1 **Monday, 20 April 2026**
2 **(2.10 pm)**
3 **THE CHAIR:** Yes, Mr Carr.
4 **MR CARR:** Chair, the next witness is Professor John Morgan.
5 **PROFESSOR JOHN MORGAN (sworn)**
6 **Questioned by MR CARR**
7 **MR CARR:** If we can start, please, with your full name.
8 **A.** I'm John Farnill Morgan.
9 **Q.** You prepared for the Inquiry a statement dated
10 3 December 2025.
11 **A.** Correct.
12 **Q.** Are its contents true to your best knowledge and belief?
13 **A.** That's correct.
14 **Q.** In your statement you set out your professional
15 background, don't you?
16 **A.** I do.
17 **Q.** I'm going to summarise that very briefly. You were
18 a medical doctor and consultant psychiatrist retiring
19 from the NHS in 2021.
20 **A.** Correct.
21 **Q.** During your NHS career, you were Associate Medical
22 Director at Leeds and your partnership NHS Foundation
23 Trust.
24 **A.** Yes.
25 **Q.** Your speciality within psychiatry was eating disorders.

1 **A.** It was initially a branch called Liaison Psychiatry and
2 then later Eating Disorders.
3 **Q.** Initially a branch called?
4 **A.** Liaison Psychiatry.
5 **Q.** Academically you have held the place of Honorary Senior
6 Lecturer and visiting Professor at St George's Hospital
7 Medical School.
8 **A.** Correct.
9 **Q.** Since your retirement in 2021, you have continued to
10 undertake medicolegal work?
11 **A.** Correct.
12 **Q.** The statement you prepared for the Inquiry focuses on
13 the work that you undertook in your capacity as chair of
14 the Patient Safety Expert Guidance Working Group under
15 the Royal College of Psychiatry.
16 **A.** That's correct.
17 **Q.** You held that role from 2013 to 2016.
18 **A.** Yes.
19 **Q.** The working group produced both a report and a guide in
20 2016 on assessing the risk to others.
21 **A.** Yes.
22 **Q.** The report being the fuller document, and then there was
23 a guide annexed to it, which was an *aide-mémoire*,
24 almost, for practitioners.
25 **A.** Correct.

1 **Q.** Now a point that you've emphasised more than once in
2 your statement is that your active involvement in this
3 area of policy essentially came to an end in 2016 with
4 the publication of that report.
5 **A.** Correct.
6 **Q.** So your evidence is mainly concerned with the work that
7 you did and the publication position in 2016.
8 **A.** Yes.
9 **Q.** You can't help us, can you, with the reason or reasons
10 why the guidance wasn't revised in 2021 as had been the
11 intention at publication?
12 **A.** No, I'm sorry, I can't.
13 **Q.** Before we turn to the guide, early in your post as Chair
14 of the Working Group, you had an article published in
15 the British Medical Journal.
16 **A.** Correct.
17 **Q.** If we can turn that up, it's WITN0058009.
18 In this article you argued in favour of emphasising
19 risk in psychiatric practice.
20 **A.** That's correct.
21 **Q.** If we look at the columns on the left, second paragraph,
22 final sentence, you state:
23 "Psychiatry risk assessment processes are flawed,
24 misdirected, and innumerate, but risk remains
25 a fundamental component of psychiatry, as in all

1 medicine."
2 **A.** Correct.
3 **Q.** Now, when you're describing risk assessment processes as
4 flawed, are there specific processes that you're
5 referring to?
6 **A.** No, I'm talking generally about risk and being an
7 inevitably flawed process based on the mathematics of
8 balancing false positives and false negatives. There
9 can never be a perfect instrument, so one is looking for
10 the correct balance.
11 **Q.** That's because you're measuring risk and you can't be
12 certain on outcomes.
13 **A.** Exactly.
14 **Q.** But notwithstanding that limitation you recognised the
15 assessment of risk as fundamental to psychiatry as in
16 all medicine, nonetheless.
17 **A.** Exactly.
18 **Q.** If we turn, please, to the second page of this article,
19 left-hand side, final paragraph you write:
20 "Most worrying, the process of 'risk assessment'
21 becomes a tick box process separated from clinical
22 examination."
23 And you go on in the same paragraph to refer to
24 a survey describing this was "often divorced from mental
25 state examination".

What, in your view, is the importance of combining or including risk assessment within the clinical examination?

A. It is crucial. So I'm arguing in favour of a combination of actuarial tick boxes and clinical assessment, and what I was trying to do politically at the time of the committee and report was to bridge some dichotomies that were arising in mental health between the two extremes, between the body of clinicians that felt that actuarial measures were useless and should be abandoned, and clinicians who felt there was something that was so reliable they could be hidden behind.

So the important thing was to consider it really on the basis of the good evidence on risk management in other areas of which the airline industry and engineering were the two prime examples, whereby a pilot would have a tick box of things they checked before they set off on their plane, without which they couldn't be certain they'd remembered everything. But equally, if they had got a hunch that their plane wasn't operating properly, they should also be able to rely on the hunch. So the combination of your clinical experience and the checklist, not one or t'other.

Q. So using both. We see the top paragraph on the right-hand side your manifesto, as you describe it, you

state:

"We need to return emphasis on risk in psychiatry to clinical examination, by systematic evaluation of signs and symptoms. We need to reposition risk assessment forms as nothing more than helpful *aide-mémoires.*"

So is that the process that you're describing there, bringing the assessment within -- the risk assessment within the examination process?

A. It is, and in my academic background, my greatest fame, for want of another word, was developing an *aide-mémoire* for screening for eating disorders, a very simple, simplistic five questions which is now used around the world in every country translated into all sorts of languages, in order to screen people within about a minute. So I'm not dismissing *aide-mémoires*, but I'm saying one has to recognise that they had limitations. They're necessary, but they are not sufficient.

Q. You described a few moments ago a dichotomy in practice in psychiatry at the time you produced this report. Was it your view that to a large extent risk assessments were nothing more than helpful *aide-mémoires*?

A. No, I think this was a rhetorical journalistic style I adopted. This was an article wrote for the BMJ, it was very much a fun debate between two extremes as part of a series of debates. So this wasn't as thought

through in terms of detail, but I do think that clinicians can arrogantly think their clinical judgement is sufficient and they don't need to rely on any tick boxes, and I think *aide-mémoires* are limited and therefore sitting in a clinic ticking boxes saying this person is a man who uses drugs and has a history of violence, for example, is necessary, but not sufficient.

And the concern is that if the *aide-mémoire* is relied wholly upon, then it can prevent people acting on the outcomes of the risk assessment. But equally, I balance that against understanding the need to have an *aide-mémoire* without which these arrogant clinicians can simply assume that their judgement is correct and they forget the basics of what's needed. So it has to be a balance between the *aide-mémoire*, the risk assessment form, and the clinical judgement; it can't be one or t'other.

Q. Thank you. We can take that articles down and if we turn now to start considering the 2016 report. It was building, wasn't it, on a previous Royal College publication from 2008, entitled "CR-150 Rethinking Others in Mental Health Services"?

A. Correct.

Q. In paragraph 14 of your statement you describe that "By 2013 ..." so this is when you commenced with the working

group:

"By 2013 the College decided that a revision was required, in light of changing commissioning arrangements in the NHS, evolving service structures, and ongoing concerns about how risk was conceptualised and managed."

What were those concerns?

A. I think they are exactly the same concerns that Dr Diss *(sic)* has later reported to this Inquiry, which are actually magnified since then: that services are becoming fragmented; there is a lack of joined-up thinking; different agencies work in a different way; that it's hard to get hold of historic information; that risk itself is dynamic, it changes day-to-day, so you can sit on a MAPPA committee one day and then the position may be changed the next week, but there isn't sufficient dynamism in these processes to adapt to the changing situation.

And furthermore, that the philosophies that underpinned crisis services, based on Assertive Outreach teams, have been lost through the asset stripping of these teams to cut costs.

Q. So if I can break down your answer, so far as conceptualisation of risk, you're referring there to dynamic risk versus static risk.

1 **A.** Correct.
2 **Q.** The concerns being that risk wasn't being considered as
3 dynamic, and then the concern about management of risk
4 is to do with fragmentation of services.
5 **A.** Correct.
6 **Q.** So far as the need for further work following the 2008
7 publication, is the position that the 2008 guidance
8 hadn't brought about changes in practice that had been
9 hoped for at the time of that publication?
10 **A.** That's exactly correct. One had a sense that people,
11 experts, were getting together to write very well
12 informed reports but actually what people did with the
13 information, their actions could be very different to
14 the policies.
15 **Q.** If we consider now the work of the group, so it's
16 a group made up of a number of psychiatrists from
17 a number of different specialities.
18 **A.** Correct.
19 **Q.** The psychiatrists involved, they're all listed in the
20 report, aren't they?
21 **A.** *(The witness nodded)*.
22 **Q.** You state that you also had input from patients and
23 carers, and considered college surveys and literature.
24 **A.** Yes.
25 **Q.** Your role, as chair of the group, was to coordinate the

1 process and to produce a report reflecting the
2 consensus.
3 **A.** And to try to achieve that consensus, which was of
4 itself almost a form of therapy, as you had people in
5 the room who adopted, again, those sorts of dichotomous
6 positions.
7 **Q.** But despite that, a consensus was reached --
8 **A.** It was reached, yeah.
9 **Q.** -- balancing the two extremes.
10 **A.** Yes.
11 **Q.** Now again, and this might be going over ground you refer
12 to in your article that we've already looked at, but in
13 paragraph 17 of your statement, you describe the
14 information considered by the group, and refer in
15 particular to the "dangers of an overly-simplistic
16 'tick-box' approach, and the risk that such forms of
17 practice could obscure rather than enhance professional
18 judgement."
19 **A.** Yes.
20 **Q.** So that tick-box approach is one extreme of the
21 dichotomy.
22 **A.** Yes.
23 **Q.** And the risk of that obscuring professional judgement,
24 why did you consider there was that risk?
25 **A.** Because I -- we all observed clinicians filling out

1 forms almost as a substitute for actually doing
2 something. An example of doing something might be you
3 have talked to the patient, you understand they're
4 a great worry, and then you have to make a phone call to
5 their mother or try to get in contact with their boss,
6 persuade them to get into hospital, find a hospital bed
7 for them, talk to them about whether they'll take
8 medication, convene a Mental Health Act if they won't.
9 Those are all actions, but instead, we have a culture
10 where clinicians can maybe spend 40 minutes with
11 a patient, and then two hours in front of a computer
12 screen filling out boxes, none of which are
13 irrelevant -- so again, I'm not criticising the
14 *aide-mémoire* approach -- but they can become
15 a substitute for actually doing something.
16 And the person participating in this process
17 convinces themselves they are doing something useful and
18 active, but actually all they're doing is substituting
19 for the action that's needed.
20 **Q.** If we can turn up the report, it's WITN0058002. If we
21 turn to page 6, please. And this sets out the "Key
22 findings and recommendations" of the working group. We
23 can see, number 1, which reflects a point in your 2013
24 article:
25 "Risk management is a core function of all medical

1 practitioners and some negative outcomes, including
2 violence can be avoided or reduced in frequency by
3 sensible contingency planning."
4 **A.** Yes.
5 **Q.** So it should be there on your screen in front of you.
6 **A.** Yeah, thank you.
7 **Q.** You go on in the same paragraph, or the group go on in
8 the same paragraph to make the point that adverse
9 outcomes cannot be eliminated, but the use of the term
10 "contingency planning" at key finding 1, is that
11 ultimately the aim of a risk assessment: to arrive at
12 a plan which reduces the chance that the risk
13 materialises?
14 **A.** Precisely.
15 **Q.** Then if we look at key finding 2, and this echoes
16 a point that you've already made a couple of times in
17 your evidence, but it's advocating, isn't it,
18 a structured approach to risk assessment?
19 **A.** Yes.
20 **Q.** You've explained in your statement the three different
21 types, so it's the two extremes of the dichotomy, as it
22 were, so the one that relies purely on a tool and the
23 one that relies not on a tool at all, purely on clinical
24 judgement, and between those is the structured
25 professional judgment so a combination of the two.

1 **A.** Yes.
2 **Q.** That's the approach which was endorsed and advocated,
3 both in the report and the annexed guide.
4 **A.** Yes.
5 **Q.** The example of a tool referred to both in your statement
6 and the report is the HCR-20.
7 **A.** Yes.
8 **Q.** Now the Inquiry has already heard evidence on that tool.
9 Ultimately, the report does not recommend HCR-20 for
10 routine use, does it?
11 **A.** No.
12 **Q.** That's essentially on the grounds of practicality.
13 **A.** Correct.
14 **Q.** The fact that it can take too long to complete.
15 **A.** Yes.
16 **Q.** In an emergency setting where time is limited you might
17 not have access to collateral information, HCR-20 is not
18 going to be useful.
19 **A.** Yes.
20 **Q.** Did the working group consider the use of that tool,
21 HCR-20, in a community setting where there aren't going
22 to be the same pressures of time in an emergency
23 setting?
24 **A.** I can't remember that discussion, but my own view would
25 be that those tools are very useful in certain settings

1 in terms of risk stratification. So if you've got
2 20 minutes at 3.00 in the morning in casualty, you might
3 take one approach, whereas if you've got a couple of
4 hours on a Friday afternoon you might use a tool such as
5 the HCR. So there's definitely a role for more
6 specialised, detailed, risk assessment tools but they
7 have to be tools that are validated on the population
8 for which they're being used.
9 The HCR-20, when I chaired the committee, hadn't
10 been validated for community-based patients but had been
11 validated for forensic patients. So it certainly had a
12 lot of promise. But I don't believe we took a position
13 one way or the other to recommend any of the very many
14 different tools. There were lots of tools out there,
15 though that was the most common one. But I certainly,
16 in no sense, was critical of that as a tool. I think
17 it's a good, useful instrument.
18 **Q.** It's paragraph 45 of your witness statement where you
19 comment on HCR-20 and you conclude that paragraph by
20 stating:
21 "The report therefore stressed the importance of
22 training, supervision and embedding the tool within
23 a broader clinical process."
24 Can you elaborate on what you mean by "embedding the
25 tool within a broader clinical process"?

1 **A.** To understand the tool's use, its validity and its
2 limitations. So if you take any instrument such as the
3 HCR-20, you're looking at the statistics of it, the
4 sensitivity, the specificity, the number of false
5 positives, the number of false negatives, and as
6 I understood it at the time, it had been well validated
7 in a forensic population of offenders to predict their
8 risk of future offending, but it hadn't been so well
9 validated in a general adult population.
10 So, therefore, if a general adult population had
11 a specific patient who seemed to have an offending
12 history, it may well be a useful tool, but if instead
13 you were assessing a 70-year old who was striking out at
14 their carer, it may not be at all valid.
15 So simply because of an act of violence in a general
16 adult patient, it wouldn't be appropriate to take that
17 specific tool and apply it to the wrong population. In
18 other words, people have to understand the instrument
19 they are using and why they are using it.
20 **Q.** What I'm trying to understand is the recommendation that
21 the report was making and the good practice it was
22 advocating for in respect of the use of tools, because
23 we've established that it is a structured professional
24 judgement that was being put forward --
25 **A.** Yes.

1 **Q.** -- which involves the use of a tool.
2 **A.** Yes.
3 **Q.** But not the HCR necessarily?
4 **A.** Yes.
5 **Q.** So in terms of the tool to be used or the approach to
6 a tool-like instrument, what was being recommended?
7 **A.** It really wasn't about the tool, it was who wielded the
8 tool. So if you imagine the tool being like a medical
9 procedure, an endoscope, let's say, you wouldn't ask the
10 GP to wield the endoscope, you'd get the GP to refer to
11 a gastroenterologist, who would wield the endoscope.
12 The HCR, when we wrote this, was predominantly a
13 tool wielded by forensic psychiatrists, so there would
14 be a role to seek an opinion from a forensic
15 psychiatrist to evaluate risk in which they might use
16 such a tool. Which isn't to say the tool isn't useful,
17 but it should be used by someone who knows how to wield
18 it, its context, and how to interpret it.
19 **Q.** If we go forward in the report, it's page 25, please,
20 and it's the very bottom right-hand corner under the
21 heading "Local forms and quality networks" starting with
22 the second sentence, which is going to lead onto the
23 next page:
24 "There remains a need for a common approach to risk
25 documentation in locally developed forms, as this might

1 be the basis of a standard approach for all patients."
2 The next two paragraphs, as you can see -- I won't
3 read them out -- there is a suggestion of developing
4 a standardised national form.
5 **A.** Yes.
6 **Q.** Was the idea that that kind of form could be used as
7 standard in the structured professional judgement
8 approach?
9 **A.** Exactly, because otherwise if a patient travels, let's
10 say theoretically, from Cambridge to Nottingham and
11 they've had one tool used in Cambridge and a different
12 tool used in Nottingham, then the longitudinal
13 assessment of that risk is far harder than if they'd
14 used the same instrument in both settings.
15 So having one tool used throughout that the health
16 culture is useful in that longitudinal assessment of
17 risk, but also it embeds it into the culture so the
18 clinicians using it know what it is and why they're
19 using it. Whereas what tends to happen is you go from
20 working in one trust to another trust and they
21 use totally different instruments, often with a vague
22 acronym, and it changes all the time, or at least it did
23 in my NHS days, and that isn't very helpful.
24 **Q.** As far as you're aware, was any work done to develop
25 that single form, as suggested, recommended in these

1 paragraphs?
2 **A.** Not as far as I'm aware, no.
3 **Q.** Okay. If we can take that down, I now want to turn to
4 the process for assessing risk. If we can put on
5 screen, please, a section of your witness statement,
6 it's WITN0058001 and if we turn to page 5 of the
7 statement, do you see at paragraphs 24-26 you address,
8 don't you, when an assessment of risk to others should
9 be undertaken?
10 **A.** Yes.
11 **Q.** At paragraph 24 you say:
12 "... whenever a patient presents with symptoms,
13 behaviours, or circumstances, that could plausibly give
14 rise to concern about harm to others."
15 So that's not limited, is it, only to acts of
16 violence?
17 **A.** No.
18 **Q.** It would include threats of violence.
19 **A.** Yes.
20 **Q.** And aggressive or threatening behaviours.
21 **A.** Absolutely, yes.
22 **Q.** Indeed, later in your statement, it's paragraph 49,
23 we'll stay on this page but at paragraph 49 of your
24 statement you describe violence as being understood "...
25 broadly in clinical risk assessment" to include not only

1 "physical assaults but also threatening behaviour,
2 intimidation, or actions that could indirectly cause
3 harm".
4 **A.** Correct.
5 **Q.** So it's a broad field of understanding for violence.
6 At paragraph 25 there on screen, you make the point
7 that the risk assessment should be a routine part of
8 psychiatry practice, not just for forensic or secure
9 settings.
10 **A.** Yes.
11 **Q.** And particularly necessary for a new patient.
12 **A.** Yes.
13 **Q.** So in your view, whenever there is a new psychiatric
14 patient, there is a need for an assessment of risk.
15 **A.** Yes.
16 **Q.** When a patient deteriorates, and when there are
17 expressions of threats or violent ideation.
18 **A.** Yes.
19 **Q.** So Professor Morgan, is what you're describing here:
20 when you have a new patient, assess risk; if you have
21 reason to think that the original level of risk may have
22 changed, may have increased, you assess risk again?
23 **A.** Yes.
24 **Q.** Another indication for assessing risk: disengagement
25 from treatment. Again, is the importance of a risk

1 assessment then because the level of risk may have
2 changed?
3 **A.** Absolutely.
4 **Q.** May have increased?
5 **A.** Yeah.
6 **Q.** Where a patient is being discharged by secondary care
7 back to primary care, back to the GP, on the grounds of
8 disengagement, in your view is it necessary then to
9 carry out a risk assessment as part of that process of
10 discharge?
11 **A.** Absolutely, yes. And create that contingency plan that
12 I was talking about.
13 **Q.** Besides points of deterioration, so specific indications
14 that the level of risk may have changed, may have
15 increased, when or how frequently should risk
16 assessments be reviewed and updated as part of
17 a routine.
18 **A.** Well, certainly at every CPA meeting, so every formal
19 multidisciplinary review of a patient there would be
20 an evaluation and update of risk. That was the practice
21 when I left the NHS, which I think was four years ago,
22 would have been expected -- but not confined to that.
23 There would also be consideration of risk at every
24 single clinical point of contact, if relevant. There
25 would be some patients for whom every time you clapped

1 eyes on them, you would be assessing their risk. The
2 nature of the risk might vary but you would be
3 considering issues of risk in every single clinical
4 contact.
5 **Q.** So that's considering risk but of course sometimes when
6 we think of risk assessment we think of an actual
7 document.
8 **A.** Yes.
9 **Q.** So a document setting out a risk, and I think the point
10 you're making is well, whenever you see the patient you
11 consider risk.
12 **A.** Yes.
13 **Q.** The question I have is when do you return to the actual
14 document, the risk assessment, and review that and
15 update it, if necessary?
16 **A.** Well, every -- my memory was of every formal meeting,
17 but my point being that the nature of the risk
18 assessment has to vary according to the patient.
19 So to give you an example from my own practice, in
20 the later stages of my career when I would assess
21 a 20-year old young female student with anorexia nervosa
22 at extremely low weight, who was at risk of a sudden
23 heart attack because of their anorexia, nonetheless at
24 the first assessment I would be completing a form
25 considering whether they kept any dangerous weapons and

1 whether they'd ever assaulted anyone, which seems quite
2 irrelevant to the patient, but nonetheless you will be
3 surprised by how, occasionally, you are amazed that
4 people you're not predicting to have that risk will have
5 it. So you do have to ask that question at the
6 beginning and, in my opinion, at the end.
7 However, towards the later stages, if I'm seeing
8 that person every two weeks, I'm not going to be asking
9 them every two weeks about whether they've now got
10 a weapon; I'll be talking to them more about their ECG
11 and their physical health.
12 So the principle is you have to ask the questions
13 around the risks which don't appear immediately
14 applicable to the individual, but you should do that for
15 every patient, certainly at the beginning, and at the
16 end, but you wouldn't necessarily do it on every
17 clinical contact, depending on the circumstance.
18 **Q.** Finally, so far as what is on screen is concerned, your
19 paragraph 26, you deal there, you make the point, it's
20 the second sentence:
21 "Risk is dynamic rather than static, and therefore
22 requires regular review ..."
23 A few moments ago when you were talking about the
24 need for further work in 2013 and concerns about the
25 conceptualisation of risk, you referred then to the need

1 to appreciate that risk is dynamic. Can you just expand
2 and explain the difference between dynamic and static
3 risk assessments?
4 **A.** I think there are two bits to it. One is that risk
5 is -- changes. Very obviously someone can be at no risk
6 at all one day and then the next week they're very much
7 at risk. So if you have a form filled out which says
8 "Low risk", you can't then assume that remains the case
9 a week later. You have to be open to the fact that that
10 might have changed quite drastically as the person's
11 circumstances have changed. They might have resumed
12 taking drugs, for example.
13 The second element is that to properly evaluate risk
14 you need a longitudinal assessment, you need to look at
15 lots of different points in time. So it may be that
16 someone presents immediately at risk because they've run
17 amok with a machete in the streets of London, but it may
18 be that they have an equal risk because they've
19 constantly, every Friday night, punched someone. So
20 smaller, repeated acts of violence are just as
21 indicative of an eventual severe risk as a single
22 one-off more dramatic act, and for that reason you need
23 to take a longitudinal view of risk.
24 So to summarise, risk is dynamic because firstly it
25 changes, and secondly because to make an accurate

1 judgement of risk, you have to take a broad longitudinal
2 picture of it.
3 **Q.** Thank you. We can take that down from the screen now.
4 We've dealt with the timing of risk assessments.
5 Who is it who should carry out a risk assessment? Which
6 professionals?
7 **A.** Whoever is doing the assessment, whoever is the
8 clinician. But I think risk assessment needs to be done
9 by qualified, established healthcare professionals, and
10 my experience and our committee was dealing solely with
11 psychiatrists. So I can't really speak for who else
12 should be involved or is suitably trained. But
13 certainly nursing staff, occupational therapists, social
14 workers, all need adequate training, but that wasn't the
15 remit of the committee.
16 I think the evidence given by the Assertive Outreach
17 expert who spoke, Dr Diss -- Dissayanaka, I think he was
18 called -- talked about his concern about the increasing
19 reliance on less qualified staff in Assertive Outreach.
20 And I think there's a valid point there: that it's like
21 giving the endoscope to someone who doesn't know how to
22 use it. So it has to be an instrument wielded by
23 someone who has the training, which would certainly
24 include nurses, social workers, occupational therapists,
25 psychiatrists, and I'm probably missing out other

1 specialities.
2 Q. But where a patient is receiving care and treatment both
3 from psychiatrists and from psychiatric nurses, who in
4 those circumstances, in your view, should be responsible
5 for the risk assessment?
6 A. Well, I've no doubt the psychiatrist should be
7 responsible, and I can't speak as to who else should
8 hold clinical responsibility.
9 Q. At paragraphs 27 and 28 of your statement, you address
10 the importance of information gathering for the purposes
11 of risk assessment.
12 A. Yes.
13 Q. Paragraph 27, you say "collateral information" is
14 "crucial [to]... obtaining an accurate picture."
15 What are the limitations, so far as accuracy are
16 concerned, if you rely solely on clinical interview and
17 examination?
18 A. Well, patients very often don't tell you what's
19 objectively true, either because they're doing so
20 deliberately or because they're mentally ill and lack
21 mental capacity. The only way you can gain a broader
22 picture is by gaining as much information as possible
23 from as many different sources as you can possibly get
24 hold of.
25 Q. You've listed at paragraph 28, a number of potential

1 sources for collateral information, so medical records,
2 GP records, police or probation reports, court
3 documents, accounts from carers or family members.
4 A. Yes.
5 Q. You emphasise over the page, paragraph 29, the need for
6 psychiatrists "actively to seek" information from those
7 sources.
8 A. Yes.
9 Q. Where a patient is a university student, would it
10 involve obtaining collateral information? Would it
11 involve seeking information from the university?
12 A. Yes.
13 Q. Then finally, at paragraph 30, you describe some of the
14 impediments to obtaining and sharing information,
15 they're described as being "considerable".
16 A. Yes.
17 Q. What were the difficulties or barriers to obtaining
18 information that the working group considered evidence
19 of?
20 A. Well, apart from the difficulties of getting disclosure
21 from other groups and other bodies who may be reluctant
22 to share relevant information, and to readily talking of
23 confidentiality issues, necessarily, there is also
24 simply the time aspects of busy services with little
25 time to do this. One of the pleasures of working as

1 a forensic psychiatrist briefly was that we had a lot of
2 time to get lots of information from lots of different
3 sources and likewise in a medicolegal arena, it's
4 a great pleasure to get hold of huge boxes of files and
5 go through everything, including GP records from when
6 someone was four, but at three o'clock in the morning in
7 casualty when I was a liaison psychiatrist in a busy
8 London teaching hospital, we were basically having to
9 base decisions on the patient that we had in front of
10 us, and then trying to ring up any relative if we
11 happened to have their telephone number.
12 Q. So there's a time issue, a resource issue?
13 A. Yes.
14 Q. Then also you, at the start of your answer, you refer to
15 issues of confidentiality.
16 A. Correct.
17 Q. If we can put back on screen the report, WITN0058002 and
18 go to page 35, Professor Morgan, what I want to do is to
19 go through some of the guidance that was given on the
20 process of risk assessment and risk formulation.
21 There's a number of bullet points, so this is from the
22 annex from the guide section?
23 A. Yes.
24 Q. So this page has a number of ticks for psychiatrists,
25 and two of these appear to be at length. So the third

1 bullet point:
2 "Be curious and look beyond face value."
3 A. Yes.
4 Q. Then the sixth bullet point:
5 "Think about what you don't know."
6 A. Yes.
7 Q. Why was that highlighted as an important tip for
8 psychiatrists?
9 A. Well, I think the curiosity comes back to the point
10 I was making earlier about the unlikely thought that one
11 of the patients I was seeing might actually have
12 a weapon. These things do happen. You have to be
13 curious and open to the unexpected, because it's these
14 unexpected, unpredictable risks that are really the most
15 dangerous ones. Who would have thought, for example,
16 that Richard Reed would try to blow up an airline using
17 a bomb concealed in his shoes, and then 10 years later
18 we're all taking our shoes off at an airport? Those
19 sorts of rare but not impossible risks need to be
20 considered.
21 "Think about what you don't know" is about the
22 difficulties of the unknown unknowns, philosophically.
23 We all know what we know. We tend to think we know what
24 we don't know, but there are areas where we don't know
25 what we don't know, and those are perhaps the most

1 important areas where we, for example, to use it in
2 a more practical sense, a psychiatrist may not realise
3 they don't know that much about epilepsy and violence,
4 for example, and therefore being open to those unknown
5 unknowns is important.
6 We were trying to move away from the arrogance of
7 clinicians who'd worked in the field for a long time
8 assuming that what they had always practised and what
9 they always understood was correct, and to be open to
10 the possibility of new information and new learning.
11 **Q.** Is it linked to the seventh bullet point:
12 "Consider the unpredictability of an evolving
13 disorder or new presentation"?
14 **A.** Yes.
15 **Q.** Where the evolving disorder or new presentation is
16 psychosis or schizophrenia, how does that consideration
17 apply?
18 **A.** It applies some -- very obviously -- and I think is
19 something which isn't relevant to what I was talking
20 about earlier -- I think that every psychiatrist would
21 know that a psychotic patient was at -- was a high risk,
22 and could change from day to day, because it's intrinsic
23 in the condition.
24 **Q.** If we move on to the next page, please, page 36, and
25 it's the bottom half of the page under the heading

1 "Factors to consider".
2 Now, the first of these is "History", the first
3 bullet point, "Previous violence, whether investigated,
4 convicted or unknown ..." and we've already gone over
5 violence in the need for broad interpretation of that in
6 clinical practice.
7 **A.** Yes.
8 **Q.** The next bullet point: "Relationship of violence to
9 mental state." Why is that relevant for the assessment?
10 **A.** Some people are violent and separately they have
11 a mental illness. Other people are violent because of
12 their mental illness. A practical example would be, you
13 know, a paranoid delusion. If you feel that people are
14 trying to kill you, you're going to try to attack them
15 first. If you have what's called a second-person
16 command auditory hallucination telling you to do
17 something, then that's going to influence your
18 behaviour.
19 So there's a direct link there between the person's
20 behavioural violence and their mental state.
21 **Q.** Which of those two features, whether the violence is
22 part of the mental state or not, that's relevant to the
23 risk assessment?
24 **A.** Correct, yeah.
25 **Q.** Then the fourth bullet point:

1 "Poor concordance with treatment, discontinuation or
2 disengagement."
3 Again, that presents a risk. Why?
4 **A.** It implies firstly the person doesn't understand that
5 they are ill and need to be treated; therefore,
6 secondly, that they are likely to not comply with
7 treatment and their mental illness is likely to get
8 worse; and thirdly that they might disappear into the
9 ether and be beyond the longitudinal risk assessment
10 process that I was describing.
11 So those would all be reasons to consider someone at
12 elevated risk.
13 **Q.** If we can go to the next page, page 37, please. Still
14 in "Factors to consider", this, under the heading
15 "Environment", we have the first two bullet points:
16 "Risk factors may vary by setting and patient group.
17 "Risk on release from restricted settings."
18 Are those two bullet points requiring
19 an appreciation that the, for instance, risk in the
20 community might present differently to that whilst
21 detained?
22 **A.** Precisely.
23 **Q.** To what extent can a risk assessment based on
24 a presentation whilst detained be a reliable indication
25 of risk in the community?

1 **A.** Well, it can't be relied upon. One has to do a risk
2 assessment in the community.
3 **Q.** The third bullet point from the bottom of the
4 "Environment" section:
5 "Access to potential victims, particularly
6 individuals identified in mental state abnormalities."
7 What is being described here?
8 **A.** If they have a preoccupation with certain people and
9 they have contact with that person, then they are at
10 risk of attacking them. I've had patients who've had
11 delusions about me, and have wanted to kill me when
12 they've been psychotic, and clearly therefore that would
13 put me at risk. But thinking about family, you have
14 people who are psychotic and they develop delusions
15 about their wives or husbands, and again, one has to
16 consider the risks to those individuals.
17 But also, you have to consider who they're living
18 around and with. Are there young children in the
19 household? Are they close to people they might be at
20 risk of attacking because of their delusional ideation?
21 **Q.** Then under "Mental state", the first bullet point, is
22 that referring essentially to symptoms of psychosis?
23 **A.** Yes.
24 **Q.** You've explained in your statement, haven't you, that
25 psychotic symptoms can heighten the risk of violence.

1 **A.** Yes.
2 **Q.** The final bullet point in this section, "Beware
3 'invisible' risk factors". What are those?
4 **A.** Well, they would include factors such as disengagement,
5 but again, coming back to the notion of unknown unknowns
6 and the need for curiosity, there may be very specific
7 risk factors for specific individuals. I've had
8 patients, for example, who, if -- sorry I won't -- I'll
9 stop -- I was about to potentially disclose clinical
10 information. But you have patients who perhaps
11 a certain individual dressed in certain clothing may
12 trigger traumatic memories of something that happened to
13 them in their army life, and that then may trigger
14 violent behaviour.
15 So there are any number of risk factors that might
16 be relevant to an individual that need to be tailor-made
17 to their own identity.
18 **Q.** I had picked up on a few of the factors over these
19 two pages on risk assessment. There are a number of
20 bullet points, we're not going to go through them all,
21 but the point ultimately is the more factors that are
22 present, the higher the risk.
23 **A.** Yes.
24 **Q.** Once the assessment has been carried out, if we turn,
25 please, to page 38, the next page, you then arrive at

1 a risk formulation.
2 **A.** Yes.
3 **Q.** That's essentially an assessment of the risk, but
4 holistic assessment of the risk, not simply low risk
5 medium risk, high risk.
6 **A.** Yes, it's based on this actuarial idea that they've
7 ticked, you know, five of the ten boxes that identify
8 risk, but separately that you have a clinical
9 understanding of who they are, where they live, whether
10 they have a job, how they get on with their mother, what
11 hobbies they have. So it's a combination of the
12 actuarial, the tick box, if you like, and the clinical
13 and social context of the patient.
14 **Q.** Once you have your risk formulation, then the next stage
15 is to devise a risk management plan.
16 **A.** And that's the crucial thing, because people will fill
17 out these risk formulations very well, very
18 descriptively, they're very good at the formulating but
19 they then have got to do something with the information;
20 they've got to act on it.
21 **Q.** And that's the plan?
22 **A.** Yeah.
23 **Q.** And we'll see, if we go to the next page, second bullet
24 point:
25 "A management plan should seek to change the balance

1 between risk and safety."
2 What's being described there?
3 **A.** Simply to address issues that are heightening the risk
4 and lower them.
5 **Q.** Then over the page, page 60 (*sic*), there are a number of
6 bullet points which describe what the management plan
7 should include, if I've understood this section
8 correctly.
9 **A.** Yes.
10 **Q.** Considerations such as whether or not admission is
11 necessary, the use of a Community Treatment Order,
12 Assertive Outreach. How does a person assessing risk,
13 having gone through the factors, formulated risk, how do
14 they determine which of these outcomes or plans of
15 management is appropriate?
16 **A.** Well, they should have the clinical training to make
17 that judgement or else have the supervision and access
18 to support to be advised what route to take.
19 **Q.** Now, a point that you make in your statement is that the
20 risk management plan must be integrated into the overall
21 care plan --
22 **A.** Yes.
23 **Q.** -- rather than being a standalone document.
24 **A.** Yes.
25 **Q.** What's the significance of that?

1 **A.** Because risk management has to run through the thread of
2 treating the patient. In treating the patient, you're
3 trying to reduce the risks to the public, and that has
4 to be integral to the purpose of treatment. You're not
5 just treating the patient; you're also having a mind for
6 public safety.
7 **Q.** What's the dangers of dealing with risk assessment by
8 way of a stand-alone document? Could you still not
9 achieve that outcome?
10 **A.** Well, you certainly can but philosophically we don't
11 want these things to be put into silos where one element
12 is considered the responsibility of one person and
13 another element the responsibility of another. So
14 a care plan has to include risk that will be known to
15 all of the team managing a patient so it's everyone's
16 business.
17 Whereas, if you have a separated risk assessment, it
18 can, for example, be, in my distant clinical experience
19 in some rare settings, it's been the case that the risk
20 management is seen as the duty of the psychiatrist and
21 another member of the team will be responsible for
22 developing a warm rapport with the patient or vice
23 versa. So it's important that the risk management is
24 everyone's business.
25 **Q.** A point you make in your statement, it's 56, when

1 describing risk management, is early warning signs. You
2 state that:
3 "Effective risk management planning depends upon
4 a structured formulation that identifies not only
5 risk factors but also protective factors, triggers, and
6 early warning signs of relapse. The plan should specify
7 what to look for ..."
8 Again, is that part of the focus on dynamic risk
9 assessment; is that an example of it?
10 **A.** It is. I mean, a typical example might be someone
11 develops some sleep disturbance and find they're
12 agitated at 3.00 in the morning and that can be a useful
13 indicator that they're at risk, or they become withdrawn
14 and isolated and they give up, you know, the hobbies
15 that they used to enjoy. Each one will be individual to
16 the patient, but often will be quite characteristic of
17 an imminent risk.
18 **Q.** If we can go back in this document, please, to page 30.
19 You've already given some evidence on sharing of
20 information when I was asking you questions about
21 gathering information for the purpose of the risk
22 assessment. This is the section of the report that
23 deals with communication and information sharing.
24 **A.** Yes.
25 **Q.** If we can look at the bottom paragraph on the left:

37

1 "Information sharing, particularly between trusts,
2 mental health teams, social services and the police, was
3 identified as a key issue in the qualitative responses
4 to the survey reported in CR150."
5 So that's a 2008 paper, isn't it, the predecessor to
6 your work?
7 **A.** Yes.
8 **Q.** Then we see underneath that a quote that appears to be
9 from that document, the second sentence of which states:
10 "Focused strategies are needed to improve sharing of
11 risk information between trusts, police, mental health,
12 and voluntary bodies and mental health teams."
13 Then underneath that, the report, this report, the
14 2016 report, says:
15 "This remains true".
16 **A.** Yes.
17 **Q.** So despite that having been highlighted in 2008, the
18 view of your working group was that that work remained
19 outstanding?
20 **A.** Yes.
21 **Q.** If we go forward, please, to page 39, this is within
22 general principles of risk management, the third bullet
23 point from the bottom:
24 "Has the patient's GP been informed? Do you need to
25 speak to the GP?"

38

1 When should the GP be informed of a risk assessment
2 process or outcome or management plan?
3 **A.** Well, every time there's a CPA meeting there should be
4 communication with the GP about what's going on, and GPs
5 pull their hair out because they have patients turning
6 up and there's been a meeting and they haven't been told
7 there's been a change of medication or circumstances.
8 So GPs are very much at the coalface of what's
9 happening and they need to be informed fairly rapidly,
10 but also in a way that they can actually read the
11 document. They don't have time to read a 30-page
12 document, they need a succinct bullet point summary of
13 what's going on.
14 But GPs are crucial in these circumstances also
15 because the old-fashioned GP will have known the patient
16 for many years.
17 **Q.** Over the page, page 40, on a similar theme, the final
18 bullet point -- and this is in relation to the risk
19 management plan -- that final bullet point asks whether:
20 "... everyone from carers to professionals have they
21 been adequately consulted and informed about the risks
22 present ..."
23 We can see just under that bullet point a whole
24 range of different professionals are identified as
25 those --

39

1 **A.** Yes.
2 **Q.** -- it appears the report seems to be suggesting should
3 be informed.
4 **A.** Yes.
5 **Q.** Okay, we can take that down now, please. Thank you very
6 much.
7 Then following the publication of the guide, as
8 you've said, you weren't involved in the dissemination
9 of the report or any work that's been done since the
10 report on assessing risk of others, but you explain in
11 your statement that your impression was that the
12 adoption of those principles set out in the report was
13 variable.
14 **A.** Yes.
15 **Q.** That a tick-box approach remained?
16 **A.** Yes.
17 **Q.** Is it your view that the principles of the guide didn't
18 filter through to general psychiatric practice?
19 **A.** I think they filtered through to many psychiatrists, but
20 of course most of the people that are administering risk
21 management aren't psychiatrists, and really the report
22 had no teeth. It had no statutory authority. It was
23 simply a guide to fellow psychiatrists "This is what we
24 think you should be doing". Whereas what health trusts
25 do is what they're told to do by commissioners, and

40

1 they're the people with teeth. And so I was left
2 feeling slightly cynical as to what value the report had
3 actually had, though I may be incorrect in that
4 interpretation.
5 **Q.** Does that cynicism remain?
6 **A.** Yes, but it may reflect my intrinsic personality.
7 **Q.** Then finally this: it's paragraph 74 of your statement,
8 but you confirm there, don't you, that your view is the
9 core principles of your report remain relevant?
10 **A.** They do.
11 **MR CARR:** Thank you, Chair. Those are my questions. There
12 are other questions.
13 **THE CHAIR:** Yes. Any questions? Anybody? No. I don't
14 think there are in fact any questions.
15 **Questioned by THE CHAIR**
16 **THE CHAIR:** I just wanted to ask one question, in fact.
17 Just in relation to the barriers to obtain
18 information, that includes other parts of the NHS,
19 doesn't it?
20 **A.** It does, yes.
21 **THE CHAIR:** And between Trusts.
22 **A.** It does, your Honour, yes.
23 **THE CHAIR:** So if somebody moves around, is it difficult to
24 get information or did you find it, by the time you
25 left, difficult to get information from other Trusts?

41

1 **A.** It can be very difficult. There can be a lack of
2 communication, your Honour.
3 **THE CHAIR:** Do you know why that is?
4 **A.** I think the fragmentation of services and the sense of
5 services increasingly working in silos, at a broader
6 quasi-political level, the sense that we're now sort of
7 operating in an internal market, whereas when I began in
8 the NHS we were all a collective organisation with
9 a single goal in mind. Now you're working for different
10 organisations as if you're going from working for
11 Barclays Bank and then working for the Halifax. So the
12 sense of collective responsibility and ownership has
13 been lost somewhat in the ether of the NHS.
14 **THE CHAIR:** Yes, thank you.
15 Well, thank you very much.
16 I think that completes for today, doesn't it. So
17 we'll start again tomorrow morning at 10.00. Thank you
18 very much.
19 **(3.11 pm)**
20 **(The hearing adjourned until 10.00 am the following day)**
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42

1 **I N D E X**
2

	Page
3 PROFESSOR JOHN MORGAN (sworn)	1
4 Questioned by MR CARR	1
5 Questioned by THE CHAIR	41

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

43

MR CARR: [3] 1/4 1/7 41/11
THE CHAIR: [7] 1/3 41/13 41/16 41/21 41/23 42/3 42/14

'

'invisible' [1] 33/3
'risk [1] 4/20
'tick [1] 10/16
'tick-box' [1] 10/16

1

10 years [1] 28/17
10.00 [2] 42/17 42/20
14 [1] 7/24
150 [1] 7/21
17 [1] 10/13

2

2.10 [1] 1/2
20 [8] 1/1 13/6 13/9 13/17 13/21 14/9 14/19 15/3
20 minutes [1] 14/2
2008 [5] 7/21 9/6 9/7 38/5 38/17
2013 [5] 2/17 7/25 8/2 11/23 22/24
2016 [6] 2/17 2/20 3/3 3/7 7/19 38/14
2021 [3] 1/19 2/9 3/10
2025 [1] 1/10
2026 [1] 1/1
24 [1] 18/11
25 [2] 16/19 19/6
26 [2] 18/7 22/19
27 [2] 25/9 25/13
28 [2] 25/9 25/25
29 [1] 26/5

3

3 December 2025 [1] 1/10
3.00 [2] 14/2 37/12
3.11 [1] 42/19
30 [2] 26/13 37/18
35 [1] 27/18
36 [1] 29/24
37 [1] 31/13
38 [1] 33/25
39 [1] 38/21

4

40 [1] 39/17
40 minutes [1] 11/10
45 [1] 14/18
49 [2] 18/22 18/23

5

56 [1] 36/25

6

60 [1] 35/5

7

74 [1] 41/7

A

abandoned [1] 5/11
able [1] 5/21
abnormalities [1] 32/6
about [28] 4/6 6/14 8/5 9/3 9/8 11/7 16/7 18/14 20/12 22/9 22/10 22/23 22/24 24/18 24/18 28/5 28/10 28/21 28/21 29/3 29/20 32/11 32/13 32/15 33/9 37/20 39/4 39/21
Absolutely [3] 18/21 20/3 20/11
academic [1] 6/9
Academically [1] 2/5
access [3] 13/17 32/5 35/17
according [1] 21/18
accounts [1] 26/3
accuracy [1] 25/15
accurate [2] 23/25 25/14
achieve [2] 10/3 36/9
acronym [1] 17/22
act [4] 11/8 15/15 23/22 34/20
acting [1] 7/9
action [1] 11/19
actions [3] 9/13 11/9 19/2
active [2] 3/2 11/18
actively [1] 26/6
acts [2] 18/15 23/20
actual [2] 21/6 21/13
actually [8] 8/10 9/12 11/1 11/15 11/18 28/11 39/10 41/3
actuarial [4] 5/5 5/10 34/6 34/12
adapt [1] 8/17
address [3] 18/7 25/9 35/3
adequate [1] 24/14
adequately [1] 39/21
adjourned [1] 42/20
administering [1] 40/20
admission [1] 35/10
adopted [2] 6/23 10/5
adoption [1] 40/12
adult [3] 15/9 15/10 15/16
adverse [1] 12/8
advised [1] 35/18
advocated [1] 13/2
advocating [2] 12/17 15/22
afternoon [1] 14/4
again [10] 10/5 10/11 11/13 19/22 19/25 31/3 32/15 33/5 37/8 42/17
against [1] 7/11
agencies [1] 8/12
aggressive [1] 18/20
agitated [1] 37/12
ago [3] 6/18 20/21 22/23
aide [10] 2/23 6/5 6/10 6/15 6/21 7/4 7/8 7/12 7/15 11/14
aide-mémoire [6] 2/23 6/10 7/8 7/12 7/15 11/14
aide-mémoires [4] 6/5 6/15 6/21 7/4
aim [1] 12/11
airline [2] 5/15 28/16
airport [1] 28/18
all [20] 3/25 4/16 6/13 9/19 10/25 11/9 11/18 11/25 12/23 15/14 17/1 17/22 23/6 24/14 28/18 28/23 31/11 33/20 36/15 42/8
almost [3] 2/24 10/4 11/1
alone [1] 36/8
already [5] 10/12 12/16 13/8 30/4 37/19
also [12] 5/21 9/22 17/17 19/1 20/23 26/23 27/14 32/17 36/5 37/5 39/10 39/14
always [2] 29/8 29/9
am [1] 42/20
amazed [1] 22/3
amok [1] 23/17
annex [1] 27/22
annexed [2] 2/23 13/3
anorexia [2] 21/21 21/23
another [6] 6/10 17/20 19/24 36/13 36/13 36/21
answer [2] 8/23 27/14
any [10] 7/3 14/13 15/2 17/24 21/25 27/10 33/15 40/9 41/13 41/14
Anybody [1] 41/13
anyone [1] 22/1
apart [1] 26/20
appear [2] 22/13 27/25
appears [2] 38/8 40/2
applicable [1] 22/14
applies [1] 29/18
apply [2] 15/17 29/17
appreciate [1] 23/1
appreciation [1] 31/19
approach [11] 10/16 10/20 11/14 12/18 13/2 14/3 16/5 16/24 17/1 17/8 40/15
appropriate [2] 15/16 35/15
April [1] 1/1
are [49]
area [1] 3/3
areas [3] 5/15 28/24 29/1
aren't [3] 9/20 13/21 40/21
arena [1] 27/3
argued [1] 3/18
arguing [1] 5/4
arising [1] 5/8
army [1] 33/13
around [4] 6/12 22/13 32/18 41/23
arrangements [1] 8/4
arrive [2] 12/11 33/25
arrogance [1] 29/6
arrogant [1] 7/12
arrogantly [1] 7/2
article [6] 3/14 3/18 4/18 6/23 10/12 11/24
articles [1] 7/18
as [54]
ask [4] 16/9 22/5 22/12 41/16
asking [2] 22/8 37/20
asks [1] 39/19
aspects [1] 26/24
assaulted [1] 22/1
assaults [1] 19/1
Assertive [4] 8/20 24/16 24/19 35/12
assess [3] 19/20 19/22 21/20
assessing [7] 2/20 15/13 18/4 19/24 21/1 35/12 40/10
assessment [46]
assessment' [1] 4/20
assessments [4] 6/20 20/16 23/3 24/4
asset [1] 8/21
Associate [1] 1/21
assume [2] 7/13 23/8
assuming [1] 29/8
at [56]
attack [2] 21/23 30/14
attacking [2] 32/10 32/20
auditory [1] 30/16
authority [1] 40/22
avoided [1] 12/2
aware [2] 17/24 18/2
away [1] 29/6

B

back [6] 20/7 20/7 27/17 28/9 33/5 37/18
background [2] 1/15 6/9
balance [4] 4/10 7/11 7/15 34/25
balancing [2] 4/8 10/9
Bank [1] 42/11
Barclays [1] 42/11
barriers [2] 26/17 41/17
base [1] 27/9
based [5] 4/7 8/20 14/10 31/23 34/6
basically [1] 27/8
basics [1] 7/14
basis [2] 5/14 17/1
be [85]
because [21] 4/11 10/25 15/15 15/22 17/9 20/1 21/23 23/16 23/18 23/24 23/25 25/19 25/20 28/13 29/22 30/11 32/20 34/16 36/1 39/5 39/15
become [2] 11/14 37/13
becomes [1] 4/21
becoming [1] 8/11
bed [1] 11/6
been [19] 3/10 8/21 9/8 14/10 14/10 15/6 15/8 20/22 32/12 33/24 36/19 38/17 38/24 39/6 39/6 39/7 39/21 40/9 42/13
before [2] 3/13 5/17
began [1] 42/7
beginning [2] 22/6 22/15
behaviour [3] 19/1 30/18 33/14
behavioural [1] 30/20
behaviours [2] 18/13 18/20
behind [1] 5/12
being [16] 2/22 4/6 9/2 9/2 14/8 15/24 16/6 16/8 18/24 20/6 21/17 26/15 29/4 32/7 35/2 35/23
belief [1] 1/12
believe [1] 14/12
Besides [1] 20/13
best [1] 1/12
between [11] 5/8 5/9 6/24 7/15 12/24 23/2 30/19 35/1 38/1 38/11 41/21
Beware [1] 33/2
beyond [2] 28/2 31/9
bits [1] 23/4
blow [1] 28/16
BMJ [1] 6/23
bodies [2] 26/21 38/12
body [1] 5/9

B

bomb [1] 28/17
boss [1] 11/5
both [6] 2/19 5/24 13/3 13/5 17/14 25/2
bottom [5] 16/20 29/25 32/3 37/25 38/23
box [5] 4/21 5/17 10/20 34/12 40/15
box' [1] 10/16
boxes [6] 5/5 7/4 7/5 11/12 27/4 34/7
branch [2] 2/1 2/3
break [1] 8/23
bridge [1] 5/7
briefly [2] 1/17 27/1
bringing [1] 6/7
British [1] 3/15
broad [3] 19/5 24/1 30/5
broader [4] 14/23 14/25 25/21 42/5
broadly [1] 18/25
brought [1] 9/8
building [1] 7/20
bullet [20] 27/21 28/1 28/4 29/11 30/3 30/8 30/25 31/15 31/18 32/3 32/21 33/2 33/20 34/23 35/6 38/22 39/12 39/18 39/19 39/23
business [2] 36/16 36/24
busy [2] 26/24 27/7
but [61]

C

call [1] 11/4
called [4] 2/1 2/3 24/18 30/15
Cambridge [2] 17/10 17/11
came [1] 3/3
can [39] 1/7 3/9 3/17 4/9 7/2 7/9 7/12 7/18 8/15 8/23 11/10 11/14 11/20 11/23 12/2 13/14 14/24 17/2 18/3 18/4 23/1 23/5 24/3 25/21 25/23 27/17 31/13 31/23 32/25 36/10 36/18 37/12 37/18 37/25 39/10 39/23 40/5 42/1 42/1
can't [9] 3/9 3/12 4/11 7/16 13/24 23/8 24/11 25/7 32/1
cannot [1] 12/9
capacity [2] 2/13 25/21
care [5] 20/6 20/7 25/2 35/21 36/14
career [2] 1/21 21/20
carer [1] 15/14
carers [3] 9/23 26/3 39/20
Carr [3] 1/3 1/6 43/4
carried [1] 33/24
carry [2] 20/9 24/5
case [2] 23/8 36/19
casualty [2] 14/2 27/7
cause [1] 19/2
certain [6] 4/12 5/19 13/25 32/8 33/11 33/11
certainly [7] 14/11 14/15 20/18 22/15 24/13 24/23 36/10
chair [7] 1/4 2/13 3/13 9/25 41/11 41/15 43/5
chaired [1] 14/9
chance [1] 12/12
change [3] 29/22 34/25 39/7
changed [6] 8/16 19/22 20/2 20/14 23/10 23/11
changes [5] 8/14 9/8 17/22 23/5 23/25
changing [2] 8/3 8/18
characteristic [1] 37/16
checked [1] 5/17
checklist [1] 5/23
children [1] 32/18
circumstance [1] 22/17
circumstances [5] 18/13 23/11 25/4 39/7 39/14
clapped [1] 20/25
clearly [1] 32/12
clinic [1] 7/5
clinical [22] 4/21 5/2 5/5 5/22 6/3 7/2 7/16 12/23 14/23 14/25 18/25 20/24 21/3 22/17 25/8 25/16 30/6 33/9 34/8 34/12 35/16 36/18
clinician [1] 24/8
clinicians [8] 5/9 5/11 7/2 7/12 10/25 11/10 17/18 29/7
close [1] 32/19
clothing [1] 33/11
coalface [1] 39/8
collateral [4] 13/17 25/13 26/1 26/10
collective [2] 42/8 42/12
college [4] 2/15 7/21 8/2 9/23
College publication [1] 7/21
columns [1] 3/21
combination [4] 5/5 5/22 12/25 34/11
combining [1] 5/1
comes [1] 28/9
coming [1] 33/5
command [1] 30/16
commenced [1] 7/25
comment [1] 14/19
commissioners [1] 40/25
commissioning [1] 8/3
committee [5] 5/7 8/15 14/9 24/10 24/15
common [2] 14/15 16/24
communication [3] 37/23 39/4 42/2
community [6] 13/21 14/10 31/20 31/25 32/2 35/11
community-based [1] 14/10
complete [1] 13/14
completes [1] 42/16
completing [1] 21/24
comply [1] 31/6
component [1] 3/25
computer [1] 11/11
concealed [1] 28/17
conceptualisation [2] 8/24 22/25
conceptualised [1] 8/5
concern [4] 7/8 9/3 18/14 24/18
concerned [3] 3/6 22/18 25/16
concerns [5] 8/5 8/7 8/8 9/2 22/24
conclude [1] 14/19
concordance [1] 31/1
condition [1] 29/23
confidentiality [2] 26/23 27/15
confined [1] 20/22
confirm [1] 41/8
consensus [3] 10/2 10/3 10/7
consider [11] 5/13 9/15 10/24 13/20 21/11 29/12 30/1 31/11 31/14 32/16 32/17
considerable [1] 26/15
consideration [2] 20/23 29/16
Considerations [1] 35/10
considered [6] 9/2 9/23 10/14 26/18 28/20 36/12
considering [4] 7/19 21/3 21/5 21/25
constantly [1] 23/19
consultant [1] 1/18
consulted [1] 39/21
contact [5] 11/5 20/24 21/4 22/17 32/9
contents [1] 1/12
context [2] 16/18 34/13
contingency [3] 12/3 12/10 20/11
continued [1] 2/9
convene [1] 11/8
convicted [1] 30/4
convinces [1] 11/17
coordinate [1] 9/25
core [2] 11/25 41/9
corner [1] 16/20
correct [23] 1/11 1/13 1/20 2/8 2/11 2/16 2/25 3/5 3/16 3/20 4/2 4/10 7/13 7/23 9/1 9/5 9/10 9/18 13/13 19/4 27/16 29/9 30/24
correctly [1] 35/8
costs [1] 8/22
could [8] 5/12 9/13 10/17 17/6 18/13 19/2 29/22 36/8
couldn't [1] 5/18
country [1] 6/13
couple [2] 12/16 14/3
course [2] 21/5 40/20
court [1] 26/2
CPA [2] 20/18 39/3
CR [1] 7/21
CR-150 [1] 7/21
CR150 [1] 38/4
create [1] 20/11
crisis [1] 8/20
critical [1] 14/16
criticising [1] 11/13
crucial [4] 5/4 25/14 34/16 39/14
culture [3] 11/9 17/16 17/17
curiosity [2] 28/9 33/6
curious [2] 28/2 28/13
cut [1] 8/22
cynical [1] 41/2
cynicism [1] 41/5

D

dangerous [2] 21/25 28/15
dangers [2] 10/15 36/7
dated [1] 1/9
day [7] 8/14 8/14 8/15 23/6 29/22 29/22 42/20
days [1] 17/23
deal [1] 22/19
dealing [2] 24/10 36/7
deals [1] 37/23
dealt [1] 24/4
debate [1] 6/24
debates [1] 6/25
December [1] 1/10
decided [1] 8/2
decisions [1] 27/9
definitely [1] 14/5
deliberately [1] 25/20
delusion [1] 30/13
delusional [1] 32/20
delusions [2] 32/11 32/14
depending [1] 22/17
depends [1] 37/3
describe [6] 5/25 7/24 10/13 18/24 26/13 35/6
described [4] 6/18 26/15 32/7 35/2
describing [6] 4/3 4/24 6/6 19/19 31/10 37/1
descriptively [1] 34/18
despite [2] 10/7 38/17
detail [1] 7/1
detailed [1] 14/6
detained [2] 31/21 31/24
deteriorates [1] 19/16
deterioration [1] 20/13
determine [1] 35/14
develop [2] 17/24 32/14
developed [1] 16/25
developing [3] 6/10 17/3 36/22
develops [1] 37/11
devise [1] 34/15
dichotomies [1] 5/8
dichotomous [1] 10/5
dichotomy [3] 6/18 10/21 12/21
did [6] 3/7 9/12 10/24 13/20 17/22 41/24
didn't [1] 40/17
difference [1] 23/2
different [13] 8/12 8/12 9/13 9/17 12/20 14/14 17/11 17/21 23/15 25/23 27/2 39/24 42/9
differently [1] 31/20
difficult [3] 41/23 41/25 42/1
difficulties [3] 26/17 26/20 28/22
direct [1] 30/19
Director [1] 1/22
disappear [1] 31/8
discharge [1] 20/10

D
discharged [1] 20/6
disclose [1] 33/9
disclosure [1] 26/20
discontinuation [1] 31/1
discussion [1] 13/24
disengagement [4] 19/24 20/8 31/2 33/4
dismissing [1] 6/15
disorder [2] 29/13 29/15
disorders [3] 1/25 2/2 6/11
Diss [2] 8/8 24/17
Dissayanaka [1] 24/17
dissemination [1] 40/8
distant [1] 36/18
disturbance [1] 37/11
divorced [1] 4/24
do [21] 1/16 5/6 7/1 9/4 18/7 21/13 22/5 22/14 22/16 26/25 27/18 28/12 30/16 32/1 34/19 35/13 38/24 40/25 40/25 41/10 42/3
doctor [1] 1/18
document [10] 2/22 21/7 21/9 21/14 35/23 36/8 37/18 38/9 39/11 39/12
documentation [1] 16/25
documents [1] 26/3
does [7] 13/9 13/10 29/16 35/12 41/5 41/20 41/22
does it [1] 13/10
doesn't [4] 24/21 31/4 41/19 42/16
doing [8] 11/1 11/2 11/15 11/17 11/18 24/7 25/19 40/24
don't [16] 1/15 7/3 14/12 18/8 22/13 25/18 28/5 28/21 28/24 28/24 28/25 29/3 36/10 39/11 41/8 41/13
done [3] 17/24 24/8 40/9
doubt [1] 25/6
down [5] 7/18 8/23 18/3 24/3 40/5
Dr [2] 8/8 24/17
Dr Diss [2] 8/8 24/17
dramatic [1] 23/22
drastically [1] 23/10
dressed [1] 33/11
drugs [2] 7/6 23/12
During [1] 1/21
duty [1] 36/20
dynamic [8] 8/14 8/25 9/3 22/21 23/1 23/2 23/24 37/8
dynamism [1] 8/17

E
Each [1] 37/15
earlier [2] 28/10 29/20
early [3] 3/13 37/1 37/6
eating [3] 1/25 2/2 6/11
ECG [1] 22/10
echoes [1] 12/15
Effective [1] 37/3
either [1] 25/19
elaborate [1] 14/24
element [3] 23/13 36/11 36/13
elevated [1] 31/12
eliminated [1] 12/9
else [3] 24/11 25/7 35/17
embedding [2] 14/22 14/24
embeds [1] 17/17
emergency [2] 13/16 13/22
emphasis [1] 6/2
emphasise [1] 26/5
emphasised [1] 3/1
emphasising [1] 3/18
end [3] 3/3 22/6 22/16
endorsed [1] 13/2
endoscope [4] 16/9 16/10 16/11 24/21
engineering [1] 5/16
enhance [1] 10/17
enjoy [1] 37/15
entitled [1] 7/21
Environment [2] 31/15 32/4
epilepsy [1] 29/3
equal [1] 23/18
equally [2] 5/19 7/10
essentially [4] 3/3 13/12 32/22 34/3
established [2] 15/23 24/9
ether [2] 31/9 42/13
evaluate [2] 16/15 23/13
evaluation [2] 6/3 20/20
eventual [1] 23/21
ever [1] 22/1
every [15] 6/13 20/18 20/18 20/23 20/25 21/3 21/16 21/16 22/8 22/9 22/15 22/16 23/19 29/20 39/3
everyone [1] 39/20
everyone's [2] 36/15 36/24
everything [2] 5/19 27/5
evidence [7] 3/6 5/14 12/17 13/8 24/16 26/18 37/19
evolving [3] 8/4 29/12 29/15
exactly [5] 4/13 4/17 8/8 9/10 17/9
examination [6] 4/22 4/25 5/3 6/3 6/8 25/17
example [13] 7/7 11/2 13/5 21/19 23/12 28/15 29/1 29/4 30/12 33/8 36/18 37/9 37/10
examples [1] 5/16
expand [1] 23/1
expected [1] 20/22
experience [3] 5/22 24/10 36/18
expert [2] 2/14 24/17
experts [1] 9/11
explain [2] 23/2 40/10
explained [2] 12/20 32/24
expressions [1] 19/17
extent [2] 6/20 31/23
extreme [1] 10/20
extremely [1] 21/22
extremes [4] 5/9 6/24 10/9 12/21
eyes [1] 21/1

F
face [1] 28/2
fact [4] 13/14 23/9 41/14 41/16
factors [12] 30/1 31/14 31/16 33/3 33/4 33/7 33/15 33/18 33/21 35/13 37/5 37/5
fairly [1] 39/9
false [4] 4/8 4/8 15/4 15/5
fame [1] 6/9
family [2] 26/3 32/13
far [7] 8/23 9/6 17/13 17/24 18/2 22/18 25/15
Farnill [1] 1/8
fashioned [1] 39/15
favour [2] 3/18 5/4
features [1] 30/21
feel [1] 30/13
feeling [1] 41/2
fellow [1] 40/23
felt [2] 5/10 5/11
female [1] 21/21
few [3] 6/18 22/23 33/18
field [2] 19/5 29/7
files [1] 27/4
fill [1] 34/16
filled [1] 23/7
filling [2] 10/25 11/12
filter [1] 40/18
filtered [1] 40/19
final [5] 3/22 4/19 33/2 39/17 39/19
finally [3] 22/18 26/13 41/7
find [3] 11/6 37/11 41/24
finding [2] 12/10 12/15
findings [1] 11/22
first [6] 21/24 30/2 30/2 30/15 31/15 32/21
firstly [2] 23/24 31/4
five [2] 6/12 34/7
flawed [3] 3/23 4/4 4/7
focus [1] 37/8
Focused [1] 38/10
focuses [1] 2/12
following [3] 9/6 40/7 42/20
forensic [6] 14/11 15/7 16/13 16/14 19/8 27/1
forget [1] 7/14
form [7] 7/16 10/4 17/4 17/6 17/25 21/24 23/7
formal [2] 20/18 21/16
forms [5] 6/5 10/16 11/1 16/21 16/25
formulated [1] 35/13
formulating [1] 34/18
formulation [4] 27/20 34/1 34/14 37/4
formulations [1] 34/17
forward [3] 15/24 16/19 38/21
Foundation [1] 1/22
four [2] 20/21 27/6
four years [1] 20/21
fourth [1] 30/25
fragmentation [2] 9/4 42/4
fragmented [1] 8/11
frequency [1] 12/2
frequently [1] 20/15
Friday [2] 14/4 23/19
front [3] 11/11 12/5 27/9
full [1] 1/7
fuller [1] 2/22
fun [1] 6/24
function [1] 11/25
fundamental [2] 3/25 4/15
further [2] 9/6 22/24
furthermore [1] 8/19
future [1] 15/8

G
gain [1] 25/21
gaining [1] 25/22
gastroenterologist [1] 16/11
gathering [2] 25/10 37/21
general [5] 15/9 15/10 15/15 38/22 40/18
generally [1] 4/6
George's [1] 2/6
get [11] 8/13 11/5 11/6 16/10 25/23 27/2 27/4 31/7 34/10 41/24 41/25
getting [2] 9/11 26/20
give [3] 18/13 21/19 37/14
given [3] 24/16 27/19 37/19
giving [1] 24/21
go [13] 4/23 12/7 12/7 16/19 17/19 27/5 27/18 27/19 31/13 33/20 34/23 37/18 38/21
goal [1] 42/9
going [12] 1/17 10/11 13/18 13/21 16/22 22/8 30/14 30/17 33/20 39/4 39/13 42/10
gone [2] 30/4 35/13
good [4] 5/14 14/17 15/21 34/18
got [6] 5/20 14/1 14/3 22/9 34/19 34/20
GP [10] 16/10 16/10 20/7 26/2 27/5 38/24 38/25 39/1 39/4 39/15
GPs [3] 39/4 39/8 39/14
great [2] 11/4 27/4
greatest [1] 6/9
ground [1] 10/11
grounds [2] 13/12 20/7
group [14] 2/14 2/19 3/14 8/1 9/15 9/16 9/25 10/14 11/22 12/7 13/20 26/18 31/16 38/18
groups [1] 26/21
guidance [4] 2/14 3/10 9/7 27/19
guide [8] 2/19 2/23 3/13 13/3 27/22 40/7 40/17 40/23

H
had [24] 3/10 3/14 5/20 6/16 9/8 9/10 9/22 10/4 14/10 14/11 15/6 15/10 17/11 27/1

H

had... [10] 27/9 29/8 32/10 32/10 33/7 33/18 40/22 40/22 41/2 41/3
hadn't [3] 9/8 14/9 15/8
hair [1] 39/5
half [1] 29/25
Halifax [1] 42/11
hallucination [1] 30/16
hand [3] 4/19 5/25 16/20
happen [2] 17/19 28/12
happened [2] 27/11 33/12
happening [1] 39/9
hard [1] 8/13
harder [1] 17/13
harm [2] 18/14 19/3
has [17] 6/16 7/6 7/14 8/9 13/8 21/18 24/22 24/23 27/24 32/1 32/15 33/24 36/1 36/3 36/14 38/24 42/12
have [58]
haven't [2] 32/24 39/6
having [5] 17/15 27/8 35/13 36/5 38/17
HCR [10] 13/6 13/9 13/17 13/21 14/5 14/9 14/19 15/3 16/3 16/12
HCR-20 [7] 13/6 13/9 13/17 13/21 14/9 14/19 15/3
he [1] 24/17
heading [3] 16/21 29/25 31/14
health [9] 5/8 7/22 11/8 17/15 22/11 38/2 38/11 38/12 40/24
healthcare [1] 24/9
heard [1] 13/8
hearing [1] 42/20
heart [1] 21/23
heighten [1] 32/25
heightening [1] 35/3
held [2] 2/5 2/17
help [1] 3/9
helpful [3] 6/5 6/21 17/23
here [2] 19/19 32/7
hidden [1] 5/12
high [2] 29/21 34/5
higher [1] 33/22
highlighted [2] 28/7 38/17
his [2] 24/18 28/17
historic [1] 8/13
history [3] 7/6 15/12 30/2
hobbies [2] 34/11 37/14
hold [4] 8/13 25/8 25/24 27/4
holistic [1] 34/4
Honorary [1] 2/5
Honour [2] 41/22 42/2
hoped [1] 9/9
hospital [4] 2/6 11/6 11/6 27/8
hours [2] 11/11 14/4
household [1] 32/19
how [10] 8/5 16/17 16/18 20/15 22/3 24/21 29/16 34/10 35/12 35/13
However [1] 22/7
huge [1] 27/4
hunch [2] 5/20 5/21
husbands [1] 32/15

I

I adopted [1] 6/23
I balance [1] 7/11
I began [1] 42/7
I can [1] 8/23
I can't [4] 3/12 13/24 24/11 25/7
I certainly [1] 14/15
I chaired [1] 14/9
I do [2] 1/16 7/1
I don't [1] 41/13
I had [1] 33/18
I have [1] 21/13
I just [1] 41/16
I left [1] 20/21
I may [1] 41/3
I mean [1] 37/10
I now [1] 18/3
I think [17] 6/22 7/4 8/8 14/16 20/21 21/9 23/4 24/8 24/16 24/17 24/20 28/9 29/18 29/20 40/19 42/4 42/16
I understood [1] 15/6
I want [1] 27/18
I was [8] 5/6 27/7 28/10 28/11 29/19 33/9 37/20 41/1
I would [2] 21/20 21/24
I'll [2] 22/10 33/8
I'm [13] 1/8 1/17 3/12 4/6 5/4 6/15 6/15 11/13 15/20 18/2 22/7 22/8 24/25
I've [4] 25/6 32/10 33/7 35/7
idea [2] 17/6 34/6
ideation [2] 19/17 32/20
identified [3] 32/6 38/3 39/24
identifies [1] 37/4
identify [1] 34/7
identity [1] 33/17
if [49]
ill [2] 25/20 31/5
illness [3] 30/11 30/12 31/7
imagine [1] 16/8
immediately [2] 22/13 23/16
imminent [1] 37/17
impediments [1] 26/14
implies [1] 31/4
importance [4] 5/1 14/21 19/25 25/10
important [5] 5/13 28/7 29/1 29/5 36/23
impossible [1] 28/19
impression [1] 40/11
improve [1] 38/10
include [6] 18/18 18/25 24/24 33/4 35/7 36/14
includes [1] 41/18
including [3] 5/2 12/1 27/5
incorrect [1] 41/3
increased [3] 19/22 20/4 20/15
increasing [1] 24/18
increasingly [1] 42/5
Indeed [1] 18/22
indication [2] 19/24 31/24
indications [1] 20/13
indicative [1] 23/21
indicator [1] 37/13
indirectly [1] 19/2
individual [4] 22/14 33/11 33/16 37/15
individuals [3] 32/6 32/16 33/7
industry [1] 5/15
inevitably [1] 4/7
influence [1] 30/17
information [26] 8/13 9/13 10/14 13/17 25/10 25/13 25/22 26/1 26/6 26/10 26/11 26/14 26/18 26/22 27/2 29/10 33/10 34/19 37/20 37/21 37/23 38/1 38/11 41/18 41/24 41/25
informed [6] 9/12 38/24 39/1 39/9 39/21 40/3
initially [2] 2/1 2/3
innumerate [1] 3/24
input [1] 9/22
Inquiry [4] 1/9 2/12 8/9 13/8
instance [1] 31/19
instead [2] 11/9 15/12
instrument [7] 4/9 14/17 15/2 15/18 16/6 17/14 24/22
instruments [1] 17/21
integral [1] 36/4
integrated [1] 35/20
intention [1] 3/11
internal [1] 42/7
interpret [1] 16/18
interpretation [2] 30/5 41/4
interview [1] 25/16
intimidation [1] 19/2
into [6] 6/13 11/6 17/17 31/8 35/20 36/11
intrinsic [2] 29/22 41/6
investigated [1] 30/3
involve [2] 26/10 26/11
involved [3] 9/19 24/12 40/8
involvement [1] 3/2
involves [1] 16/1
irrelevant [2] 11/13 22/2
is [97]
isn't [7] 8/16 12/17 16/16 16/16 17/23 29/19 38/5
isolated [1] 37/14
issue [3] 27/12 27/12 38/3
issues [4] 21/3 26/23 27/15 35/3
it [82]
it's [26] 3/17 8/13 9/15 11/20 12/17 12/21 14/17 14/18 16/19 16/20 18/6 18/22 19/5 22/19 24/20 27/3 28/13 29/22 29/25 34/6 34/11 36/15 36/19 36/23 36/25 41/7
its [4] 1/12 15/1 15/1 16/18
itself [2] 8/14 10/4

J

job [1] 34/10
John [4] 1/4 1/5 1/8 43/3
joined [1] 8/11
joined-up [1] 8/11
Journal [1] 3/15
journalistic [1] 6/22
judgement [10] 7/2 7/13 7/16 10/18 10/23 12/24 15/24 17/7 24/1 35/17
judgment [1] 12/25
just [7] 19/8 23/1 23/20 36/5 39/23 41/16 41/17

K

kept [1] 21/25
key [4] 11/21 12/10 12/15 38/3
kill [2] 30/14 32/11
kind [1] 17/6
know [16] 17/18 24/21 28/5 28/21 28/23 28/23 28/23 28/24 28/24 28/25 29/3 29/21 30/13 34/7 37/14 42/3
knowledge [1] 1/12
known [2] 36/14 39/15
knows [1] 16/17

L

lack [3] 8/11 25/20 42/1
languages [1] 6/14
large [1] 6/20
later [7] 2/2 8/9 18/22 21/20 22/7 23/9 28/17
lead [1] 16/22
learning [1] 29/10
least [1] 17/22
Lecturer [1] 2/6
Leeds [1] 1/22
left [6] 3/21 4/19 20/21 37/25 41/1 41/25
left-hand [1] 4/19
length [1] 27/25
less [1] 24/19
let's [2] 16/9 17/9
level [4] 19/21 20/1 20/14 42/6
liaison [3] 2/1 2/4 27/7
life [1] 33/13
light [1] 8/3
like [4] 16/6 16/8 24/20 34/12
likely [2] 31/6 31/7
likewise [1] 27/3
limitation [1] 4/14
limitations [3] 6/16 15/2 25/15
limited [3] 7/4 13/16 18/15
link [1] 30/19
linked [1] 29/11
listed [2] 9/19 25/25
literature [1] 9/23
little [1] 26/24
live [1] 34/9
living [1] 32/17
Local [1] 16/21
locally [1] 16/25
London [2] 23/17 27/8
long [2] 13/14 29/7
longitudinal [6] 17/12 17/16 23/14

L

longitudinal... [3] 23/23 24/1 31/9
look [6] 3/21 12/15 23/14 28/2 37/7 37/25
looked [1] 10/12
looking [2] 4/9 15/3
lost [2] 8/21 42/13
lot [2] 14/12 27/1
lots [4] 14/14 23/15 27/2 27/2
low [3] 21/22 23/8 34/4
lower [1] 35/4

M

machete [1] 23/17
made [3] 9/16 12/16 33/16
magnified [1] 8/10
mainly [1] 3/6
make [8] 11/4 12/8 19/6 22/19 23/25 35/16 35/19 36/25
making [3] 15/21 21/10 28/10
man [1] 7/6
managed [1] 8/6
management [17] 5/14 9/3 11/25 34/15 34/25 35/6 35/15 35/20 36/1 36/20 36/23 37/1 37/3 38/22 39/2 39/19 40/21
managing [1] 36/15
manifesto [1] 5/25
many [4] 14/13 25/23 39/16 40/19
MAPPA [1] 8/15
market [1] 42/7
materialises [1] 12/13
mathematics [1] 4/7
may [19] 8/16 15/12 15/14 19/21 19/22 20/1 20/4 20/14 20/14 23/15 23/17 26/21 29/2 31/16 33/6 33/11 33/13 41/3 41/6
maybe [1] 11/10
me [3] 32/11 32/11 32/13
mean [2] 14/24 37/10
measures [1] 5/10
measuring [1] 4/11
medical [7] 1/18 1/21 2/7 3/15 11/25 16/8 26/1
medication [2] 11/8 39/7
medicine [2] 4/1 4/16
medicolegal [2] 2/10 27/3
medium [1] 34/5
meeting [4] 20/18 21/16 39/3 39/6
member [1] 36/21
members [1] 26/3
memories [1] 33/12
memory [1] 21/16
mental [16] 4/24 5/8 7/22 11/8 25/21 30/9 30/11 30/12 30/20 30/22 31/7 32/6 32/21 38/2 38/11 38/12
mentally [1] 25/20
might [16] 10/11 11/2 13/16 14/2 14/4 16/15 16/25 21/2 23/10 23/11 28/11 31/8 31/20 32/19 33/15 37/10
mind [2] 36/5 42/9
minute [1] 6/15
minutes [2] 11/10 14/2
misdirected [1] 3/24
missing [1] 24/25
moments [2] 6/18 22/23
Monday [1] 1/1
more [8] 3/1 6/5 6/21 14/5 22/10 23/22 29/2 33/21
Morgan [6] 1/4 1/5 1/8 19/19 27/18 43/3
morning [4] 14/2 27/6 37/12 42/17
most [5] 4/20 14/15 28/14 28/25 40/20
mother [2] 11/5 34/10
move [2] 29/6 29/24
moves [1] 41/23
Mr [3] 1/3 1/6 43/4
Mr Carr [3] 1/3 1/6 43/4
much [8] 6/24 23/6 25/22 29/3 39/8 40/6 42/15 42/18
multidisciplinary [1] 20/19
must [1] 35/20
my [13] 6/9 6/9 13/24 17/23 21/16 21/17 21/19 21/20 22/6 24/10 36/18 41/6 41/11
mémoire [6] 2/23 6/10 7/8 7/12 7/15 11/14
mémoires [4] 6/5 6/15 6/21 7/4

N

name [1] 1/7
national [1] 17/4
nature [2] 21/2 21/17
necessarily [3] 16/3 22/16 26/23
necessary [6] 6/17 7/7 19/11 20/8 21/15 35/11
need [22] 6/2 6/4 7/3 7/11 9/6 16/24 19/14 22/24 22/25 23/14 23/14 23/22 24/14 26/5 28/19 30/5 31/5 33/6 33/16 38/24 39/9 39/12
needed [3] 7/14 11/19 38/10
needs [1] 24/8
negative [1] 12/1
negatives [2] 4/8 15/5
nervosa [1] 21/21
networks [1] 16/21
never [1] 4/9
new [7] 19/11 19/13 19/20 29/10 29/10 29/13 29/15
next [11] 1/4 8/16 16/23 17/2 23/6 29/24 30/8 31/13 33/25 34/14 34/23
NHS [9] 1/19 1/21 1/22 8/4 17/23 20/21 41/18 42/8 42/13
night [1] 23/19
no [12] 3/12 4/6 6/22 13/11 14/16 18/2 18/17 23/5 25/6 40/22 40/22 41/13
nodded [1] 9/21
none [1] 11/12
nonetheless [3] 4/16 21/23 22/2
not [28] 5/23 6/15 6/17 7/7 11/13 12/23 13/9 13/17 13/17 15/14 16/3 18/2 18/15 18/25 19/8 20/22 22/4 22/8 28/19 29/2 30/22 31/6 33/20 34/4 35/10 36/4 36/8 37/4
nothing [2] 6/5 6/21
notion [1] 33/5
Nottingham [2] 17/10 17/12
notwithstanding [1] 4/14
now [15] 3/1 4/3 6/12 7/19 9/15 10/11 13/8 18/3 22/9 24/3 30/2 35/19 40/5 42/6 42/9
number [12] 9/16 9/17 11/23 15/4 15/5 25/25 27/11 27/21 27/24 33/15 33/19 35/5
number 1 [1] 11/23
nurses [2] 24/24 25/3
nursing [1] 24/13

O

o'clock [1] 27/6
objectively [1] 25/19
obscure [1] 10/17
obscuring [1] 10/23
observed [1] 10/25
obtain [1] 41/17
obtaining [4] 25/14 26/10 26/14 26/17
obviously [2] 23/5 29/18
occasionally [1] 22/3
occupational [2] 24/13 24/24
off [3] 5/18 23/22 28/18
offenders [1] 15/7
offending [2] 15/8 15/11
often [4] 4/24 17/21 25/18 37/16
Okay [2] 18/3 40/5
old [3] 15/13 21/21 39/15
old-fashioned [1] 39/15
on [57]
once [3] 3/1 33/24 34/14
one [26] 4/9 5/23 6/16 7/16 8/15 9/10 10/20 12/22 12/23 14/3 14/13 14/15 17/11 17/15 17/20 23/4 23/6 23/22 26/25 28/10 32/1 32/15 36/11 36/12 37/15 41/16
one-off [1] 23/22
ones [1] 28/15
ongoing [1] 8/5
only [4] 18/15 18/25 25/21 37/4
onto [1] 16/22
open [4] 23/9 28/13 29/4 29/9
operating [2] 5/20 42/7
opinion [2] 16/14 22/6
or [38] 3/9 5/2 5/23 7/16 11/5 12/2 12/7 14/13 16/5 17/22 18/13 18/20 19/2 19/8 19/17 20/15 24/12 25/20 26/2 26/3 26/17 29/13 29/15 29/16 30/4 30/22 31/1 32/15 35/10 35/14 35/17 36/22 37/13 39/2 39/2 39/7 40/9 41/24
order [2] 6/14 35/11
organisation [1] 42/8
organisations [1] 42/10
original [1] 19/21
other [10] 5/15 14/13 15/18 24/25 26/21 26/21 30/11 41/12 41/18 41/25
others [5] 2/20 7/22 18/8 18/14 40/10
otherwise [1] 17/9
our [2] 24/10 28/18
out [16] 1/14 10/25 11/12 11/21 14/14 15/13 17/3 20/9 21/9 23/7 24/5 24/25 33/24 34/17 39/5 40/12
outcome [2] 36/9 39/2
outcomes [5] 4/12 7/10 12/1 12/9 35/14
Outreach [4] 8/20 24/16 24/19 35/12
outstanding [1] 38/19
over [6] 10/11 26/5 30/4 33/18 35/5 39/17
overall [1] 35/20
overly [1] 10/15
overly-simplistic [1] 10/15
own [3] 13/24 21/19 33/17
ownership [1] 42/12

P

page [25] 4/18 11/21 16/19 16/23 18/6 18/23 26/5 27/18 27/24 29/24 29/24 29/25 31/13 31/13 33/25 33/25 34/23 35/5 35/5 37/18 38/21 39/11 39/17 39/17 43/2
page 25 [1] 16/19
page 30 [1] 37/18
page 35 [1] 27/18
page 36 [1] 29/24
page 37 [1] 31/13
page 38 [1] 33/25
page 39 [1] 38/21
page 40 [1] 39/17
page 5 [1] 18/6
page 6 [1] 11/21
page 60 [1] 35/5
pages [1] 33/19
paper [1] 38/5
paragraph [21] 3/21 4/19 4/23 5/24 7/24 10/13 12/7 12/8 14/18 14/19 18/11 18/22 18/23 19/6 22/19 25/13 25/25 26/5 26/13 37/25 41/7
paragraph 14 [1] 7/24
paragraph 17 [1] 10/13
paragraph 24 [1] 18/11
paragraph 25 [1]

P

paragraph 25... [1] 19/6
paragraph 26 [1] 22/19
Paragraph 27 [1] 25/13
paragraph 28 [1] 25/25
paragraph 29 [1] 26/5
paragraph 30 [1] 26/13
paragraph 45 [1] 14/18
paragraph 49 [2] 18/22 18/23
paragraph 74 [1] 41/7
paragraphs [4] 17/2 18/1 18/7 25/9
paragraphs 24-26 [1] 18/7
paragraphs 27 [1] 25/9
paranoid [1] 30/13
part [6] 6/24 19/7 20/9 20/16 30/22 37/8
participating [1] 11/16
particular [1] 10/15
particularly [3] 19/11 32/5 38/1
partnership [1] 1/22
parts [1] 41/18
patient [30] 2/14 11/3 11/11 15/11 15/16 17/9 18/12 19/11 19/14 19/16 19/20 20/6 20/19 21/10 21/18 22/2 22/15 25/2 26/9 27/9 29/21 31/16 34/13 36/2 36/2 36/5 36/15 36/22 37/16 39/15
patient's [1] 38/24
patients [11] 9/22 14/10 14/11 17/1 20/25 25/18 28/11 32/10 33/8 33/10 39/5
people [16] 6/14 7/9 9/10 9/12 10/4 15/18 22/4 30/10 30/11 30/13 32/8 32/14 32/19 34/16 40/20 41/1
perfect [1] 4/9
perhaps [2] 28/25 33/10
person [8] 7/6 11/16 22/8 30/15 31/4 32/9 35/12 36/12
person's [2] 23/10 30/19
personality [1] 41/6
persuade [1] 11/6
philosophically [2] 28/22 36/10
philosophies [1] 8/19
phone [1] 11/4
physical [2] 19/1 22/11
picked [1] 33/18
picture [3] 24/2 25/14 25/22
pilot [1] 5/16
place [1] 2/5
plan [12] 12/12 20/11 34/15 34/21 34/25 35/6 35/20 35/21 36/14 37/6 39/2 39/19
plane [2] 5/18 5/20
planning [3] 12/3 12/10 37/3
plans [1] 35/14
plausibly [1] 18/13
please [11] 1/7 4/18 11/21 16/19 18/5 29/24 31/13 33/25 37/18 38/21 40/5
pleasure [1] 27/4
pleasures [1] 26/25
pm [2] 1/2 42/19
point [29] 3/1 11/23 12/8 12/16 19/6 20/24 21/9 21/17 22/19 24/20 28/1 28/4 28/9 29/11 30/3 30/8 30/25 32/3 32/21 33/2 33/21 34/24 35/19 36/25 38/23 39/12 39/18 39/19 39/23
points [7] 20/13 23/15 27/21 31/15 31/18 33/20 35/6
police [3] 26/2 38/2 38/11
policies [1] 9/14
policy [1] 3/3
political [1] 42/6
politically [1] 5/6
Poor [1] 31/1
population [5] 14/7 15/7 15/9 15/10 15/17
position [4] 3/7 8/16 9/7 14/12
positions [1] 10/6
positives [2] 4/8 15/5
possibility [1] 29/10
possible [1] 25/22
possibly [1] 25/23
post [1] 3/13
potential [2] 25/25 32/5
potentially [1] 33/9
practical [2] 29/2 30/12
practicality [1] 13/12
practice [10] 3/19 6/18 9/8 10/17 15/21 19/8 20/20 21/19 30/6 40/18
practised [1] 29/8
practitioners [2] 2/24 12/1
Precisely [2] 12/14 31/22
predecessor [1] 38/5
predict [1] 15/7
predicting [1] 22/4
predominantly [1] 16/12
preoccupation [1] 32/8
prepared [2] 1/9 2/12
present [3] 31/20 33/22 39/22
presentation [3] 29/13 29/15 31/24
presents [3] 18/12 23/16 31/3
pressures [1] 13/22
prevent [1] 7/9
previous [2] 7/20 30/3
primary [1] 20/7
prime [1] 5/16
principle [1] 22/12
principles [4] 38/22 40/12 40/17 41/9
probably [1] 24/25
probation [1] 26/2
procedure [1] 16/9
process [14] 4/7 4/20 4/21 6/6 6/8 10/1 11/16 14/23 14/25 18/4 20/9 27/20 31/10 39/2
processes [4] 3/23 4/3 4/4 8/17
produce [1] 10/1
produced [2] 2/19 6/19
professional [6] 1/14 10/17 10/23 12/25 15/23 17/7
professionals [4] 24/6 24/9 39/20 39/24
Professor [6] 1/4 1/5 2/6 19/19 27/18 43/3
Professor at [1] 2/6
Professor John [1] 1/4
Professor Morgan [2] 19/19 27/18
promise [1] 14/12
properly [2] 5/21 23/13
protective [1] 37/5
psychiatric [4] 3/19 19/13 25/3 40/18
psychiatrist [8] 1/18 16/15 25/6 27/1 27/7 29/2 29/20 36/20
psychiatrists [12] 9/16 9/19 16/13 24/11 24/25 25/3 26/6 27/24 28/8 40/19 40/21 40/23
psychiatry [10] 1/25 2/1 2/4 2/15 3/23 3/25 4/15 6/2 6/19 19/8
psychosis [2] 29/16 32/22
psychotic [4] 29/21 32/12 32/14 32/25
public [2] 36/3 36/6
publication [7] 3/4 3/7 3/11 7/21 9/7 9/9 40/7
published [1] 3/14
pull [1] 39/5
punched [1] 23/19
purely [2] 12/22 12/23
purpose [2] 36/4 37/21
purposes [1] 25/10
put [5] 15/24 18/4 27/17 32/13 36/11

Q

qualified [2] 24/9 24/19
qualitative [1] 38/3
quality [1] 16/21
quasi [1] 42/6
quasi-political [1] 42/6
question [3] 21/13 22/5 41/16
Questioned [4] 1/6 41/15 43/4 43/5
questions [7] 6/12 22/12 37/20 41/11 41/12 41/13 41/14
quite [3] 22/1 23/10 37/16
quote [1] 38/8

R

range [1] 39/24
rapidly [1] 39/9
rapport [1] 36/22
rare [2] 28/19 36/19
rather [3] 10/17 22/21 35/23
reached [2] 10/7 10/8
read [3] 17/3 39/10 39/11
readily [1] 26/22
realise [1] 29/2
really [5] 5/13 16/7 24/11 28/14 40/21
reason [3] 3/9 19/21 23/22
reasons [2] 3/9 31/11
receiving [1] 25/2
recognise [1] 6/16
recognised [1] 4/14
recommend [2] 13/9 14/13
recommendation [1] 15/20
recommendations [1] 11/22
recommended [2] 16/6 17/25
records [3] 26/1 26/2 27/5
reduce [1] 36/3
reduced [1] 12/2
reduces [1] 12/12
Reed [1] 28/16
refer [5] 4/23 10/11 10/14 16/10 27/14
referred [2] 13/5 22/25
referring [3] 4/5 8/24 32/22
reflect [1] 41/6
reflecting [1] 10/1
reflects [1] 11/23
regular [1] 22/22
relapse [1] 37/6
relation [2] 39/18 41/17
Relationship [1] 30/8
relative [1] 27/10
release [1] 31/17
relevant [7] 20/24 26/22 29/19 30/9 30/22 33/16 41/9
reliable [2] 5/12 31/24
reliance [1] 24/19
relied [2] 7/9 32/1
relies [2] 12/22 12/23
reluctant [1] 26/21
rely [3] 5/21 7/3 25/16
remain [2] 41/5 41/9
remained [2] 38/18 40/15
remains [4] 3/24 16/24 23/8 38/15
remember [1] 13/24
remembered [1] 5/19
remit [1] 24/15
repeated [1] 23/20
report [27] 2/19 2/22 3/4 5/7 6/19 7/19 9/20 10/1 11/20 13/3 13/6 13/9 14/21 15/21 16/19 27/17 37/22 38/13 38/13 38/14 40/2 40/9 40/10 40/12 40/21 41/2 41/9
reported [2] 8/9 38/4
reports [2] 9/12 26/2
reposition [1] 6/4
required [1] 8/3
requires [1] 22/22
requiring [1] 31/18
resource [1] 27/12
respect [1] 15/22
responses [1] 38/3
responsibility [4]

R

responsibility... [4] 25/8 36/12 36/13 42/12
responsible [3] 25/4 25/7 36/21
restricted [1] 31/17
resumed [1] 23/11
Rethinking [1] 7/22
retirement [1] 2/9
retiring [1] 1/18
return [2] 6/2 21/13
review [3] 20/19 21/14 22/22
reviewed [1] 20/16
revised [1] 3/10
revision [1] 8/2
rhetorical [1] 6/22
Richard [1] 28/16
right [2] 5/25 16/20
right-hand [2] 5/25 16/20
ring [1] 27/10
rise [1] 18/14
risk [140]
risk factors [3] 33/3 33/15 37/5
risks [6] 22/13 28/14 28/19 32/16 36/3 39/21
role [4] 2/17 9/25 14/5 16/14
room [1] 10/5
route [1] 35/18
routine [3] 13/10 19/7 20/17
Royal [2] 2/15 7/20
run [2] 23/16 36/1

S

safety [3] 2/14 35/1 36/6
said [1] 40/8
same [6] 4/23 8/8 12/7 12/8 13/22 17/14
say [5] 16/9 16/16 17/10 18/11 25/13
saying [2] 6/16 7/5
says [2] 23/7 38/14
schizophrenia [1] 29/16
School [1] 2/7
screen [8] 6/14 11/12 12/5 18/5 19/6 22/18 24/3 27/17
screening [1] 6/11
second [8] 3/21 4/18 16/22 22/20 23/13 30/15 34/23 38/9
secondary [1] 20/6
secondly [2] 23/25 31/6
section [6] 18/5 27/22 32/4 33/2 35/7 37/22
secure [1] 19/8
see [8] 5/24 11/23 17/2 18/7 21/10 34/23 38/8 39/23
seeing [2] 22/7 28/11
seek [3] 16/14 26/6 34/25
seeking [1] 26/11
seemed [1] 15/11
seems [2] 22/1 40/2
seen [1] 36/20
Senior [1] 2/5
sense [6] 9/10 14/16 29/2 42/4 42/6 42/12
sensible [1] 12/3
sensitivity [1] 15/4
sentence [4] 3/22 16/22 22/20 38/9
separated [2] 4/21 36/17
separately [2] 30/10 34/8
series [1] 6/25
service [1] 8/4
services [8] 7/22 8/10 8/20 9/4 26/24 38/2 42/4 42/5
set [3] 1/14 5/18 40/12
sets [1] 11/21
setting [5] 13/16 13/21 13/23 21/9 31/16
settings [5] 13/25 17/14 19/9 31/17 36/19
seventh [1] 29/11
severe [1] 23/21
share [1] 26/22
sharing [5] 26/14 37/19 37/23 38/1 38/10
shoes [2] 28/17 28/18
should [21] 5/10 5/21 12/5 16/17 18/8 19/7 20/15 22/14 24/5 24/12 25/4 25/6 25/7 34/25 35/7 35/16 37/6 39/1 39/3 40/2 40/24
sic [2] 8/9 35/5
side [2] 4/19 5/25
significance [1] 35/25
signs [3] 6/3 37/1 37/6
silos [2] 36/11 42/5
similar [1] 39/17
simple [1] 6/11
simplistic [2] 6/12 10/15
simply [6] 7/13 15/15 26/24 34/4 35/3 40/23
since [3] 2/9 8/10 40/9
single [5] 17/25 20/24 21/3 23/21 42/9
sit [1] 8/15
sitting [1] 7/5
situation [1] 8/18
sixth [1] 28/4
sleep [1] 37/11
slightly [1] 41/2
smaller [1] 23/20
so [74]
social [4] 24/13 24/24 34/13 38/2
solely [2] 24/10 25/16
some [10] 5/7 12/1 20/25 26/13 27/19 29/18 30/10 36/19 37/11 37/19
somebody [1] 41/23
someone [9] 16/17 23/5 23/16 23/19 24/21 24/23 27/6 31/11 37/10
something [9] 5/11 11/2 11/2 11/15 11/17 29/19 30/17 33/12 34/19
sometimes [1] 21/5
somewhat [1] 42/13
sorry [2] 3/12 33/8
sort [1] 42/6
sorts [3] 6/13 10/5 28/19
sources [4] 25/23 26/1 26/7 27/3
speak [3] 24/11 25/7 38/25
specialised [1] 14/6
specialities [2] 9/17 25/1
speciality [1] 1/25
specific [6] 4/4 15/11 15/17 20/13 33/6 33/7
specificity [1] 15/4
specify [1] 37/6
spend [1] 11/10
spoke [1] 24/17
St [1] 2/6
staff [2] 24/13 24/19
stage [1] 34/14
stages [2] 21/20 22/7
stand [1] 36/8
standalone [1] 35/23
standard [2] 17/1 17/7
standardised [1] 17/4
start [4] 1/7 7/19 27/14 42/17
starting [1] 16/21
state [10] 3/22 4/25 6/1 9/22 30/9 30/20 30/22 32/6 32/21 37/2
statement [19] 1/9 1/14 2/12 3/2 7/24 10/13 12/20 13/5 14/18 18/5 18/7 18/22 18/24 25/9 32/24 35/19 36/25 40/11 41/7
states [1] 38/9
static [3] 8/25 22/21 23/2
stating [1] 14/20
statistics [1] 15/3
statutory [1] 40/22
stay [1] 18/23
still [2] 31/13 36/8
stop [1] 33/9
strategies [1] 38/10
stratification [1] 14/1
streets [1] 23/17
stressed [1] 14/21
striking [1] 15/13
stripping [1] 8/21
structured [5] 12/18 12/24 15/23 17/7 37/4
structures [1] 8/4
student [2] 21/21 26/9
style [1] 6/22
substitute [2] 11/1 11/15
substituting [1] 11/18
succinct [1] 39/12
such [6] 10/16 14/4 15/2 16/16 33/4 35/10
sudden [1] 21/22
sufficient [4] 6/17 7/3 7/7 8/17
suggested [1] 17/25
suggesting [1] 40/2
suggestion [1] 17/3
suitably [1] 24/12
summarise [2] 1/17 23/24
summary [1] 39/12
supervision [2] 14/22 35/17
support [1] 35/18
surprised [1] 22/3
survey [2] 4/24 38/4
surveys [1] 9/23
sworn [2] 1/5 43/3
symptoms [4] 6/4 18/12 32/22 32/25
systematic [1] 6/3

T

t'other [2] 5/23 7/17
tailor [1] 33/16
tailor-made [1] 33/16
take [12] 7/18 11/7 13/14 14/3 15/2 15/16 18/3 23/23 24/1 24/3 35/18 40/5
taking [2] 23/12 28/18
talk [1] 11/7
talked [2] 11/3 24/18
talking [6] 4/6 20/12 22/10 22/23 26/22 29/19
teaching [1] 27/8
team [2] 36/15 36/21
teams [4] 8/21 8/22 38/2 38/12
teeth [2] 40/22 41/1
telephone [1] 27/11
tell [1] 25/18
telling [1] 30/16
ten [1] 34/7
tend [1] 28/23
tends [1] 17/19
term [1] 12/9
terms [3] 7/1 14/1 16/5
than [7] 3/1 6/5 6/21 10/17 17/13 22/21 35/23
thank [8] 7/18 12/6 24/3 40/5 41/11 42/14 42/15 42/17
that [177]
that's [17] 1/13 2/16 3/20 4/11 9/10 11/19 13/2 13/12 18/15 21/5 30/17 30/22 34/3 34/16 34/21 38/5 40/9
their [23] 5/18 5/20 7/2 7/13 9/13 11/5 11/5 15/7 15/14 21/1 21/23 22/10 22/11 27/11 30/12 30/20 31/7 32/15 32/20 33/13 33/17 34/10 39/5
them [12] 11/6 11/7 11/7 17/3 21/1 22/9 22/10 30/14 32/10 33/13 33/20 35/4
theme [1] 39/17
themselves [1] 11/17
then [34] 2/2 2/22 7/9 8/10 8/15 9/3 11/4 11/11 12/15 17/12 20/1 20/8 22/25 23/6 23/8 26/13 27/10 27/14 28/4 28/17 30/17 30/25 32/9 32/21 33/13 33/25 34/14 34/19 35/5 38/8 38/13 40/7 41/7 42/11
theoretically [1] 17/10
therapists [2] 24/13 24/24
therapy [1] 10/4
there [40] 2/22 4/4 4/8 5/11 6/6 8/11 8/16 8/24 10/24 12/5 13/21 14/14 14/14 16/13 16/24 17/3 19/6 19/13 19/14 19/16 20/19 20/23 20/24 22/19 23/4 24/20 26/23 28/24 30/19 32/18 33/6 33/15 33/19 35/2

T

there... [6] 35/5 39/3 41/8 41/11 41/14 42/1
there's [8] 14/5 24/20 27/12 27/21 30/19 39/3 39/6 39/7
therefore [7] 7/5 14/21 15/10 22/21 29/4 31/5 32/12
these [13] 7/12 8/17 8/22 17/25 27/25 28/12 28/13 30/2 33/18 34/17 35/14 36/11 39/14
they [57]
they'd [3] 5/19 17/13 22/1
they'll [1] 11/7
they're [16] 6/17 9/19 11/3 11/18 14/8 17/18 23/6 25/19 25/20 26/15 32/17 34/18 37/11 37/13 40/25 41/1
they've [7] 17/11 22/9 23/16 23/18 32/12 34/6 34/20
thing [2] 5/13 34/16
things [3] 5/17 28/12 36/11
think [27] 6/22 7/1 7/2 7/4 8/8 14/16 19/21 20/21 21/6 21/6 21/9 23/4 24/8 24/16 24/17 24/20 28/5 28/9 28/21 28/23 29/18 29/20 40/19 40/24 41/14 42/4 42/16
thinking [2] 8/12 32/13
third [3] 27/25 32/3 38/22
thirdly [1] 31/8
this [33] 3/2 3/18 4/18 4/24 6/19 6/22 6/23 6/25 7/5 7/25 8/9 10/11 11/16 11/21 12/15 16/12 16/25 18/23 26/25 27/21 27/24 31/14 33/2 34/6 35/7 37/18 37/22 38/13 38/15 38/21 39/18 40/23 41/7
those [18] 8/7 10/5 11/9 12/24 13/25 25/4 26/6 28/18 28/25 29/4 30/21 31/11 31/18 32/16 33/3 39/25 40/12 41/11
though [2] 14/15 41/3
thought [3] 6/25 28/10 28/15
thread [1] 36/1
threatening [2] 18/20 19/1
threats [2] 18/18 19/17
three [2] 12/20 27/6
three o'clock [1] 27/6
through [9] 7/1 8/21 27/5 27/19 33/20 35/13 36/1 40/18 40/19
throughout [1] 17/15
tick [7] 4/21 5/5 5/17 7/3 10/20 34/12 40/15
tick-box [1] 10/20
ticked [1] 34/7
ticking [1] 7/5
ticks [1] 27/24
time [17] 5/7 6/19 9/9 13/16 13/22 15/6 17/22 20/25 23/15 26/24 26/25 27/2 27/12 29/7 39/3 39/11 41/24
times [1] 12/16
timing [1] 24/4
tip [1] 28/7
today [1] 42/16
together [1] 9/11
told [2] 39/6 40/25
tomorrow [1] 42/17
too [1] 13/14
took [1] 14/12
tool [23] 12/22 12/23 13/5 13/8 13/20 14/4 14/16 14/22 14/25 15/12 15/17 16/1 16/5 16/6 16/7 16/8 16/8 16/13 16/16 16/16 17/11 17/12 17/15
tool's [1] 15/1
tools [6] 13/25 14/6 14/7 14/14 14/14 15/22
top [1] 5/24
totally [1] 17/21
towards [1] 22/7
trained [1] 24/12
training [4] 14/22 24/14 24/23 35/16
translated [1] 6/13
traumatic [1] 33/12
travels [1] 17/9
treated [1] 31/5
treating [3] 36/2 36/2 36/5
treatment [6] 19/25 25/2 31/1 31/7 35/11 36/4
trigger [2] 33/12 33/13
triggers [1] 37/5
true [3] 1/12 25/19 38/15
trust [3] 1/23 17/20 17/20
trusts [5] 38/1 38/11 40/24 41/21 41/25
try [4] 10/3 11/5 28/16 30/14
trying [6] 5/6 15/20 27/10 29/6 30/14 36/3
turn [9] 3/13 3/17 4/18 7/19 11/20 11/21 18/3 18/6 33/24
turning [1] 39/5
two [16] 5/9 5/16 6/24 10/9 11/11 12/21 12/25 17/2 22/8 22/9 23/4 27/25 30/21 31/15 31/18 33/19
two hours [1] 11/11
two pages [1] 33/19
two paragraphs [1] 17/2
two weeks [2] 22/8 22/9
types [1] 12/21
typical [1] 37/10

U

ultimately [3] 12/11 13/9 33/21
under [6] 2/14 16/20 29/25 31/14 32/21 39/23
underneath [2] 38/8 38/13
underpinned [1] 8/20
understand [5] 11/3 15/1 15/18 15/20 31/4
understanding [3] 7/11 19/5 34/9
understood [4] 15/6 18/24 29/9 35/7
undertake [1] 2/10
undertaken [1] 18/9
undertook [1] 2/13
unexpected [2] 28/13 28/14
university [2] 26/9 26/11
unknown [4] 28/22 29/4 30/4 33/5
unknown unknowns [1] 33/5
unknowns [3] 28/22 29/5 33/5
unlikely [1] 28/10
unpredictability [1] 29/12
unpredictable [1] 28/14
until [1] 42/20
up [9] 3/17 8/11 9/16 11/20 27/10 28/16 33/18 37/14 39/6
update [2] 20/20 21/15
updated [1] 20/16
upon [3] 7/9 32/1 37/3
us [2] 3/9 27/10
use [12] 12/9 13/10 13/20 14/4 15/1 15/22 16/1 16/15 17/21 24/22 29/1 35/11
use totally [1] 17/21
used [10] 6/12 14/8 16/5 16/17 17/6 17/11 17/12 17/14 17/15 37/15
useful [8] 11/17 13/18 13/25 14/17 15/12 16/16 17/16 37/12
useless [1] 5/10
uses [1] 7/6
using [6] 5/24 15/19 15/19 17/18 17/19 28/16

V

vague [1] 17/21
valid [2] 15/14 24/20
validated [5] 14/7 14/10 14/11 15/6 15/9
validity [1] 15/1
value [2] 28/2 41/2
variable [1] 40/13
vary [3] 21/2 21/18 31/16
versa [1] 36/23
versus [1] 8/25
very [22] 1/17 6/11 6/24 9/11 9/13 13/25 14/13 16/20 17/23 23/5 23/6 25/18 29/18 33/6 34/17 34/17 34/18 39/8 40/5 42/1 42/15 42/18
vice [1] 36/22
victims [1] 32/5
view [10] 5/1 6/20 13/24 19/13 20/8 23/23 25/4 38/18 40/17 41/8
violence [15] 7/7 12/2 15/15 18/16 18/18 18/24 19/5 23/20 29/3 30/3 30/5 30/8 30/20 30/21 32/25
violent [4] 19/17 30/10 30/11 33/14
visiting [1] 2/6
voluntary [1] 38/12

W

want [4] 6/10 18/3 27/18 36/11
wanted [2] 32/11 41/16
warm [1] 36/22
warning [2] 37/1 37/6
was [62]
wasn't [7] 3/10 5/20 6/25 7/20 9/2 16/7 24/14
way [5] 8/12 14/13 25/21 36/8 39/10
we [54]
we'll [3] 18/23 34/23 42/17
we're [3] 28/18 33/20 42/6
we've [4] 10/12 15/23 24/4 30/4
weapon [2] 22/10 28/12
weapons [1] 21/25
week [3] 8/16 23/6 23/9
weeks [2] 22/8 22/9
weight [1] 21/22
well [18] 9/11 15/6 15/8 15/12 20/18 21/10 21/16 25/6 25/18 26/20 28/9 32/1 33/4 34/17 35/16 36/10 39/3 42/15
were [16] 1/17 1/21 5/8 5/10 5/16 6/21 8/7 9/11 12/22 14/14 15/13 22/23 26/17 27/8 29/6 42/8
weren't [1] 40/8
what [33] 5/1 5/6 8/7 9/12 14/24 15/20 16/6 17/18 17/19 19/19 22/18 25/15 26/17 27/18 28/5 28/21 28/23 28/23 28/25 29/8 29/8 29/19 31/23 32/7 33/3 34/10 35/6 35/18 37/7 40/23 40/24 40/25 41/2
what's [9] 7/14 25/18 30/15 35/2 35/25 36/7 39/4 39/8 39/13
when [21] 4/3 7/25 14/9 16/12 18/8 19/16 19/16 19/20 20/15 20/21 21/5 21/13 21/20 22/23 27/5 27/7 32/11 36/25 37/20 39/1 42/7
whenever [3] 18/12 19/13 21/10
where [12] 11/10 13/16 13/21 14/18 20/6 25/2 26/9 28/24 29/1 29/15 34/9 36/11
whereas [5] 14/3 17/19 36/17 40/24 42/7
whereby [1] 5/16
whether [9] 11/7 21/25 22/1 22/9 30/3 30/21 34/9 35/10 39/19
which [27] 2/23 5/15 5/18 6/12 7/12 8/9 10/3 11/12 11/23 12/12 13/2 14/8 16/1

W

which... [14] 16/15 16/16 16/22 20/21 22/1 22/13 23/7 24/5 24/23 29/19 30/21 35/6 35/14 38/9
whilst [2] 31/20 31/24
who [24] 5/11 7/6 10/5 15/11 15/13 16/7 16/11 16/17 21/22 24/5 24/5 24/11 24/17 24/21 24/23 25/3 25/7 26/21 28/15 32/14 32/17 33/8 33/10 34/9
who'd [1] 29/7
who've [1] 32/10
whoever [2] 24/7 24/7
whole [1] 39/23
wholly [1] 7/9
whom [1] 20/25
why [8] 3/10 10/24 15/19 17/18 28/7 30/9 31/3 42/3
wield [3] 16/10 16/11 16/17
wielded [3] 16/7 16/13 24/22
will [8] 22/2 22/4 34/16 36/14 36/21 37/15 37/16 39/15
withdrawn [1] 37/13
within [8] 1/25 5/2 6/7 6/8 6/14 14/22 14/25 38/21
without [2] 5/18 7/12
WITN0058001 [1] 18/6
WITN0058002 [2] 11/20 27/17
WITN0058009 [1] 3/17
witness [4] 1/4 9/21 14/18 18/5
wives [1] 32/15
won't [3] 11/8 17/2 33/8
word [1] 6/10
words [1] 15/18
work [11] 2/10 2/13 3/6 8/12 9/6 9/15 17/24 22/24 38/6 38/18 40/9
worked [1] 29/7
workers [2] 24/14 24/24
working [14] 2/14 2/19 3/14 7/25 11/22 13/20 17/20 26/18 26/25 38/18 42/5 42/9 42/10 42/11
world [1] 6/13
worry [1] 11/4
worrying [1] 4/20
worse [1] 31/8
would [23] 5/17 13/24 16/11 16/13 18/18 20/19 20/22 20/23 20/25 21/1 21/2 21/20 21/24 24/23 26/9 26/10 28/15 28/16 29/20 30/12 31/11 32/12 33/4
wouldn't [3] 15/16 16/9 22/16
write [2] 4/19 9/11
wrong [1] 15/17
wrote [2] 6/23 16/12

Y

yeah [5] 10/8 12/6 20/5 30/24 34/22
year [2] 15/13 21/21
years [3] 20/21 28/17 39/16
yes [63]
you [137]
you'd [1] 16/10
you're [16] 4/3 4/4 4/11 6/6 8/24 15/3 17/24 19/19 21/10 22/4 30/14 36/2 36/4 36/5 42/9 42/10
you've [9] 3/1 12/16 12/20 14/1 14/3 25/25 32/24 37/19 40/8
young [2] 21/21 32/18
your [52]