if you have another qualification, you
20 are accountable to your responsible body, which means
21 that if you're not practising correctly, there is
22 a clear route as to what can happen there. You're
23 accountable for your actions and you potentially won't
24 carry on working in that field if things are not done to
25 a standard, which I think is also really important.

1 **Q.** Do you?
2 **A.** Yes.
3 **Q.** Why is that?
4 **A.** Because I think that there's something changes
5 sometimes, not always, in how we do because it means
6 that our role is compromised, our job is compromised
7 directly. That doesn't always work, by the way. I get
8 that.
9 **Q.** Page 31, you touched on this earlier, your third bullet
10 point:
11 "The focus of risk assessment has moved almost
12 exclusively towards suicide risk. ... There should ...
13 be a requirement to include any history of violence in
14 transfer letters and hospital discharge summaries."
15 So why do you think that shift occurred, and do you
16 have any comfort that it is being redressed now, or not?
17 **A.** No, I don't really.
18 **Q.** No.
19 **A.** I don't know why -- I think I've laid out the reasons
20 why I think we don't talk about violence risk enough,
21 but yeah, I don't think it's being addressed.
22 **Q.** You say about Community Treatment Orders: they're:
23 "... an important framework for treatment for some
24 patients."
25 Why do you say that?

1 **A.** I think the evidence around Community Treatment Orders
2 has been -- Community Treatment Orders have been
3 criticised because of the available evidence that's
4 there, which in my view was too broad. So there has
5 been -- there have been three randomised control trials
6 on community treatment orders, one in this country, and
7 it looked broadly at community treatment orders being
8 used as opposed to extended section 17 leave for
9 patients who have been detained in hospital who had
10 psychotic illness.
11 But that isn't the group that you need to focus in
12 on. The group that you need to focus in on is the
13 highly disengaged group, who don't take their treatment
14 and where there are consequences in terms of relapse and
15 potentially risk. That's where Community Treatment
16 Orders in their history came from in different
17 jurisdictions, and that's what should be the focus.
18 The available research doesn't cover that
19 adequately. We have looked at Community Treatment Order
20 use in our service, and as much as I've said negative
21 things about hospital bed days, they are massively
22 reduced by the use of Community Treatment Orders in our
23 service and the reason for that is because people have
24 been treated, so they may be recalled briefly to have
25 a depot, for example, but then they're out again and

1 they are in the community in the least restrictive
2 situation again, and staying stable.
3 So I think if you use it in the right population,
4 that's what needs to be looked at as to whether they're
5 effective or not. They're probably maybe being used too
6 widely as well, but I don't know about the figures.
7 **Q.** But not by your service --
8 **A.** Not in -- no.
9 **Q.** -- you say you need them in order to avoid
10 hospitalisation.
11 **A.** That's true, and also, as things progress and people
12 engage more, the numbers go down. I think back to 2018
13 or 2019, I had about 75 Community Treatment Orders on my
14 caseload personally. I think I'm down to about 40 now.
15 And that's not because I've tried to reduce the number
16 of CTOs, the reason is because people have got better,
17 they're more engaged, they're accepting their treatment
18 and they're staying more stable in the community.
19 **Q.** Remind us, what's your number of caseload roughly?
20 **A.** The caseload -- the capacity is 140, 150.
21 **Q.** 150.
22 **A.** Yeah.
23 **Q.** Page 32, please. You refer in the last bullet point to
24 there being an:
25 "... inadequately locally available beds in the

101

1 acute pathways rehabilitation and in forensic services."
2 **A.** Yeah.
3 **Q.** Where do you say recommendation is required in respect
4 of this issue to improve mental health services?
5 **A.** I think there are lots of people out there in the
6 community who need to be in hospital at any one time.
7 We don't have sufficient beds to accommodate them, which
8 means that people I've identified those people as
9 needing to be in hospital and having the risk that
10 warrant hospitalisation, yet they remain in the
11 community. This has been the case for quite a long
12 time. I don't know whether the Inquiry can make any
13 recommendations around that, it's just to draw attention
14 to that we don't have adequate provision.
15 **Q.** Indeed, you say at the top of page 33, these are people
16 who:
17 "... pose high and potentially unmanageable risks in
18 the community."
19 **A.** Yes.
20 **Q.** You say two bullet points down from there:
21 "Multi-agency working is problematic. Information
22 sharing across health, social care and other agencies
23 including the police, probation and prison services is
24 inconsistent and often poor."
25 What do you think the challenges are to overcome

102

1 that? So many inquiries now have identified information
2 sharing as being critical. What is it that needs to
3 change around the culture around that?
4 **A.** When we were having the conversations a few years ago
5 about the Crisis Care Concordat and about how agencies
6 would work together more constructively to jointly meet
7 the needs of people with different needs, that seemed
8 positive, in my view. We have moved away from that, as
9 far as I can tell, and we now have a situation where
10 people are not wanting to take responsibility for the
11 different aspects. So there are lots of situations
12 where somebody with a mental health condition may pose
13 significant risks. Under those circumstances, we may
14 want police involvement. That's not forthcoming these
15 days. I was listening to the evidence about Right Care,
16 Right Person --
17 **Q.** From Sir Andrew Marsh?
18 **A.** Yeah. It's not the reality on the ground. It is with
19 more senior leaders, we have those conversations.
20 They're very good, they're very sympathetic to the
21 situation that we're in. But when we make the calls and
22 we ask for police assistance, "It's a mental health
23 issue, it's not to do with us". That's what sometimes
24 is -- not maybe as explicitly as that but that's
25 definitely the tone of what's happened, and there has

103

1 been a sea change since Right Care, Right Person.
2 **Q.** What sort of assistance? You're not talking about the
3 execution of a warrant or anything like that, are you?
4 What kind of --
5 **A.** Even that can be --
6 **Q.** Really.
7 **A.** -- problematic in terms of getting police assistance
8 because it's their warrant to execute, you know, 135.
9 So even that can be problematic, yeah, getting people to
10 come for that.
11 But it can just be to support really difficult
12 assessments. You can go with somebody who has got
13 a very clear history of violence, especially in that
14 situation, and the advice that we get given is "Call 999
15 if there's a problem", and I've had that on a number of
16 occasions. I heard the evidence about the frameworks
17 that might be in place for people who pose risks, and
18 this was in relation to them leaving hospital, I think.
19 This "Potentially Dangerous Persons". I think that was
20 mentioned. We've mentioned that to police callers.
21 They didn't know what it was. It's not used, it's not
22 something that's used regularly. I've seen the
23 documentation. I was signposted to it by a safeguarding
24 lead so I was aware of it, but it's not something we've
25 ever used. So it could certainly be something that's

104

1 publicised more and, you know, commitments are made to
2 jointly use that.
3 I mention in my statement about how effective MAPPA
4 and MARAC are in my view --
5 **Q.** Not particularly.
6 **A.** -- and it's not just my opinion but we make referrals to
7 MAPPA for in mental health cases where there is a very
8 clear public protection risk, and the feedback is
9 they're not suitable for MAPPA and, you know, without
10 really clear justification as to why not, certainly that
11 we can understand. MARAC similarly, we have more people
12 who have been subject to MARAC, so that's around
13 domestic violence. And the communication isn't aided by
14 MARAC, so we can have people who have committed
15 offences, they've gone to court -- they've been
16 arrested, they've gone to court, they've ended up in
17 prison and it's only when they're in prison that we find
18 out that something has happened. So the communication
19 between agencies has not worked, even though agencies
20 have been involved in things leading to them being in
21 that situation.
22 So --
23 **Q.** Should you be the lead -- could you be the lead agency,
24 for example, in relation to patients in your cohort?
25 **A.** Oh we would be. But the frameworks are not run by us.

105

1 **Q.** No.
2 **A.** So we have no control over those frameworks. So if
3 there was something else that was, you know, fit for
4 purpose that brought the agencies together in cases that
5 were appropriate, that would be very welcome indeed.
6 **Q.** Because it is taking responsibility to bring everyone
7 together, isn't it, and you have referred to how you
8 effectively take appointments, you adapt your schedule,
9 you go where you need to go, and you refer in this
10 paragraph that the frameworks "are not sufficiently
11 dynamic and do not ensure timely communication of
12 information about risk across agencies".
13 No doubt some of the agencies and bureaucracy you've
14 dealt with don't work as you do, adaptively to each day
15 and as events emerge. That dynamic nature of risk is
16 very difficult to capture at a multi-agency level, isn't
17 it?
18 **A.** Well, it's not systemic is the problem, and this is not
19 just in, for example, the police, it's also in our
20 health systems as well. So we don't have effective ways
21 of flagging people with A&E when they go there, if we're
22 worried about them. We don't have effective systems of
23 flagging them with the police. If this person shows up,
24 "We've been looking for them, we think they're really
25 poorly, you know, could you please just at least alert

106

1 us if you see them." We don't have an effective way of
2 doing that. So it is about communication systems, not
3 just relationships.
4 **Q.** Indeed, you said in your statement, we don't need to go
5 to it, paragraph 28:
6 "The electronic patient records are difficult to
7 navigate and ... historical information about the
8 clinical presentation, hospital admissions, previous
9 treatment and risks is hard to locate."
10 Is that because you were working on different
11 systems with different access requirements to those
12 systems as well?
13 **A.** Not only that. If we have got different systems, then
14 it's impossible, so we have to put in access requests to
15 other Trusts, for example, and I've had pushback from
16 that as well, with people not wanting to share
17 information from hospital Trusts --
18 **Q.** To another unit like yours, to NHS -- (overspeaking) --
19 **A.** To us, who were taking on responsibility for the
20 patient. So I've pushed back and told them to contact
21 their Caldicott Guardian and they'll explain to you why
22 we need it and it's always forthcoming in the end, but
23 there has been reluctance on the patient information
24 governance to share it with us which I think is really
25 poor --

107

1 **Q.** It does seem surprising that across the NHS, A&E, your
2 services, other hospitals, that it wouldn't be automatic
3 that that information about patients would be shared
4 when you need to access to it.
5 **A.** Yeah, yeah. Within our own systems, though, trying to
6 navigate the system can be quite difficult, and
7 particularly when you're looking back and trying to find
8 historical risks and things like that, it's often, you
9 know, for those of us who are older and trained with
10 paper notes, it was much easier to find the information
11 in the notes than it is on an electronic sort of
12 labyrinthine system.
13 **Q.** And how could that be improved?
14 **A.** I don't know.
15 **MS LANGDALE:** Those are my questions. I know there will be
16 others.
17 **THE CHAIR:** Yes, Mr Moloney.
18 **Questioned by MR MOLONEY**
19 **MR MOLONEY:** Doctor, you've emphasised, if I may say, the
20 importance of the visits you make to particularly people
21 who would be within a high risk cohort. Would you --
22 were you able to maintain visits during the course of
23 Covid?
24 **A.** Yes.
25 **Q.** It was essential to do so, given the risks that people

108

1 might present during that time.
2 **A.** Not only because of the risks, but also to look after
3 their health.
4 **Q.** Yes.
5 **A.** Yeah.
6 **Q.** Would it --
7 **A.** And actually our patients were at higher risk during
8 Covid, quite a lot of them, because they have multiple
9 physical health issues often as well, so it was really
10 important to maintain it for their sake for all sorts of
11 reasons.
12 **Q.** Physical health issues and of course isolation during
13 that time which is not great for people faced with the
14 problems they suffer.
15 **A.** Our group is already very isolated.
16 **Q.** Yeah.
17 **A.** They have very few social contacts. Actually quite
18 a small proportion have families and carers involved as
19 well. But yeah, the isolation was worse during Covid
20 for everybody, I think.
21 **MR MOLONEY:** Thank you very much, Doctor.
22 **THE CHAIR:** Thanks. Yes, Mr Straw.
23 **Questioned by MR STRAW**
24 **MR STRAW:** Doctor, I represent Celeste and Elias Calocane.
25 As I understood your evidence earlier, you indicated

1 that often the patients that you come across who have
2 schizophrenia, a symptom of their illness is that they
3 are convinced that they're not unwell; is that right?
4 **A.** I guess it's what's referred to as insight. I don't
5 prefer that term, I think that's -- the patient doesn't
6 agree with the doctor's sort of opinion of what's going
7 on, but with the patients I see it's more trying to work
8 towards a shared understanding of what's happening for
9 them. But yes, I think it's -- people don't know that
10 they have an illness or not just that, that they need
11 treatment or the risks associated with their illness
12 with the people I see.
13 **Q.** I think you also indicated that often patients in that
14 cohort think that medical staff are involved in the
15 conspiracy against them; is that right?
16 **A.** Yes. Well, not just medical staff, but mental health
17 services generally as well as other agencies.
18 **Q.** Do those two features, so belief they're not unwell and
19 concerning conspiracy, lead that cohort to disengage, to
20 stop taking medication, to be guarded, and so on?
21 **A.** They do, but I think it's also their experience of
22 services. So the people that I see have really quite
23 traumatic experiences within services as well. So they
24 don't think they're unwell is the first thing. They
25 think that the treatment that they have is being imposed

1 upon them. And the way it's imposed upon them is that
2 they have contact with the police because it's the
3 police who are often called to take them to the
4 hospital. Once they're in the hospital they are very
5 much restricted, they spend time in seclusion, they
6 spend time in psychiatric intensive care units, they may
7 end up in forensic units, they are forcibly injected.
8 And all of this, in their view, is unwarranted because
9 they don't think there's a reason for any of it
10 happening.
11 So by the time these patients come to me, they don't
12 want to see services, not just because they think that
13 we -- there's a general paranoia and we're involved in
14 some sort of conspiracy, but also because that's what we
15 represent for them as well.
16 **Q.** Presumably that would lead them to often mask their
17 symptoms from you as well?
18 **A.** Oh, they do regularly not tell us about lots of things
19 that are going on for them internally.
20 **Q.** Looking at that cohort, so patients who are high risk
21 when they're unwell, and whose illness leads them to
22 disengage and to mask their symptoms, so that cohort
23 specifically. Is Assertive Outreach effective in
24 managing that cohort and reducing their risk?
25 **A.** It is. The level of engagement that's achieved, I speak

1 to it in my statement. Most of the time we manage to
2 build really good therapeutic relationships with people,
3 and they do over time open up about what's going on for
4 them, partly because they know the consequence is not
5 the consequence they've had before for doing so, and
6 they're looking for support as opposed to something
7 else.
8 But there is a group of people who won't do that,
9 and it really then relies just on maintaining contact
10 and treatment which does, to answer your question, does
11 have an impact on reducing risk, in my view, in any
12 event. But it's certainly not as good as having
13 a collaborative relationship with the patient.
14 **Q.** You described earlier some of the techniques, the means
15 by which your, the Assertive Outreach, does have
16 an effect, so it manages those patients, and by
17 reference to paragraph 45 of your witness statement,
18 just to pick up on a couple of others, is it right that
19 Assertive Outreach involves psychiatrists and nurses who
20 have particular expertise in managing this cohort?
21 **A.** Yes, but we have other people involved as well. So we
22 have psychiatrists; we have nurses; there are
23 occupational therapists; we have psychology; we have
24 a substance use worker; we have a housing worker. These
25 are not all full-time people but they're dedicated for

1 our service, part-time. We have a Healthy Living
2 Adviser. We have support workers as well, so we have
3 a broad range. And over time, all of those people will
4 gain experience in working with this group of patients.
5 **Q.** So within your team you have expertise, for example, in
6 detecting symptoms that a person is unwell, that they're
7 a risk, even if that's a person who tries to mask their
8 symptoms; is that right?
9 **A.** I think getting to know a person is important, and that
10 gives you -- the example I gave, you know, of the car,
11 you know, scratching the car, those things can seem
12 really innocuous but they are a sign. We're also
13 reliant on, you know, linking in closely with other
14 people who might be involved. If a family member tells
15 me that somebody is unwell, I take that really
16 seriously, because they know that person, they've lived
17 with that person; they are able to detect things
18 sometimes that I'm not able to, even if they don't know
19 quite what it is that they're detecting.
20 **Q.** Does your team also then have a particular experience,
21 particular expertise, in knowing how to encourage people
22 like this -- so people who want to disengage -- to take
23 medication, to engage with you?
24 **A.** Yeah, I mean that's what we would encourage. But
25 there's a range. There are people who are taking oral

113

1 medication. Sometimes there's a level of -- it's not
2 just about being guarded, sometimes people are just
3 disorganised. So it might be we that up our contact, we
4 go and see them more frequently. Sometimes we'll
5 supervise people taking medication for periods to get
6 things back on track. There are other people who are
7 having depot injections, and under those circumstances,
8 obviously there is some flexibility and some negotiation
9 around this, but if this carries on sort of longer term,
10 and we're worried about where that's going to go, then
11 we might be looking at whether they need to come into
12 hospital; if they are on a Community Treatment Order,
13 whether they might be recalled in order to have their
14 treatment in hospital and then be discharged again.
15 **Q.** With a depot, you just mentioned a depot. Is your
16 approach that if there are concerns about compliance
17 with medication orally, then you would consider a depot?
18 **A.** Yeah, we would consider a depot. Whether the person
19 would consider the depot is a different matter. And it
20 may be that they need to be on a framework like
21 a Community Treatment Order for that to happen.
22 **Q.** Is it your experience that patients who are properly
23 medicated under your care are more amenable to other
24 forms of therapy, for example, CBT, psycho-education
25 that sort of thing?

114

1 **A.** I think, as I -- I mean, CBT, it relies on the person
2 being able to have that distance from their experiences
3 to look at whether there might be alternative
4 explanations for their experiences, to be able to
5 reflect on that, to be consistent in seeing somebody.
6 I don't know if I'm using this term correctly, but
7 metacognition is a word I've heard. Thinking about
8 thinking. So them being able to take a step back and
9 think about the way that they're processing things,
10 that's really difficult for the people that I see, and
11 I don't think -- well, most of the people I see are not
12 engaged enough to be engaging in that.
13 Could it happen more effectively with somebody who
14 is far more engaged and perhaps earlier on in the course
15 of their illness? Maybe. The evidence for CBT and
16 psychosis, I think, personal opinion is it's slightly
17 overstated.
18 **Q.** But leaving CBT aside, other forms of sort of treatment,
19 so psychology, occupational therapy, the other sort of
20 bodies you've described, are they more likely to be
21 effective when a person is properly medicated?
22 **A.** Oh yes. I think that if you can't -- well, there are
23 two things really, so firstly seeing the person. So if
24 you can't see the person, either because if they're too
25 disengaged and too paranoid to see you, then you're not

115

1 going to be able to do anything else.
2 But working with a person when you do see them, it's
3 going to be more effective if they can tolerate that and
4 they're not so distracted and tormented by their
5 experiences to be able to do the things that we need to
6 do. And actually the things I talk about, the
7 psychology and occupational therapy, those interventions
8 tend to come later in our service anyway after a period
9 of stabilisation.
10 **Q.** The final question, please, you mentioned earlier the
11 evidence as to whether the Assertive Outreach reduces
12 inpatient bed days.
13 **A.** Yeah.
14 **Q.** Presumably that's -- if it reduces inpatient bed days,
15 it reduces the cost in that sense, that would be spent
16 on inpatients; is that right?
17 **A.** It is. I think we're very narrow in our thinking about
18 costs when it comes to severe mental illnesses though
19 because there is cost around bed days, but there's also
20 the cost of lots of other things, there's the cost of
21 physical healthcare, there is the cost of homelessness,
22 there's the cost of drug use, there is the cost of
23 criminal justice system involvement. There are loads of
24 costs which are all affected, so bed days, I think, is
25 a poor metric on many levels.

116

1 **Q.** Thank you. I was going to ask you about that, but then,
2 leaving costs to one side, would you consider that
3 a more important measure of effectiveness of Assertive
4 Outreach is whether it reduces harm?
5 **A.** No, and the reason I would say that is not because
6 I don't think it's important, it's because I think it's
7 too -- the base rate is too low. So measuring that and
8 showing discernible differences on something that's
9 uncommon is not necessarily going to -- it's not going
10 to produce the results you want.
11 The most effective measure would be around
12 engagement of the person, so maintaining contact with
13 the person, and treatment, in my view. Those are the
14 two things, the knock-on effect of which is to impact on
15 everything else. So I think those things are the most
16 important things.
17 **MR STRAW:** Okay, thank you very much.
18 Thank you, Chair.
19 **Questioned by THE CHAIR**
20 **THE CHAIR:** Thank you.
21 Yes, thank you very much. Can I just ask about, as
22 it were, the physical side of it? Your unit, is that
23 connected to a particular hospital or is it
24 freestanding?
25 **A.** We are based in a community base. There are a couple of

1 inpatient units there, but they are rehabilitation
2 units. So they're units where people are working on
3 their sort of daily living skills and things like that.
4 They're not acute wards. So our offices are in those
5 buildings, in a community setting.
6 **THE CHAIR:** I don't know whether you're aware but there are
7 some pilots in relation to neighbourhood schemes.
8 **A.** Yeah.
9 **THE CHAIR:** Is that something that would fit in with your
10 type of unit or not?
11 **A.** I don't know a lot about the neighbourhood teams. My
12 concern from what I've read is that they rely a lot on
13 patient-initiated contact. So people who are wanting
14 services drop in. The principle of being able to
15 provide a kind of broad range of things in one place is
16 a good one, but for people who are not engaged who
17 aren't going to go there who don't think they're unwell
18 or who might be excluded for, because of their substance
19 use, their risks, or lots of other things, I don't think
20 outreach is enough of a feature in those models that
21 I've seen. They may be, I don't know.
22 I worry, actually, that compared to old-style CMHTs,
23 the group that I see will be left further behind if the
24 emphasis is on people engaging with the service.
25 Engagement is a two-way process.

1 **THE CHAIR:** What I'm really looking at is whether they're
2 mutually incompatible, those two ideas of your Assertive
3 Outreach approach and having that based in
4 a neighbourhood centre.
5 **A.** I think so. I mean, we're a city-wide service, so
6 I don't know the locality makes that much difference to
7 us. And our Assertive Outreach team -- and I've been
8 with it for a long time, it's been around since about
9 2000 and we've worked with various iterations of
10 community services, so we will try to forge good
11 relationships with whatever comes.
12 **THE CHAIR:** I think I said mutually incompatible, are you
13 saying that they are --
14 **A.** No, no, they're compatible.
15 **THE CHAIR:** Thank you. I just wanted to pick up a couple of
16 points that you've raised. In relation to -- yes, the
17 way in which you organise, for example, getting warrants
18 and getting transport and so on, I think you've
19 partially covered this in relation to the Right Person
20 initiative, but how would you go about that and how have
21 you found getting police involvement where it's
22 necessary?
23 **A.** It's become more difficult over time and I think that's,
24 certainly when Right Care, Right Person came in, I think
25 that's definitely made a negative difference in terms of

1 joint working.
2 As I say, well, I think it's often the case that the
3 conversations you have with the senior people, where,
4 you know, they appreciate what the issues are and they
5 are trying to work on it, don't necessarily translate to
6 the person that you ring up on the day and say, "This is
7 what, you know, this is the situation. We're worried
8 about this person, would you be able to get involved in
9 this? Would you be able to support us to do this?"
10 Really, the answer has become no more than yes, over
11 time, which is -- yeah, problematic.
12 **THE CHAIR:** Also, in relation to access to information,
13 you've described how your route is to have to make
14 access requests on every occasion; is that correct?
15 **A.** If somebody is within our Trust, then we can access our
16 information system for those people, but --
17 **THE CHAIR:** -- *(overspeaking)* -- from the police, for
18 example?
19 **A.** Yeah, we would have to go through what's called our
20 information-sharing agreement requests, which obviously
21 I can send you the form.
22 **THE CHAIR:** Do you think that it would be possible to set
23 some criteria, that's in terms of the criteria which are
24 for your cohort and your work, which would allow, as it
25 were, a fast track on that, a general permission?

1 **A.** Well, it wouldn't be possible for me, but if there was
2 a recommendation that supported that, then I think that
3 would be appreciated.
4 **THE CHAIR:** Yes, thank you.
5 Just in relation to the clozapine. I think you said
6 that that's very difficult to use when somebody is in
7 the community; is that correct?
8 **A.** It can be. We have people who have done very well on
9 clozapine and, actually, having the right treatment has
10 been the thing that's meant that they've been well
11 enough to maintain the treatment. So their compliance
12 -- and obviously we give them an awful lot of support to
13 get their medication, which we usually would deliver
14 ourselves, or to get to the place where they need to do
15 the blood tests. We have a new machine which we can do
16 finger prick testing on, which might open things up more
17 broadly.
18 So we do everything we can, but the difficulty is if
19 somebody is really inconsistent with their medication,
20 clozapine can be very dangerous. If you miss clozapine
21 for 48 hours, you have to reiterate because -- you have
22 to start again -- because of the risk, the physical risk
23 that it poses, which really isn't feasible for this
24 group of patients.
25 So if you can't find them, I mean one of the things

1 is finding people to actually see them, if people are
2 really disengaged, it's just not a medication that
3 works. And then the blood tests, a lot of people don't
4 go with the blood tests, they won't have the blood
5 tests.
6 **THE CHAIR:** How often would you have to take the blood test?
7 **A.** It starts off weekly, but then it reduces to monthly,
8 I think is where it ends up. So relatively infrequent,
9 but yes, for some people that's just not going to work.
10 And you have to have the blood tests at the right time
11 in order to get the next prescription of the clozapine.
12 So it becomes really tricky for people who are very
13 chaotic or don't want to have it.
14 **THE CHAIR:** Yes. Just in relation to your use of CTOs,
15 I think you've said that at present you've reduced the
16 number that you have on your workload from 75 down to 40
17 I think you said.
18 **A.** It's on the rise again, but yes.
19 **THE CHAIR:** It's on the rise again. There seems to have
20 been a concern generally -- and I think you've referred
21 to it -- about the over-use of CTOs. How have you found
22 the availability of them in your particular type of
23 practice?
24 **A.** What do you mean by the availability?
25 **THE CHAIR:** Has it been useful? Has it not been useful?

1 **A.** Oh --
2 **THE CHAIR:** There was a suggestion that they may be
3 abolished altogether at one stage.
4 **A.** There was, and I think that would be really bad news for
5 the patients who have done very well on them. As I say,
6 I think if you target the right cohort, then I think
7 they can be incredibly effective.
8 I mentioned that we'd looked at -- and I keep going
9 back to bed days -- but we looked at the hospital use of
10 patients who we have on CTOs. In virtually, I believe,
11 every case the bed use had substantially reduced, and
12 this is after being with our team, and that not being
13 enough to reduce it.
14 One chap had, I think, something like a thousand bed
15 days before the use of the CTO, and in the same period
16 after it had zero bed days, and it was just about
17 maintaining care consistent treatment. And it's not
18 just that, it's then with the consistent treatment that
19 leads to. So with people recovering, becoming engaged
20 with their families again, being able to function
21 better, just feeling much better and having a better
22 quality of life. There are lots of benefits which have
23 come directly, in my view, from CTOs for some patients.
24 I think the cohort could be smaller than it is.
25 It's not -- CTOs are not a substitute for good care, and

1 I think that's the concern, is people, you know, the
2 people who are using them as a kind of way of not doing
3 the other things. That shouldn't be -- it shouldn't be
4 the case. It should be just for this group who are very
5 disengaged who need treatment, who aren't having
6 treatment, who then end up having to be repeatedly
7 detained.
8 **THE CHAIR:** As far as the idea of Community Treatment Orders
9 is concerned, your approach, the Assertive Outreach
10 approach, looks at all of the surrounding circumstances,
11 like housing --
12 **A.** Yeah.
13 **THE CHAIR:** -- benefits and so on. So in a sense the
14 community that they are living in.
15 **A.** It's really important. The importance of social
16 determinants of health are -- not just in mental health
17 but in mental health are massively underestimated.
18 I mean even if you go to the management of risk,
19 unstable social situations, if you can't see somebody
20 you can't treat them. That's one thing. So if they're
21 homeless that makes it a lot more complicated. But
22 things like substance use, all the adversities that
23 people face, it's really important to address those
24 things as well as treating somebody. It's really
25 foundational. It matters in terms of recovery and

1 people staying well, because if you treat them just with
2 medication and then expose them to all the same
3 destabilisers, you're not going to have the same result.
4 **THE CHAIR:** As far as the -- I think you've said rebalancing
5 of the risk to others versus risk to self approach --
6 **A.** Yeah.
7 **THE CHAIR:** -- I know that you were involved in the
8 *(unclear)* -- the review which led to some of the changes
9 in the Mental Health Act. Do you think that that has
10 been achieved by the changes that have been made? That
11 there's sufficient consideration of risk to the public?
12 **A.** I don't think so. My concern -- so the main area that's
13 going to affect me is Community Treatment Orders. And
14 I was on the Topic Group, and one of the changes that is
15 coming is around the use of CTOs, not just the frequency
16 and time limits and things like that, but also what it
17 talks about is the nature, degree of mental disorder
18 which was there before, but then there are additional
19 things about the likelihood of harm and the how soon
20 that harm might occur. That really concerns me, because
21 risk is dynamic, so you can have somebody who is stable
22 for quite a long time, but if you remove treatment then
23 that can change very quickly.
24 So the likelihood of our setting some sort of
25 notional percentage on that is really difficult, it's

1 not something that any doctor can do reliably, and the
2 imminence of it is also something that's really
3 difficult. What you can say is that this person needs
4 treatment and there's a very clear history that if they
5 don't have treatment, they become unwell, they become a
6 risk to other people.
7 You can say that and their view hasn't changed, the
8 patient still doesn't accept that they have an illness,
9 they still don't think they need treatment, and they
10 imminence their risk of violence. All of those things
11 can be true, but if tribunals or manager hearings focus
12 on imminence or likelihood, then I can see a lot more
13 people being discharged from CTOs who really need to
14 stay on them and that really will be a very big concern.
15 **THE CHAIR:** Thank you, that's very helpful. Thank you.
16 Right, well, we'll rise now until 2.00. Thank you.
17 **(1.01 pm)**
18 **(The short adjournment)**
19
20
21
22
23
24
25

1 **I N D E X**

2 Page
3 RACHEL WATSON (affirmed) 1
4 Questioned by MR BLAKE 1
5 Questioned by MR MOLONEY 39
6 Questioned by MS CARTWRIGHT 42
7 Questioned by THE CHAIR 48
8
9 DR NUWAN DISSAYANAKA (affirmed) 50
10 Yes, Ms Langdale. 50
11 Questioned by MS LANGDALE 50
12 Questioned by MR MOLONEY 108
13 Questioned by MR STRAW 109
14 Questioned by THE CHAIR 117

15
16
17
18
19
20
21
22
23
24
25

MR BLAKE: [5] 1/3 1/9 14/8 22/12 39/5
MR MOLONEY: [5] 39/10 39/22 42/15 108/19 109/21
MR STRAW: [2] 109/24 117/17
MS CARTWRIGHT: [7] 42/18 45/10 46/4 46/6 46/14 46/20 48/12
MS LANGDALE: [4] 50/12 50/17 60/9 108/15
THE CHAIR: [44] 1/5 1/8 13/18 22/3 39/8 39/17 39/19 42/16 45/8 46/2 46/5 46/9 46/11 46/16 48/15 48/24 49/11 49/20 50/5 50/7 50/15 60/4 108/17 109/22 117/20 118/6 118/9 119/1 119/12 119/15 120/12 120/17 120/22 121/4 122/6 122/14 122/19 122/25 123/2 124/8 124/13 125/4 125/7 126/15
THE WITNESS: [3] 22/4 48/13 60/8

.

...she [1] 45/22

1

1 February 2024 [1] 26/15
1.01 [1] 126/17
10 February [3] 16/19 16/23 23/7
10B [1] 3/7
11 [1] 68/15
11 December 2025 [1] 1/10
11.05 [1] 50/9
11.20 [2] 50/8 50/11
117 [1] 77/23
11th [1] 41/7
12 [3] 3/11 75/20 76/2
12 months [1] 90/13
123 [1] 27/5
13 June [2] 12/2 14/17
13 June 2023 [1] 11/17
135 [1] 104/8
13th June [2] 14/23 15/3
14 [1] 69/23
140 [1] 101/20
15 [2] 1/1 68/18
150 [2] 101/20 101/21
16 [1] 85/9
17 [3] 43/21 43/21 100/8
178 [1] 6/5
18 [4] 45/24 47/3 77/5 77/6
18 months [1] 90/17
18 November 2024 [1] 24/23
18,000 [1] 90/20
19 [2] 12/13 13/9
1970s [1] 69/1
1980 [1] 68/25
1992 [1] 77/13

2

2.00 [1] 126/16
20 [2] 79/4 97/3
20 February 2024 [1] 26/25
2000 [1] 119/9
2001 [1] 52/8
2006 [1] 78/20
2010 [1] 90/8
2018 [2] 82/1 101/12
2019 [1] 101/13
2020 [1] 90/16
2021 [2] 36/6 38/14
2023 [3] 11/17 12/12 26/6
2024 [17] 1/21 9/1 15/10 15/15 16/16 18/13 20/21 24/12 24/23 26/14 26/15 26/25 27/3 27/21 29/15 39/14 40/2
2025 [6] 1/10 9/2 22/15 33/3 34/19 34/20
2026 [4] 1/1 1/12 40/6 50/18
21 [1] 80/7
22 [1] 1/21
22 February 2024 [1] 18/13
22 July 2025 [1] 34/20
22 October [1] 16/16
23 February 2026 [1] 50/18
24 [2] 70/11 70/16
24 years [1] 51/5
25 [3] 70/16 77/25 83/11
25 September 2024 [1] 27/21
26 [2] 70/18 95/23
26 March 2024 [2] 24/12 27/3
27 [1] 96/3
27 January 2025 [1] 22/15
27 September 2023 [1] 12/12
27,500 [1] 90/19
28 [2] 70/18 107/5
28 day [1] 41/20
29 [1] 85/9
29 January 2024 [1] 26/14

3

3 May 2024 [1] 15/15
30 [3] 34/23 88/17 97/22
31 [1] 99/9
32 [2] 79/6 101/23
33 [2] 17/23 102/15
34 [1] 89/19
35 [1] 91/4

4

40 [2] 101/14 122/16
44 [1] 93/5
45 [2] 70/7 112/17
48 hours [1] 121/21

5

5 February 2024 [1] 15/10
5 May 2023 [1] 26/6
50 [1] 95/23
53 [1] 97/22
57 [1] 17/22
59 [1] 13/19

6

65 [1] 90/21
66 [2] 15/17 43/23

7

7 April [1] 40/8
7 April 2026 [1] 1/12
75 [3] 68/18 101/13 122/16

8

80 [1] 90/12
88 [1] 27/2

9

9,500 [1] 90/20
9.59 [1] 1/2
91 [1] 29/8
999 [1] 104/14

A

ability [3] 18/5 58/21 86/4
able [39] 14/20 15/23 16/11 18/17 20/23 21/8 23/17 24/14 25/4 33/7 34/6 34/7 35/20 36/22 37/15 49/2 50/1 56/15 59/24 66/18 73/23 74/3 74/25 83/9 83/18 88/21 89/2 108/22 113/17 113/18 115/2 115/4 115/8 116/1 116/5 118/14 120/8 120/9 123/20
abolished [1] 123/3
about [158] 9/16 10/17 21/21 28/5 32/13 35/14 38/14 44/4 44/8 47/21 59/16 72/8 72/21 75/25 81/13 89/12 91/19 109/7 109/17 116/6 118/22 121/9 122/1
above [1] 7/2
absolute [2] 20/13 32/11
absolutely [14] 27/18 29/12 31/20 32/9 43/16 54/25 55/21 61/15 61/18 62/21 65/1 72/23 81/4 86/16
abuse [1] 35/2
academic [1] 82/21
accept [3] 25/2 86/4 126/8
accepted [3] 27/4 52/22 89/22
accepting [1] 101/17
access [12] 61/25 74/19 83/22 84/12 85/5 93/10 107/11 107/14 108/4 120/12 120/14 120/15
accessed [3] 29/18 30/5 32/12
accessible [1] 38/9
accessing [4] 17/25 83/20 95/12 95/13
accommodate [2] 74/25 102/7
accordance [1] 7/7
account [5] 33/15 49/23 63/18 63/20 64/11
accountability [3] 47/15 47/18 98/17
accountable [2] 98/20 98/23
accounts [3] 12/9 63/23 64/4
accredited [1] 36/21
accurate [1] 50/19
accurately [1] 2/25
achieve [1] 88/21
achieved [3] 93/19 111/25 125/10
acknowledge [1] 17/8
acknowledged [1] 40/14
across [12] 10/3 31/15 33/11 33/12 74/13 78/25 87/13 93/7 102/22 106/12 108/1 110/1
Act [4] 3/7 51/11 98/13 125/9
acting [2] 13/10 43/10
action [2] 3/4 5/25
actions [8] 11/20 11/23 14/15 14/22 18/11 29/5 63/2 98/23
active [2] 31/6 41/4
actively [1] 9/7
activity [1] 84/16
acts [2] 59/18 62/25
actually [24] 8/12
acute [4] 89/21 91/2 102/1 118/4
adapt [2] 58/21 106/8
adaptively [1] 106/14
add [2] 15/23 18/5
added [5] 4/6 22/19 22/20 22/23 25/25
addendum [3] 28/2 28/3 28/6
addition [7] 18/20 29/19 34/6 52/9 66/20 71/10 84/2
additional [3] 15/12 30/4 125/18
address [6] 2/12 6/23 30/2 37/17 67/14 124/23
addressed [10] 11/19 17/3 17/4 17/6 23/10 25/2 32/8 49/10 82/18 99/21
addresses [2] 51/14 73/8
addressing [1] 62/1
adequate [1] 102/14
adequately [1] 100/19
adjourned [1] 41/14
adjournment [1] 126/18
adjusted [1] 23/2
admissions [1] 107/8
admit [1] 86/20
admitted [1] 85/25
admitting [2] 62/4 69/18
adult [2] 74/1 91/2
adults [1] 56/6
adversely [1] 73/22
adversities [1] 124/22
advice [3] 47/8 47/12 104/14
Adviser [1] 113/2
advising [1] 19/25
advocating [1] 93/24
affect [2] 14/3 125/13
affected [5] 3/24 63/2 73/22 81/20 116/24
affirmed [4] 1/6 50/14 127/3 127/9
affirms [1] 95/6
afraid [1] 28/5
after [15] 14/17 16/24 39/13 40/1 49/13 51/25 69/13 69/19 78/8 90/14 90/18 109/2 116/8 123/12 123/16

A

aftercare [2] 77/23 77/23
aftermath [1] 14/23
afterwards [1] 49/19
again [42] 15/7 15/24 18/15 21/2 22/12 23/4 23/7 24/11 24/14 24/21 24/24 26/20 27/2 28/12 28/13 32/5 32/6 32/9 32/21 34/2 34/17 40/18 45/12 45/19 46/15 46/23 63/16 74/25 90/15 91/21 91/23 93/1 94/25 95/15 96/10 100/25 101/2 114/14 121/22 122/18 122/19 123/20
against [7] 3/4 4/5 24/9 38/20 60/20 61/12 110/15
agencies [9] 71/4 102/22 103/5 105/19 105/19 106/4 106/12 106/13 110/17
agency [5] 56/2 56/5 102/21 105/23 106/16
ago [3] 9/13 47/19 103/4
agree [5] 25/20 32/10 43/17 43/18 110/6
agreed [2] 26/22 35/14
agreement [2] 19/16 120/20
AI [2] 95/4 95/14
aided [1] 105/13
aims [1] 2/17
albeit [1] 42/7
alert [1] 106/25
all [56] 1/24 6/24 10/12 12/8 15/2 20/4 20/14 22/1 22/6 28/16 29/5 32/25 33/25 37/4 38/8 40/5 42/1 46/16 48/17 53/16 53/20 57/21 57/22 58/4 58/5 58/11 60/11 60/24 62/1 68/8 69/14 71/8 77/19 79/8 82/5 82/25 83/1 86/19 87/11 88/2 89/16 89/18 90/16 91/18 91/20 93/22 94/4 109/10 111/8 112/25 113/3 116/24 124/10 124/22 125/2 126/10
allegations [2] 33/3 34/18
alleged [3] 6/16 6/21 26/10
allow [1] 120/24
almost [4] 31/15 33/12 83/25 99/11
along [2] 34/4 78/4
already [6] 21/24 23/3 35/12 42/24 43/14 109/15
also [50] 3/7 4/5 4/23 7/12 12/20 14/23 15/1 17/25 20/8 20/15 24/2 24/18 25/5 31/17 32/20 33/1 39/2 48/20 48/25 49/7 52/7 53/11 54/21 55/12 55/23 58/14 60/14 61/8 68/3 68/4 68/6 69/16 77/25 82/5 85/22 89/6 97/5 98/25 101/11 106/19 109/2 110/13 110/21 111/14 113/12 113/20 116/19 120/12 125/16 126/2
alternative [2] 66/15 115/3
although [2] 7/11 79/2
altogether [1] 123/3
always [6] 9/23 74/10 81/11 99/5 99/7 107/22
am [9] 1/2 4/8 21/17 28/16 29/2 30/15 50/9 50/11 50/25
amber [1] 88/4
amenable [1] 114/23
America [1] 69/4
American [1] 78/17
amongst [2] 65/4 69/16
amount [4] 17/8 21/13 22/13 25/18
amplified [1] 94/25
Andrew [1] 103/17
announced [2] 38/24 47/19
another [5] 24/11 35/19 38/12 98/19 107/18
answer [5] 30/9 44/2 84/8 112/10 120/10
anti [1] 81/10
anti-stigma [1] 81/10
anticipate [1] 53/22
anticipated [1] 48/21
antipsychotic [2] 91/12 92/1
antipsychotics [1] 91/9
antisocial [2] 82/24 83/8
any [34] 2/9 2/9 7/1 8/13 12/17 13/13 13/23 19/16 20/11 20/19 21/13 28/11 37/16 37/17 38/12 39/5 42/2 43/8 47/20 48/20 53/3 54/15 55/1 57/22 80/16 83/23 89/17 99/13 99/16 102/6 102/12 111/9 112/11 126/1
anyone [7] 7/13 34/3 42/13 53/25 73/21 73/21 84/24
anything [13] 2/5 13/2 13/12 24/2 34/6 35/7 53/1 76/17 89/3 92/18 93/3 104/3 116/1
anyway [2] 94/2 116/8
apart [1] 93/3
apologetic [1] 33/12
apologise [2] 40/17 40/18
appear [1] 13/24
appearance [1] 21/11
appears [1] 6/13
applications [2] 36/5 38/9
appointments [1] 106/8
appreciate [3] 22/9 63/11 120/4
appreciated [3] 21/4 81/5 121/3
appreciation [1] 83/16
approach [26] 57/12 57/15 57/16 57/20 65/6 65/11 65/15 65/17 67/25 69/7 71/3 75/14 75/24 76/5 76/10 76/21 77/22 81/8 96/16 96/21 97/17 114/16 119/3 124/9 124/10 125/5
approaches [1] 69/25
approaching [1] 49/14
appropriate [17] 3/5 4/23 4/25 6/14 7/3 7/6 7/19 9/9 9/19 10/7 11/2 14/24 19/22 19/24 41/3 93/11 106/5
approved [1] 26/24
approximately [1] 83/13
April [5] 1/1 1/12 1/21 35/13 40/8
April 2024 [1] 1/21
April 2026 [1] 1/1
are [226]
area [6] 5/7 60/15 67/1 82/7 95/24 125/12
areas [6] 53/19 62/1 79/1 82/23 96/21 98/14
aren't [7] 66/18 71/14 75/8 76/7 97/10 118/17 124/5
arguments [1] 35/2
arise [1] 21/21
arising [1] 16/21
around [29] 25/7 31/12 31/25 36/24 53/18 61/6 71/24 77/4 81/11 82/23 82/24 82/24 82/25 90/16 90/19 90/19 90/21 91/10 97/6 100/1 102/13 103/3 103/3 105/12 114/9 116/19 117/11 119/8 125/15
arrangements [1] 87/3
arrest [2] 26/11 26/12
arrested [2] 4/12 105/16
arrived [2] 15/7 26/20
Arvato [1] 26/6
as [177]
aside [1] 115/18
ask [12] 2/8 35/15 37/12 43/19 48/15 53/21 55/2 60/4 84/13 103/22 117/1 117/21
asked [7] 9/11 13/11 20/9 40/9 44/1 51/13 94/8
asking [5] 19/20 31/19 57/5 84/19 97/10
aspect [1] 85/14
aspects [7] 81/11 82/21 85/19 85/21 86/20 87/11 103/11
assault [2] 26/6 26/10
assertive [42] 51/5 51/15 51/18 51/22 51/24 57/11 60/11 68/16 69/2 69/21 69/22 70/19 71/2 75/9 75/13 75/13 76/5 76/15 76/21 77/9 78/1 78/10 78/18 78/24 79/2 79/10 79/16 79/20 85/11 89/22 90/3 91/5 94/14 96/1 111/23 112/15 112/19 116/11 117/3 119/2 119/7 124/9
assess [1] 65/3
assesses [1] 13/20
assessment [12] 11/22 26/17 33/22 48/3 55/17 63/13 75/25 80/4 85/4 96/7 96/9 99/11
assessments [3] 17/21 56/18 104/12
assist [10] 7/15 19/6 20/23 27/8 28/3 28/6 34/20 37/14 51/17 75/10
assistance [3] 103/22 104/2 104/7
assists [1] 15/18
associated [4] 36/20 52/3 68/4 110/11
association [3] 80/14 82/16 82/22
associations [1] 83/3
assumptions [1] 31/22
assurance [1] 33/14
assurances [2] 25/9 33/4
Astwell [5] 14/12 17/23 46/8 46/18 46/24
at [123] 2/3 2/11 2/16 2/17 3/11 5/8 6/5 9/4 9/6 9/8 10/3 10/6 10/12 12/8 14/5 16/10 16/23 17/1 17/15 18/6 18/8 19/8 19/21 20/14 22/6 22/8 22/10 22/23 23/7 24/25 25/20 26/3 26/10 27/10 29/8 29/23 30/1 31/17 31/22 32/19 34/10 34/24 35/11 38/13 38/19 41/7 41/9 41/14 43/1 43/7 43/21 43/21 45/18 46/23 47/2 48/22 49/22 55/23 56/6 56/8 57/8 58/19 64/17 66/15 66/18 67/1 67/2 67/6 68/15 69/4 69/14 69/23 72/7 73/19 74/1 74/1 74/6 74/10 76/2 77/5 77/6 77/15 77/19 79/4 79/6 79/20 80/7 81/10 82/1 84/4 84/10 84/13 84/14 84/23 84/24 87/7 89/24 90/4 90/6 90/13 90/15 90/16 94/4 96/1 97/4 100/7 100/19 101/4 102/6 102/15 106/16 106/25 109/7 111/20 114/11 115/3 119/1 122/10 122/15 123/3 123/8 123/9 124/10
attack [1] 7/17
attacked [1] 84/5
attacks [1] 24/18
attended [1] 26/9
attention [8] 9/7 12/2 17/1 20/24 20/25 35/8 53/5 102/13
attitude [1] 66/14
attract [1] 58/24
attributable [1] 18/22
atypical [1] 91/20
audio [2] 13/23 13/25
audit [2] 10/10 30/24
audits [1] 25/12

A

August [1] 9/1
August 2024 [1] 9/1
authorisation [1] 13/20
authorities [2] 10/7 11/2
authority [7] 4/23 4/25 6/14 7/3 7/18 7/19 54/24
automatic [1] 108/2
autonomy [2] 62/19 87/23
autumn [3] 21/5 21/16 21/25
availability [2] 122/22 122/24
available [9] 30/4 55/4 58/1 91/9 94/23 95/2 100/3 100/18 101/25
avenues [1] 72/7
avoid [3] 20/19 42/2 101/9
avoided [1] 80/10
await [2] 16/21 34/5
awaiting [3] 23/11 23/19 25/4
aware [6] 21/1 21/4 51/12 85/8 104/24 118/6
away [4] 52/24 58/1 73/7 103/8
awful [2] 89/8 121/12
awfully [1] 9/12

B

back [21] 9/6 41/3 45/21 46/2 46/6 46/25 68/23 71/14 71/15 71/18 74/17 77/6 77/11 82/2 85/1 101/12 107/20 108/7 114/6 115/8 123/9
background [3] 18/16 27/22 58/7
backlog [1] 9/5
bad [1] 123/4
balance [2] 62/15 62/20
Barnaby [1] 15/8
base [4] 70/1 93/13 117/7 117/25
based [4] 13/22 75/3 117/25 119/3
basically [1] 34/24
basis [4] 21/8 33/19 47/9 80/4
be [232]
became [4] 23/14 29/15 32/12 69/1
because [97] 4/1 9/11 9/12 12/5 20/1 20/17 21/7 21/10 23/11 24/1 26/21 30/8 30/15 31/13 34/2 34/12 37/13 41/25 47/13 47/16 48/15 50/2 51/20 52/23 53/8 53/12 53/18 57/22 58/3 58/14 61/16 61/25 62/23 62/24 63/19 64/5 65/6 65/20 66/12 66/13 67/24 68/1 68/6 71/13 71/21 71/21 72/5 75/5 76/23 77/12 78/13 80/14 80/20 80/22 80/23 81/7 84/4 85/1 86/10 86/10 88/22 89/3 92/4 92/8 92/18 92/21 94/12 94/15 95/6 97/9 97/13 99/4 99/5 100/3 100/23 101/15 101/16 104/8 106/6 107/10 109/2 109/8 111/2 111/8 111/12 111/14 112/4 113/16 115/24 116/19 117/5 117/6 118/18 121/21 121/22 125/1 125/20
become [11] 7/20 7/25 8/16 9/10 52/3 56/1 97/13 119/23 120/10 126/5 126/5
becomes [1] 122/12
becoming [1] 123/19
bed [18] 78/14 89/19 90/4 90/12 90/19 90/20 90/20 90/23 91/1 100/21 116/12 116/14 116/19 116/24 123/9 123/11 123/14 123/16
beds [6] 87/13 89/21 91/2 91/2 101/25 102/7
been [89] 1/21 7/19 9/23 12/1 13/22 15/19 15/22 16/1 17/6 17/12 17/21 17/25 18/1 18/3 20/12 21/10 24/23 25/2 25/4 25/4 25/10 25/24 27/10 29/4 30/5 30/10 30/20 31/2 31/5 31/6 31/8 31/18 31/20 32/5 32/7 34/3 34/11 34/12 35/9 35/12 41/10 41/19 45/17 45/18 45/22 45/25 48/21 49/2 49/5 52/19 52/25 53/9 54/17 54/21 67/21 69/13 69/16 70/1 74/21 76/5 84/14 84/16 84/18 85/15 87/10 89/2 93/8 100/2 100/2 100/5 100/5 100/9 100/24 102/11 104/1 105/12 105/15 105/20 106/24 107/23 119/7 119/8 121/10 121/10 122/20 122/25 122/25 125/10 125/10
before [22] 5/9 12/8 15/7 19/17 26/20 28/11 36/7 40/13 42/3 43/7 49/4 49/17 67/25 70/5 85/21 87/7 90/14 90/17 96/13 112/5 123/15 125/18
began [3] 24/24 39/13 40/1
begging [1] 71/24
begin [1] 2/13
beginning [6] 17/1 25/19 25/20 32/19 46/3 96/1
behalf [1] 41/12
behave [1] 13/4
behaved [3] 4/4 12/17 13/3
behaving [1] 64/14
behaviour [7] 52/13 52/21 52/23 53/4 67/14 69/15 69/20
behavioural [1] 66/17
behaviours [1] 67/8
behind [3] 25/23 67/7 118/23
being [40] 3/4 6/7 6/12 9/7 9/8 14/8 33/15 33/21 37/11 37/22 38/1 38/15 43/25 46/17 46/18 46/21 65/9 66/18 73/4 73/17 84/2 86/7 93/21 94/13 99/16 99/21 100/7 101/5 101/24 103/2 105/20 110/25 114/2 115/2 115/8 118/14 123/12 123/12 123/20 126/13
belief [4] 1/16 29/24 79/24 110/18
beliefs [1] 95/14
believe [5] 5/15 24/1 41/20 64/16 123/10
below [1] 6/25
benefit [2] 58/12 58/14
benefits [5] 36/20 61/25 70/1 123/22 124/13
bereaved [2] 7/16 9/2
best [6] 1/16 1/17 53/16 58/24 59/2 84/23
best-case [1] 84/23
better [15] 22/1 22/5 31/25 49/6 56/11 56/12 59/25 67/5 81/13 83/10 89/15 101/16 123/21 123/21 123/21
between [10] 4/15 17/18 25/18 26/17 41/25 65/23 74/13 82/16 92/16 105/19
bi [1] 21/17
bi-weekly [1] 21/17
bias [1] 31/14
biased [2] 21/10 33/22
big [2] 79/23 126/14
billion [1] 36/14
biopsychosocial [1] 66/4
bipolar [1] 76/20
bit [6] 2/13 22/3 51/7 60/7 77/11 80/19
bladed [1] 68/6
BLAKE [5] 1/7 39/12 40/9 42/24 127/4
blank [1] 57/2
blood [9] 92/4 92/7 92/9 121/15 122/3 122/4 122/4 122/6 122/10
board [1] 38/1
bodies [4] 38/18 39/2 42/3 115/20
body [4] 5/2 7/22 38/12 98/20
Bond [1] 33/23
both [3] 1/15 1/17 58/16
bottom [3] 2/17 32/11 76/4
boundaries [1] 20/15
boundary [1] 37/9
box [2] 12/15 12/21
boxes [1] 88/11
brand [1] 53/9
breach [2] 34/11 34/12
break [2] 50/7 50/10
brief [1] 91/8
briefing [6] 18/12 18/16 18/18 18/22 19/17 22/22
briefly [11] 3/19 15/21 18/16 19/6 24/14 29/11 31/10 33/7 36/22 43/19 100/24
bring [11] 2/14 6/3 11/11 14/13 15/17 18/8 24/8 27/2 27/19 36/3 106/6
bringing [2] 12/18 78/9
broad [9] 7/9 10/2 10/17 14/19 15/3 84/7 100/4 113/3 118/15
broader [2] 60/21 79/18
broadly [7] 8/14 10/24 15/22 15/23 76/13 100/7 121/17
brokering [1] 71/4
brought [5] 4/5 12/2 20/24 20/25 106/4
build [3] 48/19 61/21 112/2
building [2] 62/8 62/14
buildings [1] 118/5
builds [1] 62/2
built [1] 28/22
bullet [6] 6/19 7/24 96/3 99/9 101/23 102/20
bulletin [1] 76/3
bundle [1] 90/9
burden [1] 8/2
bureaucracy [2] 55/3 106/13
burnout [1] 58/17
but [175]

C

calculated [1] 89/22
Caldicott [1] 107/21
call [4] 1/3 50/12 67/20 104/14
called [8] 5/4 5/5 25/10 41/10 69/21 77/14 111/3 120/19
callers [1] 104/20
calls [3] 89/2 89/3 103/21
Calocane [2] 8/24 109/24
came [10] 9/7 16/5 31/14 33/11 33/12 35/8 69/13 78/3 100/16 119/24
campaigns [1] 81/10
can [129]
can't [19] 5/11 28/5 29/3 34/7 45/7 49/21 63/5 70/6 70/21 72/20 75/4 84/22 92/9 92/13 115/22 115/24 121/25 124/19 124/20
candidates [2] 58/24 59/2
cannot [1] 69/24
capabilities [1] 17/14
capability [1] 32/17
capacity [3] 32/16 79/9 101/20
capture [2] 71/12 106/16
captured [3] 53/8 88/2 88/3
car [4] 44/19 68/7 113/10 113/11
care [22] 53/24 60/18 60/19 63/1 66/20 70/25 71/3 71/10 77/21 77/22 97/24 98/8 98/11 102/22 103/5 103/15 104/1 111/6 114/23 119/24 123/17 123/25
carefully [1] 74/6

C

carers [1] 109/18
carries [1] 114/9
carry [3] 3/8 97/4 98/24
carrying [1] 68/6
cars [2] 67/21 68/1
Cartwright [6] 42/16 42/17 45/9 46/2 46/13 127/6
case [36] 5/3 5/6 6/11 7/17 8/10 9/14 9/20 10/7 10/24 11/7 12/22 16/15 19/13 21/21 24/21 28/24 30/8 35/5 37/12 40/3 47/5 51/13 56/14 57/13 74/4 77/13 77/13 78/22 82/9 83/12 84/14 84/23 102/11 120/2 123/11 124/4
caseload [9] 57/13 57/21 71/1 71/8 83/13 86/23 101/14 101/19 101/20
caseloads [3] 70/24 70/25 75/2
cases [6] 5/22 53/4 59/21 77/17 105/7 106/4
cast [1] 48/1
catalyst [1] 78/23
catch [2] 6/24 39/25
catch it [1] 39/25
categories [1] 7/2
categorisation [4] 43/17 46/15 46/21 47/11
categorised [1] 45/6
categorises [1] 47/9
categorising [1] 44/12
causation [1] 47/25
cause [1] 95/9
caused [2] 4/21 43/11
causes [1] 92/4
caution [1] 44/22
CBT [4] 114/24 115/1 115/15 115/18
Celeste [1] 109/24
cell [1] 92/4
centrally [1] 78/5
centre [2] 11/16 119/4
certain [1] 94/25
certainly [19] 10/3 21/16 25/3 28/7 31/4 38/20 40/3 49/3 57/8 64/24 66/5 66/11 82/22 93/2 95/9 104/25 105/10 112/12 119/24
cetera [1] 38/11
chain [1] 20/5
Chair [8] 1/3 13/15 48/14 50/12 117/18 117/19 127/7 127/14
challenge [2] 62/15 64/24
challenges [1] 102/25
challenging [1] 66/15
change [7] 75/5 81/25 95/8 95/9 103/3 104/1 125/23
changed [3] 71/11 81/14 126/7
changes [5] 27/1 99/4 125/8 125/10 125/14
changing [1] 95/18
chaotic [1] 122/13
chap [2] 77/14 123/14
chat [1] 37/5
check [3] 31/18 32/2 73/1
check-ins [1] 32/2
checking [1] 72/18
Chief [8] 5/4 23/12 23/21 24/6 24/9 24/16 24/25 25/15
chiefs [1] 37/24
Chiefs' [3] 19/12 20/16 37/19
childhood [1] 82/24
choice [1] 91/17
choose [1] 91/24
Christopher [1] 77/14
circumstance [1] 73/18
circumstances [5] 73/14 85/7 103/13 114/7 124/10
city [2] 11/16 119/5
Civil [1] 1/24
clarity [4] 25/11 47/14 47/20 47/21
clear [31] 2/3 16/1 17/10 19/24 20/12 20/17 20/17 25/20 27/11 28/16 29/15 30/3 30/19 31/21 32/12 33/21 39/22 42/6 43/16 46/3 47/13 63/21 64/4 64/13 65/6 76/7 98/22 104/13 105/8 105/10 126/4
clearly [12] 8/9 16/3 26/21 27/9 30/12 31/9 32/13 33/11 33/13 42/13 44/19 76/16
clinic [2] 75/3 89/9
clinic-based [1] 75/3
clinical [3] 60/18 60/18 107/8
clinician [2] 51/5 54/7
clinics [1] 89/18
clock [2] 16/23 23/7
close [3] 41/10 92/5 96/8
closely [2] 55/25 113/13
clozapine [9] 91/10 92/1 92/12 93/3 121/5 121/9 121/20 121/20 122/11
Clunis [1] 77/14
CMHTs [1] 118/22
co [1] 83/4
co-morbidities [1] 83/4
cognitive [1] 66/16
cohort [17] 79/25 80/3 92/15 93/14 96/11 96/19 105/24 108/21 110/14 110/19 111/20 111/22 111/24 112/20 120/24 123/6 123/24
collaborating [1] 93/24
collaboration [3] 62/7 64/18 64/22
collaborative [1] 112/13
colleagues [1] 58/17
College [3] 51/1 76/1 76/19
collision [4] 11/21 11/23 43/15 44/13
column [1] 45/16
come [28] 5/11 10/22 13/25 18/5 22/25 25/5 29/7 35/17 46/5 46/5 48/16 49/17 61/9 74/23 75/19 76/8 76/24 87/10 89/9 89/13 90/6 92/25 104/10 110/1 111/11 114/11 116/8 123/23
comes [12] 24/3 38/2 39/4 48/24 57/18 60/25 68/8 77/13 81/14 81/23 116/18 119/11
comfort [1] 99/16
comfortable [2] 89/12 89/15
coming [5] 82/2 90/12 90/14 90/18 125/15
comment [2] 2/8 51/13
commissioned [4] 30/17 31/4 33/18 33/23
commit [5] 35/20 52/23 62/24 80/16 82/11
commitments [1] 105/1
committed [4] 12/19 59/18 63/4 105/14
Comms [1] 19/19
communicate [1] 73/15
communicated [1] 34/3
communicating [1] 85/3
communication [7] 19/18 24/19 85/14 105/13 105/18 106/11 107/2
Communications [2] 19/2 19/8
community [50] 51/9 57/12 57/25 68/16 69/22 69/24 70/5 70/20 70/22 75/1 77/24 79/18 79/24 85/16 86/11 86/16 87/18 88/11 89/7 89/25 90/1 90/7 92/6 92/14 92/20 93/10 97/25 99/22 100/1 100/2 100/6 100/7 100/15 100/19 100/22 101/1 101/13 101/18 102/6 102/11 102/18 114/12 114/21 117/25 118/5 119/10 121/7 124/8 124/14 125/13
compared [2] 28/18 118/22
compatible [1] 119/14
compel [1] 84/22
complainant [1] 6/10
complained [3] 6/17 6/21 15/13
complaint [20] 4/1 4/9 4/10 4/13 4/14 6/8 6/11 7/4 8/5 8/24 15/5 15/9 18/18 18/20 19/23 22/20 22/21 22/23 24/12 41/22
complaints [18] 2/22 2/24 3/15 3/19 3/20 5/11 9/5 9/6 10/25 15/12 17/3 23/10 24/9 33/19 33/20 35/11 35/13 35/16
complete [3] 48/22 49/3 49/12
completed [3] 35/21 40/6 40/12
completely [3] 23/15 26/21 48/1
completeness [1] 43/1
complex [7] 10/1 38/17 47/14 47/16 51/4 52/9 52/15
complexity [2] 17/17 49/7
compliance [2] 114/16 121/11
compliant [1] 69/9
complicated [3] 58/15 92/21 124/21
comply [1] 92/13
comprehensive [1] 53/13
compromised [2] 99/6 99/6
Computer [1] 29/20
concept [1] 44/24
concern [6] 88/10 118/12 122/20 124/1 125/12 126/14
concerned [7] 33/13 49/20 50/20 72/12 87/24 88/7 124/9
concerning [3] 35/7 35/10 110/19
concerns [6] 14/21 24/16 36/22 36/24 114/16 125/20
conclude [2] 25/5 28/13
concluded [5] 12/12 12/16 13/5 18/3 32/18
concludes [1] 50/1
concluding [1] 49/18
conclusion [2] 14/10 33/19
conclusions [1] 12/13
concordance [1] 91/7
Concordat [1] 103/5
concurred [1] 33/18
concurrent [1] 52/10
condemn [1] 10/12
condition [2] 23/23 103/12
conditions [2] 86/13 92/14
conduct [26] 2/18 2/20 3/16 3/25 4/2 4/2 4/10 4/12 4/21 5/3 5/5 6/9 6/11 6/17 6/18 6/21 6/22 7/5 8/6 26/4 26/8 26/14 26/23 34/9 41/13 48/10
conducted [1] 36/4
conferences [1] 21/22
confident [2] 17/13 20/3
Confidential [1] 81/25
confirm [3] 1/15 50/18 73/11
confirmed [3] 40/4 43/14 95/14
conflicted [1] 78/16
confront [1] 63/22
confrontational [2] 64/1 64/24
confronted [1] 82/18
confusing [1] 44/25
confusion [1] 44/5

C

connected [2] 42/9 117/23
conscious [1] 55/5
consequence [2] 112/4 112/5
consequences [3] 62/24 81/3 100/14
consider [8] 48/6 48/19 73/23 84/15 114/17 114/18 114/19 117/2
considerable [1] 25/18
consideration [3] 42/2 74/9 125/11
considered [8] 9/8 10/5 12/5 12/10 13/6 27/17 45/22 76/6
considering [3] 7/22 14/5 97/17
considers [1] 7/3
consistency [1] 66/13
consistent [3] 115/5 123/17 123/18
conspiracy [5] 61/12 94/24 110/15 110/19 111/14
Constable [7] 5/4 23/12 23/21 24/6 24/10 24/16 25/1
Constable's [1] 25/16
constructive [2] 62/11 93/25
constructively [1] 103/6
consultant [6] 50/24 51/6 74/10 96/5 96/14 96/17
consultants [2] 79/16 79/17
consulted [1] 19/22
contact [23] 4/19 10/23 11/15 15/2 43/8 43/11 44/1 44/25 45/25 47/4 47/9 71/6 71/20 72/14 72/25 88/18 89/1 107/20 111/2 112/9 114/3 117/12 118/13
contacts [1] 109/17
contain [1] 35/1
contained [1] 35/1
containing [1] 36/15
content [1] 59/23
contents [1] 50/19
context [7] 17/17 18/1 43/25 46/23 67/6 68/3 84/2
contextualise [1] 43/20
continually [1] 22/24
continue [1] 94/11
continued [2] 36/24 88/23
continuing [1] 40/10
continuity [1] 67/18
contrast [1] 52/21
contributed [2] 4/22 43/12
control [3] 44/7 100/5 106/2
controlled [1] 68/18
conversation [3] 44/6 63/25 86/25
conversations [9] 34/16 63/9 64/17 65/20 88/8 95/16 103/4 103/19 120/3
conversely [1] 90/11
convicted [1] 52/25
conviction [1] 18/14
convictions [1] 52/18
convinced [1] 110/3
coordination [1] 97/24
coordinator [1] 53/25
coordinators [1] 70/25
Copthorne [1] 24/7
copy [1] 57/2
core [3] 2/10 39/6 40/9
coroner [1] 7/12
coroners [1] 7/8
correct [7] 1/13 1/14 1/19 12/7 40/7 120/14 121/7
correctly [2] 98/21 115/6
correlated [1] 55/24
correspondence [1] 41/3
cost [8] 90/25 116/15 116/19 116/20 116/20 116/21 116/22 116/22
costs [3] 116/18 116/24 117/2
could [43] 2/14 4/5 4/21 6/3 7/22 8/15 10/18 11/11 13/25 14/3 14/13 14/25 27/17 27/19 29/4 29/24 30/5 30/6 31/8 32/12 32/13 33/21 36/3 38/21 40/15 43/20 43/22 45/12 46/25 47/11 54/12 57/1 57/22 73/14 86/10 86/10 95/15 104/25 105/23 106/25 108/13 115/13 123/24
couldn't [4] 12/23 72/11 85/7 97/19
Council [3] 19/12 20/16 37/20
count [2] 7/23 92/5
country [3] 78/25 87/13 100/6
couple [6] 31/23 47/19 71/19 112/18 117/25 119/15
course [28] 7/12 8/16 8/22 10/10 12/7 13/24 14/22 19/7 20/8 22/4 22/5 23/2 24/1 25/6 30/3 35/23 37/7 46/4 70/11 71/11 74/5 74/21 75/18 95/10 96/12 108/22 109/12 115/14
court [2] 105/15 105/16
cover [1] 100/18
coverage [1] 79/6
covered [2] 98/15 119/19
covers [2] 15/1 15/2
COVID [5] 88/18 88/24 108/23 109/8 109/19
crashes [1] 44/20
crime [1] 45/23
criminal [7] 4/6 12/19 52/24 53/6 55/11 69/19 116/23
crisis [5] 78/5 85/23 85/24 86/2 103/5
criteria [5] 5/16 5/17 96/1 120/23 120/23
critical [2] 75/8 103/2
criticised [1] 100/3
criticism [1] 70/21
crosses [1] 37/9
CTO [1] 123/15
CTOs [8] 101/16 122/14 122/21 123/10 123/23 123/25 125/15 126/13
culturally [1] 93/11
culture [3] 65/18 97/6 103/3
currency [1] 48/17
current [2] 53/2 79/5
custody [1] 4/19
cuts [1] 79/8

D

daily [4] 71/9 88/8 88/9 118/3
dangerous [5] 94/15 94/18 95/15 104/19 121/20
database [2] 29/19 39/1
databases [2] 29/18 31/7
date [4] 16/10 82/2 95/1 95/17
dated [4] 1/10 1/11 40/8 50/18
day [15] 12/3 41/20 45/25 61/7 61/7 62/6 62/6 71/15 71/18 71/20 79/14 97/2 97/3 106/14 120/6
days [15] 90/12 90/19 90/20 90/20 90/23 91/1 100/21 103/15 116/12 116/14 116/19 116/24 123/9 123/15 123/16
days' [1] 90/4
deal [5] 26/17 42/20 57/23 65/16 97/7
dealing [12] 10/25 45/17 54/17 56/4 58/14 60/22 65/12 66/1 75/3 93/23 97/2 97/3
dealt [6] 25/8 29/24 42/24 46/17 46/18 106/14
death [9] 3/16 4/16 4/22 6/16 42/22 42/25 43/7 43/13 46/1
deaths [2] 2/20 81/23
December [1] 1/10
decide [1] 19/3
decided [1] 32/10
decision [13] 5/2 5/13 9/18 9/19 16/19 16/24 20/7 20/7 20/10 21/6 23/8 30/18 32/5
decision-making [1] 5/2
decisions [3] 11/20 17/22 20/11
decline [1] 78/8
declining [1] 89/11
decreased [1] 70/2
dedicated [3] 96/6 97/8 112/25
deep [2] 30/14 61/9
deeply [1] 35/10
deferring [1] 19/14
define [1] 4/14
defined [1] 76/16
definitely [4] 41/2 79/12 103/25 119/25
definition [12] 6/4 6/23 7/9 9/15 9/21 10/8 26/22 42/25 43/5 44/5 47/4 52/17
definitions [1] 45/13
degree [2] 50/24 125/17
deinstitutionalisation [1] 69/4
delay [2] 17/9 28/22
deliberately [1] 41/24
deliver [1] 121/13
demands [1] 58/25
demonising [1] 80/18
department [1] 90/15
departments [2] 11/4 28/19
depend [1] 74/4
depending [1] 70/18
depends [3] 72/21 73/13 79/13
depot [8] 91/18 100/25 114/7 114/15 114/15 114/17 114/18 114/19
depth [2] 67/25 86/24
describe [1] 83/11
described [3] 112/14 115/20 120/13
describing [1] 83/4
deserved [1] 15/25
designed [1] 51/25
desperately [1] 28/19
despite [1] 87/23
destabilisers [2] 92/22 125/3
destabilises [1] 93/1
detail [3] 2/14 46/14 57/6
details [1] 46/21
detained [3] 52/4 100/9 124/7
detect [1] 113/17
detecting [2] 113/6 113/19
detention [1] 86/7
deteriorating [3] 71/21 74/23 86/12
deterioration [3] 55/24 72/12 86/10
determinants [1] 124/16
determination [1] 5/18
determine [1] 91/17
determined [1] 9/9
devastating [1] 81/4
develop [1] 97/6
developments [1] 13/14
device [1] 84/24
diagnosis [1] 66/2
diary [1] 74/24
Dickinson [1] 33/24
did [21] 8/9 15/25 19/16 25/15 27/11 27/14 29/21 30/15 33/14 33/19 37/18 39/17 40/17 42/11 64/13 72/13 73/1 80/11 89/24 90/5 90/5
didn't [10] 22/9 26/21 27/10 39/20 39/24 40/16 44/15 69/18 73/15 104/21
dies [1] 4/18
difference [6] 30/7 65/23 90/4 91/24 119/6 119/25
differences [3] 63/22 79/15 117/8
different [33] 1/24 3/25 4/1 4/17 8/23 22/7 32/15 58/3 59/23 62/19 63/20 65/5 65/7 65/11 67/4 71/4 71/4

D

different... [16] 75/4 88/1 90/22 90/24 91/15 91/23 94/14 96/21 98/10 100/16 103/7 103/11 107/10 107/11 107/13 114/19
difficult [18] 47/12 49/11 53/18 53/22 58/24 60/5 60/17 64/14 85/5 104/11 106/16 107/6 108/6 115/10 119/23 121/6 125/25 126/3
difficulty [3] 66/12 92/6 121/18
digitally [1] 84/9
dip [2] 32/1 38/21
direct [3] 5/20 43/8 66/20
directed [2] 56/6 73/19
direction [1] 5/23
directly [12] 4/20 5/11 41/11 43/12 53/13 59/16 66/24 86/2 87/4 87/12 99/7 123/23
Director [1] 1/18
discernible [1] 117/8
discharge [6] 72/5 77/25 85/13 87/5 87/7 99/14
discharged [3] 87/14 114/14 126/13
disciplinary [5] 4/4 12/18 34/11 65/21 71/7
disciplines [1] 98/10
disclosed [1] 40/8
discriminatory [1] 37/6
discuss [1] 48/4
discussed [2] 74/13 74/14
discussion [3] 26/17 44/9 64/24
discussions [1] 63/6
disengage [5] 97/11 97/13 110/19 111/22 113/22
disengaged [7] 51/8 52/1 73/10 100/13 115/25 122/2 124/5
disengaging [1] 75/16
disorder [2] 83/8 125/17
disorders [1] 83/5
disorganised [1] 114/3
display [1] 43/1
displayed [2] 43/20 45/13
dissatisfaction [2] 3/22 19/19
Dissayanaka [3] 50/13 50/14 127/9
dissemination [1] 36/17
distance [1] 115/2
distinction [1] 92/15
distorted [1] 64/8
distracted [1] 116/4
distressing [4] 59/14 59/20 60/2 60/10
diverted [1] 52/24
do [141]
do do [1] 70/20
doctor [5] 74/20 108/19 109/21 109/24 126/1
doctor's [1] 110/6
document [6] 2/16 29/7 45/14 45/19 46/3 78/7
documentation [1] 104/23
documents [3] 37/10 88/3 88/4
does [31] 2/25 3/2 7/1 8/2 8/6 9/2 9/12 13/24 15/24 26/7 37/9 52/17 52/17 54/2 54/2 57/19 62/12 62/14 64/22 68/11 70/15 70/19 72/16 76/22 84/24 92/3 108/1 112/10 112/10 112/15 113/20
does it [3] 26/7 52/17 54/2
doesn't [19] 23/3 28/10 34/12 34/13 34/14 34/15 35/6 53/20 54/13 63/11 68/9 71/12 80/24 89/3 90/23 99/7 100/18 110/5 126/8
doing [16] 2/4 9/24 10/3 10/12 13/2 19/20 26/1 59/19 60/13 67/23 87/12 88/12 89/8 107/2 112/5 124/2
domestic [1] 105/13
don't [92] 2/2 7/18 9/23 10/2 10/9 10/9 13/13 14/1 15/17 21/21 22/10 27/2 31/22 34/8 36/25 38/19 39/5 52/2 53/16 61/1 61/10 61/11 61/25 62/5 63/15 66/4 70/7 70/10 74/16 74/19 75/12 75/14 75/21 76/10 76/15 76/17 76/22 78/13 80/16 81/5 84/11 84/12 84/17 85/2 85/6 85/23 89/17 91/16 92/18 93/3 94/4 95/5 95/7 95/16 97/10 97/11 99/17 99/19 99/20 99/21 100/13 101/6 102/7 102/12 102/14 106/14 106/20 106/22 107/1 107/4 108/14 110/4 110/9 110/24 111/9 111/11 113/18 115/6 115/11 117/6 118/6 118/11 118/17 118/19 118/21 119/6 120/5 122/3 122/13 125/12 126/5 126/9
done [16] 8/10 10/18 19/25 25/22 25/22 31/18 34/2 40/15 41/19 48/6 49/19 86/20 90/8 98/24 121/8 123/5
door [1] 24/25
doubt [3] 47/14 48/5 106/13
doubtless [1] 18/5
doubtlessly [1] 20/2
down [12] 16/3 16/8 22/3 29/7 48/2 75/19 76/24 83/12 101/12 101/14 102/20 122/16
Dr [4] 41/11 50/13 50/14 127/9
Dr Dissayanaka [1] 50/13
Dr Kumar [1] 41/11
DR NUWAN [2] 50/14 127/9
drafted [2] 15/22 16/5
draw [1] 102/13
drawing [1] 80/14
drawn [1] 53/4
drew [1] 16/25
driven [1] 44/18
driving [1] 11/21
drop [2] 72/4 118/14
drop-out [1] 72/4
dropping [1] 72/2
drops [1] 92/4
drug [3] 68/4 92/23 116/22
DSI [19] 6/9 6/24 7/5 12/6 12/11 26/13 26/19 26/22 43/17 44/5 44/10 44/14 44/21 45/1 45/6 46/15 46/22 47/9 48/10
dual [1] 38/10
due [2] 8/22 60/19
during [13] 13/24 14/17 23/2 25/5 71/11 88/18 88/24 98/10 108/22 109/1 109/7 109/12 109/19
duties [1] 43/10
duty [1] 48/6
dynamic [6] 11/22 85/4 93/2 106/11 106/15 125/21

E

each [5] 3/18 11/6 17/19 17/19 106/14
earlier [10] 27/16 45/25 49/3 78/17 93/15 99/9 109/25 112/14 115/14 116/10
earliest [1] 27/6
early [3] 21/16 65/12 78/4
easier [1] 108/10
easily [2] 38/9 97/21
education [1] 114/24
effect [4] 53/6 63/11 112/16 117/14
effective [13] 3/4 27/13 92/2 101/5 105/3 106/20 106/22 107/1 111/23 115/21 116/3 117/11 123/7
effectively [7] 3/9 37/22 58/8 61/5 72/25 106/8 115/13
effectiveness [1] 117/3
effects [3] 91/14 91/22 91/23
efficacy [2] 68/19 68/21
efficiently [1] 3/9
efforts [1] 85/12
eight [6] 16/12 24/22 28/12 28/15 28/21 29/1
eight months [6] 16/12 24/22 28/12 28/15 28/21 29/1
either [8] 4/18 4/20 39/16 42/11 70/18 86/12 90/1 115/24
electronic [2] 107/6 108/11
elevate [1] 30/11
Elias [2] 8/24 109/24
Elias Calocane [2] 8/24 109/24
else [10] 8/5 23/1 24/2 51/12 73/21 89/3 106/3 112/7 116/1 117/15
email [5] 20/5 20/20 21/1 30/1 41/11
emailed [1] 30/1
emerge [1] 106/15
emerging [1] 95/4
emphasis [1] 118/24
emphasised [1] 108/19
employment [1] 69/12
encourage [2] 113/21 113/24
end [10] 18/6 19/8 28/17 29/15 37/10 80/21 85/10 107/22 111/7 124/6
ended [3] 16/8 53/11 105/16
endorsement [1] 51/1
ends [1] 122/8
engage [9] 19/10 59/24 64/19 71/5 71/22 72/6 84/17 101/12 113/23
engaged [6] 75/3 101/17 115/12 115/14 118/16 123/19
engagement [7] 24/19 57/11 66/13 87/24 111/25 117/12 118/25
engaging [5] 72/2 72/6 92/7 115/12 118/24
England [2] 2/22 79/5
enormous [1] 87/13
enough [12] 20/17 23/14 34/13 41/4 95/17 97/12 98/5 99/20 115/12 118/20 121/11 123/13
enquiries [1] 29/17
enquiry [1] 64/2
ensure [13] 10/4 20/4 21/18 21/19 22/5 22/7 32/3 33/20 37/21 38/8 38/25 47/10 106/11
ensuring [2] 25/15 61/20
enthusiastic [1] 59/10
entire [1] 47/15
entirely [1] 29/12
environment [1] 89/7
envisaged [1] 32/18
episode [1] 65/15
episodes [1] 60/13
equates [1] 91/1
err [1] 44/22
escalated [2] 22/8 97/16
escalation [3] 68/5 68/13 73/25
especially [1] 104/13
essential [5] 12/22 13/1 58/13 88/19 108/25
essentially [4] 8/2 9/14 27/23 30/23
establish [1] 25/6
established [2] 37/19 90/2
esteem [1] 98/8
estimated [1] 79/6
et [1] 38/11
et cetera [1] 38/11

E

evaluate [1] 14/4
evaluated [1] 68/17
even [17] 7/21 9/18 20/3 21/9 25/19 34/10 44/22 55/15 64/14 66/23 70/17 104/5 104/9 105/19 113/7 113/18 124/18
evenings [1] 58/10
event [2] 28/11 112/12
events [6] 10/14 12/7 15/3 63/19 97/9 106/15
eventually [1] 49/25
ever [2] 54/18 104/25
every [12] 2/2 10/10 21/22 31/21 35/15 86/22 86/23 86/24 97/2 97/3 120/14 123/11
everybody [6] 56/22 56/25 64/19 72/24 83/25 109/20
everyone [2] 51/12 106/6
everything [8] 34/17 55/15 88/12 88/16 88/25 92/25 117/15 121/18
evidence [23] 16/21 17/1 18/4 28/11 29/25 48/25 49/13 49/14 49/16 52/20 57/1 68/19 70/1 80/1 82/18 93/13 100/1 100/3 103/15 104/16 109/25 115/15 116/11
exactly [5] 25/12 27/17 29/5 68/14 73/20
example [23] 6/15 7/7 7/13 8/23 17/19 25/8 25/12 28/25 32/2 48/8 52/18 54/16 65/13 71/23 100/25 105/24 106/19 107/15 113/5 113/10 114/24 119/17 120/18
examples [2] 16/2 37/4
exasperated [1] 44/11
exchange [1] 36/18
excluded [2] 84/9 118/18
exclusively [1] 99/12
excuse [2] 17/16 25/24
execute [1] 104/8
execution [2] 43/10 104/3
executive [1] 36/10
exercises [1] 3/15
exhaustive [2] 70/12 70/17
exhibiting [1] 67/8
expand [2] 43/22 89/21
expect [3] 13/3 35/4 53/2
experience [12] 10/6 10/13 10/22 51/3 51/15 81/3 90/24 93/11 110/21 113/4 113/20 114/22
experienced [2] 30/18 96/6
experiences [10] 59/21 59/24 60/2 66/16 82/25 94/6 110/23 115/2 115/4 116/5
expertise [6] 51/3 51/9 96/22 112/20 113/5 113/21
explain [5] 55/16 59/1 83/10 96/2 107/21
explained [2] 3/14 13/9
explanation [1] 64/3
explanations [3] 66/15 78/21 115/4
explicitly [1] 103/24
explore [1] 94/11
explored [1] 36/19
exploring [1] 72/7
expose [2] 94/16 125/2
express [1] 64/9
expressed [2] 19/2 96/18
expresses [1] 3/21
expressing [1] 19/19
expression [1] 76/14
extended [2] 58/9 100/8
extensively [1] 68/17
extent [3] 14/24 14/24 21/2
external [6] 20/9 21/6 21/12 33/23 34/19 35/15
extra [1] 29/25
extreme [1] 80/21

F

face [5] 31/17 44/11 88/18 88/18 124/23
faced [2] 40/22 109/13
facilitate [1] 66/20
facing [1] 60/10
fact [6] 48/21 49/23 62/16 75/21 85/9 97/11
factor [2] 60/14 61/1
factors [3] 79/22 82/25 83/5
factory [1] 26/10
facts [1] 64/25
failure [1] 77/16
fair [3] 17/2 33/15 35/4
fairly [6] 6/1 9/25 28/15 28/17 44/16 90/2
faith [1] 79/9
fall [2] 7/1 47/11
falls [1] 8/2
false [2] 47/14 73/8
falsely [1] 61/16
families [22] 9/10 15/7 15/25 20/2 21/7 24/11 24/19 24/20 25/25 27/3 29/13 30/1 33/13 34/4 35/12 40/14 40/21 41/5 41/12 41/17 109/18 123/20
family [12] 7/16 16/8 30/13 37/11 72/10 72/13 72/14 72/17 73/13 73/15 73/19 113/14
far [12] 32/9 45/16 49/20 50/19 75/3 82/8 82/8 82/20 103/9 115/14 124/8 125/4
fashion [1] 97/18
fast [1] 120/25
Fazel [2] 82/15 82/20
fear [1] 80/9
fearful [1] 59/19
feasible [2] 87/7 121/23
feature [1] 118/20
features [4] 52/9 57/17 72/9 110/18
February [14] 15/10 16/19 16/23 18/13 23/7 25/17 26/15 26/25 30/2 33/3 34/19 39/14 40/2 50/18
February 2024 [2] 39/14 40/2
February 2025 [2] 33/3 34/19
feedback [3] 34/15 48/4 105/8
feel [3] 34/7 61/12 74/2
feeling [2] 67/2 123/21
felt [5] 41/11 74/7 86/13 87/21 93/16
Feven [1] 45/18
few [8] 20/5 31/12 31/24 33/20 35/19 78/16 103/4 109/17
fidelity [10] 57/17 70/8 70/17 72/9 74/18 76/17 79/3 79/7 85/19 90/23
field [1] 98/24
figures [1] 101/6
fill [3] 54/4 56/22 57/3
filling [2] 53/14 54/1
final [9] 7/9 11/12 13/20 27/23 29/14 32/5 32/21 49/15 116/10
finalise [5] 16/11 16/12 22/17 24/22 50/4
finalised [3] 16/15 22/15 24/23
finally [2] 16/8 46/25
finance [1] 79/23
finances [2] 61/7 79/12
financial [1] 79/8
find [16] 7/21 22/25 37/1 47/23 53/7 58/24 59/25 71/25 72/11 73/2 73/11 75/21 105/17 108/7 108/10 121/25
finding [4] 12/22 64/22 72/18 122/1
findings [4] 18/6 48/19 49/23 90/21
finger [1] 121/16
finish [2] 35/25 75/17
finished [2] 23/17 50/2
Finsbury [1] 77/15
firm [2] 34/19 35/15
first [16] 1/10 3/11 5/11 6/15 12/1 16/15 16/19 19/18 20/4 24/12 26/24 27/3 40/4 65/15 90/8 110/24
first-episode [1] 65/15
firstly [1] 115/23
fit [2] 106/3 118/9
five [3] 11/8 90/17 91/1
five-year [1] 91/1
fixed [1] 41/13
flagged [1] 84/18
flagging [2] 106/21 106/23
flags [1] 73/9
flex [1] 58/21
flexibility [1] 114/8
flexible [1] 74/24
focus [10] 22/12 29/2 81/8 81/22 82/8 99/11 100/11 100/12 100/17 126/11
focusing [2] 7/23 10/22
follow [1] 53/6
followed [2] 38/15 68/5
following [10] 4/19 18/14 18/19 24/20 25/14 37/18 39/4 44/18 44/19 44/19
follows [2] 6/6 15/6
footage [2] 13/23 13/25
force [19] 5/3 5/7 5/12 5/12 5/21 5/22 5/24 8/3 17/19 17/19 17/20 19/18 24/4 25/9 25/11 26/18 28/18 32/16 53/20
forces [18] 11/3 15/1 19/10 19/12 19/25 31/19 31/21 37/21 37/25 38/6 38/13 38/19 38/20 44/21 45/2 47/8 47/23 48/3
forcibly [1] 111/7
forensic [4] 29/1 52/22 102/1 111/7
forerunner [1] 77/24
foreseen [2] 12/23 13/1
forge [1] 119/10
Forgive [1] 44/15
forgotten [1] 16/10
form [7] 54/1 54/4 57/2 57/6 57/8 79/1 120/21
formal [1] 56/3
formally [1] 12/2
format [1] 56/5
former [3] 19/7 24/6 25/15
forms [4] 56/21 56/21 114/24 115/18
formulation [3] 66/25 67/1 67/4
formulations [1] 66/21
forthcoming [2] 103/14 107/22
forward [6] 26/23 30/22 37/20 39/3 56/12 56/13
forwards [1] 9/25
found [8] 26/3 34/18 34/22 69/6 80/17 96/13 119/21 122/21
foundational [1] 124/25
four [2] 40/5 76/3
fracture [1] 45/21
fragmentation [1] 85/24
framed [1] 94/13
framework [7] 2/16 3/12 78/4 86/15 88/13 99/23 114/20
frameworks [4] 104/16 105/25 106/2 106/10
frankly [1] 21/11
fraught [1] 80/8
freestanding [1] 117/24
frequency [1] 125/15

F

frequent [1] 88/7
frequently [2] 69/3 114/4
fresh [1] 49/16
friendly [2] 31/15 33/12
friends [2] 36/19 37/11
front [1] 1/9
frontline [1] 51/4
frustrated [1] 44/15
full [2] 88/18 112/25
full-time [1] 112/25
fully [2] 10/2 25/6
function [3] 3/3 38/17 123/20
functioning [2] 62/1 69/11
functions [1] 3/9
fundamental [1] 20/13
fundamentally [2] 4/15 49/5
further [9] 13/12 20/11 22/21 29/17 33/1 39/5 47/12 47/20 118/23

G

gain [1] 113/4
gave [2] 47/20 113/10
GBH [1] 45/24
GDPR [1] 57/5
gear [1] 88/24
geared [1] 38/22
general [8] 1/18 21/15 29/1 45/1 80/24 96/14 111/13 120/25
generalisation [1] 35/6
generally [4] 48/5 56/11 110/17 122/20
get [36] 8/22 11/12 28/9 28/23 28/25 31/21 32/10 34/1 44/21 45/1 45/1 48/4 49/15 53/16 54/22 55/1 56/15 59/5 61/21 62/3 62/10 63/8 63/15 65/10 67/18 67/19 71/20 87/14 98/11 99/7 104/14 114/5 120/8 121/13 121/14 122/11
gets [1] 54/9
getting [12] 18/4 21/17 32/24 56/16 86/18 92/7 104/7 104/9 113/9 119/17 119/18 119/21
give [10] 9/9 17/17 18/1 23/13 33/14 47/13 55/8 85/6 91/8 121/12
given [10] 10/12 10/13 34/15 44/3 45/24 48/8 49/14 58/25 104/14 108/25
gives [2] 8/15 113/10
giving [3] 7/25 57/1 73/7
glad [1] 30/15
go [36] 14/1 14/18 24/13 27/23 28/2 28/20 38/3 41/24 46/2 46/6 46/11 46/25 58/19 70/7 71/14 71/15 71/19 74/17 74/24 77/11 89/9 92/23 97/22 101/12 104/12 106/9 106/9 106/21 107/4 114/4 114/10 118/17 119/20 120/19 122/4 124/18
goes [3] 6/23 45/20 70/14
going [47] 2/3 2/8 2/13 9/25 11/6 29/5 30/21 32/3 35/19 37/12 37/13 39/3 41/24 46/11 49/21 58/25 60/20 64/19 71/5 71/18 73/2 84/5 85/1 87/4 87/8 88/24 89/4 89/4 89/14 92/13 95/20 95/21 97/16 110/6 111/19 112/3 114/10 116/1 116/3 117/1 117/9 117/9 118/17 122/9 123/8 125/3 125/13
gone [5] 17/24 20/18 49/1 105/15 105/16
good [19] 1/3 21/11 34/13 42/18 58/12 60/17 60/18 62/22 62/23 68/19 70/23 77/20 78/7 103/20 112/2 112/12 118/16 119/10 123/25
Gosemore [1] 11/9
got [9] 23/3 40/23 75/1 79/1 79/1 88/11 101/16 104/12 107/13
governance [1] 107/24
government [2] 47/16 77/7
Grace [1] 15/8
great [1] 109/13
greater [3] 42/21 47/2 47/7
green [1] 88/4
Griffin [2] 44/1 44/3
grip [1] 21/23
groomed [1] 84/15
ground [1] 103/18
group [25] 25/8 37/18 51/10 56/10 59/3 59/4 65/5 65/13 69/2 88/19 92/21 93/2 93/4 93/19 96/22 100/11 100/12 100/13 109/15 112/8 113/4 118/23 121/24 124/4 125/14
groups [2] 37/5 93/11
guarded [2] 110/20 114/2
Guardian [1] 107/21
guess [2] 64/1 110/4
guidance [19] 6/4 8/8 8/13 9/24 10/19 13/2 38/7 38/8 42/22 43/4 43/5 47/2 47/8 47/20 52/8 76/1 76/20 76/21 78/6

H

had [55] 13/3 15/7 15/19 17/2 17/4 17/6 17/11 19/2 19/17 21/3 21/12 23/9 25/9 26/20 30/8 30/10 30/13 30/15 32/16 32/20 33/25 35/9 35/12 35/16 35/17 36/23 40/17 40/18 41/9 41/11 43/8 45/21 49/2 52/12 54/18 64/11 64/12 68/2 68/9 68/10 69/8 69/10 81/22 88/22 89/5 92/12 94/6 100/9 101/13 104/15 107/15 112/5 123/11 123/14 123/16
half [1] 35/8
halfway [2] 48/16 83/12
handle [2] 2/24 20/1
handling [2] 6/8 7/4
happen [10] 34/16 41/13 54/13 63/5 81/18 86/2 89/5 98/22 114/21 115/13
happened [18] 9/4 17/11 34/13 34/14 36/7 48/21 64/3 64/4 64/5 67/25 68/1 68/3 68/6 69/1 81/6 81/22 103/25 105/18
happening [11] 63/16 67/11 67/11 67/13 67/14 69/4 86/25 87/2 87/3 110/8 111/10
happens [4] 7/15 7/17 64/7 81/17
happily [1] 35/23
happy [1] 74/22
hard [4] 71/22 72/5 89/1 107/9
harm [3] 117/4 125/19 125/20
harmed [1] 73/17
has [53] 1/11 1/12 5/10 6/7 6/20 7/19 9/3 9/23 13/25 14/9 17/2 17/24 22/13 23/12 25/2 29/9 29/11 31/18 32/7 32/10 34/2 34/3 36/4 39/12 40/9 45/17 49/2 53/4 61/24 63/12 63/20 64/20 64/23 67/21 69/14 70/18 76/5 76/16 84/1 99/11 100/2 100/4 102/11 103/25 104/12 105/18 105/19 107/23 120/10 121/9 122/25 122/25 125/9
hasn't [4] 34/12 49/1 81/13 126/7
have [285]
have -- I [1] 17/10
haven't [5] 23/3 25/4 51/13 52/19 89/17
having [23] 12/1 21/8 44/8 57/20 57/23 58/20 63/17 63/18 85/20 86/24 95/14 97/1 97/14 97/17 102/9 103/4 112/12 114/7 119/3 121/9 123/21 124/5 124/6
he [15] 13/1 13/3 19/8 19/21 19/23 19/23 19/24 20/5 44/2 44/7 68/9 68/10 83/2 83/6 94/18
he'll [1] 83/9
he's [1] 44/6
head [4] 19/2 19/8 19/18 39/21
health [36] 51/11 57/25 61/14 61/15 68/17 70/21 70/22 75/1 77/4 79/12 81/7 81/12 89/25 90/1 90/7 93/10 96/24 98/3 98/6 98/8 98/11 98/13 102/4 102/22 103/12 103/22 105/7 106/20 109/3 109/9 109/12 110/16 124/16 124/16 124/17 125/9
healthcare [2] 89/14 116/21
Healthy [1] 113/1
hear [4] 4/23 48/25 53/23 60/5
heard [4] 23/12 24/3 104/16 115/7
hearing [5] 29/25 34/25 41/9 41/13 82/14
hearings [2] 50/3 126/11
held [2] 1/23 33/15
Hello [1] 42/19
help [3] 21/23 51/20 68/11
helpful [6] 56/3 73/4 75/21 93/12 93/18 126/15
helpfully [1] 43/4
helping [1] 66/23
her [3] 23/16 25/1 25/4
here [4] 19/13 32/22 66/17 78/9
high [11] 45/1 52/13 58/15 71/6 75/2 90/23 96/4 97/4 102/17 108/21 111/20
high-risk [1] 58/15
higher [3] 63/16 96/7 109/7
highlighted [1] 19/1
highly [2] 85/4 100/13
him [1] 83/7
his [3] 26/11 45/7 83/7
historical [2] 107/7 108/8
histories [2] 52/14 56/9
history [13] 52/16 53/10 53/19 58/7 67/7 83/14 84/1 84/3 91/6 99/13 100/16 104/13 126/4
hit [1] 12/24
hm [2] 3/17 20/22
HMICFRS [2] 38/18 38/25
hold [1] 53/20
home [2] 84/4 87/7
homeless [3] 52/12 71/23 124/21
homelessness [3] 52/12 76/22 116/21
homicide [2] 81/4 81/23
homicides [3] 80/21 80/25 82/1
honest [4] 64/17 65/19 80/20 81/16
honesty [2] 64/16 64/22
hope [6] 13/16 18/2 23/23 49/25 50/1 50/4
hopefully [1] 32/24
hoping [2] 23/17 39/2
hospital [32] 52/5 53/11 62/4 69/8 69/18 78/11 78/12 78/14 78/18 85/16 85/22 86/8 86/14 86/21 86/22 87/16 88/13 92/23 99/14 100/9 100/21 102/6 102/9 104/18 107/8 107/17 111/4 111/4 114/12 114/14 117/23 123/9

H

hospitalisation [4] 70/2 85/18 101/10 102/10
hospitalised [2] 69/3 85/15
hospitals [2] 87/17 108/2
hour [1] 41/7
hours [2] 58/9 121/21
house [2] 71/3 89/10
housing [5] 61/6 61/24 69/10 112/24 124/11
how [49] 3/25 4/17 7/20 9/2 20/1 20/23 25/7 32/2 53/2 53/6 53/11 56/10 59/14 62/15 63/23 63/25 64/14 65/5 65/16 67/14 71/12 71/17 73/1 74/10 75/9 76/13 83/24 85/3 85/5 85/17 89/8 91/13 91/24 95/2 95/6 96/2 97/7 99/5 103/5 105/3 106/7 108/13 113/21 119/20 119/20 120/13 122/6 122/21 125/19
however [2] 19/16 78/8
hybrid [1] 69/25

I

I agree [1] 25/20
I am [4] 28/16 29/2 30/15 50/25
I anticipate [1] 53/22
I apologise [1] 40/17
I arrived [2] 15/7 26/20
I ask [1] 53/21
I believe [1] 64/16
I call [1] 50/12
I can [8] 13/15 19/7 28/6 50/21 53/23 103/9 120/21 126/12
I can't [3] 28/5 29/3 45/7
I carry [1] 97/4
I certainly [1] 66/5
I commissioned [2] 30/17 33/23
I did [1] 42/11
I didn't [2] 39/20 39/24
I do [6] 17/12 21/9 42/5 43/18 44/24 64/5
I don't [32] 2/2 9/23 10/2 10/9 22/10 61/1 70/7 74/16 74/19 75/12 75/14 76/15 76/22 81/5 95/5 95/7 95/16 99/17 99/19 99/21 101/6 102/12 108/14 115/6 115/11 117/6 118/6 118/11 118/19 118/21 119/6 125/12
I gave [1] 113/10
I get [1] 99/7
I got [1] 40/23
I guess [2] 64/1 110/4
I had [1] 101/13
I have [6] 9/11 13/22 51/1 51/2 51/9 59/21
I haven't [1] 89/17
I heard [1] 104/16
I hope [1] 13/16
I instructed [1] 21/5
I interview [1] 59/4
I just [6] 3/18 33/8 39/20 42/20 45/16 119/15
I keep [2] 74/24 123/8
I know [7] 8/8 41/2 49/11 59/17 66/3 108/15 125/7
I may [1] 108/19
I mean [15] 37/4 60/25 62/12 63/6 72/4 72/21 74/15 83/20 88/10 93/22 113/24 115/1 119/5 121/25 124/18
I mention [1] 105/3
I mentioned [1] 123/8
I might [1] 67/19
I personally [1] 78/13
I please [1] 1/3
I remember [1] 32/18
I represent [1] 109/24
I right [1] 4/8
I said [2] 25/20 27/15
I say [3] 89/17 120/2 123/5
I see [6] 59/25 84/1 94/4 110/7 110/12 115/11
I should [4] 12/7 15/24 19/7 24/5
I speak [1] 111/25
I start [1] 51/18
I suspect [3] 10/9 11/1 22/9
I take [1] 113/15
I talk [2] 62/11 116/6
I then [2] 43/19 45/11
I think [165]
I thought [1] 21/7
I took [1] 12/8
I tried [1] 96/20
I understand [2] 9/11 35/2
I understood [1] 109/25
I want [3] 6/2 20/18 28/16
I was [11] 21/1 21/4 39/18 47/16 47/17 51/10 103/15 104/23 104/24 117/1 125/14
I wasn't [1] 83/6
I will [2] 35/23 40/18
I wish [1] 49/2
I worry [1] 118/22
I would [10] 17/15 25/21 34/9 49/18 49/25 66/3 74/23 79/2 79/23 117/5
I wouldn't [1] 10/11
I'd [3] 50/1 50/4 83/6
I'll [1] 77/11
I'm [37] 2/3 2/8 2/13 8/9 11/6 12/8 17/10 17/13 22/10 23/17 25/20 25/25 27/14 28/5 32/9 32/22 35/5 37/12 39/2 41/24 41/24 44/16 44/16 44/24 49/2 50/6 50/24 64/23 74/14 74/24 77/17 82/1 85/8 101/14 113/18 115/6 119/1
I've [26] 10/13 16/1 16/9 21/15 49/4 49/16 51/4 74/17 78/22 85/21 86/23 93/15 97/2 97/7 99/19 100/20 101/15 102/8 104/15 104/22 107/15 107/20 115/7 118/12 118/21 119/7
Ian [1] 15/8
idea [4] 68/9 68/10 79/18 124/8
ideas [1] 119/2
identified [5] 27/24 79/25 80/1 102/8 103/1
identify [3] 8/7 56/10 81/13
ideological [1] 79/15
if [140]
ignored [1] 30/10
ill [4] 61/10 61/16 62/16 94/4
illicit [1] 92/23
illness [15] 52/1 55/24 59/13 60/19 67/13 80/12 81/12 98/12 100/10 110/2 110/10 110/11 111/21 115/15 126/8
illnesses [2] 80/16 116/18
illustrated [1] 81/24
imagine [1] 61/22
immediately [1] 72/11
imminence [3] 126/2 126/10 126/12
impact [4] 21/3 83/2 112/11 117/14
impacted [2] 21/3 73/23
impacting [1] 95/3
impartial [1] 33/15
impartiality [1] 20/14
Implementation [2] 52/8 78/6
implementing [1] 11/5
implies [1] 93/16
imply [1] 42/11
importance [5] 20/13 63/17 98/3 108/20 124/15
important [29] 21/11 30/12 31/16 31/19 58/17 61/2 61/3 63/10 64/16 64/19 66/9 66/10 67/16 67/17 67/19 74/20 90/25 96/19 97/8 97/19 98/25 99/23 109/10 113/9 117/3 117/6 117/16 124/15 124/23
imposed [2] 110/25 111/1
impossible [2] 48/1 107/14
improve [3] 10/18 10/19 102/4
improved [3] 8/8 69/11 108/13
improvement [1] 85/13
improving [1] 10/23
inadequately [1] 101/25
inappropriate [4] 33/4 36/18 37/5 37/5
incident [5] 26/7 26/10 27/25 45/17 45/18
incidents [1] 49/9
include [4] 7/8 23/23 96/4 99/13
included [1] 85/12
includes [1] 98/12
including [6] 2/20 39/2 52/16 81/20 81/20 102/23
incompatible [3] 75/6 119/2 119/12
incomplete [1] 53/12
inconsistent [2] 102/24 121/19
incorporated [1] 30/20
increased [1] 68/3
increasing [1] 36/16
increasingly [1] 98/5
incredibly [5] 38/17 59/16 59/20 61/3 123/7
indeed [10] 4/5 12/10 19/11 42/9 47/15 76/25 82/14 102/15 106/5 107/4
independence [2] 31/16 62/9
independent [2] 2/18 36/4
indicated [2] 109/25 110/13
indicates [1] 45/4
indication [3] 4/3 12/16 43/11
indirect [6] 43/9 44/25 45/6 46/22 47/4 47/9
indirectly [2] 4/20 43/12
individual [4] 11/7 57/13 70/25 91/16
individuals [2] 20/6 29/6
induction [1] 98/16
indulge [1] 77/11
inevitably [1] 47/25
influencing [1] 83/24
infomatics [1] 90/15
inform [1] 85/12
information [48] 7/6 30/4 36/18 51/16 53/12 53/14 53/15 53/17 54/1 54/3 54/9 54/14 54/15 54/16 54/19 54/22 55/2 55/8 55/19 56/2 56/11 56/15 57/2 57/3 57/6 58/2 58/13 63/18 72/16 72/17 72/20 72/22 72/22 73/18 73/25 83/22 95/1 102/21 103/1 106/12 107/7 107/17 107/23 108/3 108/10 120/12 120/16 120/20
information-sharing [1] 120/20
informed [5] 6/8 6/13 20/5 27/3 33/3
infrequent [1] 122/8
initial [4] 8/13 16/24 31/9 94/1
initiate [3] 86/5 86/7 88/1
initiated [2] 36/11 118/13
initiative [1] 119/20
inject [1] 21/19
injected [1] 111/7
injections [1] 114/7
injured [1] 4/18
injures [1] 44/20
injuries [3] 2/21 11/16 45/20
injury [10] 3/16 4/16 4/22 6/20 42/23 42/25 43/7 43/13 45/24 46/1

I

innocuous [2] 67/22 113/12
inordinately [1] 25/25
inpatient [3] 116/12 116/14 118/1
inpatients [1] 116/16
INQT0000037 [2] 43/21 43/21
inquiries [1] 103/1
Inquiry [35] 2/12 7/12 10/14 13/24 16/21 18/3 18/5 23/12 23/15 23/16 23/16 24/2 25/6 25/17 25/19 28/11 32/23 35/19 45/17 48/18 48/24 49/15 49/18 49/20 49/24 49/25 50/17 51/7 51/17 76/25 77/1 80/1 81/25 96/12 102/12
inreach [1] 85/11
ins [1] 32/2
insight [2] 86/3 110/4
insignificant [1] 81/1
inspect [1] 38/19
inspection [1] 38/23
inspects [1] 38/18
instability [1] 52/11
instant [2] 36/5 38/8
instead [3] 94/14 94/14 94/20
instigation [2] 23/5 25/19
instructed [2] 21/5 34/19
instrument [1] 68/7
intelligence [1] 29/17
intended [1] 33/11
intense [2] 58/20 59/23
intensity [1] 71/6
intensive [1] 111/6
intention [4] 18/2 40/5 49/4 62/4
interaction [1] 26/16
interactions [1] 17/18
interest [6] 6/7 6/12 7/4 7/12 7/14 9/15
interested [10] 6/2 6/5 6/9 7/2 7/20 8/1 8/15 8/16 9/10 27/17
interesting [2] 7/23 21/15
internally [1] 111/19
Internet [3] 84/10 94/23 95/2
interrogated [1] 31/20
intervening [1] 97/18
intervention [2] 65/12 78/4
interventions [2] 68/17 116/7
interview [1] 59/4
interviewers [1] 31/14
interviewing [2] 31/12 33/9
interviews [2] 32/1 32/2
into [34] 5/4 5/5 7/1 10/22 11/14 14/15 17/24 18/11 24/9 25/10 26/4 26/12 29/17 30/19 30/20 30/21 34/1 34/10 36/4 39/15 41/24 45/8 46/11 47/11 48/16 49/23 55/21 58/25 60/25 62/1 69/18 85/11 98/16 114/11
introduced [1] 69/1
invariably [1] 91/6
investigate [2] 26/21 35/15
investigates [1] 2/19
investigating [7] 7/19 7/22 8/4 22/22 37/13 37/14 55/11
investigation [57] 2/6 2/9 4/14 5/8 5/20 5/21 5/22 8/14 10/10 11/14 12/1 12/12 12/14 12/16 13/5 13/11 13/16 14/15 14/20 15/5 16/7 18/10 18/11 18/17 19/13 21/4 22/14 23/2 23/4 23/24 24/9 24/15 24/18 24/24 26/4 26/5 26/12 27/18 27/22 28/12 28/22 29/9 29/23 30/8 30/12 30/16 30/21 31/9 33/1 34/10 35/4 36/12 40/20 41/15 41/18 46/13 47/10
investigations [24] 8/12 11/7 11/8 14/9 16/20 17/10 21/18 21/22 22/2 22/7 25/21 28/16 29/3 30/21 32/25 33/24 35/21 39/12 40/1 40/5 48/17 48/20 50/2 55/6
investigative [1] 32/1
investigator [6] 12/10 29/23 30/17 31/2 33/10 33/23
investigator's [1] 46/7
investment [1] 77/4
invite [1] 53/25
invited [1] 95/23
involve [3] 4/1 4/9 64/20
involved [17] 10/11 20/6 20/7 40/23 58/6 66/5 69/21 71/2 77/10 105/20 109/18 110/14 111/13 112/21 113/14 120/8 125/7
involvement [3] 103/14 116/23 119/21
involves [2] 51/22 112/19
involving [2] 2/19 2/21
IOPC [62] 1/18 2/14 2/15 3/1 3/8 3/12 3/15 5/9 5/14 5/15 5/17 5/18 5/19 5/23 6/13 7/3 8/4 8/6 9/1 9/22 10/5 10/20 10/24 12/3 12/8 13/6 15/6 15/9 15/23 16/1 16/2 16/6 17/2 19/5 19/8 19/10 19/13 19/17 23/9 26/1 26/19 27/11 29/22 33/1 33/4 33/20 34/10 34/22 36/4 36/11 36/14 36/23 37/15 38/12 38/16 38/20 39/12 40/1 42/3 45/19 46/1 48/19
IOPC's [2] 3/3 12/2
IOPC0000004 [1] 11/11
IOPC0000027 [1] 36/3
IOPC0000031 [1] 27/20
IOPC0000043 [1] 26/3
IOPC0000046 [1] 18/8
IOPC0000050 [1] 14/13
IOPC0000055 [2] 45/14 45/14
IOPC0000064 [1] 24/8
IOPC0000090 [1] 28/2
IP [1] 27/4
IPSO [3] 18/21 19/23 22/23
is [398]
isn't [28] 5/25 10/15 25/23 40/22 46/17 47/13 47/21 53/5 58/20 62/22 65/8 67/12 72/2 76/23 79/25 82/9 83/21 88/10 91/23 94/7 94/16 94/23 98/4 100/11 105/13 106/7 106/16 121/23
isolated [4] 60/24 95/12 95/13 109/15
isolation [2] 109/12 109/19
issue [14] 4/9 9/16 15/21 20/20 25/15 30/3 33/7 33/13 35/17 45/11 48/10 82/9 102/4 103/23
issues [15] 11/19 17/16 17/17 17/25 21/20 22/19 25/5 36/15 42/3 52/11 61/6 65/6 109/9 109/12 120/4
it [366]
it's [168]
items [1] 70/18
iterations [1] 119/9
its [4] 23/5 68/19 75/12 76/25
itself [7] 5/19 12/10 22/22 24/18 47/13 71/2 83/8

J

January [3] 22/15 26/14 40/6
January 2026 [1] 40/6
job [1] 99/6
joined [1] 36/7
joint [1] 120/1
jointly [2] 103/6 105/2
Jonathan [1] 77/14
judged [1] 30/8
judgement [1] 47/24
July [1] 34/20
June [7] 11/17 12/2 14/17 14/23 15/3 19/9 20/21
June 2024 [1] 20/21
jurisdiction [1] 3/15
jurisdictions [1] 100/17
just [92] 2/13 3/18 9/16 15/1 17/23 18/1 22/3 30/20 32/19 33/8 34/11 35/16 37/14 39/1 39/10 39/18 39/19 39/20 40/9 42/6 42/11 42/20 43/19 43/19 43/22 45/11 45/12 45/16 46/2 46/5 46/21 46/25 47/1 48/15 56/11 56/13 59/13 60/4 60/21 62/22 65/23 66/4 66/25 67/8 75/4 75/4 75/15 75/17 75/20 76/18 76/19 77/11 80/19 80/20 80/22 80/22 81/16 84/3 85/20 89/3 89/21 91/8 94/15 96/10 96/16 102/13 104/11 105/6 106/19 106/25 107/3 110/10 110/16 111/12 112/9 112/18 114/2 114/2 114/15 117/21 119/15 121/5 122/2 122/9 122/14 123/16 123/18 123/21 124/4 124/16 125/1 125/15
justice [3] 52/24 69/19 116/23
justification [1] 105/10
justify [1] 12/18

K

KC [2] 20/9 21/6
keen [1] 29/2
keep [6] 21/23 72/6 74/24 84/19 85/1 123/8
keeping [4] 60/12 83/14 84/4 84/12
kept [3] 6/7 6/12 38/25
key [7] 10/19 11/19 21/22 25/14 31/11 31/12 31/24
killed [1] 77/14
killings [1] 83/22
kind [17] 4/9 32/20 35/17 38/21 43/8 48/2 55/18 56/5 57/6 59/3 63/24 66/22 81/24 85/20 104/4 118/15 124/2
kinds [1] 63/6
knew [3] 24/17 26/20 63/23
knock [1] 117/14
knock-on [1] 117/14
know [70] 3/23 7/18 8/8 14/1 17/12 21/9 22/11 41/2 49/11 53/3 55/22 56/1 58/1 58/11 59/9 59/17 61/23 62/3 63/13 64/20 65/10 65/14 66/3 67/20 67/24 68/10 68/10 71/24 72/19 72/25 74/16 74/19 74/22 75/2 76/23 79/8 84/20 89/10 89/14 95/5 98/18 99/19 101/6 102/12 104/8 104/21 105/1 105/9 106/3 106/25 108/9 108/14 108/15 110/9 112/4 113/9 113/10 113/11 113/13 113/16 113/18 115/6 118/6 118/11 118/21 119/6 120/4 120/7 124/1 125/7
knowing [5] 98/12 98/12 98/13 98/13 113/21
knowledge [3] 1/16 1/17 67/16
known [3] 14/25 24/17 56/9
Kumar [1] 41/11

L

lack [3] 77/18 86/3 86/3
lacking [1] 69/25
laid [2] 78/22 99/19
landmark [1] 68/25
Langdale [4] 50/15 50/16 127/10 127/11
language [3] 16/25 23/8 32/6
large [2] 70/23 88/23
largely [1] 80/9
last [10] 21/2 21/17 21/25 40/9 41/14 41/17 43/6 96/3 97/3 101/23
late [1] 30/2
later [2] 57/18 116/8
latest [1] 41/17
law [5] 34/19 47/5 47/13 47/21 48/7
lawyers [1] 40/15
lay [1] 96/20
lead [6] 30/16 104/24 105/23 105/23 110/19 111/16
leaders [1] 103/19
leadership [2] 11/3 37/24
leading [2] 10/14 105/20
leads [2] 111/21 123/19
learn [2] 95/21 98/10
learning [5] 12/20 21/13 27/24 31/10 38/4
learnt [1] 31/10
least [3] 92/22 101/1 106/25
leave [4] 87/3 87/6 87/6 100/8
leaving [3] 104/18 115/18 117/2
led [4] 78/1 79/22 96/5 125/8
Leeds [1] 89/19
left [2] 19/8 118/23
legislation [1] 5/18
legitimate [2] 7/11 37/8
Leicester [1] 48/9
Leicestershire [3] 26/4 26/9 30/4
length [1] 25/24
lengthy [1] 90/9
Leonard [1] 68/24
less [6] 20/3 59/22 65/15 69/8 69/8 88/9
lessons [3] 30/20 31/10 31/11
let [5] 16/3 57/1 83/6 84/23 84/24
let's [1] 7/15
letters [1] 99/14
level [10] 5/9 22/6 29/23 30/7 30/11 44/5 69/7 106/16 111/25 114/1
levels [1] 116/25
liaise [2] 54/20 54/21
lies [2] 24/25 62/20
life [2] 67/6 123/22
light [5] 13/25 14/7 20/10 37/23 49/17
lighter [1] 65/16
like [32] 7/14 7/17 10/11 21/20 25/21 27/14 38/22 56/20 59/2 59/3 59/11 65/10 65/16 67/22 76/8 76/9 76/18 84/10 87/9 87/15 87/22 96/10 104/3 107/18 108/8 113/22 114/20 118/3 123/14 124/11 124/22 125/16
liked [1] 42/14
likelihood [3] 125/19 125/24 126/12
likely [2] 49/12 115/20
limit [1] 88/22
limitations [1] 73/12
limited [3] 90/22 93/13 93/14
limits [1] 125/16
line [5] 11/24 28/19 31/3 41/11 48/2
lines [1] 25/13
linked [1] 78/10
linking [2] 45/18 113/13
list [4] 2/2 70/12 70/17 74/18
listening [2] 41/4 103/15
literally [1] 41/7
little [5] 2/13 44/16 53/21 77/11 82/6
live [2] 83/21 87/9
lived [2] 93/11 113/16
living [4] 85/16 113/1 118/3 124/14
load [2] 56/14 83/12
loads [1] 116/23
local [5] 5/9 5/20 7/18 11/24 54/24
locality [1] 119/6
locally [1] 101/25
locate [1] 107/9
logic [2] 56/8 78/13
long [14] 9/12 20/25 28/14 28/20 32/9 34/21 36/7 50/6 59/8 61/21 62/7 102/11 119/8 125/22
Longdale [1] 18/7
longer [7] 25/21 25/22 28/17 32/17 34/2 87/1 114/9
longitudinal [2] 67/24 96/9
look [18] 2/11 10/11 31/22 38/13 44/15 45/12 45/16 55/23 57/8 67/6 74/6 76/2 81/10 84/23 84/24 87/8 109/2 115/3
looked [13] 44/11 69/14 77/19 89/24 90/3 90/6 90/15 90/16 100/7 100/19 101/4 123/8 123/9
looking [24] 10/6 45/17 46/23 51/25 58/19 64/17 66/15 67/1 67/2 72/7 73/10 79/20 82/1 83/1 84/9 84/13 84/14 90/13 106/24 108/7 111/20 112/6 114/11 119/1
looks [3] 34/10 54/13 124/10
lose [1] 70/1
lost [2] 58/2 67/18
lot [25] 17/11 17/18 17/21 17/24 51/16 61/5 79/2 82/5 83/21 84/8 85/2 89/1 89/8 89/12 91/24 92/11 94/4 97/4 109/8 118/11 118/12 121/12 122/3 124/21 126/12
lots [13] 37/4 58/12 67/3 69/13 77/16 79/22 98/14 102/5 103/11 111/18 116/20 118/19 123/22
low [2] 79/3 117/7

M

machine [1] 121/15
made [17] 4/11 4/13 15/15 18/21 26/12 29/13 29/16 31/9 33/10 35/9 35/12 38/14 76/25 77/20 105/1 119/25 125/10
main [3] 3/14 61/1 125/12
maintain [4] 65/19 108/22 109/10 121/11
maintained [1] 69/12
maintaining [3] 112/9 117/12 123/17
major [1] 10/21
majority [3] 49/19 80/15 82/10
make [32] 2/3 5/12 5/18 7/5 8/13 9/19 11/4 19/22 20/2 20/18 27/16 29/2 29/16 30/6 30/13 31/20 31/22 35/3 37/23 37/25 42/6 62/13 64/13 88/12 92/8 93/5 95/19 102/12 103/21 105/6 108/20 120/13
makers [1] 30/18
makes [3] 63/21 119/6 124/21
making [6] 5/2 20/7 20/8 21/7 41/5 56/18
manage [4] 63/23 70/21 85/23 112/1
managed [2] 86/17 97/19
management [19] 55/18 55/20 55/20 56/21 57/13 60/17 61/7 64/18 64/18 64/20 75/25 76/3 77/18 78/15 80/3 85/17 94/17 96/7 124/18
manager [3] 54/5 54/9 126/11
manages [1] 112/16
managing [4] 61/20 89/11 111/24 112/20
manner [1] 12/17
many [7] 44/21 52/13 52/23 71/17 94/9 103/1 116/25
MAPPA [3] 105/3 105/7 105/9
mapping [1] 55/25
MARAC [4] 105/4 105/11 105/12 105/14
March [3] 13/9 24/12 27/3
Marcin [1] 43/15
Marsh [1] 103/17
Mary [1] 68/24
mask [3] 111/16 111/22 113/7
mass [1] 83/22
massively [2] 100/21 124/17
material [2] 30/7 94/23
matter [16] 4/2 4/10 4/13 6/9 6/9 6/12 6/24 7/5 7/5 8/6 16/18 28/10 47/10 47/24 71/9 114/19
matters [16] 2/12 2/19 2/20 3/14 3/16 3/16 3/25 4/16 37/14 47/3 52/18 61/23 63/12 63/12 65/20 124/25
may [38] 4/1 4/3 4/12 7/2 7/7 8/5 8/5 8/17 9/2 12/17 15/15 26/6 35/8 37/13 43/11 49/11 50/12 51/7 52/10 53/19 60/2 65/15 79/16 79/17 80/23 86/14 91/10 93/12 95/9 96/4 100/24 103/12 103/13 108/19 111/6 114/20 118/21 123/2
May 2025 [1] 9/2
maybe [3] 101/5 103/24 115/15
mayor [1] 5/6
mayoral [1] 5/6
me [19] 13/15 22/8 30/1 35/13 41/11 44/15 60/16 77/11 78/9 82/20 83/3 83/10 94/8 97/4 111/11 113/15 121/1 125/13 125/20
mean [34] 8/2 23/3 31/21 34/12 34/13 34/14 34/15 37/4 39/3 42/11 44/15 57/15 60/25 62/12 63/6 64/22 66/25 72/4 72/21 74/15 80/11 80/25 83/20 88/10 93/22 95/5 96/14 96/15 113/24 115/1 119/5 121/25 122/24 124/18
meaning [5] 66/6 67/7 68/2 68/11 81/1
meaningfully [1] 95/18
means [9] 21/25 51/2 75/15 76/15 76/23 98/20 99/5 102/8 112/14
meant [4] 16/4 27/13 30/15 121/10
measure [2] 117/3 117/11
measures [4] 20/4 27/16 31/24 38/24
measuring [1] 117/7
media [3] 18/12 18/13 20/1
medical [4] 50/24 53/8 110/14 110/16
medically [1] 65/25
medicated [2] 114/23 115/21
medication [19] 52/2 61/11 62/17 62/21 66/3 69/10 86/4 87/25 91/6 92/24 110/20 113/23 114/1 114/5 114/17 121/13 121/19 122/2 125/2
medications [3] 91/9 91/12 91/18
meet [3] 26/22 94/5 103/6
meeting [4] 15/6 16/8 71/7 71/10
meetings [2] 8/13 74/10
meets [2] 5/15 43/16
member [5] 3/21

M

member... [4] 4/11 7/16 50/25 113/14
members [7] 11/15 12/24 54/4 57/22 58/4 73/13 85/11
memories [1] 64/6
memory [1] 51/21
mental [33] 51/11 52/1 55/24 57/25 61/14 61/15 68/17 70/20 70/22 75/1 77/4 80/12 80/16 81/11 81/12 89/25 90/1 90/7 93/10 98/2 98/6 98/11 98/13 102/4 103/12 103/22 105/7 110/16 116/18 124/16 124/17 125/9 125/17
mention [2] 94/5 105/3
mentioned [8] 33/8 49/17 77/12 104/20 104/20 114/15 116/10 123/8
mentioning [1] 77/17
merit [1] 94/12
messaging [3] 36/5 37/5 38/9
met [2] 30/3 35/13
metacognition [1] 115/7
metric [1] 116/25
metrics [1] 78/10
Meynell [2] 23/12 24/16
Meynell's [1] 24/6
microphone [3] 39/15 53/21 60/6
middle [1] 48/2
might [56] 7/13 29/18 35/4 37/7 47/12 51/20 53/22 55/8 55/12 55/14 55/15 57/23 59/7 59/22 63/16 63/20 64/10 64/21 65/14 65/16 65/17 67/2 67/7 67/19 68/10 68/12 71/24 71/25 73/8 73/18 73/19 73/22 75/16 78/22 79/14 81/18 83/24 84/23 86/9 87/9 91/17 93/19 93/20 94/5 95/2 95/13 104/17 109/1 113/14 114/3 114/11 114/13 115/3 118/18 121/16 125/20
mightn't [1] 73/19
Miller [1] 43/15
mind [3] 45/7 70/7 70/10
minority [1] 66/11
miscommunication [1] 21/20
misconduct [7] 2/5 29/25 30/7 30/9 30/11 34/25 41/9
misinformation [1] 80/9
misplaced [1] 79/9
miss [1] 121/20
missed [2] 71/13 97/21
mistakes [1] 31/9
mistrust [1] 61/10
mists [1] 67/18
misunderstanding [1] 45/5
misuse [1] 52/11
mitigate [1] 60/20
mix [1] 92/22
Mm [6] 3/17 16/14 20/22 23/6 33/6 38/5
Mm-hm [2] 3/17 20/22
model [12] 21/25 51/15 51/19 51/22 51/23 51/24 51/24 57/11 75/9 76/16 76/18 90/24
models [2] 67/4 118/20
Moloney [6] 39/8 39/9 108/17 108/18 127/5 127/12
moment [7] 9/5 10/4 14/5 28/9 38/19 41/14 76/9
money [1] 79/11
monitoring [7] 24/2 32/3 38/10 92/5 92/9 96/8 97/18
monitors [1] 38/18
monthly [1] 122/7
months [12] 13/5 16/12 22/17 24/22 28/12 28/15 28/21 29/1 35/19 47/19 90/13 90/17
morbidities [1] 83/4
morbidity [1] 60/23
more [76] 10/24 11/1 14/25 15/23 16/5 17/11 17/19 21/23 31/6 31/24 32/2 34/2 40/15 42/12 55/3 55/4 55/5 55/6 56/3 60/7 61/18 62/9 64/1 66/5 67/9 67/24 69/9 69/10 69/19 75/2 75/3 75/15 80/20 80/23 81/11 81/12 81/22 82/8 82/8 82/20 83/2 84/5 87/20 88/6 88/7 88/9 88/11 89/12 89/15 91/14 91/21 92/2 93/17 94/3 94/22 95/22 101/12 101/17 101/18 103/6 103/19 105/1 105/11 110/7 114/4 114/23 115/13 115/14 115/20 116/3 117/3 119/23 120/10 121/16 124/21 126/12
morning [2] 1/3 42/18
mortality [1] 60/23
most [14] 30/18 43/6 59/5 59/17 66/3 68/16 76/17 78/19 80/15 80/21 112/1 115/11 117/11 117/15
motivating [2] 60/14 61/1
motivational [1] 60/9
move [5] 6/2 14/12 24/7 26/2 43/3
moved [6] 21/24 39/21 53/18 85/16 99/11 103/8
moving [3] 17/15 18/7 39/18
MR [15] 1/7 14/16 39/8 39/9 39/12 40/9 42/24 108/17 108/18 109/22 109/23 127/4 127/5 127/12 127/13
MR BLAKE [5] 1/7 39/12 40/9 42/24 127/4
Mr Moloney [6] 39/8 39/9 108/17 108/18 127/5 127/12
Mr Straw [3] 109/22 109/23 127/13
Ms [16] 39/5 39/10 42/10 42/15 42/16 42/17 42/18 42/20 45/9 46/2 46/13 50/15 50/16 127/6 127/10 127/11
Ms Cartwright [6] 42/16 42/17 45/9 46/2 46/13 127/6
Ms Langdale [4] 50/15 50/16 127/10 127/11
Ms Watson [6] 39/5 39/10 42/10 42/15 42/18 42/20
much [30] 4/15 10/24 12/9 13/1 22/1 32/17 42/10 42/15 48/12 55/4 60/21 66/22 67/24 71/12 72/10 74/14 76/9 81/9 88/7 91/13 92/2 94/22 100/20 108/10 109/21 111/5 117/17 117/21 119/6 123/21
multi [6] 56/2 56/5 65/21 71/7 102/21 106/16
multi-agency [3] 56/2 56/5 102/21
multi-disciplinary [1] 71/7
multiple [1] 109/8
must [2] 25/24 48/21
mutually [2] 119/2 119/12
my [43] 1/17 20/25 21/5 21/9 22/20 30/1 30/14 32/22 35/8 39/18 39/21 50/24 57/18 62/21 62/25 70/7 74/24 78/22 80/6 80/19 81/3 83/13 83/25 84/8 88/2 89/18 90/9 90/9 92/21 93/15 100/4 101/13 103/8 105/3 105/4 105/6 108/15 112/1 112/11 117/13 118/11 123/23 125/12
myself [1] 16/9

N

narrow [1] 116/17
narrowed [1] 16/7
national [10] 11/24 19/12 20/16 29/19 29/20 37/19 77/8 78/1 78/3 81/25
nationwide [1] 38/13
nature [4] 18/17 24/15 106/15 125/17
navigate [2] 107/7 108/6
near [1] 51/21
nearer [1] 53/22
necessarily [8] 5/10 53/20 68/9 72/17 83/9 95/8 117/9 120/5
necessary [7] 41/11 62/18 62/22 86/13 86/18 96/11 119/22
necessitated [1] 87/25
need [50] 8/17 11/2 14/1 14/4 14/6 15/17 24/4 27/2 32/20 42/21 47/1 47/7 49/9 49/16 53/17 55/22 58/3 58/6 58/11 61/11 61/19 62/6 62/15 62/16 63/13 66/14 73/18 81/19 82/7 85/25 88/7 88/13 93/4 95/21 100/11 100/12 101/9 102/6 106/9 107/4 107/22 108/4 110/10 114/11 114/20 116/5 121/14 124/5 126/9 126/13
needed [10] 5/25 18/1 21/6 25/6 27/12 32/10 71/13 86/19 87/21 96/21
needing [1] 102/9
needs [14] 52/9 52/15 58/21 71/4 82/18 92/5 96/24 96/24 96/25 101/4 103/2 103/7 103/7 126/3
negative [2] 100/20 119/25
negotiation [1] 114/8
neighbourhood [3] 118/7 118/11 119/4
networks [3] 72/7 72/8 72/10
neutral [1] 19/5
never [1] 78/14
new [6] 21/24 25/13 30/16 30/17 53/9 121/15
Newcastle [1] 50/25
newer [3] 65/13 91/20 91/22
newly [1] 90/2
news [1] 123/4
next [7] 12/3 12/20 28/10 34/4 50/12 70/14 122/11
NHFT0015099 [2] 75/20 76/2
NHS [2] 107/18 108/1
NICE [1] 76/20
NICHE [5] 30/23 30/24 31/1 32/12 32/12
NMC [1] 98/19
no [41] 5/25 12/16 12/20 17/7 19/25 21/7 23/11 26/11 27/7 27/24 32/5 37/10 39/16 39/19 46/14 47/5 47/6 47/14 60/8 71/8 72/4 72/4 83/6 85/8 85/9 85/24 87/19 87/19 87/19 87/19 94/10 99/17 99/18 101/8 106/1 106/2 106/13 117/5 119/14 119/14 120/10
nod [1] 39/17
nodded [5] 15/11 22/16 54/8 55/10 57/4
non [9] 18/12 18/16 18/18 18/22 36/17 36/19 36/21 37/3 87/24
non-accredited [1] 36/21
non-attributable [1] 18/22
non-engagement [1] 87/24
non-police [3] 36/17 36/19 37/3
non-reportable [1] 18/16
None [1] 20/6
Nonetheless [1] 28/20
nor [1] 2/9

N

normal [2] 19/10 88/24
norms [1] 65/11
not [218]
noted [1] 27/1
notes [3] 53/8 108/10 108/11
notices [1] 34/23
notified [1] 9/2
notional [1] 125/25
Nottingham [2] 11/16 45/4
Nottinghamshire [7] 11/14 14/16 15/2 18/11 18/19 24/4 24/10
November [1] 24/23
now [35] 11/6 13/22 15/24 16/18 17/12 21/17 23/16 23/16 24/23 27/17 31/24 37/15 40/12 41/24 42/24 44/11 49/6 49/14 49/19 50/7 51/6 55/5 76/7 78/25 79/5 82/2 82/7 83/21 91/19 94/23 99/16 101/14 103/1 103/9 126/16
number [13] 1/23 17/20 45/1 49/9 68/1 68/2 78/15 79/20 91/1 101/15 101/19 104/15 122/16
numbers [1] 101/12
nurse [1] 98/18
nurses [4] 59/5 98/1 112/19 112/22
NUWAN [2] 50/14 127/9

O

objection [1] 94/1
oblique [1] 42/7
observation [1] 69/17
obtain [2] 23/17 63/21
obvious [3] 31/2 59/8 70/4
obviously [9] 25/17 35/9 46/7 48/16 80/21 84/19 114/8 120/20 121/12
occasion [1] 120/14
occasions [2] 27/15 104/16
occupation [1] 96/24
occupation/social [1] 96/24
occupational [5] 58/5 65/22 112/23 115/19 116/7
occur [1] 125/20
occurred [3] 20/20 64/11 99/15
October [3] 16/9 16/10 16/16
off [7] 22/21 41/10 42/12 54/5 61/11 74/18 122/7
offence [1] 12/19
offences [3] 52/23 82/12 105/15
offending [6] 52/13 52/16 52/20 69/15 69/20 82/17
offensive [1] 37/6
offer [4] 69/24 71/2 93/9 94/13
offered [3] 8/17 27/4 72/1
Office [2] 2/18 20/12
officer [16] 4/3 5/3 11/21 11/23 12/17 12/23 13/3 13/21 32/11 32/14 44/1 44/1 44/3 44/12 44/13 45/4
officer's [1] 11/22
officers [16] 17/22 24/3 26/5 26/9 29/18 30/6 31/14 32/21 33/9 35/3 35/18 36/12 37/1 37/3 37/4 54/20
officers' [1] 34/24
offices [1] 118/4
often [21] 28/20 28/25 35/1 52/12 53/12 56/9 59/8 61/13 64/3 79/11 81/18 83/15 102/24 108/8 109/9 110/1 110/13 111/3 111/16 120/2 122/6
Oh [7] 22/4 43/24 86/9 105/25 111/18 115/22 123/1
okay [2] 89/9 117/17
old [2] 91/21 118/22
old-style [1] 118/22
older [4] 91/18 91/19 91/21 108/9
omission [1] 83/25
on [182]
once [8] 21/4 22/12 23/4 23/25 24/5 40/23 86/22 111/4
one [55] 14/9 16/2 17/20 21/15 22/19 23/17 24/25 25/1 27/14 30/6 30/18 31/12 31/24 32/25 33/8 34/3 35/15 38/24 41/21 41/25 42/7 42/7 42/20 47/3 53/19 54/5 55/21 57/17 57/23 59/12 67/20 68/16 72/8 74/15 76/22 78/9 78/11 79/23 80/9 85/19 88/25 90/9 92/13 96/17 96/25 100/6 102/6 117/2 118/15 118/16 121/25 123/3 123/14 124/20 125/14
ones [7] 56/13 66/1 86/1 91/20 91/20 91/21 91/22
ongoing [7] 2/9 37/16 46/9 46/12 55/6 65/3 80/4
only [8] 14/9 25/17 32/18 35/8 96/17 105/17 107/13 109/2
onto [1] 36/3
onwards [2] 3/11 95/23
open [3] 20/8 112/3 121/16
opening [1] 76/25
openness [1] 66/14
operate [1] 72/4
operated [1] 45/22
operating [1] 21/24
Operation [14] 8/11 8/20 11/9 14/12 17/23 18/7 24/7 26/2 27/20 28/6 39/10 46/7 46/18 46/24
operational [1] 36/16
operationally [2] 36/13 36/25
opined [1] 19/23
opinion [3] 105/6 110/6 115/16
opinions [1] 19/2
opportunity [6] 7/25 8/16 8/18 9/10 27/6 79/19
opposed [6] 57/24 79/9 81/23 92/17 100/8 112/6
option [1] 72/2
or [134]
oral [2] 91/12 113/25
orally [1] 114/17
order [10] 42/12 58/8 74/25 86/11 100/19 101/9 114/12 114/13 114/21 122/11
orders [14] 51/10 77/25 86/17 88/12 99/22 100/1 100/2 100/6 100/7 100/16 100/22 101/13 124/8 125/13
organisation [1] 55/1
organisational [1] 38/4
organisations [2] 18/13 54/16
organise [2] 85/25 119/17
organising [2] 86/1 86/18
original [4] 15/18 30/8 68/23 69/17
other [57] 8/12 15/1 16/20 21/22 28/24 29/17 31/7 31/8 35/11 36/5 38/8 38/10 39/2 42/3 49/1 51/7 53/19 54/12 54/15 54/16 56/24 59/22 60/22 60/24 63/4 64/5 64/21 65/11 69/13 72/7 73/10 73/16 74/2 74/15 76/10 78/17 82/2 82/23 88/3 92/22 94/3 94/18 98/17 102/22 107/15 108/2 110/17 112/21 113/13 114/6 114/23 115/18 115/19 116/20 118/19 124/3 126/6
others [7] 12/9 36/17 76/1 81/1 108/16 112/18 125/5
ought [1] 24/17
our [69] 2/4 2/10 8/8 8/11 8/12 8/13 10/23 13/19 14/2 18/2 18/5 20/14 21/6 23/8 26/17 28/16 29/2 30/18 30/22 31/16 32/6 33/22 33/22 34/4 38/16 48/3 48/18 49/3 54/4 54/4 54/11 55/21 56/25 62/3 66/7 66/11 66/17 66/20 66/21 67/19 67/21 85/1 86/2 89/1 90/7 90/13 90/14 90/15 90/18 90/24 99/6 99/6 100/20 100/22 106/19 108/5 109/7 109/15 113/1 114/3 116/8 116/17 118/4 119/7 120/15 120/15 120/19 123/12 125/24
ours [3] 59/11 65/10 88/10
ourselves [3] 36/25 85/23 121/14
out [58] 2/16 2/25 3/8 3/11 5/17 6/6 7/21 11/18 14/14 14/19 18/8 18/15 19/11 24/3 26/11 27/22 28/10 28/19 34/18 34/22 39/12 43/4 47/4 48/1 49/4 51/22 52/7 53/7 53/12 53/14 54/4 54/23 57/5 62/1 67/21 71/4 72/2 72/4 72/18 73/6 74/9 77/4 77/6 78/1 78/10 78/22 83/21 84/6 91/4 92/1 92/25 96/1 96/20 97/8 99/19 100/25 102/5 105/18
outcome [2] 14/3 77/9
outcomes [1] 49/22
outlined [1] 1/25
outlining [1] 2/13
outreach [40] 51/5 51/15 51/18 51/22 51/24 60/11 69/2 69/21 70/20 75/9 75/13 75/14 75/24 76/5 76/16 76/21 77/9 78/1 78/10 78/19 78/24 79/2 79/10 79/16 79/20 85/11 89/23 90/3 91/5 94/14 96/2 111/23 112/15 112/19 116/11 117/4 118/20 119/3 119/7 124/9
outset [3] 2/3 16/2 27/18
outside [2] 13/2 37/11
outstanding [1] 17/5
over [27] 3/15 11/18 14/18 16/18 17/20 18/15 18/23 23/4 24/13 28/9 32/5 36/9 36/13 38/3 59/8 68/18 69/18 81/6 90/17 91/1 92/12 106/2 112/3 113/3 119/23 120/10 122/21
over-use [1] 122/21
overall [1] 47/18
overcome [1] 102/25
overlap [1] 4/15
oversees [1] 2/22
oversight [3] 22/1 22/6 77/18
overspeaking [4] 54/23 55/7 107/18 120/17
overstated [1] 115/17
overstepping [1] 20/14
overt [1] 41/1
overview [2] 38/22 91/8
own [6] 33/22 39/1 75/12 81/3 83/7 108/5

P

pace [2] 17/15 21/19
page [37] 2/16 2/17 6/5 11/18 12/13 14/18 14/18 18/15 18/23 24/13 27/21 27/23 28/10 32/14 36/9 38/3 43/2 43/3 43/21 43/21 43/23 45/14 46/6 47/2 70/11 70/14 75/20 76/2 77/6 85/9 95/23 96/3 97/22 99/9 101/23 102/15 127/2
page 1 [1] 46/6
page 12 [2] 75/20

P

page 12... [1] 76/2
page 16 [1] 85/9
page 17 [2] 43/21 43/21
page 178 [1] 6/5
page 19 [1] 12/13
page 2 [2] 18/15 24/13
page 24 [1] 70/11
page 26 [1] 95/23
page 27 [1] 96/3
page 3 [4] 2/16 11/18 18/23 27/21
page 30 [1] 97/22
Page 31 [1] 99/9
Page 32 [1] 101/23
page 33 [1] 102/15
page 4 [4] 36/9 43/2 43/3 45/14
page 5 [1] 47/2
page 66 [1] 43/23
page 9 [1] 77/6
painful [1] 25/25
palatable [1] 81/11
pally [1] 31/15
Panel [1] 34/25
paper [4] 38/25 47/19 68/25 108/10
paragraph [33] 3/11 6/25 7/10 12/14 13/19 15/17 27/2 27/5 36/10 47/3 51/19 51/19 52/15 57/10 68/15 69/23 70/7 77/5 77/6 79/4 80/7 83/11 85/9 85/10 88/17 89/19 91/4 93/5 95/23 97/22 106/10 107/5 112/17
paragraph 11 [1] 68/15
paragraph 123 [1] 27/5
paragraph 14 [1] 69/23
paragraph 18 [3] 47/3 77/5 77/6
paragraph 20 [1] 79/4
paragraph 21 [1] 80/7
Paragraph 25 [1] 83/11
paragraph 28 [1] 107/5
Paragraph 29 [1] 85/9
paragraph 30 [1] 88/17
Paragraph 34 [1] 89/19
Paragraph 35 [1] 91/4
paragraph 4 [1] 51/19
Paragraph 44 [1] 93/5
paragraph 45 [1] 112/17
Paragraph 50 [1] 95/23
paragraph 53 [1] 97/22
paragraph 59 [1] 13/19
paragraph 6 [1] 51/19
paragraph 66 [1] 15/17
paragraph 8 [1] 52/15
paragraph 88 [1] 27/2
Paragraph 9 [1] 57/10
paragraphs [1] 29/8
paragraphs 90-91 [1] 29/8
paranoia [2] 94/22 111/13
paranoid [6] 82/10 93/20 93/21 93/23 94/17 115/25
parity [1] 98/7
Park [1] 77/15
part [33] 3/3 4/25 23/11 23/16 25/3 27/18 34/3 34/5 38/17 41/21 41/21 41/25 41/25 42/7 42/7 42/8 46/18 47/18 48/18 49/17 61/3 61/12 63/12 63/15 69/3 74/14 79/12 83/14 84/11 93/15 94/3 98/17 113/1
part one [1] 41/21
part-time [1] 113/1
partially [1] 119/19
participant [1] 2/10
Participants [2] 39/7 40/9
particular [16] 8/11 10/6 12/22 17/6 22/14 27/24 37/12 52/17 54/2 80/3 96/11 112/20 113/20 113/21 117/23 122/22
particularly [11] 7/23 10/1 10/13 10/16 25/7 35/7 44/9 84/14 105/5 108/7 108/20
partly [4] 21/18 21/19 35/12 112/4
partners [1] 37/17
parts [2] 34/1 34/1
passion [1] 59/6
passionate [1] 59/10
past [1] 84/1
pathways [1] 102/1
patient [36] 52/6 58/6 58/13 58/22 59/3 59/20 62/14 62/19 63/20 63/22 64/10 65/7 66/24 67/3 68/3 72/13 72/18 72/20 73/14 80/20 80/25 81/4 86/22 86/23 86/25 92/15 92/21 93/18 96/22 107/6 107/20 107/23 110/5 112/13 118/13 126/8
patient's [1] 87/23
patient-initiated [1] 118/13
patients [59] 51/8 51/23 51/25 52/10 53/3 56/4 57/21 58/15 59/4 59/13 59/14 59/25 60/9 62/12 63/3 63/7 66/12 66/12 66/17 67/21 69/2 69/6 71/8 71/23 75/4 80/23 81/20 82/19 83/13 83/19 84/8 89/22 89/25 90/16 91/5 91/15 92/6 93/13 93/14 94/4 96/12 96/19 99/24 100/9 105/24 108/3 109/7 110/1 110/7 110/13 111/11 111/20 112/16 113/4 114/22 121/24 123/5 123/10 123/23
patients' [1] 64/6
pattern [1] 52/6
pausing [1] 75/17
paying [1] 87/23
PCC [1] 5/6
peer [3] 93/9 93/19 94/13
pending [1] 53/1
Penhallow [11] 8/11 8/20 26/2 27/20 28/7 33/10 39/10 40/3 40/12 40/22 41/22
people [138]
people's [1] 56/9
percentage [1] 125/25
perception [1] 31/13
perfectly [1] 41/4
performance [1] 34/16
perhaps [11] 13/15 17/16 22/25 35/3 42/25 43/6 46/20 48/8 49/8 57/6 115/14
period [8] 23/14 59/9 86/7 87/1 90/17 91/1 116/8 123/15
periods [2] 52/12 114/5
permission [1] 120/25
permit [1] 13/15
perpetrators [1] 80/24
persecuted [1] 59/19
persist [1] 85/7
persistent [1] 52/16
person [46] 6/9 6/12 6/14 6/16 6/20 7/1 7/2 8/16 9/15 9/19 27/17 43/8 43/9 54/2 64/21 67/17 67/23 68/6 71/20 73/11 86/20 87/4 89/6 94/6 96/17 103/16 104/1 106/23 113/6 113/7 113/9 113/16 113/17 114/18 115/1 115/21 115/23 115/24 116/2 117/12 117/13 119/19 119/24 120/6 120/8 126/3
person's [1] 67/6
personal [2] 80/19 115/16
personality [3] 82/24 83/4 83/8
personally [4] 19/23 30/1 78/13 101/14
persons [8] 6/2 6/5 7/20 7/23 8/1 8/15 9/10 104/19
pertinent [2] 55/15 73/8
phone [1] 84/22
phones [4] 83/19 84/10 84/11 85/1
photographs [1] 37/2
phrase [1] 75/13
physical [8] 66/2 96/24 98/8 109/9 109/12 116/21 117/22 121/22
pick [3] 53/23 112/18 119/15
picked [3] 97/12 97/14 97/15
picking [2] 45/11 87/19
pilots [1] 118/7
PIN [2] 98/18 98/18
place [14] 12/8 17/11 17/13 19/17 19/25 21/21 27/11 27/16 37/10 50/4 71/25 104/17 118/15 121/14
plainly [2] 44/10 44/14
plan [1] 76/3
planned [2] 71/10 71/11
planning [4] 47/17 71/9 77/22 87/8
plans [1] 85/13
plates [2] 68/1 68/2
play [2] 5/1 66/10
played [1] 79/12
please [43] 1/3 1/15 2/15 6/3 11/11 11/18 12/13 14/13 14/18 18/7 19/6 24/8 24/13 27/19 27/21 36/3 36/9 38/3 39/10 39/19 42/21 43/2 43/20 45/11 45/13 45/15 45/16 46/6 47/1 50/12 50/22 51/18 51/22 57/3 70/11 76/24 83/11 85/9 89/19 97/22 101/23 106/25 116/10
pleased [1] 47/17
plus [1] 97/3
pm [1] 126/17
point [17] 6/19 9/8 16/10 19/21 22/10 22/23 25/14 40/25 41/9 59/14 62/8 67/12 78/25 96/3 97/16 99/10 101/23
pointed [1] 39/12
pointing [1] 73/5
points [5] 7/24 41/5 76/3 102/20 119/16
police [83] 2/18 2/20 2/21 2/22 2/23 3/4 3/7 3/23 4/2 4/3 4/19 4/20 5/3 8/3 11/3 11/20 12/17 14/16 14/22 14/25 15/1 15/2 18/12 18/19 19/12 20/16 24/10 26/5 26/9 26/18 28/18 29/19 29/19 30/5 31/14 31/19 32/16 33/14 36/6 36/13 36/17 36/19 36/20 37/2 37/3 37/10 37/19 37/21 37/24 38/6 38/13 38/18 38/24 43/9 44/17 44/17 44/18 45/5 45/24 47/15 53/4 53/5 53/14 53/19 54/1 54/10 54/10 55/8 63/18 63/18 63/21 64/12 102/23 103/14 103/22 104/7 104/20 106/19 106/23 111/2 111/3 119/21 120/17
Police's [1] 11/14
police-related [1] 37/2
policies [3] 11/24 38/2 38/7
policing [11] 7/18 10/3 17/18 37/8 37/11 37/19 38/18 38/23 49/13 50/3 50/3
policy [5] 14/2 34/11 52/7 72/4 78/6
political [1] 79/13
poor [5] 83/15 91/6 102/24 107/25 116/25
poorly [1] 106/25
population [1] 101/3
pose [4] 62/23

P

pose... [3] 102/17 103/12 104/17
poses [1] 121/23
position [5] 1/21 49/21 63/8 79/5 83/18
positions [1] 1/24
positive [2] 69/25 103/8
possibility [2] 4/21 14/3
possible [6] 20/19 29/3 49/13 76/14 120/22 121/1
post [2] 12/8 48/16
potential [6] 13/25 29/17 30/11 31/7 31/8 63/15
potentially [14] 4/6 12/5 14/1 30/6 37/2 42/1 47/22 63/2 63/14 95/15 98/23 100/15 102/17 104/19
practical [5] 61/5 61/6 61/23 62/6 86/19
practically [1] 7/25
practice [4] 8/10 63/14 66/22 122/23
practices [1] 38/7
practising [1] 98/21
prefer [1] 110/5
prejudice [4] 2/5 13/16 42/2 49/22
prejudicing [1] 55/5
premature [1] 60/23
preparation [1] 87/5
prepared [2] 50/17 51/14
prescribed [1] 78/5
prescription [1] 122/11
present [5] 7/17 65/14 83/16 109/1 122/15
presentation [1] 107/8
presenting [1] 65/14
press [2] 20/12 22/22
pressed [2] 40/15 40/15
pressure [1] 87/13
presumably [5] 58/21 63/19 85/4 111/16 116/14
prevent [3] 58/16 72/16 84/17
previous [3] 83/15 90/10 107/8
previously [1] 68/23
prick [1] 121/16
principal [2] 2/25 11/8
principle [2] 97/23 118/14
prior [5] 1/23 11/15 11/21 11/22 14/16
priorities [1] 79/13
prioritised [2] 23/15 32/23
prioritising [1] 10/20
prison [4] 54/22 102/23 105/17 105/17
prisons [1] 54/21
private [1] 36/21
proactive [2] 8/6 75/15
proactively [1] 4/11
probably [5] 10/19 70/16 79/22 98/6 101/5
probation [5] 54/17 54/18 54/20 54/20 102/23
problem [5] 9/15 60/8 84/11 104/15 106/18
problematic [5] 47/22 102/21 104/7 104/9 120/11
problems [4] 60/22 91/22 91/23 109/14
procedures [4] 11/25 17/22 20/9 87/22
proceedings [4] 4/4 12/19 53/6 55/11
process [3] 9/3 20/15 118/25
processes [1] 27/13
processing [1] 115/9
produce [1] 117/10
profession [2] 79/15 81/6
Professional [2] 11/4 28/18
professions [1] 65/5
Professor [2] 82/15 82/20
Professor Fazel [2] 82/15 82/20
profiles [1] 91/14
programme [4] 10/21 30/22 77/22 82/19
progress [5] 21/18 22/1 22/6 42/12 101/11
progressed [1] 52/19
prohibit [1] 2/4
project [1] 60/7
prominent [1] 78/19
promote [1] 11/1
proper [2] 47/10 82/19
properly [7] 6/7 6/13 10/4 11/5 13/3 114/22 115/21
proportion [2] 6/1 109/18
prosecution [1] 52/19
protecting [1] 61/2
protection [2] 84/4 105/8
protective [1] 88/24
protocol [2] 19/11 20/17
protocols [1] 87/22
provide [5] 13/15 47/12 60/18 70/6 118/15
provided [6] 7/6 33/4 35/18 45/23 47/8 79/19
provides [1] 60/12
providing [2] 57/8 72/17
provision [3] 77/9 78/24 102/14
psychiatric [3] 65/23 98/1 111/6
psychiatrist [4] 50/24 53/24 96/6 96/17
psychiatrists [11] 51/1 62/18 65/22 65/25 66/3 76/1 76/20 79/17 96/14 112/19 112/22
psychiatry [2] 51/2 95/1
psycho [1] 114/24
psycho-education [1] 114/24
psychological [4] 59/24 61/8 65/24 66/6
psychologists [4] 65/22 66/5 66/7 66/19
psychology [4] 58/4 112/23 115/19 116/7
psychosis [11] 51/4 51/8 59/15 61/25 65/15 82/11 82/17 83/9 92/3 95/4 115/16
psychotic [9] 59/7 59/15 59/21 59/23 60/1 60/13 64/15 73/9 100/10
public [12] 3/3 3/21 4/11 11/16 12/24 56/7 60/12 61/2 62/22 81/7 105/8 125/11
publicised [1] 105/1
pull [1] 53/21
purpose [3] 2/16 2/25 106/4
pursuant [1] 57/1
pursue [2] 31/3 74/8
pursued [2] 31/6 44/13
pursuing [1] 13/21
pursuit [1] 44/2
pushback [2] 55/1 107/15
pushed [1] 107/20
put [6] 27/16 33/11 34/1 35/14 70/16 107/14
putting [2] 21/21 32/25

Q

qualification [3] 98/2 98/3 98/19
qualifications [2] 50/22 98/11
qualified [5] 65/25 82/20 83/2 97/24 97/25
quality [3] 15/19 32/3 123/22
query [1] 48/10
question [14] 5/4 5/5 9/12 9/14 13/21 25/10 39/20 39/21 39/23 39/24 64/1 84/8 112/10 116/10
Questioned [16] 1/7 39/9 42/17 48/14 50/16 108/18 109/23 117/19 127/4 127/5 127/6 127/7 127/11 127/12 127/13 127/14
questioning [1] 31/7
questions [4] 39/6 39/6 43/25 108/15
queue [2] 9/6 9/11
quick [1] 29/3
quicker [4] 28/17 29/4 49/5 87/15
quickly [7] 17/11 20/23 34/2 42/13 42/13 97/12 125/23
quite [37] 7/9 19/19 20/25 23/14 28/23 28/25 31/12 31/23 31/24 35/1 36/7 41/1 41/7 44/23 45/1 53/17 55/12 55/25 60/2 60/5 61/13 61/20 75/4 78/5 80/13 84/6 90/22 91/20 92/11 92/20 102/11 108/6 109/8 109/17 110/22 113/19 125/22

R

Rachel [3] 1/4 1/6 127/3
Rachel Watson [1] 1/4
RAG [2] 88/4 88/10
raised [4] 24/10 24/12 31/13 119/16
randomised [2] 68/18 100/5
range [4] 71/1 113/3 113/25 118/15
ranging [1] 15/4
rapport [1] 62/14
rare [2] 80/22 81/7
rate [1] 117/7
rates [1] 70/2
rather [7] 9/8 13/23 44/23 52/25 57/13 71/3 88/19
rationale [1] 45/23
reach [3] 9/18 9/18 21/14
reached [2] 9/1 14/10
reaches [1] 5/9
reaching [1] 87/4
REACT [3] 78/19 89/24 90/11
read [3] 6/5 81/1 118/12
readily [1] 55/4
realisable [1] 16/7
realise [2] 39/20 62/3
realised [2] 16/6 20/2
reality [2] 64/11 103/18
really [67] 6/25 21/2 22/11 29/4 31/16 31/18 32/18 33/15 33/21 55/25 58/15 58/17 59/3 59/5 61/24 63/10 63/14 64/16 64/19 65/19 65/20 66/17 67/16 67/17 67/19 67/22 74/20 75/14 76/15 76/23 77/20 89/10 89/16 91/2 94/19 94/19 97/19 98/25 99/17 104/6 104/11 105/10 106/24 107/24 109/9 110/22 112/2 112/9 113/12 113/15 115/10 115/23 119/1 120/10 121/19 121/23 122/2 122/12 123/4 124/15 124/23 124/24 125/20 125/25 126/2 126/13 126/14
reason [7] 37/8 58/1 86/9 100/23 101/16 111/9 117/5
reasonable [1] 13/6
reasonably [1] 10/2
reasons [6] 25/23 58/12 78/21 88/25 99/19 109/11
reassure [1] 3/3
rebalancing [1] 125/4
rebuilding [2] 31/1 32/15
rebuilt [1] 32/13
recalled [3] 86/14 100/24 114/13
receive [2] 15/25 45/12
received [3] 3/22 45/21 69/6
receiving [3] 56/23 72/16 72/22
recent [1] 38/24
reckless [1] 94/19
recognising [1] 92/16

R

recollections [1] 64/25
recommendation [3] 93/6 102/3 121/2
recommendations [13] 37/20 37/23 37/25 38/4 38/10 38/14 38/20 39/1 39/4 77/2 77/21 95/24 102/13
recommended [2] 38/6 77/20
recordable [4] 6/8 6/11 6/18 6/22
recorded [1] 45/19
records [2] 53/13 107/6
recovering [1] 123/19
recovery [2] 59/8 124/25
recurrences [1] 20/19
red [3] 73/9 88/4 88/6
redressed [1] 99/16
reduce [3] 90/23 101/15 123/13
reduced [4] 78/18 100/22 122/15 123/11
reduces [5] 116/11 116/14 116/15 117/4 122/7
reducing [4] 69/20 79/20 111/24 112/11
reduction [6] 77/9 78/12 78/24 90/12 90/19 90/20
refer [13] 5/13 44/22 48/5 52/15 58/20 85/23 89/19 91/9 94/22 97/23 97/25 101/23 106/9
reference [27] 2/4 2/10 14/14 14/19 15/18 15/22 16/5 16/11 16/13 16/25 18/9 18/24 21/3 22/12 22/15 22/18 22/25 23/8 24/14 24/22 26/24 32/7 48/18 49/24 77/1 93/5 112/17
references [2] 45/19 75/24
referral [7] 5/11 5/25 16/24 26/8 26/13 26/15 46/1
referrals [5] 26/18 36/15 45/2 45/12 105/6
referred [13] 5/12 5/17 12/3 15/9 16/15 16/19 44/21 48/9 75/20 82/14 106/7 110/4 122/20
referring [2] 68/21 75/9
refers [1] 76/21
reflect [2] 70/19 115/5
reflected [2] 8/19 44/9
reflecting [1] 28/13
reflective [2] 66/14 66/21
reform [2] 3/7 38/25
refusing [1] 92/7
regard [1] 90/11
regarding [2] 18/12 33/4
regret [1] 30/14
regular [2] 41/19 96/9
regularly [5] 65/1 74/20 88/15 104/22 111/18
regulation [1] 34/23
rehabilitation [3] 51/2 102/1 118/1
reinvestigate [1] 14/6
reinvestigated [1] 14/8
reinvestigation [1] 14/2
reiterate [1] 121/21
relapse [1] 100/14
relapses [2] 52/4 83/15
relate [2] 11/20 36/16
related [5] 36/15 36/18 37/2 41/22 55/17
relates [4] 6/18 6/22 26/6 28/8
relating [1] 33/1
relation [15] 8/19 10/14 14/16 17/23 20/11 26/5 53/3 104/18 105/24 118/7 119/16 119/19 120/12 121/5 122/14
relationship [4] 41/25 63/10 93/18 112/13
relationships [4] 62/11 107/3 112/2 119/11
relative [1] 6/16
relatively [1] 122/8
relevant [8] 2/12 23/1 51/7 53/15 54/10 56/21 83/1 85/4
reliably [2] 52/2 126/1
reliant [2] 12/9 113/13
relies [2] 112/9 115/1
reluctance [1] 107/23
reluctant [1] 55/6
rely [1] 118/12
remain [3] 19/5 97/24 102/10
remaining [1] 79/7
remarks [2] 33/10 37/6
remember [2] 28/5 32/18
Remind [1] 101/19
reminded [1] 20/12
remote [1] 88/19
remove [1] 125/22
reopen [2] 13/11 30/12
reopened [10] 14/8 28/7 29/9 29/11 30/16 30/21 32/5 40/13 41/8 41/15
reopening [3] 29/22 40/20 41/1
repeat [2] 3/13 39/24
repeatedly [4] 52/2 52/4 89/4 124/6
replaced [1] 26/14
report [20] 11/12 11/19 12/10 13/20 28/3 28/3 28/6 29/14 30/18 46/7 48/25 70/8 75/8 75/12 77/1 77/12 77/13 77/19 90/9 93/6
reportable [3] 18/12 18/16 18/18
reported [1] 27/20
reporting [1] 18/21
reports [1] 29/1
represent [3] 95/9 109/24 111/15
representations [3] 29/13 29/16 30/14
represents [2] 63/4 95/8
request [6] 53/14 54/3 54/15 55/18 56/18 57/3
requested [1] 54/19
requests [4] 56/23 107/14 120/14 120/20
require [5] 2/11 52/18 80/3 96/5 96/8
required [3] 3/8 28/4 102/3
requirement [4] 31/25 49/24 92/10 99/13
requirements [1] 107/11
research [5] 68/23 83/7 90/22 95/17 100/18
resistance [8] 29/22 40/20 40/21 40/23 40/24 40/24 41/1 41/2
resistant [3] 92/2 92/16 92/17
resourced [3] 38/22 49/6 76/8
resources [1] 58/16
respect [11] 6/24 13/13 21/13 22/13 35/20 37/15 42/22 43/14 65/19 87/23 102/3
respond [1] 93/3
responses [2] 14/15 32/21
responsibility [5] 85/20 97/5 103/10 106/6 107/19
responsible [1] 98/20
restricted [2] 54/11 111/5
restrictions [2] 88/23 92/3
restrictive [4] 55/12 61/19 63/14 101/1
result [3] 6/17 6/21 125/3
results [2] 33/25 117/10
return [1] 5/24
revealed [1] 36/12
reverse [1] 90/5
review [20] 20/9 20/16 21/6 22/24 24/4 31/4 33/17 33/18 36/4 36/6 36/11 36/19 37/18 38/6 47/18 49/16 51/11 71/8 96/9 125/8
reviewed [2] 15/19 86/23
reviewer [1] 31/5
reviewing [1] 88/15
reviews [2] 2/11 68/18
revised [2] 8/12 9/24
rewards [2] 59/7 60/9
Reynolds [1] 44/2
right [47] 1/22 3/10 4/8 4/12 9/20 12/25 14/11 15/6 16/16 16/17 16/21 16/22 17/13 17/14 17/14 22/8 26/8 26/15 26/16 27/25 32/22 41/16 41/23 43/22 46/16 48/11 49/7 54/15 68/23 80/5 101/3 103/15 103/16 104/1 104/1 110/3 110/15 112/18 113/8 116/16 119/19 119/24 119/24 121/9 122/10 123/6 126/16
ring [1] 120/6
rise [3] 122/18 122/19 126/16
risk [71] 11/22 37/9 52/25 55/17 55/20 56/6 56/18 58/15 59/17 60/17 60/19 61/20 62/23 63/13 64/17 64/18 64/20 64/21 65/3 68/13 73/16 73/21 73/22 73/25 74/2 74/7 75/25 77/18 78/15 80/4 80/8 80/13 80/22 80/25 81/14 82/6 82/22 84/18 85/4 93/1 94/17 95/11 95/12 96/7 96/9 96/25 97/4 98/12 99/11 99/12 99/20 100/15 102/9 105/8 106/12 106/15 108/21 109/7 111/20 111/24 112/11 113/7 121/22 121/22 124/18 125/5 125/5 125/11 125/21 126/6 126/10
risks [22] 36/20 52/3 52/13 55/22 55/23 56/1 58/7 68/12 83/16 96/4 96/5 96/8 97/16 102/17 103/13 104/17 107/9 108/8 108/25 109/2 110/11 118/19
Ritchie [6] 77/1 77/12 77/12 77/19 79/25 96/12
robust [5] 18/6 34/14 38/1 93/9 96/8
role [9] 1/23 2/2 50/23 53/2 65/24 65/24 66/10 96/16 99/6
roll [2] 78/1 78/10
roll-out [2] 78/1 78/10
room [1] 44/7
roughly [1] 101/19
round [3] 49/1 60/1 89/16
route [4] 88/1 94/15 98/22 120/13
routinely [2] 44/20 83/18
Royal [3] 50/25 76/1 76/19
run [3] 24/17 58/9 105/25
run-up [1] 24/17

S

safe [4] 10/15 60/12 76/14 92/8
safeguarding [2] 98/14 104/23
safeguards [1] 91/10
said [25] 15/16 15/18 18/4 25/20 27/15 29/8 33/2 65/21 70/5 73/13 76/7 78/17 81/7 86/23 89/17 93/15 94/10 96/12 100/20 107/4 119/12 121/5 122/15

S

said... [2] 122/17 125/4
sake [2] 81/19 109/10
same [17] 4/9 49/22 56/8 56/15 56/24 56/25 65/18 70/16 71/15 71/18 71/20 81/15 90/5 98/16 123/15 125/2 125/3
sample [2] 32/1 38/21
saving [1] 91/3
say [62] 5/24 7/16 10/15 12/7 13/12 15/24 17/2 17/15 19/7 19/15 23/9 24/25 29/3 34/6 34/7 34/9 39/15 39/16 39/19 45/7 48/5 56/13 57/10 61/5 63/17 64/2 65/7 66/3 67/3 68/21 69/23 70/4 72/25 74/21 75/10 79/4 79/23 80/7 82/19 83/12 85/10 88/17 88/21 89/17 93/12 94/7 96/2 96/11 98/2 99/22 99/25 101/9 102/3 102/15 102/20 108/19 117/5 120/2 120/6 123/5 126/3 126/7
saying [4] 35/5 73/7 95/7 119/13
says [11] 2/17 6/6 6/25 11/13 12/15 14/14 36/10 44/7 67/20 85/6 90/23
Scale [5] 57/17 70/18 72/9 76/17 85/19
scared [1] 59/18
scattered [1] 97/20
scenario [1] 84/23
schedule [1] 106/8
schemes [1] 118/7
schizophrenia [6] 82/11 82/17 82/23 83/5 92/3 110/2
school [1] 74/1
scope [1] 85/13
scratch [1] 68/7
scratching [2] 67/21 113/11
screen [10] 2/15 6/3 11/11 14/13 18/8 24/8 27/19 36/3 70/9 70/16
scroll [1] 28/9
scrutiny [1] 21/12
sea [1] 104/1
sec [1] 45/24
seclusion [1] 111/5
second [8] 1/11 12/14 12/15 13/9 14/18 35/8 36/10 40/8
section [7] 3/7 7/7 43/6 77/23 77/25 96/20 100/8
section 10B [1] 3/7
section 117 [1] 77/23
section 17 [1] 100/8
Section 25 [1] 77/25
secure [1] 86/18
see [51] 12/13 18/23 24/2 24/13 32/13 36/9 37/4 37/7 38/3 38/13 52/6 56/8 59/8 59/25 61/9 64/2 66/11 66/19 74/21 74/23 74/24 76/2 78/12 78/13 79/4 84/1 87/2 87/3 87/3 87/6 88/8 88/8 89/4 89/10 93/22 94/4 107/1 110/7 110/12 110/22 111/12 114/4 115/10 115/11 115/24 115/25 116/2 118/23 122/1 124/19 126/12
seeing [12] 53/9 66/24 81/3 83/20 83/23 85/3 87/4 89/6 89/7 89/15 115/5 115/23
seek [5] 19/16 25/11 53/11 54/23 63/17
seem [7] 9/12 28/22 35/6 67/22 89/9 108/1 113/11
seemed [2] 25/10 103/7
seems [5] 25/8 34/17 44/16 76/9 122/19
seen [12] 10/13 21/8 25/5 30/5 30/10 30/24 31/8 32/11 32/14 72/5 104/22 118/21
self [2] 84/4 125/5
self-protection [1] 84/4
send [3] 37/1 57/3 120/21
sending [2] 55/21 56/23
sends [1] 54/5
senior [11] 15/20 16/3 16/5 21/23 22/1 22/6 37/24 44/12 45/4 103/19 120/3
sense [4] 62/13 95/19 116/15 124/13
sensible [2] 41/5 94/21
sensitive [2] 2/19 8/18
sent [2] 41/3 41/17
sentencing [2] 39/13 40/2
separate [3] 33/1 35/25 60/17
separately [2] 3/18 31/13
September [2] 12/12 27/21
sequence [1] 97/9
serious [14] 2/19 2/20 3/16 4/16 4/22 5/16 6/20 42/22 42/25 43/7 43/13 45/5 46/1 74/12
seriously [5] 4/18 81/19 82/8 98/4 113/16
service [24] 1/24 3/22 15/25 34/13 36/6 36/13 54/10 54/11 55/2 58/9 59/11 65/10 67/19 78/3 90/7 90/18 97/8 100/20 100/23 101/7 113/1 116/8 118/24 119/5
services [30] 10/23 52/1 52/22 53/10 54/12 54/24 56/24 61/10 61/14 61/15 65/11 65/12 65/13 76/17 78/4 78/5 79/19 93/10 97/11 97/11 102/1 102/4 102/23 108/2 110/17 110/22 110/23 111/12 118/14 119/10
serving [1] 43/9
set [20] 2/25 3/11 5/17 10/25 19/11 43/4 47/3 49/4 51/21 52/7 54/6 57/5 74/9 76/7 77/4 77/6 91/4 96/1 97/7 120/22
sets [9] 2/16 2/23 11/18 14/14 14/19 18/8 18/15 27/22 28/10
setting [5] 89/14 92/6 92/20 118/5 125/24
settled [1] 47/5
severe [3] 51/25 62/25 116/18
severity [1] 45/24
Shall [1] 70/9
share [14] 35/23 37/3 51/16 53/15 55/6 55/14 72/20 73/14 73/18 73/23 74/3 97/5 107/16 107/24
shared [7] 29/14 37/11 57/12 57/20 73/12 108/3 110/8
sharing [10] 35/20 54/15 56/2 56/12 58/13 58/17 93/17 102/22 103/2 120/20
Sharon [1] 43/15
Sharon Miller [1] 43/15
sharp [1] 68/4
sharply [1] 12/24
she [3] 23/14 23/15 24/17
sheet [1] 75/17
shift [1] 99/15
shine [1] 37/22
short [2] 50/10 126/18
shortly [2] 39/13 40/1
should [55] 1/9 2/24 4/6 5/13 5/16 5/19 5/20 5/22 7/22 7/24 8/10 10/16 12/7 14/25 15/24 17/10 18/2 19/5 19/7 19/12 19/14 19/24 23/25 24/5 25/22 26/1 26/19 27/10 29/16 30/13 31/2 31/5 31/6 32/23 34/14 35/21 40/18 45/22 45/23 45/25 49/5 56/15 56/19 56/20 67/3 80/19 81/8 81/16 83/1 93/8 97/24 99/12 100/17 105/23 124/4
shouldn't [3] 40/17 124/3 124/3
show [1] 84/22
showed [2] 90/11 90/18
showing [2] 68/19 117/8
shown [1] 70/1
shows [1] 106/23
sic [1] 7/23
side [7] 32/25 44/22 91/14 91/21 91/23 117/2 117/22
sight [1] 16/5
sign [1] 113/12
significance [1] 22/9
significant [8] 17/8 68/5 79/6 81/2 82/16 91/2 96/4 103/13
significantly [1] 43/6
signposted [1] 104/23
signs [1] 97/14
similar [1] 94/6
similarities [1] 77/16
similarly [1] 105/11
simply [5] 5/24 27/9 31/17 60/6 92/17
since [8] 1/21 16/18 21/16 21/16 24/24 44/8 104/1 119/8
single [4] 2/2 31/21 35/15 57/24
Sir [1] 103/17
Sir Andrew [1] 103/17
sites [1] 94/25
situation [13] 13/4 54/18 57/24 61/22 63/24 71/9 89/13 101/2 103/9 103/21 104/14 105/21 120/7
situations [5] 53/7 55/22 63/19 103/11 124/19
six [1] 7/24
skills [2] 58/3 118/3
slicker [1] 39/3
slightly [5] 8/23 44/24 59/23 88/22 115/16
slip [1] 27/14
slow [2] 17/12 22/3
small [5] 6/1 70/24 70/24 71/1 109/18
smaller [1] 123/24
so [262]
social [15] 52/11 54/24 58/5 69/10 72/7 72/8 72/10 82/25 85/21 96/24 98/1 102/22 109/17 124/15 124/19
socially [1] 60/24
softly [1] 60/5
solicitor [2] 16/9 41/6
solicitors [3] 13/10 14/4 29/14
some [49] 5/22 5/24 8/11 17/17 17/25 18/1 25/7 25/9 25/13 25/23 26/16 26/25 29/21 30/19 33/25 36/16 39/6 40/20 49/9 53/10 56/5 58/1 66/17 67/21 69/11 71/23 75/6 76/11 77/20 79/1 79/14 79/16 79/17 88/3 89/13 91/22 94/12 99/23 106/13 111/14 112/14 114/8 114/8 118/7 120/23 122/9 123/23 125/8 125/24
somebody [23] 7/15 8/5 54/17 61/24 63/11 72/11 73/9 85/6 89/8 89/15 94/16 94/17 103/12 104/12 113/15 115/5 115/13 120/15 121/6 121/19 124/19 124/24 125/21
someone [9] 3/23 4/13 4/18 6/7 8/17 54/6 64/10 92/13 92/16
something [43] 4/10 5/14 7/20 22/25 31/5 46/12 46/17 46/23 55/9 60/20 63/21 65/9 65/18 69/15 72/1 75/10 81/8 81/17 81/17 81/18 82/7 84/19 87/9 89/6 94/7 94/9 94/11 95/20 95/21 97/6 98/4 99/4 104/22 104/24 104/25 105/18 106/3 112/6

S

something... [5] 117/8 118/9 123/14 126/1 126/2
sometimes [19] 28/22 37/3 37/6 52/21 54/13 56/24 61/21 62/21 81/5 84/3 84/5 87/14 92/24 99/5 103/23 113/18 114/1 114/2 114/4
soon [6] 23/18 32/24 49/13 49/18 50/2 125/19
sorry [19] 4/5 8/9 22/4 27/14 39/17 39/18 39/20 39/22 39/24 44/15 46/2 49/2 50/6 51/19 60/4 67/3 74/17 86/6 90/5
sort [20] 7/13 21/16 31/25 50/3 62/11 74/19 79/14 88/4 94/3 96/23 104/2 108/11 110/6 111/14 114/9 114/25 115/18 115/19 118/3 125/24
sorts [1] 109/10
sound [1] 73/2
sounds [1] 87/22
speak [5] 48/3 53/21 60/4 83/7 111/25
speaks [1] 59/16
special [4] 17/22 20/9 51/1 51/2
specialise [1] 56/14
specialist [4] 36/12 79/18 79/25 80/3
specific [5] 51/24 55/13 77/17 96/22 98/9
specifically [9] 51/13 56/6 66/16 83/8 88/14 93/20 97/23 98/15 111/23
speculating [1] 22/10
spend [2] 111/5 111/6
spent [2] 97/2 116/15
spill [1] 69/18
spills [1] 62/1
split [1] 42/12
spoken [3] 41/21 42/6 60/5
squeamish [1] 80/13
stabilisation [1] 116/9
stability [1] 69/12
stable [4] 69/10 101/2 101/18 125/21
staff [18] 15/20 16/6 21/5 21/9 33/2 33/5 33/20 33/22 34/10 36/17 41/21 55/21 58/10 58/14 59/9 71/1 110/14 110/16
stage [3] 48/22 66/18 123/3
standalone [1] 76/18
standard [6] 69/24 70/4 70/5 71/6 75/1 98/25
standards [5] 2/23 10/25 11/4 27/11 28/18
stands [1] 92/1
start [7] 3/19 11/8 50/2 51/18 61/11 97/13 121/22
started [4] 22/21 23/3 25/17 26/13
starts [2] 6/6 122/7
statement [40] 1/25 2/1 3/12 13/10 13/23 15/13 15/16 19/1 23/11 23/13 23/19 24/6 25/1 25/4 25/16 27/1 27/5 29/8 33/2 40/4 40/8 43/2 47/1 50/17 51/14 51/20 57/10 57/18 58/19 68/15 76/25 77/5 78/23 79/4 83/25 93/15 105/3 107/4 112/1 112/17
statements [7] 1/10 17/5 28/24 34/23 34/24 35/18 49/15
States [1] 69/22
station [1] 77/15
statistics [1] 83/3
status [1] 27/4
statutory [3] 3/12 6/4 43/5
stay [1] 126/14
stayed [1] 90/1
staying [3] 101/2 101/18 125/1
stays [1] 20/8
Stein [1] 68/24
step [1] 115/8
steps [3] 8/6 8/10 34/4
sticking [1] 86/13
stigma [4] 80/9 81/10 81/13 82/9
stigmatising [1] 80/14
still [21] 7/2 11/13 23/19 25/13 25/18 29/22 32/5 34/4 40/10 44/4 45/4 46/9 46/12 52/20 71/12 72/25 80/10 81/14 89/5 126/8 126/9
stop [4] 16/23 23/7 71/17 110/20
stopped [1] 40/24
straightforward [1] 44/17
strategy [1] 77/7
Straw [3] 109/22 109/23 127/13
straying [1] 45/8
streams [1] 83/21
strengthening [1] 77/21
strengths [1] 62/9
stress [1] 58/16
striking [1] 77/15
structurally [1] 75/6
structure [1] 56/4
stuck [1] 67/2
studied [1] 44/8
studies [4] 69/13 78/16 78/16 78/17
study [4] 69/17 78/20 89/24 90/11
stuff [1] 85/22
style [2] 91/19 118/22
subject [6] 14/8 33/9 33/17 72/13 80/8 105/12
subsequent [1] 36/17
subsequently [3] 18/21 77/2 77/8
substance [6] 2/9 52/10 82/23 112/24 118/18 124/22
substantially [1] 123/11
substitute [1] 123/25
such [6] 4/4 39/4 61/6 63/5 70/1 93/13
suddenly [1] 75/5
suffer [1] 109/14
suffered [1] 6/20
suffering [1] 26/1
sufficient [5] 7/5 15/19 16/3 102/7 125/11
sufficiently [13] 2/12 5/16 9/21 10/7 15/20 17/3 17/4 17/6 23/9 25/2 32/7 74/12 106/10
suggest [4] 45/3 76/10 95/24 97/25
suggesting [1] 64/23
suggestion [1] 123/2
suicide [3] 81/23 82/6 99/12
suitable [2] 51/23 105/9
summaries [1] 99/14
summarise [7] 14/20 18/17 24/15 29/11 33/7 36/22 96/10
summary [6] 2/1 2/2 12/14 13/16 18/9 36/10
summer [1] 21/1
supervise [1] 114/5
supervised [1] 77/25
supervision [6] 16/4 17/14 27/12 30/17 31/25 66/21
supervisors [1] 32/1
support [17] 59/13 61/5 61/6 61/8 62/5 69/7 85/17 85/18 85/21 93/9 93/19 94/13 104/11 112/6 113/2 120/9 121/12
supported [1] 121/2
supporting [1] 87/6
supports [1] 94/24
suppose [1] 79/19
sure [10] 8/13 11/4 25/25 27/16 29/4 37/25 44/23 82/1 88/12 92/8
surprised [2] 44/16 44/24
surprising [1] 108/1
surrounding [2] 82/15 124/10
survivor [1] 7/16
survivors [2] 13/11 14/4
suspect [4] 10/9 11/1 22/9 79/2
sustaining [1] 11/16
swift [1] 23/25
swiftly [1] 24/5
sympathetic [1] 103/20
symptom [1] 110/2
symptoms [7] 59/15 60/10 69/9 111/17 111/22 113/6 113/8
system [28] 2/22 5/6 5/8 30/23 30/24 31/1 31/18 31/21 36/21 38/17 39/3 47/15 47/18 52/24 53/16 54/6 55/3 56/25 69/19 75/6 88/4 88/5 88/10 97/20 108/6 108/12 116/23 120/16
systematic [2] 68/18 88/16
systemic [3] 77/16 97/17 106/18
systems [12] 27/12 31/8 31/20 56/11 56/20 106/20 106/22 107/2 107/11 107/12 107/13 108/5

T

take [29] 3/18 7/13 8/6 8/10 8/23 11/6 28/23 28/25 34/18 37/20 49/23 50/7 52/2 62/7 62/19 65/11 66/4 81/7 81/19 82/8 92/18 100/13 103/10 106/8 111/3 113/15 113/22 115/8 122/6
taken [16] 3/4 16/19 17/11 19/17 20/10 22/13 23/4 25/21 26/23 32/9 34/2 37/25 50/3 50/6 74/17 98/4
takes [3] 9/16 61/18 61/20
taking [9] 1/23 31/17 84/6 87/25 106/6 107/19 110/20 113/25 114/5
talk [8] 62/11 63/3 82/21 83/2 91/19 95/4 99/20 116/6
talked [6] 31/10 77/21 77/22 77/24 83/6 85/21
talking [10] 44/6 66/16 70/8 73/16 75/19 80/12 80/13 95/18 98/7 104/2
talks [2] 93/21 125/17
tangible [1] 74/7
target [1] 123/6
taxing [1] 58/16
team [61] 17/13 17/15 35/6 41/17 49/6 53/25 54/4 54/4 54/7 54/7 54/9 57/12 57/15 57/20 57/20 57/22 57/25 58/4 58/4 58/21 65/4 65/21 66/7 66/20 66/21 66/23 67/20 67/23 69/7 69/21 71/1 71/2 71/3 71/7 72/24 74/9 74/15 75/1 78/24 85/11 85/17 86/2 86/17 86/20 87/18 89/23 89/25 90/2 90/3 90/13 90/14 91/5 96/5 96/16 96/21 97/5 97/17 113/5 113/20 119/7 123/12
teams [14] 69/24 70/5 70/20 70/21 70/22 78/2 78/11 79/7 79/18 79/21 79/24 85/24 90/7 118/11
techniques [1] 112/14
technological [1] 32/16
telephone [1] 89/2
tell [14] 15/21 19/16 50/22 57/7 57/15 65/23 66/25 68/15 76/24 77/8 85/2 89/12 103/9 111/18
telling [1] 61/16
tells [2] 89/7 113/14
ten [4] 22/17 77/7 91/2 91/2
ten months [1] 22/17
ten-year [1] 77/7
tend [7] 37/9 38/19 44/21 47/23 48/3

T

tend... [2] 91/21 116/8
term [4] 10/15 110/5 114/9 115/6
termed [1] 35/2
terminology [1] 75/21
terms [60] 2/4 2/10 14/14 14/19 14/19 15/18 15/22 16/4 16/11 16/12 16/25 18/9 18/24 19/14 21/3 22/12 22/14 22/17 22/24 23/8 24/14 24/21 26/24 32/6 34/17 40/22 42/7 48/18 49/8 49/9 49/24 51/8 53/10 53/24 61/19 65/7 73/12 77/16 77/18 79/24 82/9 84/11 86/17 88/22 90/25 91/13 91/14 91/16 91/24 91/24 93/18 94/22 95/8 95/9 97/6 100/14 104/7 119/25 120/23 124/25
territory [1] 45/8
terrorist [1] 84/16
test [3] 51/21 68/24 122/6
testing [1] 121/16
tests [6] 92/8 121/15 122/3 122/4 122/5 122/10
than [26] 13/23 15/23 17/20 25/21 25/22 32/17 34/2 44/23 52/25 55/3 57/13 59/25 60/21 71/3 80/24 82/20 83/3 83/10 84/6 87/1 87/15 88/9 88/19 108/11 120/10 123/24
thank [43] 1/9 1/18 2/3 11/6 13/18 13/19 18/23 26/2 26/13 27/19 29/7 35/24 39/5 40/4 42/10 42/15 43/2 43/3 43/22 45/3 45/10 46/6 47/2 48/8 48/12 48/13 50/5 50/7 50/8 51/12 57/10 60/7 109/21 117/1 117/17 117/18 117/20 117/21 119/15 121/4 126/15 126/15 126/16
thanks [2] 29/12 109/22
that [773]
that's [97] 1/22 3/10 6/1 7/9 9/20 10/15 12/20 14/11 15/6 21/5 23/4 26/8 26/16 27/15 35/5 35/5 35/25 40/3 40/7 41/16 41/23 46/9 48/11 49/17 52/7 54/6 54/17 56/5 57/22 59/21 61/1 62/12 63/9 64/4 67/12 69/15 70/21 71/21 71/21 72/21 80/6 80/21 80/22 81/5 81/21 84/2 84/14 84/18 84/19 86/19 87/7 87/9 87/10 87/20 92/5 93/4 93/22 94/9 95/2 95/5 95/21 96/11 97/7 97/12 97/19 100/3 100/15 100/17 101/4 101/11 101/15 103/14 103/23 103/24 104/22 104/25 105/12 110/5 111/14 111/25 113/7 113/24 114/10 115/10 116/14 117/8 119/23 119/25 120/23 121/6 121/10 122/9 124/1 124/20 125/12 126/2 126/15
Theemis [5] 75/8 75/12 75/22 76/19 93/6
their [77] 11/4 20/13 26/1 26/5 29/13 38/1 38/6 39/1 40/14 41/6 43/10 48/6 49/14 49/15 52/2 58/7 58/7 59/23 60/1 62/9 62/23 63/1 63/2 63/5 64/3 64/6 65/15 65/17 69/9 69/10 69/12 71/9 83/15 84/9 84/22 85/12 86/14 87/2 87/8 89/7 89/10 90/4 91/14 92/23 95/14 96/23 96/24 98/10 100/13 100/16 101/17 104/8 107/21 109/3 109/10 110/2 110/11 110/21 111/8 111/16 111/22 111/24 113/7 114/13 115/2 115/4 115/15 116/4 118/3 118/18 118/19 121/11 121/13 121/19 123/20 126/7 126/10
them [93] 4/5 7/6 7/25 8/15 10/12 16/3 17/4 19/3 19/20 23/1 25/22 29/14 31/15 33/14 34/1 34/22 37/7 42/12 49/3 53/5 57/23 58/8 59/13 60/3 61/13 61/16 62/4 62/5 62/9 62/16 62/24 63/1 63/25 64/13 68/7 69/11 71/25 73/1 73/2 74/23 74/24 82/15 83/24 84/12 84/13 84/18 84/22 87/7 87/15 88/8 88/8 88/8 89/4 89/7 93/24 93/24 93/24 93/25 94/5 95/20 101/9 102/7 104/18 105/20 106/22 106/23 106/24 107/1 107/20 109/8 110/9 110/15 111/1 111/1 111/3 111/15 111/16 111/19 111/21 112/4 114/4 115/8 116/2 121/12 121/25 122/1 122/22 123/5 124/2 124/20 125/1 125/2 126/14
themselves [2] 3/23 37/24
then [74] 3/19 4/8 4/13 4/13 4/16 5/5 5/15 5/18 6/23 6/24 8/15 9/8 14/12 16/7 18/7 21/16 22/22 23/25 24/7 26/2 26/14 28/2 30/2 30/12 34/7 39/24 41/14 41/14 43/19 44/6 44/11 44/19 45/11 45/12 46/20 46/25 48/5 48/6 48/10 50/4 52/4 53/18 54/9 60/19 62/3 63/15 64/18 73/17 74/7 84/18 89/11 90/3 92/25 92/25 100/25 107/13 112/9 113/20 114/10 114/14 114/17 115/25 117/1 120/15 121/2 122/3 122/7 123/6 123/18 124/6 125/2 125/18 125/22 126/12
theories [1] 94/24
theory [1] 4/8
therapeutic [1] 112/2
therapies [2] 59/25 66/7
therapists [2] 65/22 112/23
therapy [5] 58/5 66/17 114/24 115/19 116/7
there [191]
there'd [1] 72/10
there's [50] 2/1 2/2 4/3 4/15 4/20 5/6 5/25 6/4 6/24 12/13 14/2 21/20 21/20 21/25 31/12 32/25 34/11 37/16 38/9 42/21 47/1 47/5 47/10 47/14 65/9 67/3 69/13 75/24 76/10 79/22 82/6 83/20 85/24 87/13 88/25 90/8 94/22 95/4 95/17 99/4 104/15 111/9 111/13 113/25 114/1 116/19 116/20 116/22 125/11 126/4
therefore [3] 23/13 45/3 46/11
these [26] 12/7 21/18 25/21 33/24 34/22 35/9 35/13 42/2 48/17 50/1 55/22 67/17 70/12 70/13 74/14 77/19 85/15 90/21 95/7 96/8 97/20 98/14 102/15 103/14 111/11 112/24
they [220]
they'd [2] 48/25 94/7
they'll [2] 35/1 107/21
they're [86] 4/1 4/19 8/4 40/10 52/11 55/11 56/22 57/25 59/18 59/19 59/19 61/10 61/16 62/16 64/7 66/22 66/24 67/8 67/11 70/23 71/17 71/21 71/22 72/5 73/4 73/7 73/7 73/21 74/22 75/3 81/11 83/20 84/5 84/9 84/13 84/14 84/20 85/2 85/3 86/11 86/11 86/12 86/12 86/22 87/1 87/6 89/8 89/10 89/15 91/18 91/20 92/19 92/24 94/4 97/13 97/20 99/22 100/25 101/4 101/5 101/17 101/17 101/18 103/20 103/20 105/9 105/17 106/24 110/3 110/18 110/24 111/4 111/21 112/6 112/25 113/6 113/19 115/9 115/24 116/4 118/2 118/4 118/17 119/1 119/14 124/20
they've [14] 3/22 48/6 52/25 53/9 75/1 87/10 94/10 105/15 105/15 105/16 105/16 112/5 113/16 121/10
thing [13] 6/6 56/24 66/22 67/22 76/23 90/25 93/17 95/15 98/16 110/24 114/25 121/10 124/20
things [63] 20/18 22/8 27/13 34/13 37/2 42/12 58/11 60/25 61/19 62/2 62/6 65/17 67/11 67/17 69/15 71/11 74/14 74/15 76/11 77/19 78/11 79/11 81/12 83/1 84/10 87/11 89/11 95/6 95/7 95/18 96/23 97/7 97/15 98/9 98/15 98/24 100/21 101/11 105/20 108/8 111/18 113/11 113/17 114/6 115/9 115/23 116/5 116/6 116/20 117/14 117/15 117/16 118/3 118/15 118/19 121/16 121/25 124/3 124/22 124/24 125/16 125/19 126/10
think [220]
thinking [4] 95/3 115/7 115/8 116/17
third [3] 6/19 79/1 99/9
thirds [2] 83/13 84/3
this [168]
those [72] 1/15 3/18 10/22 16/12 20/6 22/17 23/10 27/15 30/14 31/23 32/4 32/24 32/25 35/21 38/14 38/19 39/2 52/4 52/9 52/15 53/3 53/7 56/23 58/10 58/11 59/10 60/10 60/24 62/2 63/6 63/9 63/23 65/6 68/2 69/6 69/14 73/8 73/14 78/22 82/10 85/7 86/19 87/11 88/14 88/15 92/11 93/9 94/24 96/25 97/7 98/11 102/8 103/13 103/19 106/2 107/11 108/9 108/15 110/18 112/16 113/3 113/11 114/7 116/7 117/13 117/15 118/4 118/20 119/2 120/16 124/23 126/10
though [7] 21/9 23/3 55/15 64/14 105/19 108/5 116/18
thought [8] 19/24 21/7 25/9 27/9 31/5 35/6 73/22 74/2
thousand [1] 123/14
three [6] 3/14 13/5 26/4 71/19 76/3 100/5
three months [1] 13/5
thresholds [1] 96/7
through [25] 9/5 11/6 14/2 26/25 29/5 29/13 29/25 30/22 35/17 38/15 40/14 41/5 48/17 58/19 59/13 63/9 74/20 77/22 77/23 78/3 80/1 82/19 86/2 95/16 120/19
time [46] 9/12 9/16 12/1 21/1 21/14 22/8 22/13 23/14 25/18 25/24 27/11 34/17 35/11 35/22 36/7 43/7 48/24 49/22 49/25 56/8 59/9 61/21 62/7 67/18 69/5 81/6 90/8

T
time... [19] 97/15 102/6 102/12 109/1 109/13 111/5 111/6 111/11 112/1 112/3 112/25 113/1 113/3 119/8 119/23 120/11 122/10 125/16 125/22
timeframe [1] 13/7
timely [2] 97/18 106/11
times [6] 20/14 71/17 71/19 71/19 86/3 94/9
timing [1] 48/15
tion [1] 45/24
today [2] 34/7 48/9
together [5] 35/14 74/14 103/6 106/4 106/7
told [3] 13/22 72/14 107/20
tolerability [1] 91/15
tolerate [4] 91/16 91/17 98/7 116/3
tone [1] 103/25
too [14] 15/22 17/12 28/13 28/20 31/15 32/9 33/11 81/9 100/4 101/5 115/24 115/25 117/7 117/7
took [13] 12/8 12/8 16/12 20/3 21/14 22/17 24/22 28/12 30/2 32/15 32/17 34/21 90/17
top [4] 7/24 18/9 43/22 102/15
topic [5] 6/2 35/25 42/20 51/10 125/14
tormented [1] 116/4
totally [1] 35/25
touch [1] 65/16
touched [1] 99/9
towards [4] 29/15 80/25 99/12 110/8
track [2] 114/6 120/25
Traditionally [1] 66/1
trained [1] 108/9
trainees [1] 90/10
training [8] 9/24 13/2 42/22 65/4 82/5 97/23 98/10 98/15
transfer [1] 99/14
transformation [2] 10/21 30/22
translate [1] 120/5
transport [2] 86/19 119/18
traumatic [1] 110/23
trawling [1] 71/24
treat [2] 124/20 125/1
treated [5] 46/22 48/10 82/19 92/24 100/24
treating [1] 124/24
treatment [54] 51/3 51/10 52/5 61/20 65/17 66/2 68/16 69/22 77/24 86/11 86/14 86/16 87/2 87/8 88/12 91/11 92/2 92/8 92/16 92/17 97/14 99/22 99/23 100/1 100/2 100/6 100/7 100/13 100/15 100/19 100/22 101/13 101/17 107/9 110/11 110/25 112/10 114/12 114/14 114/21 115/18 117/13 121/9 121/11 123/17 123/18 124/5 124/6 124/8 125/13 125/22 126/4 126/5 126/9
treatment-resistant [2] 92/2 92/16
treatments [1] 92/11
trials [2] 68/19 100/5
tribunals [1] 126/11
tricky [1] 122/12
tried [2] 96/20 101/15
tries [1] 113/7
true [6] 1/15 1/17 40/3 50/19 101/11 126/11
trust [8] 21/8 54/12 56/25 61/21 62/2 62/14 93/7 120/15
Trusts [5] 56/13 56/14 56/20 107/15 107/17
truth [1] 64/22
try [11] 25/11 34/1 37/17 42/12 60/6 71/20 71/25 73/11 76/11 83/1 119/10
trying [11] 42/1 55/23 67/4 67/8 72/6 75/15 95/16 108/5 108/7 110/7 120/5
turn [5] 11/18 18/15 18/23 27/21 36/9
twice [1] 90/8
two [29] 1/9 4/15 11/15 13/10 16/18 16/24 20/3 23/5 24/24 26/9 32/6 33/25 34/1 34/5 35/16 41/21 41/25 42/8 70/16 71/19 83/13 84/3 88/25 102/20 110/18 115/23 117/14 118/25 119/2
two years [5] 16/18 16/24 23/5 24/24 32/6
two-thirds [1] 84/3
twofold [1] 59/12
type [4] 28/21 57/2 118/10 122/22
typical [2] 28/15 28/17
typically [1] 61/9

U
ultimately [4] 11/3 37/21 47/24 62/10
unable [1] 23/13
unclear [2] 66/12 125/8
uncomfortable [1] 60/3
uncommon [1] 117/9
unconnected [1] 42/8
under [9] 3/7 5/23 45/13 47/1 86/15 93/9 103/13 114/7 114/23
underestimated [3] 49/8 49/8 124/17
underlying [1] 20/20
undermine [1] 48/20
undermining [1] 31/16
underpinned [1] 57/11
underpinning [1] 3/12
understand [21] 4/8 9/11 10/8 26/18 35/2 42/4 42/5 58/6 64/13 66/23 67/5 67/9 68/9 68/11 72/24 75/14 76/15 83/19 85/5 95/16 105/11
understandably [2] 19/19 23/15
understanding [11] 22/20 32/22 57/21 64/6 64/9 66/6 67/12 68/8 83/23 93/17 110/8
understands [1] 56/22
understatement [1] 40/21
understood [7] 9/22 10/2 10/4 10/16 10/17 83/11 109/25
undertake [4] 5/19 5/21 5/22 33/24
undertaken [3] 17/21 17/22 18/19
undertaking [1] 10/21
undertook [2] 25/12 29/6
unfortunately [3] 8/9 19/21 32/15
unhelpful [1] 80/17
unit [7] 26/17 36/12 48/4 76/11 107/18 117/22 118/10
units [6] 76/7 111/6 111/7 118/1 118/2 118/2
university [2] 50/25 74/1
unless [1] 24/1
unmanageable [1] 102/17
unqualified [2] 94/16 98/6
unstable [2] 61/24 124/19
until [5] 9/2 22/15 25/14 34/20 126/16
unusual [5] 23/1 28/15 28/21 29/2 35/3
unwarranted [1] 111/8
unwell [17] 23/13 52/3 56/1 59/7 64/7 83/16 84/2 92/19 97/13 110/3 110/18 110/24 111/21 113/6 113/15 118/17 126/5
up [52] 1/23 2/14 6/3 10/14 12/8 14/13 14/23 15/3 15/17 16/8 18/6 18/8 22/25 24/8 24/17 25/5 27/2 27/19 37/10 38/22 39/4 40/24 45/11 46/5 46/5 53/11 53/21 53/23 54/6 60/4 76/7 84/12 87/10 87/19 90/10 95/1 95/17 97/12 97/15 97/15 97/16 105/16 106/23 111/7 112/3 112/18 114/3 119/15 120/6 121/16 122/8 124/6
update [4] 35/20 35/23 41/17 41/20
updates [1] 21/17
upon [4] 83/2 89/21 111/1 111/1
upset [1] 64/10
urgent [1] 87/20
urgently [1] 25/11
URN [2] 1/11 1/12
us [52] 2/4 2/11 7/15 14/5 14/20 15/21 19/6 19/14 20/3 20/23 21/8 21/23 27/8 28/3 29/11 34/20 37/14 38/21 39/2 44/21 44/22 48/8 50/22 51/16 53/15 54/13 57/1 57/7 57/15 61/9 62/3 65/23 66/23 66/25 68/11 68/15 76/24 77/8 85/2 88/24 91/8 96/10 101/19 103/23 105/25 107/1 107/19 107/24 108/9 111/18 119/7 120/9
use [44] 16/24 23/8 32/6 36/1 36/4 36/14 36/16 36/24 36/25 37/8 38/10 38/11 51/9 54/11 68/4 78/11 78/12 78/14 78/18 78/18 82/24 86/4 89/19 89/21 92/13 92/14 92/23 93/4 98/13 100/20 100/22 101/3 105/2 112/24 116/22 118/19 121/6 122/14 122/21 123/9 123/11 123/15 124/22 125/15
used [15] 34/24 37/22 55/3 55/4 68/7 76/13 91/10 91/19 93/23 97/2 100/8 101/5 104/21 104/22 104/25
useful [4] 18/4 73/6 122/25 122/25
using [9] 36/13 36/21 38/2 66/6 83/14 84/6 95/19 115/6 124/2
usual [1] 5/8
usually [3] 52/3 84/17 121/13

V
valid [1] 5/25
value [3] 15/24 31/17 60/11
van [4] 11/15 13/21 44/17 44/18
variation [1] 79/6
various [5] 18/13 77/18 78/21 91/12 119/9
vary [2] 64/25 91/13
vast [2] 49/19 80/15
VC [13] 12/23 14/16 15/1 15/2 17/18 18/14 24/17 26/10 39/13 40/2 44/2 44/13 44/18
VC's [2] 24/11 51/13
veer [1] 12/24
vehicle [2] 44/18 44/19
verdict [1] 18/20
versed [1] 94/16
version [1] 70/19
versus [1] 125/5
very [109] 2/3 7/11 8/9 8/14 10/24 12/9 14/19 15/3 16/1 17/1 17/10 17/13 18/4 19/24 23/18 23/25 24/5 25/20 27/14 28/16 35/4 38/1 41/10 42/10 42/15 45/1 47/14 47/16 47/17 48/12 49/18 51/24 55/13 55/15 56/9 58/15 58/20 59/6 59/7 59/10 59/18 59/19 59/19 60/5 60/16 60/24 64/3 64/7 64/7 65/1 66/22 67/2 70/23 72/9 73/9 74/6 74/14 75/2 76/9 76/16 78/6 79/3 79/12 79/17

V

very... [45] 81/18 82/6 84/17 86/24 87/12 88/15 88/16 90/9 90/22 90/24 91/8 91/15 92/5 92/25 93/1 93/20 93/23 93/23 93/25 94/17 95/12 95/13 103/20 103/20 104/13 105/7 106/5 106/16 109/15 109/17 109/21 111/4 116/17 117/17 117/21 121/6 121/8 121/20 122/12 123/5 124/4 125/23 126/4 126/14 126/15
via [3] 54/9 56/21 78/3
victim [1] 45/21
victims [5] 24/11 63/5 63/12 80/23 81/20
video [1] 89/2
videos [1] 83/21
view [16] 31/1 44/12 62/21 62/25 64/10 66/4 80/6 80/19 100/4 103/8 105/4 111/8 112/11 117/13 123/23 126/7
viewing [3] 83/19 84/20 85/3
views [2] 62/19 94/24
violence [29] 52/16 56/7 59/17 60/13 60/17 60/19 62/23 63/3 67/13 68/5 73/16 78/15 80/8 80/13 80/17 80/22 80/23 80/24 81/14 82/6 82/22 84/1 96/5 97/4 99/13 99/20 104/13 105/13 126/10
violent [5] 59/18 62/25 80/25 82/11 82/17
virtually [1] 123/10
visits [7] 71/11 71/13 88/22 88/23 89/18 108/20 108/22
visual [1] 13/23
vulnerable [1] 84/15

W

wait [1] 32/20
waiting [1] 17/5
Wales [1] 2/23
want [28] 3/18 6/2 8/17 20/18 28/16 42/20 45/16 49/18 55/8 55/14 55/14 55/17 59/11 64/10 72/13 73/15 74/17 75/10 85/6 94/7 94/8 94/10 97/11 103/14 111/12 113/22 117/10 122/13
wanted [2] 78/12 119/15
wanting [4] 92/18 103/10 107/16 118/13
ward [2] 87/5 87/20
wards [3] 85/12 87/12 118/4
warehouse [1] 26/7
warning [1] 97/14
warrant [5] 26/11 30/10 102/10 104/3 104/8
warrants [2] 86/18 119/17
was [178]
wasn't [12] 13/2 20/25 27/9 27/9 34/19 35/4 39/22 40/12 41/1 41/3 41/8 83/6
watertight [1] 20/19
Watson [9] 1/4 1/6 39/5 39/10 42/10 42/15 42/18 42/20 127/3
way [30] 4/4 4/6 8/18 20/1 21/7 33/16 38/12 49/1 56/12 56/13 67/5 67/11 69/7 70/13 70/22 75/5 75/7 82/3 83/23 87/20 93/25 94/18 95/6 99/7 107/1 111/1 115/9 118/25 119/17 124/2
ways [5] 59/25 64/23 65/7 75/6 106/20
we [330]
we have [1] 75/20
we'd [8] 35/14 50/1 63/25 73/10 85/22 86/2 87/11 123/8
we'll [15] 4/23 5/24 8/22 11/8 11/12 23/17 28/9 46/20 49/16 50/7 54/22 76/8 82/14 114/4 126/16
we're [39] 9/5 9/24 10/11 10/20 10/21 20/15 21/21 24/1 28/15 28/19 31/19 32/3 38/17 38/21 42/1 45/8 46/3 46/23 53/9 55/21 58/9 62/8 73/16 74/22 88/6 88/12 88/15 93/23 95/21 97/1 97/2 103/21 106/21 111/13 113/12 114/10 116/17 119/5 120/7
we've [17] 20/12 20/12 24/3 25/5 25/10 27/16 32/20 74/21 78/25 81/22 88/11 90/7 94/8 104/20 104/24 106/24 119/9
weapons [2] 83/14 84/6
wedded [1] 79/17
Wednesday [1] 1/1
week [9] 21/22 40/9 41/18 71/12 74/21 86/24 87/1 87/1 87/2
weekends [1] 58/10
weekly [3] 21/17 71/7 122/7
welcome [1] 106/5
well [70] 4/7 10/16 16/18 21/15 23/14 23/25 24/5 32/21 33/17 35/3 37/18 46/16 46/16 46/20 52/14 55/21 56/9 58/10 58/11 58/18 59/5 60/25 61/8 62/25 63/1 67/17 69/25 70/14 73/19 75/11 76/22 77/8 79/16 83/6 84/17 84/17 85/22 86/15 87/8 88/15 89/8 89/14 91/13 91/25 92/25 96/20 101/6 106/18 106/20 107/12 107/16 109/9 109/19 110/16 110/17 110/23 111/15 111/17 112/21 113/2 115/11 115/22 120/2 121/1 121/8 121/10 123/5 124/24 125/1 126/16
went [4] 26/25 27/8 30/19 90/2
were [58] 11/23 14/24 15/12 15/19 16/7 16/11 16/23 17/4 19/20 20/6 22/19 23/11 24/23 26/24 27/3 27/13 31/9 33/3 33/10 33/13 33/14 33/20 34/1 34/22 34/23 35/11 35/14 36/13 41/5 43/25 48/16 48/18 49/1 49/21 64/14 69/2 69/8 69/9 69/11 72/11 73/23 74/1 74/2 78/15 88/21 89/25 94/5 95/23 98/7 103/4 106/5 107/10 107/19 108/22 109/7 117/22 120/25 125/7
weren't [6] 9/2 19/3 22/15 33/21 42/11 71/22
what [127] 2/10 3/19 4/16 4/25 4/25 7/15 7/17 9/4 10/13 10/18 11/12 14/20 14/22 15/21 19/6 19/14 19/20 24/16 25/12 27/8 29/17 30/5 30/19 30/23 31/7 31/11 31/19 32/10 32/11 32/13 34/9 35/1 37/1 37/15 42/1 45/5 46/3 47/8 47/23 48/3 48/20 51/22 52/7 55/13 55/22 56/1 57/15 60/10 61/3 61/14 62/12 63/4 63/23 64/2 64/2 64/3 64/4 64/5 64/7 64/11 65/7 66/25 67/7 67/23 68/12 68/21 69/1 69/6 70/5 70/19 70/19 71/9 72/18 72/22 73/12 73/13 73/13 76/15 76/23 77/8 77/10 78/23 79/13 80/11 83/19 83/20 83/23 84/13 84/13 84/20 84/20 85/2 87/8 87/20 89/24 90/10 90/18 90/22 91/16 93/4 93/15 93/16 94/20 95/5 96/18 96/20 97/1 98/2 98/22 100/17 101/4 102/25 103/2 103/23 104/2 104/4 104/21 111/14 113/19 113/24 118/12 119/1 120/4 120/7 122/24 125/16 126/3
what's [19] 43/23 44/12 45/7 45/18 63/17 81/6 81/22 86/25 87/2 87/3 87/4 95/20 101/19 103/25 110/4 110/6 110/8 112/3 120/19
whatever [4] 31/7 67/1 67/12 119/11
WhatsApp [14] 25/8 36/1 36/5 36/13 36/14 36/15 36/19 36/25 37/8 37/22 38/2 38/7 38/8 38/11
WhatsApp-related [1] 36/15
when [53] 3/21 4/2 4/18 7/15 7/17 9/6 9/7 16/4 16/15 19/13 21/5 21/19 21/20 23/14 23/23 31/19 32/11 35/12 36/11 38/2 39/3 44/2 44/13 47/13 49/11 55/1 56/1 59/18 62/24 64/7 64/15 68/21 71/17 80/12 81/14 81/23 82/5 83/16 89/9 91/10 92/23 103/4 103/21 105/17 106/21 108/4 108/7 111/21 115/21 116/2 116/18 119/24 121/6
where [56] 3/5 16/2 24/21 47/10 47/20 49/21 53/4 54/18 55/11 56/2 59/7 62/8 62/9 62/15 62/20 63/8 63/19 64/25 71/13 71/24 71/25 73/1 73/2 73/4 73/5 73/5 73/14 73/18 78/9 78/25 80/15 85/6 87/9 87/24 87/25 88/6 88/6 89/15 92/16 97/16 97/20 97/20 98/14 100/14 100/15 102/3 103/9 103/12 105/7 106/9 114/10 118/2 119/21 120/3 121/14 122/8
Wherever [1] 54/22
whether [39] 2/11 5/13 5/19 5/20 5/21 11/12 11/23 14/6 19/22 26/18 29/4 34/10 37/15 37/16 38/13 42/21 43/8 43/12 47/1 52/25 53/1 56/21 56/22 63/25 74/19 82/15 86/3 94/9 95/19 101/4 102/12 114/11 114/13 114/18 115/3 116/11 117/4 118/6 119/1
which [76] 1/24 2/23 3/15 6/18 6/22 6/25 13/17 13/19 13/25 14/24 14/25 16/4 18/5 19/5 19/21 20/3 20/5 21/2 25/24 26/1 28/7 30/20 31/15 42/2 46/12 46/17 49/23 51/2 51/23 53/19 55/13 57/18 60/2 69/14 71/5 71/8 71/10 74/25 75/14 76/17 78/6 78/16 78/17 78/19 82/2 82/25 85/3 86/13 90/20 90/21 92/22 96/4 96/21 98/6 98/20 98/25 100/4 102/7 107/24 109/13 112/10 112/15 116/24 117/14 119/17 120/11 120/20 120/23 120/24 121/13 121/15 121/16 121/23 123/22 125/8 125/18
whichever [1] 72/10
while [6] 4/19 26/11 28/23 28/25 33/9 75/19
whilst [2] 87/10 93/12
white [4] 11/15 38/25 47/19 92/4
who [104] 6/7 6/20 7/1 7/13 7/22 8/14 10/22 17/25 23/12 26/9 27/17 32/16 43/9 49/14 51/25 52/1 52/1

W

who... [87] 52/2 52/4 52/10 52/22 52/23 54/5 56/6 57/25 59/2 59/6 59/9 59/17 59/22 59/24 59/25 62/19 63/1 64/21 65/13 65/13 66/1 66/7 69/2 69/6 71/2 73/9 75/16 77/14 80/15 80/16 84/15 85/15 88/9 89/13 89/25 90/10 92/6 93/2 93/20 94/16 94/16 94/17 94/24 95/13 95/13 97/3 97/10 100/9 100/9 100/13 102/6 102/16 104/12 104/17 105/12 105/14 107/19 108/9 108/21 110/1 111/3 111/20 112/8 112/19 113/7 113/14 113/22 113/25 114/6 114/22 115/13 118/13 118/16 118/16 118/17 118/18 121/8 122/12 123/5 123/10 124/2 124/4 124/5 124/5 124/6 125/21 126/13
who'd [2] 86/1 90/6
who's [1] 94/6
whole [7] 6/6 57/12 57/15 57/20 74/9 96/16 96/16
whole-team [1] 57/20
whose [4] 5/3 5/4 6/16 111/21
why [39] 20/3 27/15 28/3 28/5 28/6 29/11 34/20 45/23 51/23 55/14 55/17 55/18 57/5 57/16 58/12 61/17 63/5 67/9 67/10 67/13 67/13 67/13 68/9 70/4 78/21 88/21 93/14 94/8 96/10 96/18 97/7 97/19 99/3 99/15 99/19 99/20 99/25 105/10 107/21
wide [1] 119/5
widely [1] 101/6
width [1] 9/21
will [35] 2/9 5/12 5/18 6/12 18/5 20/7 20/10 21/23 22/5 22/7 25/14 35/23 37/1 37/3 39/3 39/15 40/1 40/18 47/23 47/24 51/17 53/8 53/10 57/7 61/23 86/4 86/7 88/1 94/7 94/11 108/15 113/3 118/23 119/10 126/14
wish [3] 17/10 34/3 49/2
within [21] 9/22 10/20 10/23 13/5 16/6 29/22 36/5 37/7 54/12 58/3 66/7 67/23 71/3 79/15 81/5 88/13 108/5 108/21 110/23 113/5 120/15
without [5] 29/4 67/22 83/9 92/9 105/9
WITN0339001 [3] 1/11 43/1 47/2
WITN0339003 [1] 2/15
WITN0339008 [1] 6/3
WITN0339015 [1] 1/12
WITN0412001 [2] 70/11 77/6
witness [21] 1/10 1/25 2/1 13/10 13/22 15/11 15/13 15/16 17/5 19/1 22/16 23/19 27/1 28/23 33/2 46/25 50/12 54/8 55/10 57/4 112/17
witnessed [1] 64/5
witnesses [3] 17/21 17/25 49/14
Womble [1] 33/23
won't [8] 3/13 6/5 13/16 72/5 82/11 98/23 112/8 122/4
word [1] 115/7
words [1] 76/10
work [32] 9/3 10/3 17/24 30/1 36/18 36/20 37/16 49/19 58/5 58/8 58/25 59/2 59/3 60/11 60/14 68/25 71/12 75/2 82/5 82/15 85/17 89/3 89/18 91/13 91/25 99/7 103/6 106/14 110/7 120/5 120/24 122/9
work-related [1] 36/18
worked [4] 9/3 51/4 105/19 119/9
worker [4] 57/24 93/20 112/24 112/24
workers [2] 98/1 113/2
workforce [2] 98/3 98/6
working [25] 9/5 20/15 37/16 37/18 51/8 56/5 59/4 59/6 60/1 60/9 62/8 69/8 69/11 72/8 75/5 75/7 88/19 93/25 98/24 102/21 107/10 113/4 116/2 118/2 120/1
workload [1] 122/16
works [2] 96/2 122/3
worldwide [1] 36/14
worried [3] 106/22 114/10 120/7
worry [1] 118/22
worse [1] 109/19
worsen [1] 95/7
worth [1] 70/8
would [131]
wouldn't [12] 10/10 10/11 21/9 34/15 34/16 38/16 86/1 89/2 94/20 98/7 108/2 121/1
written [3] 14/5 25/11 47/16
wrong [4] 20/18 27/8 30/19 45/8
wrote [1] 90/10

Y

yeah [34] 16/14 41/7 55/12 57/9 58/23 66/19 72/20 73/3 73/7 80/2 84/25 84/25 86/9 88/2 92/20 95/25 99/21 101/22 102/2 103/18 104/9 108/5 108/5 109/5 109/16 109/19 113/24 114/18 116/13 118/8 120/11 120/19 124/12 125/6
year [11] 16/20 19/9 21/2 21/17 21/25 25/18 32/19 35/13 77/7 90/17 91/1
years [10] 16/18 16/24 17/20 23/5 24/24 32/6 51/5 92/12 97/3 103/4
yes [102] 1/5 1/8 1/17 2/7 3/2 3/6 3/10 4/15 4/24 8/4 8/21 8/25 9/17 9/20 11/10 12/4 12/11 13/8 13/9 14/11 14/12 14/22 15/6 15/14 16/17 16/22 18/18 18/25 19/4 24/16 26/16 28/1 29/10 30/25 33/8 34/22 35/23 36/2 36/8 39/8 39/11 39/16 39/17 39/19 39/22 40/3 40/7 40/13 40/25 41/6 41/16 41/20 42/5 42/9 43/18 43/24 46/10 46/19 48/11 48/23 50/7 50/15 54/11 54/20 56/17 57/14 63/8 68/20 70/3 71/16 72/15 73/24 74/11 74/17 75/18 75/23 77/3 82/4 82/13 83/17 86/9 88/20 89/20 95/12 99/2 102/19 108/17 108/24 109/4 109/22 110/9 110/16 112/21 115/22 117/21 119/16 120/10 121/4 122/9 122/14 122/18 127/10
yet [8] 14/1 17/3 17/4 23/9 25/2 26/11 32/7 102/10
you [427]
you'd [2] 13/3 82/19
you're [29] 34/6 37/13 37/16 43/16 46/11 50/19 54/17 56/4 56/15 58/25 60/4 60/20 61/16 64/17 65/21 67/1 67/2 74/10 75/8 75/19 87/24 95/7 98/21 98/22 104/2 108/7 115/25 118/6 125/3
you've [40] 1/21 1/23 3/11 3/14 8/19 13/9 15/12 15/16 15/18 19/1 27/1 27/4 29/8 31/10 33/2 38/6 40/14 41/21 42/6 42/24 43/4 43/14 48/16 54/18 65/21 70/5 75/20 76/7 82/14 96/18 106/13 108/19 115/20 119/16 119/18 120/13 122/15 122/15 122/20 125/4
your [82] 1/16 1/25 2/11 3/8 3/11 10/6 13/9 15/13 15/16 16/25 17/1 19/1 20/24 27/1 27/5 29/8 31/1 33/2 40/4 40/8 41/17 43/1 43/2 44/11 44/12 46/25 49/22 49/23 50/22 50/23 51/15 51/19 51/20 53/2 53/3 56/14 57/10 58/19 63/3 63/13 68/15 72/24 77/5 79/4 80/1 82/17 83/11 83/18 83/19 84/8 85/16 85/17 92/4 92/15 98/20 98/23 99/9 101/7 101/19 105/24 106/8 107/4 108/1 109/25 112/10 112/15 112/17 113/5 113/20 114/15 114/22 114/23 117/22 118/9 119/2 120/13 120/24 120/24 122/14 122/16 122/22 124/9
yours [2] 93/14 107/18

Z

zero [1] 123/16
Zito [1] 77/15
zone [2] 88/6 88/14
zoning [1] 88/5