

Friday, 29 May 2026

1
2 (2.00 pm)
3 **THE CHAIR:** Yes, Mr Carr.
4 **MR CARR:** Chair, may I call, please, Professor Tim Kendall.
5 **THE CHAIR:** Yes.
6 **PROFESSOR TIMOTHY KENDALL (affirmed)**
7 **Questioned by MR CARR**
8 **THE CHAIR:** Yes. Please sit down, and just pull your chair
9 forward so we can hear what you're saying. Thank you.
10 **THE WITNESS:** Okay.
11 **MR CARR:** Professor Kendall, you've prepared a statement for
12 the purposes of this inquiry, haven't you?
13 **A.** I have.
14 **Q.** It's dated 11 November 2025.
15 **A.** Yes.
16 **Q.** Is that statement true to your best knowledge and
17 belief?
18 **A.** It is.
19 **Q.** It sets out your professional background, and I'm going
20 to summarise it briefly. You're a consultant
21 psychiatrist?
22 **A.** Yes.
23 **Q.** You're currently at a neighbourhood mental health
24 service in Sheffield?
25 **A.** Yes.

1

1 **A.** Yes.
2 **Q.** It's a subject you have expertise in?
3 **A.** Some expertise. I've never researched it.
4 **Q.** I'm not going to go through it, it's in your statement
5 and your statement will be uploaded. There's just one
6 point I'm going to take you to, it's in one of the
7 papers that you cite. It's NHSE0002413 and this is the
8 2020 case control study.
9 We've heard some evidence on this already today,
10 Professor Kendall, from one of the authors, Louis
11 Appleby. There's one point that I want you to address.
12 If we look, if we go down to the second half of the
13 page, the column on the left, about six lines down, it
14 refers to:
15 "Homicide committed by a person with schizophrenia
16 is a rare event, with studies reporting that 6% of
17 homicides in England are committed by these
18 individuals."
19 Do you see that?
20 **A.** I do.
21 **Q.** You refer to that 6% figure in your statement, don't
22 you?
23 **A.** Yes.
24 **Q.** Just dealing with the use of the term "rare", would you
25 agree that six out of 100 is not rare; that's

3

1 **Q.** You're also Visiting Professor at University College
2 London and Honorary Professor at the University of
3 Sheffield?
4 **A.** That's correct.
5 **Q.** You've led the development of more than 30 NICE
6 Guidelines?
7 **A.** That's correct.
8 **Q.** That includes the management of schizophrenia, the
9 management of psychosis and schizophrenia in children
10 and young people, and the guideline on psychosis and
11 co-existing substance misuse?
12 **A.** That's correct.
13 **Q.** From 2016 to 2023, you were the National Clinical
14 Director for Mental Health at NHS England.
15 **A.** That's correct.
16 **Q.** Currently, you're the National Clinical Lead for New
17 Models of Mental Health in England?
18 **A.** That's correct.
19 **Q.** Your statement gives details, doesn't it, of the 24/7
20 Neighbourhood Mental Health Centre Programme that you're
21 pioneering in that NHS England role?
22 **A.** That's correct.
23 **Q.** I will come to that in a moment. Your statement also
24 addresses, doesn't it, the literature and thinking on
25 schizophrenia in the links to violence.

2

1 statistically significant, isn't it?
2 **A.** I think with these kind of catastrophic events, "rare"
3 seems an odd thing to say.
4 **Q.** So "rare" shouldn't be there, 6% is not rare in
5 statistical terms, is it?
6 **A.** It's a judgement. I don't think there's any
7 statistical way of saying this is rare and this isn't.
8 **Q.** 6% is statistically significant, isn't it?
9 **A.** I genuinely don't know how one would determine if that
10 was statistically significant.
11 **Q.** You refer to the fact that we're dealing here with
12 a catastrophic event. Yesterday afternoon the Inquiry
13 heard evidence from Julian Hendy, so he's the person who
14 set up the Hundred Families charity, and he gave
15 evidence that even if 6% or even if the number of
16 homicides is rare, that's not reassuring. Where there
17 are catastrophic events, they need to be taken seriously
18 with the amount of work going into their prevention that
19 you'd see, for instance, that goes into the prevention
20 of plane crashes?
21 Would you agree with that?
22 **A.** I'd agree that we need to pay much more attention to
23 this issue, yes.
24 **Q.** That can come down, thank you.
25 If we now turn to the issue of the 24/7

4

1 Neighbourhood Community Mental Health Scheme and you
2 describe, it's page 12 of your statement, at
3 paragraph 41, you describe the impetus for that being:

4 "... the airing of two documentaries about inpatient
5 services [one] in Manchester ... [one] in Essex ..."

6 Which led to:

7 "... a public outcry about how appallingly
8 vulnerable ... patients [were being] treated ..."

9 **A.** That's correct.

10 **Q.** Part of the response, as you set out just further down
11 on that page, paragraph 44, part of the response was the
12 development of the 24/7 Neighbourhood Model?

13 **A.** Yes, that's correct.

14 **Q.** So far there are six pilot sites, and we see those set
15 out on page 16 of your statement at the top of page 16,
16 it's the subparagraphs to paragraph 54.

17 Those are the six pilot sites set out on screen?

18 **A.** That's correct.

19 **Q.** If we just go back and explore the principles and
20 essentially what these centres are, perhaps if we can
21 look from paragraphs 47 to 49, so page 13 and into 14.

22 Whilst that's on screen, it was just on screen, we
23 zoomed in a little bit too much, but while that's on
24 screen, Professor Kendall, do you just want to explain
25 what it is these centres do? What is the 24/7

5

1 **Q.** Effectively gets rid of teams.

2 **A.** You would -- you'd keep the specialisms, keep the -- so
3 for example, if an Early Intervention Team becomes
4 a part of that, the key interventions that an Early
5 Intervention Team in Psychosis -- what they have is CBT
6 for psychosis and family interventions.

7 So you want to keep that but they would become
8 a part of the neighbourhood team.

9 **Q.** Just so we're clear then, does the vision involve an EIP
10 team within one of these centres, or would there be no
11 EIP team, but instead some of the principles of an EIP
12 team implemented by the staff in the centre?

13 **A.** No, the therapies would be available.

14 **Q.** So the therapies would be available --

15 **A.** Yeah.

16 **Q.** -- but there wouldn't be, as it were, an EIP team
17 operating within one of these centres?

18 **A.** No, but the point of having the centre in the middle of
19 the community means that the team is able to be a part
20 of the community and to go into the community, and the
21 community to be able to come into the centre.

22 Now, the reason that's important is that quite
23 commonly, a lot of these 13-odd teams are all sited up
24 in hospitals, which might be three, four, five miles
25 from their neighbourhood. So the first thing that

7

1 Neighbourhood Model?

2 **A.** Okay, so each centre has a physical presence in the
3 middle of their neighbourhood, and that becomes a base
4 for all the staff working there. They're open usually
5 at least 12 hours from the morning through until mid- to
6 late evening, and then they have beds as well. The
7 reason that they don't open much beyond 8 or sometimes
8 10 is because of safety of staff, but effectively, they
9 can look after people at night, they've got six beds
10 each, most of them.

11 Now the staff that are based there are taking all
12 the staff that would provide services for that part of
13 the community. I think I say in my statement that for
14 every geography in England, we now have about 13
15 community teams. So in the patch that I'm working in,
16 there are 13 teams that serve that patch and each one of
17 them has criteria for acceptance and rejection, and
18 quite commonly, they were rejecting 50% of people
19 referred to them.

20 **Q.** Just on that point, because your statement does deal
21 with fragmentation, where there are 13 teams, the
22 thinking behind these Neighbourhood Centres is that all
23 services would be, as it were, under one roof and under
24 one team; is that right?

25 **A.** Yes --

6

1 everyone has noticed is that they're not travelling.

2 They're seeing patients in their own homes as a routine.

3 **Q.** Is there a risk of losing something, though, in that
4 model which doesn't involve, as it were, sub-specialism,
5 such as an EIP team to deal with somebody who is on a --
6 or would be on a First Episode Psychosis pathway?

7 **A.** Okay, the aim would be to have the EIP team as part of
8 the centre, but they would get their supervision from
9 the team that they used to be a part of. They'd do all
10 their CPD with other people in the city who would be in
11 early intervention. So it doesn't stop them --

12 **Q.** So it doesn't stop an EIP team from existing?

13 **A.** No.

14 **Q.** Would the EIP team still exist, as it were, somewhere
15 else or would it be part of --

16 **A.** No, a small number of people from the EIP team would be
17 a part of the centre. And if you had the centres all
18 over the city, you'd have small parts of EIP in each
19 part of the city. But they would all still do their CPD
20 and have their supervision centrally.

21 The important issue is to make sure that all the
22 people who are in that geography can access all their
23 mental health care through the centre, unless they are
24 under the Mental Health Act, in which case then they
25 would go to an inpatient unit.

8

1 Q. You say they're open 12 hours a day. The aim is for
2 these to be open 24 hours a day?
3 A. They will operate 24 hours a day but they can't open
4 their doors to strangers beyond 8.00 or 10.00 at night.
5 Q. At paragraph 49, which is on the screen, the point is
6 made:
7 "They represent a shift towards a single integrated
8 neighbourhood team with a unified holistic care model
9 ..."
10 Which is why I was asking the questions as to how,
11 for instance, an EIP team would fit into that, because
12 that seems to be suggesting you've just got one team in
13 the community kind of dealing with anything that arises
14 with a mental health patient in the community.
15 A. Yes, we would integrate, or we are in the process of
16 integrating -- some are fully integrated already -- all
17 the teams that ordinarily would have served that patch.
18 At least the core teams. So Primary Care Mental Health
19 Team, the Community Mental Health Team, the Home
20 Treatment Team, the Crisis Team, the Early Intervention
21 Team. They're the bulk of the teams.
22 Now, if you needed specialist help from a Perinatal
23 Mental Health Team, the idea would be that they would
24 come down to the centre. So you would still get people
25 getting their treatment and care either at home or in

9

1 A. Yes.
2 Q. And then if we go on to page 22, point 8, we can see
3 there one of the principles:
4 "Promoting freedom autonomy and choice: People ...
5 in control of their own care ... make choices about what
6 they do and do not want?"
7 Again, that's promoting autonomy, isn't it?
8 A. Yeah.
9 Q. And the basis for this approach, you've explained in
10 your statement, paragraph 46, for instance, on page 13:
11 "The Programme is testing the 'Neighbourhood Mental
12 Health ... [care] model which is recognised by the
13 World Health Organisation as central to the most
14 advanced, community-based mental health care systems in
15 the world."
16 So this is, as it were, a WHO-endorsed approach to
17 providing in mental health care in the community?
18 A. Yes.
19 Q. And you've produced as part of your evidence, attached
20 to your statement, some of the World Health
21 Organization's guidance on these services and I want to
22 spend a bit of time looking at one of those, so if we
23 can have, please, NHSE0002422.
24 This is the WHO "Guidance on community mental health
25 services". If we go to page 37 of this document, and

11

1 the centre within their neighbourhood.
2 So it's quite a radical shift to the delivery of
3 care as close to people's homes as possible, and there's
4 no waiting time, there's no waiting list. People can
5 drop in when they wish to and families can to.
6 Q. Some of the principles underlying this are set out at
7 pages 21 and 22 of your statement. So we can see the
8 first seven principles there:
9 "Continuity of care".
10 So that's a point you've already spoken about and
11 that's the idea that where a patient sees somebody in
12 one of these centres, that person, as it were, stays
13 with them --
14 A. Yeah.
15 Q. -- throughout their mental health journey.
16 Then number 4, "Open access":
17 "People can get help when they need it, where they
18 need it, there is no criteria or referrals needed. It
19 is easy to get a bed when you need it, and easy to leave
20 when you want to."
21 Now, does that idea of open access, being able to
22 come and go as a patient pleases, is that something that
23 feeds in with what you've described in your statement
24 about this programme being aligned with choice and
25 autonomy, least restrictive approach?

10

1 it's the second half of the page under the heading
2 "Non-coercive practices", so looking at the second
3 paragraph under that heading there's reference there,
4 isn't there, to:
5 "Many stakeholders now calling for the elimination
6 of coercive practices and the implementation of
7 alternatives in mental health and related services. The
8 right to Liberty and security of person in the CRPD
9 underscores actions to address coercion by prohibiting
10 the deprivation of liberty based on a person's
11 disability."
12 A. Yeah.
13 Q. Then the paragraph that follows underneath it refers to,
14 again, rights of the CRDP which are suggested to be
15 inconsistent with forced admission, treatment, seclusion
16 and restraint and the administering of antipsychotic
17 medication.
18 A. The WHO, this whole document, is at least in part to
19 address practices that have gone on in large parts of
20 the world where mental health services barely exist, but
21 where they do, they're almost wholly institutional, and
22 they exercise a great deal of coercion. So some of the
23 things in this probably don't apply greatly to the UK.
24 Q. Well, let's deal with that. So the CRPD, that's the
25 Convention on the Rights of Persons with Disabilities?

12

1 A. Yes.
 2 Q. It's ratified by the UK, isn't it?
 3 A. Yeah.
 4 Q. It's a UN Convention?
 5 A. Yes.
 6 Q. The WHO is a UN agency, isn't it?
 7 A. Yes.
 8 Q. Now the Wesley report, so the Independent Review on the
 9 Mental Health Act, that set out the fact that the UN's
 10 committee on the Rights of Persons with Disabilities had
 11 proposed or has proposed that the UK should abolish
 12 involuntary and compulsory treatment.
 13 A. But we disagreed with that.
 14 Q. It would be a radical shift, wouldn't it?
 15 A. Yeah.
 16 Q. There's no doubt that the way things are done here is
 17 that those who are ill can and should be compelled to
 18 receive treatment or detention to prevent them harming
 19 themselves or others?
 20 A. Indeed.
 21 Q. But that's at odds, isn't it, with certain committees
 22 within the UN?
 23 A. It may appear at odds. From my point of view, it's
 24 really important that when someone is very ill with
 25 severe schizophrenia, that we do protect them from

13

1 provide trusting relationships, that we have continuity
 2 of care, that they know where to get help, that we --
 3 all the principles that we extracted, all of that is
 4 true. But if somebody is so ill that they are -- that
 5 they become a danger to themselves or to others, then we
 6 should act accordingly, and --
 7 Q. So if we look at page -- just on the same theme, if we
 8 look at page 38 of this document, it's the next page,
 9 and the second paragraph there, where it reads:
 10 "In any instances, coercive practices are justified,
 11 by those who use them, on the basis of 'risk' or
 12 'dangerousness', which raises concerns given the
 13 potential for bias and subjectivity."
 14 When one reads that, you get the sense, don't you,
 15 particularly given the quotation marks, of a pretty
 16 cynical view being taken here to compulsory treatment;
 17 would you agree?
 18 A. Yeah.
 19 Q. The next paragraph endorses the creation of services
 20 free of coercion, and I think from the answers you've
 21 given, you're clear that you certainly wouldn't be of
 22 the view that there's no place for coercion in the
 23 treatment of mental health?
 24 A. There is a place for coercion, but, as I say, it's, you
 25 know, you don't help people recover from schizophrenia

15

1 themselves, because quite commonly when someone is very
 2 ill, they do either become a danger to themselves or to
 3 others. And I think it's right and proper that we
 4 should do that. And that does sometimes --
 5 Q. But if the UK was to implement -- (*overspeaking*) --
 6 A. Sorry.
 7 Q. If the UK was to follow this suggestion and to abolish
 8 involuntary and compulsory treatment, then we wouldn't
 9 be able to treat the type of patients you're referring
 10 to, would we?
 11 A. I'm absolutely not endorsing these parts of the -- the
 12 report was there for us to try and extract what would be
 13 relevant and usable in a UK -- in an English context, to
 14 start to develop non -- defragmented community mental
 15 health services. So we haven't followed everything in
 16 this document by any means.
 17 Q. But it is important to note, isn't it, and to be aware
 18 of the fact that the basis for these models arises in
 19 circumstances where the focus is very much not on
 20 coercion and indeed the suggestions and calls for
 21 coercive practices to be abolished.
 22 A. As I've said, these are not things I would support.
 23 I think there's no doubt that if you want to help people
 24 with schizophrenia or other serious mental health
 25 problems in particular, it is very important that we

14

1 by relying entirely on coercion, yeah?
 2 So our view is that it should be minimal but where
 3 needed, it should be used. And that's what the Mental
 4 Health Act is.
 5 Q. But that's slightly at odds, isn't it, with, as it were,
 6 the philosophical underpinnings of what the World Health
 7 Organization is recommending in this approach to
 8 community treatment?
 9 A. Okay. At the NHS England board meeting that triggered
 10 all of this, we were asked -- the view of some of the
 11 non-execs on the board believed that the system we'd got
 12 with all these fragmented teams and as a result an
 13 excessive reliance on inpatient units, that we needed to
 14 look abroad and elsewhere to see where we should go,
 15 which is what we did.
 16 But our view was that we should extract the best of
 17 what they were offering or suggesting in Community
 18 Mental Health Teams and services, but it should be an
 19 English version, it shouldn't be -- and we've got
 20 a Mental Health Act. Some of these places don't have
 21 the kind of Mental Health Act that we have.
 22 Q. There's a number of examples given in this document, and
 23 we won't go through all of them, where different
 24 community health hubs from around the world are
 25 identified and explanation is given of the services. So

16

1 we can look at, I think, the first one, page 46 of the
2 document, Afiya House, and it goes through, over the
3 course of a couple of pages to describe how it operates,
4 and, at page 48, it has a section on non-coercive
5 practices.

6 That's repeated for all of the different examples --

7 **A.** Yeah.

8 **Q.** -- given, isn't it? For the near entirety of them,
9 there's either a non-coercive approach taken or a very
10 minimalist coercive approach taken. I think that's
11 fair, isn't it?

12 **A.** I think that's fair and that's absolutely appropriate
13 when you're working with the majority of the people most
14 of the time, but sometimes that is not possible.

15 **Q.** Just looking at the other WHO document that you have
16 provided to the Inquiry as providing a foundation for
17 these models, it's NHSE0002421:

18 "Comprehensive mental health service networks".

19 "Promoting person-centred and rights-based
20 approaches".

21 And if we look at page 19 of that document under the
22 heading "Key recommendations", paragraph at the bottom
23 of the page, it suggested that:

24 "In order to successfully integrate
25 a person-centred, recovery-oriented and rights-based

17

1 like me, the Consultant Psychiatrists, are very involved
2 in those cases. And we do have them. And, you know, it
3 requires me going to see people sometimes at home,
4 sometimes with the police. And that, you know, that is
5 a possibility. It isn't common.

6 **Q.** No.

7 **A.** One of the advantages about these centres is that over
8 time, you can do what I think is rare in mental health
9 services in England, is that you can start doing
10 secondary prevention. So when someone has had their
11 first schizophrenic breakdown, for example, once you've
12 established a relationship with them, you can keep in
13 touch with them afterwards. And when there are signs of
14 a further breakdown, you're available, and available to
15 the family.

16 **Q.** Well, that would be a hope and ambition.

17 **A.** Yeah.

18 **Q.** You're going to have some people who are going to
19 recognise that they're ill, they're going to be happy to
20 go to a Neighbourhood Centre which is down the road
21 rather than having to go to hospital far away?

22 **A.** Yeah.

23 **Q.** And there are going to be others who, once that
24 relationship is built and there's a degree of trust, are
25 going to engage, but there are going to be a cohort, and

19

1 approach in mental health, countries must change and
2 broaden mindsets, address stigmatizing attitudes and
3 eliminate coercive practices."

4 And again, from the answers you've given, you would
5 disagree with that?

6 **A.** I do disagree with that.

7 **Q.** Is the reality, Professor Kendall, that an approach to
8 community treatment as envisaged in these models, which
9 is based on trusted relationships, based on compassion
10 and encouragement, it's not going to work for everyone
11 all of the time, is it?

12 **A.** No.

13 **Q.** Compulsory treatment is always going to need to be
14 an option?

15 **A.** That's right.

16 **Q.** Particularly for those who are disengaged,
17 non-concordant, lacking insight, previously violent?

18 **A.** Yes.

19 **Q.** The risk factors you've identified earlier in your
20 statement?

21 **A.** Yes.

22 **Q.** That can increase the risk of serious violence and
23 increase the risk of homicide.

24 **A.** Absolutely. And when you do have patients like that in
25 a Neighbourhood Centre it's really important that people

18

1 in fact it's often the most risky and most violent
2 cohort, who aren't going to acknowledge that they are
3 ill, and aren't going to engage with a kind of "turn up
4 when you want, come and go" Neighbourhood Centre.
5 There's always a risk of that, isn't there?

6 **A.** Well, no, because the Neighbourhood Centre is the base
7 for the staff to work in and to work into their
8 community, so they're right in the middle of the
9 community. It's a place for patients to come and go, as
10 you say, but it's also for the staff to be able to go to
11 people's homes. And I would say most of our time, most
12 of the times in most of the centres, is spent actually
13 going into people's homes. It's not expecting them to
14 come to us. And that's a really important issue.

15 I've worked for the last 15 years in a homeless
16 service which effectively is an Assertive Outreach Team
17 but for homeless people, and, you know, you don't see
18 people in a centre or in a hospital or whatever.
19 Instead, you see them wherever they are. And, you know,
20 the people -- when people are homeless, that might mean
21 seeing them on a park bench. It's not -- I'm quite used
22 to the idea that we should -- my view is we should all
23 be working like this.

24 **Q.** But many community health teams are divorced from
25 a hospital, aren't they? So in this case, I'm not sure

20

1 the extent to which you've followed the evidence, but
 2 VC's EIP team, for instance, was based at the
 3 Stonebridge Centre, so not part of the hospital, a
 4 separate premises; and that's not uncommon, is it?
 5 **A.** No, it's not. It's not uncommon that --
 6 **Q.** But the difference with these -- and correct me if I'm
 7 wrong -- the difference with these Neighbourhood Centres
 8 is that they're much more homely. So there's
 9 a suggestion of them being in residential premises, much
 10 more inviting. Isn't that part of the idea?
 11 **A.** It is. The aim is to make it as easy to access and to
 12 be less clinical, so to speak, but I wouldn't want you
 13 to go away with the idea that somehow this isn't
 14 a psychiatric centre. It is. It's a mental health
 15 centre. And, you know, my primary concern with all of
 16 these centres is that they provide really good care and
 17 help people recover from schizophrenia, bipolar
 18 disorder, and so on. It has to be suitable for people
 19 with serious mental health problems.
 20 **Q.** But the point that I'm exploring with you is that
 21 approach is not going to work for everyone.
 22 **A.** No.
 23 **Q.** So we looked at the principles, the open access, easy to
 24 get a bed when you need, easy to leave when you want,
 25 promoting Freedom and autonomy, people in control of

21

1 Now, I'm going to come back to the issue of
 2 assertively engaging which you've already referenced in
 3 your answers, but just going through some of these other
 4 factors. So far as being offered a bed, VC was never
 5 agreeable to going into hospital when he was up for
 6 assessment. So that is something, and that isn't
 7 something which is going to change, is it, just because
 8 the offer of a bed is more local?
 9 **A.** No, my experience of working with people who have
 10 a history of being violent and who have disengaged from
 11 services and have schizophrenia, my experience of that
 12 is that you're always looking to the long term. So as
 13 far as possible you're developing a relationship with
 14 them which is safe, and that they can trust you, and so
 15 on.
 16 Part of that is also to protect them and the public
 17 from what they could do, to avoid the catastrophes that,
 18 you know, this whole public Inquiry is about.
 19 So it may seem a contradiction, but the basis to
 20 have services that really help people with schizophrenia
 21 and to help them recover and not become dangerous for
 22 others is the basis of what these centres are about.
 23 But it doesn't mean to say that if someone becomes
 24 dangerous or we are concerned about them, that we
 25 wouldn't do something. We would.

23

1 their own care can make choices about what they do and
 2 do not want.
 3 For those patients at risk that we've identified,
 4 that kind of approach is not going to be suitable, is
 5 it; the lack insight, non-concordant, disengaged?
 6 **A.** Well, as I say, we do have people like that, and I know
 7 that that's true for each of the centres, and you, yeah,
 8 you have to take a bit of a different approach.
 9 I say a bit of a different -- you've got to go out
 10 and see them. And if they present a risk to themselves
 11 or to others, in the same way as I, you know, would do
 12 in the homeless service, then you may have to be more
 13 coercive and you might have to use the Mental Health
 14 Act.
 15 **Q.** If we look at your paragraph 61, please, it's page 18 of
 16 your statement, and in that paragraph you apply the
 17 principles to VC's case as you understand them, and you
 18 say it's your view:
 19 "... that if a patient in a similar situation to
 20 [VC] ... had access to a Mental Health Centre, it would
 21 be unlikely that they would be discharged, rather they
 22 would be assertively engaged, and may be offered a bed
 23 in the Mental Health Centre and persuaded to take
 24 a depot injection and even offered broader psychological
 25 and social support."

22

1 **Q.** But how do you engage them in the first place? Isn't
 2 the danger and the limitation of this approach is that
 3 for a patient who doesn't accept that they're unwell
 4 they just won't turn up? They just won't go to one?
 5 **A.** As I've said, you're going to them. I mean, when you're
 6 working with homeless people, it's no different. You
 7 are -- you have to go where they are, and sometimes that
 8 will involve working with the police to find out where
 9 the person is.
 10 **Q.** So when you describe they would be assertively engaged,
 11 how does that work with the Neighbourhood Model?
 12 **A.** As I say, the huge advantage that they're in the middle
 13 of their neighbourhood, it is not difficult for them to
 14 go into people's homes. Every centre have all described
 15 that they've saved huge amounts of time on travel, you
 16 know, that they can see patients instead. They've saved
 17 huge amounts of time on referral meetings, and so on.
 18 So there is a much -- it's far more straightforward to
 19 work assertively from one of these centres than it is to
 20 do it for a city-wide team.
 21 **Q.** So that would require, would it, the workers in the
 22 Mental Health Centre, so the nurses or the
 23 psychiatrists, and other staff who have a caseload.
 24 It's all integrated so it's quite broad so they're
 25 having to provide what would have been general community

24

1 mental health, what would have been EIP, what would have
2 been Crisis, and have a caseload. That would involve
3 them with patients who are disengaging, then
4 implementing, as it were, principles of assertive
5 engagement?

6 **A.** Yeah.

7 **Q.** Do you agree that that isn't sufficient, and what is
8 required is a dedicated, Assertive Outreach service?
9 The Inquiry has heard evidence from VC's EIP team that,
10 notwithstanding reference to assertive principles that
11 were applicable for them, when VC became an Assertive
12 Outreach patient, they were unable to deal with him,
13 they were not equipped.

14 **A.** Okay, so while I was doing work for NICE, I did three
15 iterations of the NICE Guideline on schizophrenia and
16 psychosis. In the most recent one, we did not recommend
17 Assertive Outreach teams. We did a full analysis of
18 the -- of Assertive Outreach teams, and there's a set of
19 other teams very similar to Assertive Outreach: one's
20 called Assertive Community Treatment or ACT; another one
21 is called Intensive Case Management.

22 Now when we looked at the trials, and there's tens
23 and tens of these trials, what they claimed to be was
24 often very similar, yeah, but it was labelled something
25 different. So the recommendation that we had was not

25

1 contact with hospital services .., often restrictive and
2 traumatic ..."

3 And reference to "Section 135 warrants to force
4 entry".

5 Now, for the type of patients that he is describing
6 there, the kind of Neighbourhood Centre,
7 attend-when-you-wish type model, realistically it's
8 never going to be appropriate, is it?

9 **A.** I disagree. I think it would be. I think that
10 Assertive Outreach teams, or Assertive Community
11 Treatment, I think is absolutely essential for people
12 who are itinerant and homeless and so on. I think it's
13 really important to have teams for this group.

14 **Q.** So you accept there is a need for a dedicated Assertive
15 Outreach Team?

16 **A.** Absolutely, but specifically for people who do not have
17 a home. If people --

18 **Q.** So only for the homeless?

19 **A.** No, for homeless or itinerants, people who are
20 frequently moving, vulnerable to losing their homes.
21 For that group, I think this would be ideal and it's
22 what I've been doing for the last 15 years. So I do
23 think that's essential, but for people --

24 **Q.** Why ideal for the homeless and itinerant but those who
25 fall into the category that I've just described by

27

1 that we should have Assertive Outreach teams for people
2 who disengage, instead we said intensive case management
3 because we thought that captured what Assertive Outreach
4 teams and Assertive Community Treatment does.

5 I think the point is that there are different ways
6 for doing intensive, assertive work. That's -- I'm
7 afraid that's what the guideline recommends, is doing
8 intensive case management, but it subsumes Assertive
9 Outreach teams.

10 **Q.** You have, for the purposes of giving evidence, you've
11 been given a copy, haven't you, or an extract from the
12 statement of Dr Dissanayaka?

13 **A.** Yes.

14 **Q.** And if we can look, please, at his statement, we'll
15 start -- it's WITN0412001. At page 13 of the statement,
16 paragraph 25, he is describing there his caseload. So
17 he's an Assertive Outreach Consultant and he's
18 describing that amongst his caseload are patients with
19 "psychotic illness, usually schizophrenia", "demonstrate
20 poor awareness of their illness, not recognising they
21 are unwell ... consequently, non-compliance with
22 treatment, disengagement from community services ...
23 frequent relapses associated with high risks ...

24 "... two-thirds ... have a history of keeping or
25 using weapons as part of their previous relapses ...

26

1 Dr Dissanayaka? Why not have a dedicated Assertive
2 Outreach for those difficult, violent, patients who lack
3 insight?

4 **A.** Because I think we can deal with those patients better
5 by using --

6 **Q.** A "Come when you like" approach?

7 **A.** Not -- I think that's not a fair description of what I'm
8 saying a Neighbourhood Mental Health Centre does. Yes,
9 we want to be open, and we want to be a really good
10 option for people that people are not frightened of.
11 That's true. But that's so we can do the best treatment
12 we can and practice -- as I say, secondary prevention.
13 If we've got somebody who's been ill, we have a much
14 better chance of re-engaging them.

15 Now, you know, we've got an Assertive Outreach Team
16 in Sheffield, it has a waiting list, a waiting time of
17 nearly six months. The Birmingham Assertive Outreach
18 Team has a waiting time of four months. The problem
19 about having city-wide, large, Assertive Community
20 Treatment teams is that the number of people that you're
21 covering is huge, and --

22 **Q.** So you would disagree with his recommendation for
23 a dedicated resource, for intensive and assertive care
24 for those individuals who need it, without
25 a qualification of homelessness?

28

1 **A.** I personally think that it would be better that we
2 expected the Neighbourhood Mental Health Centres to deal
3 with the vast majority of people who live in their
4 patch. But if you have people who are itinerant, or
5 they are homeless, or they're in unstable housing and
6 moving a lot, then I think you do need a city-wide,
7 dedicated Assertive Outreach Team.

8 **Q.** You deal in your statement with some of the next steps
9 for these six pilots, so if we look at your
10 paragraph 58, you say that:

11 "The next stage in the transformation of community
12 care is [bringing] ... the different community teams and
13 services together ..."

14 And that's aimed, isn't it, at what we were talking
15 about before this one model, integrated model without
16 the kind of sub-specialities?

17 **A.** Sorry, what's the question?

18 **Q.** Paragraph 58. So this is "The next stage in the
19 transformation", you're describing here, is bringing the
20 community teams and services together, and that's in
21 line with the principle you were describing before about
22 there being one integrated model under one roof,
23 essentially?

24 **A.** That's right, and it's -- I should say, it means that
25 you are going to have people who can give debt advice,
29

1 I think there may be a cost to do this 24/7; and
2 secondly, it's to look at the quantitative data, such as
3 bed use and so on -- and safety.

4 **Q.** Then, finally, at paragraphs 67 and 68, so just a little
5 bit further down on that page, you deal with the funding
6 of this pilot scheme, and you say it's coming to an end
7 this year, 2026. Though "The 10-year plan states a move
8 towards this model", at the time of your statement there
9 wasn't funding for a national roll-out.

10 Do you have any update on that? What is the future
11 for this model?

12 **A.** NHS England have made available a sum of £316 million
13 capital to build about 150 Neighbourhood Centres. Now,
14 I am reasonably sure, from the calculations we've done,
15 that if you took the Primary Care Teams, the Community
16 Mental Health Teams, the Crisis Teams, the Home
17 Treatment Teams for that patch, and Early Intervention,
18 if you put those into those centres, they'd be able to
19 operate 8.00 until 8.00 seven days a week.

20 Whether or not we could do it overnight, I don't
21 know and that, I think, is a really important part of
22 the evaluation.

23 **Q.** Does that amount to national coverage then with --

24 **A.** No, nothing like. That would be over a four-year
25 period. If we had 150, I'd be delighted. I think we
31

1 who can help with housing, people who can help with
2 substance misuse problems, are all able to occupy the
3 same space.

4 **Q.** That's an important point, isn't it. So when you're
5 bringing teams together, it goes beyond just the
6 medical, as you're describing?

7 **A.** Yeah.

8 **Q.** It's bringing in Social Services, housing. So it's, as
9 it were, a one-stop shop for those who are vulnerable
10 and disadvantaged?

11 **A.** Yes.

12 **Q.** Then your paragraphs 65-66, page 19, you describe there
13 the external evaluation which is being led by
14 Ipsos Mori.

15 When are they due to report? Have they reported
16 yet?

17 **A.** They haven't reported yet. They will report in the
18 autumn, and what we've asked them to do is to look at
19 the different sites and evaluate what are the key
20 ingredients to making this work and what are the
21 contextual factors that promote the right kind of model
22 of working. So they would be able to describe how each
23 centre has done it and what has worked and what hasn't.

24 Alongside that, there will be two other bits of
25 information: one is the cost of these things, because
30

1 need about 1,200.

2 **Q.** But there is funding to carry on and expand this,
3 essentially; that's the position that we're in at
4 present?

5 **A.** There's capital funding, not recurrent money, and it's
6 the recurrent money that I'm particularly keen for
7 seeing if you can go overnight.

8 **MR CARR:** Yes, thank you very much.

9 Chair, those are my questions. There are a series
10 of other questions.

11 **THE CHAIR:** Thank you. Mr Moloney.

12 Questioned by MR MOLONEY

13 **MR MOLONEY:** Professor Kendall, is it possible that whilst
14 this model may work for a large, even very large,
15 percentage of patients with poor mental health in the
16 community, it might not work for every patient?

17 **A.** Completely agree. There are some patients, as I say,
18 I would still want to engage even the most difficult
19 patients, but if we needed to admit them, for example,
20 which is still happening, then our job is to stay in
21 touch with them when they're admitted.

22 So our MDTs, we have it so that we cover all the
23 people from our patch that are anywhere in the mental
24 health system, including those who might be out of area.

25 So even though we may not -- we couldn't deal with
32

1 everybody in the mental health -- in the Neighbourhood
 2 Centre, there's no doubt that we'd stay in touch with
 3 them.

4 **Q.** Can I just explore, as it were, one type of patient
 5 that's particularly pertinent to these proceedings.

6 **A.** Sure.

7 **Q.** That is an actively care-avoidant patient in the way
 8 that it appears in many instances VC was care avoidant.
 9 And I just want to explore one possible manifestation of
 10 difficulty in relation to a care-avoidant patient in
 11 this way, that in order to avoid the reach of the
 12 Neighbourhood Centre then they might move home in order
 13 to -- if there is a Neighbourhood Centre that, as you
 14 say, is actively going out to find them, then they may
 15 move home simply to avoid the reach of that. Is that
 16 a possibility?

17 **A.** That is a possibility, and I have had patients who
 18 change their name, you know, so they've moved and
 19 changed their name.

20 You know, it's our job with people like that to find
 21 the best ways we can to reach them, and sometimes that
 22 will involve the use of the Mental Health Act.

23 **Q.** Indeed. Then, could I just perhaps explore one
 24 implication of their moving, in that it might
 25 paradoxically cause more instability in their lives in

33

1 elective care towards general practice and them having
 2 to absorb, as it were, more hospital-level mental health
 3 management is some concern expressed by GPs, isn't it?

4 **A.** I don't think, in the Neighbourhood Mental Health
 5 Centres, that's the case. It's absolutely essential
 6 that these are built up, and all the six sites we've
 7 got, they've been built up with the community and with
 8 the people in primary care. So yeah, in my own one in
 9 Sheffield, I've met with all the GPs, I go to their
 10 meetings, you know, they've got our phone number, they
 11 can come up and see us. I actually think primary care
 12 is very favourable to this.

13 **Q.** Right. So you would say that that concern is misplaced.
 14 But there's also concern that increased workload might
 15 lead to independent practices having to merge. What
 16 would you say about that?

17 **A.** I'd be surprised, but, I mean, if there were examples of
 18 that, I'd be keen to see them. I can't see why that
 19 would be the case. Much more a danger is that we'll
 20 have people coming to us without going through their GP,
 21 and that it's very important that we let the GP know
 22 that we've seen people.

23 **Q.** Just finally, Professor Kendall, if I may, Professor Sir
 24 Louis Appleby gave evidence today that its advisory
 25 group recommended that the national comprehensive (*sic*)

35

1 that way by moving in that way?

2 **A.** I mean, it may well do. I mean --

3 **Q.** Well, that's not a matter for your expertise, but one of
 4 essentially common sense, isn't it?

5 In terms of going out to see them, can I just
 6 explore this: that we have evidence that VC did not want
 7 visits to his home and that care clinicians were meeting
 8 him in a sandwich shop. That's potentially problematic
 9 with somebody who is care avoidant as well, isn't it,
 10 and building that relationship?

11 **A.** I'm not sure it's problematic in itself. When I've been
 12 working with homeless people, you meet them wherever.
 13 One of the safest places to meet people is in third
 14 sector organisations, homeless places that provide, you
 15 know, food outlets and clothing. So I would spend a lot
 16 of time going into those.

17 So I don't think seeing people in odd places is
 18 necessarily problematic. If someone is disengaged, we
 19 have to go to them.

20 **Q.** Just in terms of reaction from general practitioners,
 21 there's been mixed reaction to it. Some very positive,
 22 in terms of recognising, acknowledging the benefits that
 23 may come from multidisciplinary approaches in this way,
 24 some less positive in that a concern that this may shift
 25 the burden of coordinating mental health and the

34

1 Inquiry cease its comprehensive data collection on
 2 homicide. Were you part of that advisory group?

3 **A.** I was a member of the advisory group at the time, yeah.

4 **Q.** Yeah. Because Professor Appleby was asked about that
 5 decision. Did you play a part in that decision? Were
 6 you supportive of that decision?

7 **A.** I was a part -- we -- it wasn't actually our decision.
 8 The decision was taken by NHS England that all the
 9 national sentinel audits and all the Confidential
 10 Inquiries would be cut by 15%.

11 **Q.** Right.

12 **A.** So everybody had to go back to their Independent
 13 Advisory Groups, tell them "You've got to cut by 15%".
 14 All the advisory group did was to work with Louis's
 15 group to find out what was the least damaging way of
 16 cutting 15%.

17 **Q.** Sir Louis gave evidence reasons about the reasons why
 18 that was cut. It wasn't cut just for no reason. There
 19 were reasons why it was cut and did you agree with those
 20 reasons as to why those cuts were made?

21 **A.** To be honest, I never agree with -- it was NHS England
 22 decided that they were all going to be cut by 15%, and
 23 it depended on the advisory groups to work with either
 24 the Confidential Inquiries or the national sentinel
 25 audits to then determine what should be cut. And that

36

1 was done between the advisory group and Louis's group,
 2 which would damage them the least.
 3 **MR MOLONEY:** Okay, thank you very much, Professor Kendall.
 4 **THE WITNESS:** Thank you.
 5 **THE CHAIR:** Yes, Ms Cartwright.

6 **Questioned by MS CARTWRIGHT**

7 **MS CARTWRIGHT:** Good afternoon, Professor Kendall.
 8 **A.** Good afternoon.
 9 **Q.** I ask questions on behalf of the survivors. Obviously
 10 you've been taken through the community model you've
 11 described, I think you've referenced in particular a lot
 12 of the work that you do, particularly with patients with
 13 mental health difficulties who are homeless, and
 14 obviously the context you seem to be describing is
 15 individuals that can have really quite complex mental
 16 health difficulties.
 17 I just wondered, in light of what you've been
 18 saying, is there sufficient use being used of patients
 19 who have been on a Section 3, so have had a detention
 20 for treatment, which entitles them to Section 117
 21 aftercare to assist them with accommodation, which is
 22 obviously one of the other risk factors for
 23 deteriorating mental health, if you've not got stable
 24 accommodation?
 25 **A.** It's -- I mean, I'm glad you've raised this. It's

37

1 So the end consequence is that their accommodation,
 2 they break down, they're not --
 3 **Q.** No, I appreciate that, but as part of -- obviously
 4 you've given information about the funding that's
 5 available for this initiative, what's being done
 6 essentially to have that holistic approach to ensuring
 7 the issue you've identified as very real to make sure
 8 that there is the appropriate accommodation?
 9 **A.** In the Neighbourhood Mental Health Centres, I know that
 10 at least three of those centres have Housing
 11 Associations involved in the centres. So problems
 12 around accommodation can be addressed, but I couldn't
 13 tell you how effective or successful that is now.
 14 **Q.** Thank you. Now, you've dealt with, with Mr Moloney, the
 15 risk factors being relevant to when it might be
 16 necessary for coercion.
 17 **A.** Yes.
 18 **Q.** But can we just look, just whilst we've got you, please,
 19 you've very helpfully, in your statement, provided some
 20 information about risk of harm to others, particularly
 21 of patients with schizophrenia. Can we just briefly
 22 look at that together. WITN0076001, at page 10.
 23 Obviously this is summarising as well research you've
 24 proved, at paragraph 36 you say this:
 25 "However, people with schizophrenia appear to have

39

1 a massive problem. So when you're working on the
 2 street, the biggest rate-limiting factor to helping
 3 people is getting accommodation. In my own hometown in
 4 Sheffield, we have -- the council has less than a tenth
 5 of the available accommodation than they had 15 to
 6 20 years ago. So that's absolutely true, but I also
 7 think other supports that people should get very often
 8 they are not getting.
 9 **Q.** But again, noting what you've said about the property
 10 stock of local authorities --
 11 **A.** Yes.
 12 **Q.** -- the reality is they have a statutory duty under
 13 Section 117 to provide that accommodation free for
 14 patients who need it, and so it can't just be "We don't
 15 have the property", they have legal duties that they
 16 need to fulfil?
 17 **A.** They do have legal duties which they're not always able
 18 to fulfil if they don't have somewhere, but one of the
 19 consequences is that people get placed in areas that
 20 are, you know, five, six, seven miles from the city
 21 centre, and for somebody who is homeless, that's
 22 useless. They have to go into the city centre to get
 23 most of their food and their clothing, that kind of
 24 thing. So, you know, putting somebody 6 miles out is
 25 not always helpful.

38

1 a higher risk of violence towards others than in the
 2 general population. The difficulty with the data in
 3 this area is that studies tend to be of much broader
 4 groups, such as people with [schizophrenia spectrum
 5 disorder], rather than solely those with schizophrenia."
 6 Is that correct?
 7 **A.** That's correct.
 8 **Q.** And so actually, would you agree that having clarity of
 9 diagnosis to inform data is highly important in
 10 a patient's clinical journey?
 11 **A.** Yes, although I suspect that anybody who has
 12 a psychosis, whether it's a depressive psychosis or
 13 a manic psychosis, or schizophrenia or schizoaffective
 14 psychosis, I suspect all of them will be at higher risk
 15 of violence towards others and towards themselves.
 16 **Q.** Thank you. I think you then go on to say risks of
 17 violence is increased if the factors that you've then
 18 identified at paragraph 37, including "not taking
 19 appropriate medication", and I think that necessarily
 20 follows, because if you're not receiving your
 21 antipsychotic, and your delusions and hallucinations
 22 continue, that's a significant risk factor; would you
 23 agree?
 24 **A.** Yeah, absolutely.
 25 **Q.** Then if we carry on:

40

1 "... substance misuse problem including alcohol
2 intoxication or use of excessive drugs;
3 "has dedicated from services;
4 "is living in disadvantaged circumstances."
5 And again, would you agree that not having available
6 accommodation, or stable accommodation, is a significant
7 factor that then increases risk?
8 **A.** Absolutely.
9 **Q.** Then male, and then have a history of violence. And
10 I think would you agree that all of these risk factors
11 should be well known in clinicians when assessing risk
12 for patients with schizophrenia that have any, all, or
13 many of these features?
14 **A.** Absolutely, and if you're in a Neighbourhood Mental
15 Health Centre, I would expect that we will know who
16 these patients are.
17 **Q.** And then you've obviously identified the history of
18 violence. So plainly having an understanding of that
19 forensic history is key, but can I ask you also, if
20 there was a history also of patients not just having
21 a history of violence, but also disclosing thoughts of
22 murder would you agree also that has to be really
23 carefully looked at by the clinician? Even further
24 still increasing risk if the patient is disclosing risks
25 and thoughts of murder?

41

1 help you find someone like that?
2 **A.** Yes.
3 **Q.** Has that happened in a number of cases that you've been
4 involved with?
5 **A.** I very recently was involved in one in the Neighbourhood
6 Centre where someone with a strong history of violence
7 wouldn't meet me and I went to their home with two
8 police, a nurse, and we went into the neighbour's home.
9 He wasn't there, but -- so yes, I think, you know, my
10 experience is that that's been quite good.
11 The only thing I will say -- and this is what I've
12 heard from other psychiatrists -- is that since there
13 have been a number of Chief Constables who have said
14 "mental health is not our business anymore", it has been
15 more difficult.
16 And I don't think that we can do our job effectively
17 in protecting the public if we are not working alongside
18 the police, and I think there needs to be a sort of,
19 a better arrangement for how we can work together more
20 safely.
21 **Q.** In paragraph 24 of your witness statement, you say that:
22 "When treated, and with the right support ... 70% of
23 people with chronic schizophrenia ... do very well ..."
24 **A.** Yes.
25 **Q.** What does "treated, and with the right support" mean?

43

1 **A.** Absolutely agree with you.
2 **Q.** Thank you. And then you say this at paragraph 38:
3 "People with schizophrenia are also more likely than
4 people in the general population to kill someone.
5 However, the overall risk of being killed by someone
6 with schizophrenia remains very low."
7 But again, would you agree the risk factors in
8 paragraph 37 are highly relevant to assessing that risk
9 of homicide?
10 **A.** Absolutely and I must say that there is -- the use of
11 these statistics, you know, is it low, is it high, is
12 it -- they miss the point when it comes to situations
13 like this, where, you know, these are tragedies that
14 happen, and whether it's low risk or not really doesn't
15 matter. We should be aware of this.
16 **MS CARTWRIGHT:** Thank you, Professor Kendall.
17 **THE WITNESS:** Thank you.
18 **THE CHAIR:** Yes, Mr Straw.
19 **Questioned by MR STRAW**
20 **MR STRAW:** Professor Kendall, you mentioned earlier that
21 you've worked for 15 years in a homeless-related
22 service, and you have experience of working with police
23 to find where one of your patients who's homeless is?
24 **A.** Yes.
25 **Q.** Is it your experience that police are commonly able to

42

1 **A.** Okay, so the NICE guideline is what I would refer to
2 as -- so that should involve effective treatment with
3 antipsychotics, it should involve access to cognitive
4 behavioural therapy for psychosis, it should have access
5 to family interventions, either with the patient or just
6 with the family, depending on what's acceptable. And it
7 should also have access to individual placement and
8 support, which is a kind of supported employment with
9 a good evidence base for people with schizophrenia. And
10 there are a range of other things that need to be there,
11 most of which are to make the experience of care good.
12 **Q.** We've seen the NICE Guidelines say that that full
13 package should come into place within two weeks of the
14 referral to the EIP service; is that your view?
15 **A.** Yeah. I mean, yes. With the right level of funding,
16 that is exactly what should happen, yeah.
17 **Q.** Why is it important that that happens early?
18 **A.** Okay, so in 2005, Max Marshall published a paper and
19 there have been several since, which follow up people
20 with schizophrenia over long periods of time and I refer
21 to some of them in my statement. And what they've shown
22 is that the longer a person has untreated psychosis in
23 the first instance, the longer that period, the worse
24 the prognosis, yeah? So in the long run, they are more
25 difficult to help if you're not there quickly.

44

1 Q. So is it right, over time, they can become more --
2 harder and harder to treat?
3 A. Yeah, it's -- this is obviously a statistical thing so
4 I can't make it -- I can't be too -- I can't describe
5 every one that this would cover, but in general terms,
6 it means that their responsiveness to medication, their
7 responsiveness to psychological treatments, they're less
8 likely to respond to it.

9 So it seems, when someone is psychotic, it's like
10 something is happening in their brain that puts them
11 into a world that's more akin to a dream where you
12 believe things that suddenly pop into your mind and you
13 might hear voices or see things or whatever. The longer
14 that period goes on untreated the less likely you're
15 going to be able to help them in the future.

16 Q. So in the earlier stage, they tend to be more open, more
17 engaging, than if you leave it two years, three years
18 down the line?

19 A. Yes.

20 MR STRAW: Thank you very much.

21 THE CHAIR: Yes, thank you. Ms Grey? No? Thank you.

22 **Questioned by THE CHAIR**

23 THE CHAIR: I just wanted to ask you a question arising out
24 of what you said in response to Mr Straw about police
25 can help you find people and you gave an example of

45

1 And I also think that it's more attractive for
2 people when this -- when the Neighbourhood Mental Health
3 Centre has got people in the community coming in, people
4 from families and so on. I mean, it's something we have
5 to do as psychiatrists, is to persuade people that we
6 can help.

7 And I absolutely agree that sometimes that is really
8 difficult to do. And I think I've said in my witness
9 statement, for about 10% of people with schizophrenia,
10 they remain ill most of their lives, and they are quite
11 common on the street.

12 THE CHAIR: Yes, thank you.

13 Right, well, I think we'll finish and take a break
14 now until perhaps --

15 MR CARR: Appropriate time for a break.

16 THE CHAIR: -- 3.25. Thank you.

17 MR CARR: Thank you.

18 (3.08 pm)

19 (A short break)

20 (3.25 pm)

21 MS LANGDALE: Chair, may I call Mr Hart, please.

22 THE CHAIR: Yes, thank you.

23 **CHRISTOPHER DAVID HART (sworn)**

24 **Questioned by MS LANGDALE**

25 THE CHAIR: Thank you. Please sit down.

47

1 someone with a history of violence where you went along
2 with two officers and you said you went to the
3 neighbour's house and he wasn't there. Did you find
4 him?

5 A. In the end I did, yeah.

6 THE CHAIR: How long did that take?

7 A. It took several weeks. He'd left Sheffield.

8 THE CHAIR: Right. During that time, do you know whether he
9 had his medication or not?

10 A. I would doubt it.

11 THE CHAIR: You would doubt it?

12 A. Yeah.

13 THE CHAIR: Thank you. Just in relation to patients who, as
14 you've said, have fixed beliefs which become more fixed
15 with time, and in some cases it could be that they feel
16 there's a conspiracy of the police and the health
17 workers, and everybody is against them, how would you
18 engage someone like that to come into a centre where
19 they think everybody is involved in a conspiracy?

20 A. That would -- with some difficulty, I would guess. But
21 someone who is in that state, and they're that
22 distrustful, they're probably going to end up on an
23 inpatient unit, during which time it is up to us to go
24 and meet with them and to persuade them that "this is
25 a better place".

46

1 Yes.

2 MS LANGDALE: Mr Hart, you've prepared a statement dated
3 30 January 2026 for the Inquiry. Can you confirm the
4 contents are true and accurate as far as you're
5 concerned.

6 A. I can.

7 Q. Can we have, please, pages 1 and 2 on the screen,
8 WITN0075001, and Mr Hart can you tell us, please, about
9 your qualifications and something of your career.

10 A. I trained as a general and adult nurse first and then
11 moved into mental health a few years after that. Upon
12 qualifying I went to the Maudsley Hospital where
13 I started as a staff nurse and then moved on eventually
14 becoming a ward manager. I then went to north London
15 where I worked as a service manager with responsibility
16 for a hospital and acute mental health services in the
17 community, and then eventually went back into clinical
18 work where I was a team leader for a Community Team
19 which was based in a residential centre in our local
20 community, where we provided a number of functions
21 including a crisis service and Assertive Outreach
22 service.

23 And after that, I moved to St George's Hospital as
24 part of the south-west London and St George's Mental
25 Health Trust as a nurse consultant in liaison

48

1 psychiatry. I did that for nine years and then was
2 asked to go and work in a forensic service where there
3 had been a homicide and two suicides and the role,
4 really, was to try to rebuild the nursing service there.

5 That led on to doing the same thing for our
6 Psychiatric Intensive Care Unit and part of that job was
7 also working as a principal lecturer in the university.
8 And I left there in 2013, carried on as a lecturer for
9 another three years but now work as an independent Nurse
10 Consultant with a group of colleagues.

11 **Q.** Before we continue, Mr Hart, is that fan a bit close
12 you? Are you comfortable with that?

13 **A.** I'm comfortable, yes.

14 **Q.** It's how you like it.

15 You are also a writer, aren't you, you've published
16 various publications, in particular if we go to page 4
17 of your statement, in particular A Pocket Guide to Risk
18 Assessment and Management in Mental Health; is that
19 right?

20 **A.** It is, yeah.

21 **Q.** If we look at page 5, you've had various appointments
22 and memberships, including Chair of the Association of
23 Nurse Consultants between 2002 and 2009.

24 **A.** Mm-hm.

25 **Q.** Can we go to page 9 of your statement, please, and at
49

1 particularly if the nurse who is the main -- the term
2 "care coordinator" gets used, but I think it's
3 a misleading term. If their primary nurse, primary care
4 nurse or whatever we're going to call it --

5 **Q.** Care co-ordinator or inpatient primary nurse, but the
6 key nurse?

7 **A.** The key nurse working with this person, if they don't
8 see all of these different elements of care,
9 particularly when the person is in crisis, I think it's
10 quite hard for that relationship to really explore those
11 things, which are often very difficult for the person to
12 talk about retrospectively.

13 **Q.** What about out-of-area beds or private bed placements
14 and break of continuity there; does that impact on the
15 therapeutic relationship that the nurse may have?

16 **A.** Again, it's very complicated. It's going to depend on
17 the nature of the relationship, it's going to depend on
18 how the person feels about going into hospital. What
19 the hospital is like when they go there. What their
20 experience is. If they're detained, obviously that's
21 going to be very different.

22 So I think there's not one simple answer to any of
23 this. This work is extremely complex, far more complex
24 than is often credited, and not always necessarily
25 understood by people who make policy or who are not

51

1 paragraph 36 on page 9 you refer to the fact that, for:

2 "... mental health nurses [they] are themselves the
3 therapeutic 'tool' and the efficacy of their individual
4 work rests upon the relationship they establish with the
5 patient, their thinking about the patient and decision
6 making."

7 So you are clear, aren't you, in this statement,
8 that the patient-nurse relationship is fundamental to
9 therapeutic work?

10 **A.** Absolutely. It's the core.

11 **Q.** It often takes time to develop, doesn't it, and requires
12 an ongoing relationship?

13 **A.** Mm-hm.

14 **Q.** Would multiple short periods of detention in hospital
15 threaten the quality of that relationship because of
16 changing wards and nursing teams?

17 **A.** It may and it may not. One of the problems which
18 I referred to later in my statement is when patients
19 have to navigate their way through a variety of
20 community teams, as well as inpatient units,
21 particularly if they have to go from one ward to another
22 and that does break continuity of care. And I think it
23 makes the experience for the patient extremely
24 difficult. And if they then come back to the
25 substantive relationship, yeah, that can be problematic,

50

1 involved as nurses, and I think that's one of the
2 fundamental problems we're trying to address.

3 **Q.** That can come down, please. Your evidence sets out the
4 importance of undertaking capacity assessments,
5 particularly when making decisions about treatment. We
6 don't have to put it on screen, but it's paragraph 209.
7 Do you consider that the training provided for nurses is
8 sufficient to allow them to undertake capacity
9 assessments?

10 **A.** I think if you look at the documentation, a lot of
11 people would say it's a fairly simple process. It's
12 not. I don't think nurses are properly trained or
13 equipped to do many of the tasks that they're expected
14 to undertake, and this will be one of them.

15 **Q.** What about the overlap and indeed differences between
16 the Mental Health Act the Mental Capacity Act; do you
17 think that's sufficiently understood within nursing and
18 generally, when approaching the issue of capacity?

19 **A.** No, I don't think it is. I think the nature of how the
20 Mental Health Act supersedes the Mental Capacity Act,
21 but also what the nature of capacity is, the
22 multidimensional nature of it, in relation to how
23 somebody may then be assessed under the Mental Health
24 Act. I think these are sometimes vague areas for
25 nurses.

52

1 Q. Can we have on the screen, please, WITN0299002, page 13,
2 and that's an extract, as you know, Mr Hart, of the Code
3 of Professional standards of practice and behaviour for
4 nurses, midwives, and nursing associates.

5 We see one of the key roles, competences a nurse has
6 in relation to recordkeeping. In essence, it's
7 important for accurate records to be kept, isn't it, and
8 to maintain regulatory standards?

9 A. Absolutely, yeah. It's essential.

10 Q. The Responsible Clinician in any case should be able to
11 rely, shouldn't they, on notes being accurate and up to
12 date?

13 A. Yeah, I mean, nurses are going to have far more contact
14 with the person that they're working with than
15 a Consultant Psychiatrist or a Responsible Clinician.
16 So the accuracy of the notes. But not just the accuracy
17 of the notes, what is being documented and how that
18 reflects the work that's being done, all of this becomes
19 incredibly pertinent.

20 Q. We'll come on to risks shortly, but every interaction
21 with the patient can be relevant to risk, can't it, in
22 assessment and notes and records are really important in
23 relation to that issue?

24 A. Yeah. Again, it's a fundamental aspect of the work.

25 Q. And nurses' input into multidisciplinary meetings and

53

1 responsibility to their governing body, the NMC, is long
2 gone."

3 Why do you say that?

4 A. Because a nurse might want to make all sorts of
5 decisions as a registered practitioner in their own
6 right, which might be related to the safety of the
7 patient or the group of patients that they're working
8 with. Now, and this largely because of resource,
9 I think, and the shortage of beds, caseload numbers if
10 you are in the community, the pressures on services,
11 they have to defer in most cases to other people.

12 So there was a time, if you were working in the
13 community as a nurse, and you thought somebody needed to
14 be admitted, you would discuss that with other members
15 of the team and that decision could then be made.
16 That's long eradicated.

17 If you're a nurse on an inpatient unit and the ward
18 was particularly disturbed, or there were no beds, and
19 you didn't think it was applicable to move somebody
20 else, that could be your decision as a registered nurse.
21 Again, that's long gone. Nurses can't do that.

22 That filters through to lots of aspects of
23 decision-making and it also is mirrored at what's going
24 on higher up the hierarchy even at a national level,
25 where nurses have lost their voice in policy making and

55

1 care is also important, isn't it? It's a key aspect of
2 nursing role to share their observations, what they make
3 from them and assess from them within the
4 multidisciplinary setting.

5 A. It is. But if I can just kind of elaborate on that
6 slightly. A lot of this will depend on what the nurse
7 is trying to do, how the nurse sees their role within
8 the service that they're working. So whether it's in
9 the community or an inpatient unit, what are they trying
10 to do with the person they are working with? The
11 patient may have one agenda; the team may have a
12 separate agenda. It's going to be the nurse that has to
13 negotiate that chasm and try to bridge that gap on
14 a day-to-day basis.

15 So the continuity, the plan that they have, the way
16 they enact that plan, and the knowledge and the skills
17 that they're able to bring into that conversation, into
18 that relationship, they will become integral which
19 should then be reflected in the documentation.

20 Q. Your evidence is that the role of the nurse in the
21 hierarchy of clinicians has changed. That's at
22 paragraph 80, and you say:

23 "The time when a nurse could exert the clinical
24 authority they derive from being a registered
25 practitioner in their own right, whose ultimate

54

1 decision-making in many arenas.

2 Q. Does it deskill them as well on the ward?

3 A. Yeah, yeah, because you just become used to deferring.
4 You know, you might be working in the community with
5 somebody, and really worried about their safety or the
6 safety of others, as a result of the changes in their
7 mental state. If you start to explore that in great
8 depth, you're going to find answers to questions that
9 you might not want to hear because you're the person who
10 is going to be carrying the can for that, and you're the
11 person who has got to manage that and work with that.

12 You may be thinking: this is beyond me, I really
13 need this person to be in hospital, because at the
14 moment things are too risky; or I'm going to need
15 additional help with this, I'm going to have to see them
16 more frequently, and you know that's not going to be
17 possible.

18 So I think nurses then tailor their approach to what
19 they think is available to them, rather than trying to
20 do the work of assessing the situation, setting out
21 a plan of what the person needs, in their opinion, and
22 then having a look at what's available, which may not be
23 what you recommend, but at least having gone through
24 that process.

25 Q. Different topic. In your evidence you set out different

56

1 schools of thought about whether a patient should be
2 told about their diagnosis or not. That's
3 paragraphs 159-164. Is it your view, ultimately, it may
4 depend on the patient and the level of information that
5 they want to know?

6 **A.** It's a bit like -- we talk about nurses as if it's, you
7 know, a single group who all think and act the same.
8 You know, there are thousands and thousands of nurses in
9 mental health, and the discrepancies and the variations
10 about how they work are enormous. Some practise very
11 differently to others; so it is with patients.

12 The thing around disclosure, the thing around this
13 kind of discussion about diagnosis, in part at least,
14 has to be based on what that person is looking for, what
15 we think they need, which may not be what they want, but
16 we have to make these decisions and we have to be -- we
17 have to really try our best to do the best thing for the
18 person.

19 **Q.** It's nevertheless always important for clinicians to
20 properly understand when a diagnosis has been made.

21 **A.** Yeah.

22 **Q.** And those working with a patient.

23 **A.** Yeah.

24 **Q.** Howsoever it's considered, the information needs to be
25 communicated to that patient.

57

1 to be a clear document which sets out all of the key
2 information relevant to a patient's risk and to their
3 illness, particularly when the illness is linked to
4 risk, isn't it?

5 **A.** Mm-hm, yeah.

6 **Q.** It's important because many nurses and staff will be
7 responsible for assessing a patient who don't have time
8 to read back through many pages of records.

9 **A.** Yeah, electronic record systems have their advantages,
10 but one of the disadvantages is trying to find things
11 quickly and easily, you know, which can take quite
12 a long time, and also, it might sound odd, but a lot of
13 people aren't properly trained to use the system. There
14 are things that they may not be aware of, shortcuts and
15 ways of collating information.

16 **Q.** More specifically, identifying warning signs of relapse,
17 increased risk for a particular patient, for example not
18 taking medication, disengaging, is very important. You
19 describe it as a "relapse profile", but it's an
20 important part of risk assessment, isn't it?

21 **A.** Yeah, again, this is really part of this relationship
22 that we're talking about, is to be able to walk the
23 person through what happened to them, which again may be
24 a very uncomfortable process for them, but walking
25 through this process to find out how things developed

59

1 **A.** Absolutely, and again there may not be uniform agreement
2 amongst the whole team, which is the function of
3 a properly working Multi-Disciplinary Team is to talk
4 about these things, to gain some element of consensus
5 based on the knowledge each person within the team has
6 gained.

7 **Q.** You refer to there being no clear definition of violence
8 used by clinicians, in particular no consistent
9 definition of what's violence and what's aggression, and
10 the interchangeability of those two terms. What's the
11 significance of that in terms of treatment and
12 assessment of risk, the fact that they're used
13 interchangeably?

14 **A.** You will often find nurses will write "Oh this person
15 has been violent" or "This person has been aggressive"
16 but without actually explaining what it is they mean.

17 So my interpretation of violence might be different
18 to somebody else's, but I see the word "violence"
19 written down and then I form my own opinion about what
20 that means. Much better, in terms of documentation, to
21 describe exactly what's happened and how it's happened.

22 **Q.** Key facts?

23 **A.** Key facts.

24 **Q.** Can we have page 45 of your statement on screen, and
25 while we do, risk assessment: it's important for there

58

1 and they went as they did and then what steps might be
2 taken to prevent that.

3 **Q.** It's particularly important where the patient's high
4 risk when unwell, and signs might be subtle, for example
5 masking, trying to --

6 **A.** Yeah.

7 **Q.** -- detect --

8 **A.** Yeah.

9 **Q.** -- those.

10 Is there a clear policy for nurses surrounding risk
11 assessment and training in respect of risk assessment?

12 **A.** Every Trust has got one. But that doesn't mean that
13 it's adhered to consistently throughout very large
14 organisations and different clinical settings, and
15 again, I think it is partly -- part of the problem is,
16 you know, there are so many different clinical settings
17 with teams with different objectives.

18 One system may not entirely suit everybody, or each
19 part of the service. There are fundamental principles
20 that have to be adhered to, but again, how do you
21 communicate that? That's an enormous question. How do
22 you communicate this information to all of the staff?

23 Having a policy in its own is not going to change
24 anything. It's magical thinking that by writing
25 a policy and disseminating that, everybody is going to

60

1 implement it. Because again, this work is complex, it's
 2 challenging, it takes time, and people have to learn how
 3 to do it.

4 **Q.** You say, it's paragraph 221:
 5 "... few ... NHS Trusts adopt and implement the best
 6 practice for risk assessment and risk management."
 7 On what basis do you say that; you're aware of that?

8 **A.** Sorry, can you say --

9 **Q.** Paragraph 221. I'm going to go to your hypothetical
 10 example in a moment, but in terms of risk assessment,
 11 your understanding is that few trusts implement best
 12 practice for risk assessment and I want you to outline
 13 with this example you've got at paragraph 149 how you
 14 see risk assessment, static, stable factors, dynamic,
 15 future risk, et cetera?

16 **A.** Again, I think quite a lot of Trusts will use that kind
 17 of terminology but they won't have trained their staff,
 18 they won't be looking at best examples of training and
 19 education practices.

20 Again, we use the word "training" and really what
 21 we're talking about is education. We want to draw out
 22 from people what their experience is, we want to build
 23 on that, and we want to take in a body of knowledge that
 24 they can utilise. And this is, again, this is not
 25 simple, straightforward stuff.

61

1 'what if' factor is really important. We don't know
 2 what it is, but again, if we have to walk somebody
 3 through this, it gives us an idea about what maybe will
 4 happen in the future.

5 That's where we bring all of this together --

6 **Q.** If you have page 57 of your statement on the screen, you
 7 set out best practice in risk management plans and the
 8 risk formulation, if you can have the whole of 194 and
 9 195, please, on the screen. You need to expand down
 10 a bit.

11 Thank you.

12 You were coming onto that. So tell us why are these
 13 questions important and specific?

14 **A.** Well, hopefully, as you read it, it becomes apparent.
 15 We absolutely need to know how serious is the risk. So
 16 we're looking at the risk of violence, what would that
 17 be? How would somebody enact a risk -- a violent act?
 18 Is it specific or is it general? Might they assault
 19 anybody in certain circumstances or is there a person
 20 they're thinking about? How immediate is this?

21 **Q.** Fixations matter, you look at specifics?

22 **A.** Fixations matter, delusional content matters. There may
 23 be people who have got something about -- they might
 24 have something about the healthcare team working with
 25 them. They might think that this group of people are

63

1 **Q.** Tell us about the example on the screen, 149.

2 **A.** Yeah.

3 **Q.** Hypothetical example. What's the key message about how
 4 you're looking at risk at various points?

5 **A.** Well, this is linking risk history with the current
 6 situation and how things might project into the future.
 7 And what's really important is to link past risk factors
 8 with current risk factors, and things that have happened
 9 in the past which have affected risk, they're static.
 10 So if somebody has assaulted somebody in the past,
 11 that's a static risk factor. That's not going to
 12 change.

13 We can't change that but knowing that that's what
 14 happens in certain circumstances is important.

15 **Q.** It stays as an important static factor, risk factors --

16 **A.** It stays as an essential factor in that.

17 History of psychotic disorder or diagnosis is then
 18 a stable factor. That's not going to change enormously.
 19 It might evolve over time, our understanding might
 20 change, but that again tells us something very
 21 important. The really important risk factors there are
 22 the dynamic ones, the ones that we can try and exert
 23 influence over. But we have to see those in the context
 24 of static risk factors and stable risk factors.

25 But then we have to think about what if, and the

62

1 holding them wrongly, illegally, doing things to them,
 2 have an ulterior motive that they're not disclosing. So
 3 that might put the staff at risk. Could be all sorts of
 4 things.

5 How immediate is it? Is it happening right now? Is
 6 this risk ongoing at this moment or would it only occur
 7 in certain circumstances? If somebody says it was
 8 a risk in the past and they're not now a risk, the
 9 crucial question: what's changed? This was happening
 10 for you, you're saying it's not now. How did that
 11 change come about? And you need to get that explanation
 12 to be satisfied that that change has occurred.

13 **Q.** You referred to it at paragraph 195, the "Six Point Risk
 14 Assessment Model (Hart 2024)". Do you know how widely
 15 those six points are used? Is that conventionally
 16 accepted now? We've seen your book about it, but is
 17 this you suggesting this, it's not something you
 18 understand as integral to risk assessment?

19 **A.** No, I developed this with a colleague of mine, Justin
 20 O'Brien, that I used to work with. We developed this
 21 out of looking at many, many, many incidents where we
 22 saw that there was a gap between risk assessment and
 23 risk management plan, and we thought a risk formulation
 24 that was very simple, very easy to understand, but
 25 covered all of the elements of it would help people

64

1 bridge that gap.
2 But when I'm moving around places and teaching, many
3 people haven't seen this. They find it incredibly
4 useful because it is very simple and straightforward and
5 it asks the fundamental questions.

6 **Q.** Page 71 and 72 on the screen, please. You speak here
7 about integrating the principles of best practice into
8 mental health nursing clinical practice. You say, it's
9 a stark comment, Mr Hart, at 226, your:

10 "... concerns about how the principles of best
11 practice are rarely integrated into mental health
12 nursing clinical practice ..."

13 Why do you think that is?

14 **A.** We could talk about this for many days.

15 **Q.** Sadly, we don't have that, but as best you can.

16 **A.** I think, fundamentally, organisations have become very
17 distracted. You know, for many, it's an existential
18 question about whether they'll survive, financially,
19 organisationally. Developing clinical excellence is
20 something many people talk about, but as an example, a
21 lot of trusts have reduced the amount of time they spend
22 on risk assessment training. Universities have cut back
23 on post-reg modules that they used to provide in this
24 area because trusts weren't sending people along.

25 So in any -- in lots of ways, and particularly

65

1 a lack of resource, and incredibly significant demands,
2 increased demand, for the service that we provide.

3 **Q.** Well, you refer, if we look on the screen, at page 72,
4 at 229 and 230, about the funding cuts. What do you say
5 about that, at paragraph 230?

6 **A.** Well, I think, you know, it's self-evident that when --
7 I think other people have made this point already, that
8 although the NHS gets a large amount of money, the
9 mental health services within it do not receive
10 the proportionate amount of funding for the level of
11 service that they provide. That's been cut back.

12 So just one thing, Assertive Outreach teams, have
13 lost 59% of funding since 2010. And then they're
14 expected to carry out exactly the same function. And
15 again, the training for the needs of that type of
16 service are not being provided. So what we find is that
17 there's been this huge loss of funding, and nurses are
18 expected to do more, often with bigger caseloads, with
19 even less preparation.

20 **Q.** You also say there's been a dramatic loss of clinical
21 leadership roles in mental health nursing. What do you
22 think the impact on that is, of that?

23 **A.** Well, it's not a discussion about -- there's not
24 a discussion about ideas, about good practice on these
25 national forums. When there were about 110 nurse

67

1 around nursing -- and I do come back to this -- the
2 largest part of the workforce is -- has just been
3 neglected and there's not much thought about what
4 happens at the clinical interface between nurses and
5 patients.

6 **Q.** What about support from professional bodies? Do you
7 think they play a part in this and could do more, could
8 support the profession --

9 **A.** It could certainly do more. If you look at the NMC Code
10 of Conduct, it doesn't really talk about any of the
11 fundamentals of nursing. It's kind of got these very
12 broad principles, but it doesn't help some -- doesn't
13 help a staff nurse who's on an acute admission ward
14 about how they utilise best practice when they're under
15 pressure to do all sorts of things. It doesn't help
16 them resolve the ethical dilemma of being asked to
17 either discharge somebody or move them to another
18 hospital when that nurse doesn't think it's in that
19 patient's best interests.

20 **Q.** Is there an ethical helpline in either of the
21 professional bodies, the Royal College of Nursing or the
22 NMC --

23 **A.** Yeah, there are, and there are routes and avenues for
24 people to access. But again, I think there's a huge
25 change over the last 20 years which is largely about

66

1 consultants across England, going back to the early
2 2000s, and that was -- within that group there were
3 forums, specialty forums, so Nurse Consultants could
4 come together from their different areas to talk about
5 their experiences, to share ideas, take back good
6 practice. But within a local service, they would be
7 a point of contact for nurses at all sorts of levels.

8 As a Nurse Consultant, without a managerial role,
9 which is very rare for senior nurses, you might be
10 talking to the Chief Executive about nursing practice
11 and can talk more -- you can talk differently than, say,
12 a Director of Nursing who's got an operational role, and
13 then be talking with nurses in a clinical setting within
14 a few hours and talking to them about practice and
15 talking about best practice, and helping them develop.

16 So that type of forum has gone. There was a period
17 of time when there were national conferences where you'd
18 have huge sharing of ideas, and again most of those have
19 gone because people can't get the time off, there's no
20 funding for them. So we've lost --

21 **Q.** And post-Covid even worse, presumably?

22 **A.** Post-Covid even worse. And we've got a generation of
23 post-Covid nurses who (a) had to have online lectures,
24 rather than face-to-face lectures, and we know many
25 people don't really sit and watch a whole lecture

68

1 through that process, and missed out on clinical
2 placements. So there's a huge knowledge and practice
3 gap for a whole generation of nurses that we've not
4 addressed at all.

5 **Q.** And experience?

6 **A.** Well, they're working with nurses who may not be
7 terribly experienced in their role. That's the other
8 thing. The loss of senior nursing roles, particularly
9 in clinically developed roles, has a massive impact.

10 So you'll often find in Trusts that nurses are
11 prematurely promoted, they may not have the full body of
12 experience that they'd benefit from. They're trying to
13 mentor and develop nurses in sort of junior positions
14 who -- and they're not able to do that as successfully.

15 And this is an old man talking but, you know, my
16 generation learned from extremely experienced, well
17 versed, talented nurses who had, you know, a huge amount
18 of knowledge and skills at their disposal.

19 **Q.** Can we have pages 73 and 74 on the screen, please, and
20 Mr Hart this is where you suggest recommendations that
21 the Inquiry may make. And you deal at paragraphs 235,
22 236, and 237 with training, that you suggest is
23 required, including a national standard for the teaching
24 of a five-day competency-based module, and for the
25 teaching of risk assessment and risk management.

69

1 go through clinical simulations where you practise that
2 and you find the difficulties that there are with it,
3 and you learn ways of developing your own thinking, the
4 way you understand people, the way you relate to people
5 and get feedback on that, that enables you to practice
6 much more effectively, and we've got a whole body of
7 evidence that supports the use of clinical simulations,
8 which we've been doing for 20 years, and in loads of --
9 in many, many different clinical settings with people
10 from different backgrounds, non-mental health
11 practitioners, as well as mental health practitioners.

12 And that's how people learn. Even four days, for
13 this complex, complex work, is the bare minimum.

14 **Q.** Paragraph 238, you say:

15 "Standardise the risk assessment template for all
16 electronic record systems used by ... Trusts, linking
17 risk assessment ... formulation and ... management
18 plans, with new prompts and more detailed guidance."

19 What should the template be? Have you given further
20 thought to that or are you saying in principle this is
21 what's required?

22 **A.** Again, it's a long answer to that, I'm afraid. But
23 essentially, a template around risk assessment has to
24 cover the essentials, but it has to link up your risk
25 assessment with your risk formulation, directly to a

71

1 At 236 you say:

2 "... introduce ... a Mental Health Nursing
3 curriculum clinical simulation-based modules on advanced
4 communication skills ..."

5 And you say at paragraph 237:

6 "... a four-day mandatory module for all Mental
7 Health Nurses working in NHS mental health services, to
8 be attended every three years, with a two-day refresher
9 annually ..."

10 Time taken off, of course, costs would be extensive
11 with that. What do you say is the benefit for that?
12 What's the argument for these suggestions?

13 **A.** If you go back to I think the first question you asked
14 about the therapeutic relationship. The first thing is
15 the understanding of a therapeutic relationship has been
16 diluted over the years, and this may sound a little bit
17 flippant but if you look at how it's framed now, it's
18 almost: "Be nice to people, have a good conversation
19 with them, be a professional friend to them and help
20 them." That's not the therapeutic relationship. The
21 therapeutic relationship is about helping somebody
22 effect change. And you need skills and knowledge to do
23 that.

24 Now you can read about that and you can talk about
25 that, but actually being placed in a situation where you

70

1 risk management plan. And unfortunately at the moment
2 in most electronic record systems that doesn't happen.

3 So -- and there's often this very huge gap. There
4 may be a very good risk assessment, there may not be,
5 but how that gets translated into a plan --

6 **Q.** A plan of action --

7 **A.** -- is often where there's a huge gap, and that's partly
8 where the six-factor model came from, myself and
9 Justin O'Brien who were looking at this, seeing that
10 they're trying to figure out where this gap was between
11 risk assessment and risk management.

12 Again, I think part of this, though, is
13 understanding what goes into a risk assessment, about
14 how one conducts that. Over time, from what you see,
15 what you hear, and how you combine these static, stable,
16 dynamic risk factors.

17 **Q.** Page 74, paragraph 242, you say:

18 "Re-establish the position of [a] Director of Mental
19 Health Nursing at a national level with a nursing
20 directorate that can lead on the development of nursing
21 policy ..."

22 If we can have page 75 on and 73 down, please.

23 But that position of the Director of Mental Health
24 Nursing, re-establishing it, when was that lost, if you
25 like, to the system and what do you think the benefit

72

1 -- (overspeaking) --

2 A. It was quite a while ago, I think it was 2013. It got
3 diluted and then when the Directorate moved it, moved
4 out of the Department of Health, it was lost then.

5 But if you think about it, you've got the largest
6 component of the mental health workforce with no
7 national policy leadership and no national framework
8 with which directs what it should be doing and how it
9 should be doing it.

10 Q. You say:

11 "There would be a focus," and "an immediate focus"
12 and if we look at (c) in front of us:

13 "Where necessary, a risk management plan, agreed
14 with the patient should be recorded and passed on to
15 appropriate healthcare professionals and agencies that
16 are involved in the person's care and treatment before
17 the patient leaves the care of the inpatient team."

18 So what would the Director of Mental Health Nursing
19 be able to do to assist with all of that thinking?

20 A. Well, the thinking is essential. That's the first part
21 of this and, you know, asked about what's happened, you
22 know, why we've gone so awry. A large part of it is
23 because we've stopped thinking about these things. You
24 know, we are -- policies come out, nurses have very
25 little input into that. We're the people who are going

73

1 following major surgery or, you know, a massive car
2 crash with multiple injuries, if they were going to be
3 nursed by people who had no specialist training, there'd
4 be a national outcry.

5 Here we put our most, acute, unwell, disturbed and
6 distressed people who need the most care, and the nurses
7 responsible for delivering that have no specialist
8 training. It makes absolutely no sense at all.

9 Q. Paragraphs 248 and 249 you deal with multi-disciplinary
10 working, multi-agency working, rather, and the role of
11 that. Can you tell us what you're suggesting here?

12 A. Well, you know, we have a small group of people within
13 each community who are really difficult to reach,
14 they're really difficult to work with, multiple agencies
15 are involved in various ways. It may be that the police
16 have arrested this person on several occasions, it may
17 be that they've had to detain them on a Section 136,
18 they come into hospital, they get discharged from
19 hospital; they go to a Crisis Team, from the Crisis Team
20 they may go to a different team, then come back to their
21 original team if it's the Early Intervention Service or
22 whatever. Social services have been involved. There
23 are issues around housing, benefits, all sorts of
24 things. We've got models where multi-agency working can
25 be very effective. The group of people, you know, I'm

75

1 to be delivering it, and what we want is a framework
2 that allows us access to national thinking, expert
3 thinking. But then it comes down to -- a lot of it does
4 come down to how people practise on the ground locally
5 and what people do within this. But again, we need --
6 a nurse who's working in a clinical setting needs
7 something that anchors them, and that's what you're
8 looking for from a national body.

9 We've had several, I think three -- two or three --
10 reviews of mental health nursing over the decades. None
11 of them have managed to shift the dial significantly
12 because there is not that linking of a national body of
13 work with what happens locally. And we do need -- it
14 needs to go in both directions.

15 Q. Page 77 of your statement on the screen, please, and
16 leave the whole page on if you can.

17 Paragraph 245:

18 "Introduce specialist training that provides for
19 a post-registration qualification for nurses working in
20 highly specialist services."

21 So forensic or psychiatric intensive care. It may
22 seem obvious but why do you think specialist training is
23 necessary in those positions?

24 A. Well, if you said to the public, whose relative had been
25 admitted to an intensive care unit in an acute hospital,

74

1 talking about, they take up an enormous amount of time
2 and resource, very often still with not great results.

3 It may be, and it would have to be tested out, but
4 it may be that actually bringing together a multi-agency
5 team that get specialist training would be beneficial
6 and it would enable services to provide a more cohesive,
7 consistent approach.

8 MS LANGDALE: Mr Hart, those are my questions. I'm
9 conscious you've written extensively on risk assessment
10 and given us a detailed statement. Is there anything
11 you'd like to add or say or that I've omitted at this
12 point in your evidence?

13 A. Well, I think just one thing really -- well there are
14 couple of things, I think, very briefly. I was
15 listening to the debate around Assertive Outreach, for
16 instance. These terms get bandied about. What does it
17 mean, Assertive Outreach? Assertive Outreach means
18 finding somebody when they don't want to be found. How
19 do we do that? You have to build a profile. You have
20 to know the person.

21 If they don't -- the first thing is people don't
22 turn up for appointments, so then you try and go to
23 their house, or where they're accommodated. They're not
24 there. Where might they go? Who might they be with?
25 Who do they associate with? What about their family?

76

1 What do their family know? If they're in education or
2 if they're in work, might they be there? Might we be
3 able to find them there?

4 You then need the skills to engage somebody when
5 they don't want to be engaged, and the decision-making
6 to know when you have to escalate concerns quickly,
7 rather than waiting. It's the same with home treatment
8 teams. If you go to somebody's house, why are you going
9 there? How do you build a consistent relationship with
10 this person?

11 Again, if you've got nurses chopping and changing,
12 different nurses coming in with a template of questions
13 to ask, the person is very quickly going to switch off.
14 They go through the same process. They get really
15 frustrated. They find it antagonistic. We've got to be
16 smarter, but most of this stuff can be done by groups of
17 nurses who work within the community, who know the
18 community, who get to know their patients and their
19 patients get to know them, who have got a very direct
20 link with the inpatient services that they may or may
21 not need.

22 These are the kinds of things that we've really got
23 to think about. Fundamentally, we have to improve the
24 knowledge and the skills of the workforce, otherwise
25 none of this will ever change and we will be going

77

1 **A.** Well, every MDT meeting I've been in has been
2 documented. But if I talk more generally -- and again,
3 you know, I've been involved in investigating incidents
4 in numerous settings -- it's a question of what gets
5 documented. More fundamental is what's the quality of
6 the conversation? Who's involved in the conversation?
7 Who makes the decisions? How are those decisions made?
8 Once that's documented -- if that gets documented
9 accurately, we can see a narrative about how things
10 evolve, and the team can look back and see a narrative
11 of how things evolve.

12 I suggest it gives people more opportunity to
13 reflect on the direction things might be going in.

14 **Q.** So there's a fundamental value to the documentation of
15 those meetings?

16 **A.** The documentation is essential, but so is the quality of
17 the thinking and the decision-making. And that's based
18 on the information that -- so we talk a lot -- sorry,
19 I just want to go into this one thing. We talk a lot
20 about clinical curiosity.

21 **Q.** Yes.

22 **A.** Clinical curiosity on its own is nothing, it means
23 nothing. The question is: how much information can we
24 gather through being curious? And curiosity is
25 essential. What is this person telling me? Why are

79

1 through this process as we have been for the last
2 30 years. You go back to the Christopher Clunis
3 Inquiry, you go even before that. We've been talking
4 about the same stuff, for year on year on year.

5 The fundamental principle is to equip the main group
6 of staff who do this work with the skills, the support,
7 the knowledge that they need. And organisations are not
8 going to change as a result of inquiries; they're going
9 to change because they have a deeply-felt understanding
10 of what's happened within their own organisation, and
11 a real desire to change that from within. How did we
12 get to the position we're in? This has happened in
13 Nottingham. It could have happened in many, many other
14 Trusts. What will we do to be different? And why did
15 we allow ourselves to reach the point that we have
16 reached where something like this can happen?

17 **MS LANGDALE:** Thank you. There will be other questions,
18 Mr Hart.

19 **THE CHAIR:** Yes, Mr Moloney. Thank you.

20 **Questioned by MR MOLONEY**

21 **MR MOLONEY:** Just one question, please, on behalf of the
22 bereaved families.

23 It's just this: having worked in a number of roles,
24 how common is it, in your experience, that MDT meetings
25 are not documented?

78

1 they telling me this? What are they not telling me?
2 Why won't they talk to me about something?

3 But then it's our analysis of that. And what do we
4 do with that information? What judgement do we arrive
5 at? Clinical judgement is essential. It's much more
6 than curiosity. If we document that, we've got a clear
7 narrative as to how we got from point A to point B. And
8 if we have a proper plan, a dynamic plan, not
9 a year-long plan that somebody is going to review
10 remotely, if we've got a dynamic plan about the current
11 risk and we're reviewing that on an ongoing basis, we've
12 got a much better chance of charting our way safely
13 through these very difficult waters.

14 **MR MOLONEY:** Thank you very much, Mr Hart.

15 **THE CHAIR:** Ms Cartwright.

16 **Questioned by MS CARTWRIGHT**

17 **MS CARTWRIGHT:** Good afternoon, Mr Hart. I ask questions on
18 behalf of the survivors.

19 Can I just pick up on what you've just said to
20 Mr Moloney. You've plainly referenced the essential
21 need for clinical curiosity, but in answering questions
22 to Ms Langdale KC on nurses in deferral, you gave some
23 fairly alarming and concerning evidence about the nurse
24 who doesn't start to explore in great depth because they
25 might find answers to questions they don't want to hear,

80

1 because they're going to be the person carrying the can,
2 or they're not going to be able to see them as needed.
3 So obviously you've given that evidence as to something
4 that you're aware of as happening in the practice of
5 essentially nurses not doing what required by the NMC to
6 provide proper clinical care and essentially not asking
7 the questions.

8 How can you address that cultural issue?
9 **A.** It is a cultural issue. You have to create a culture of
10 safety. People have got to know that they're supported.
11 For instance, just imagine you're either visiting
12 somebody at home or you're seeing them in the community
13 or you're having this conversation on an inpatient unit.
14 They don't want to talk to you about what's going on in
15 their mind. You're really concerned that there might be
16 something that's -- puts that person at risk themselves,
17 or puts others at risk. How do you have that
18 conversation? Because if I probe and somebody has got
19 a history of violence, are they going to be violent to
20 me? How are they going to respond to my questions?
21 So it may be, either consciously or not consciously,
22 somebody can be on the ward, they self-isolated, they
23 don't really join in with things. I go to talk to them
24 and they say they don't want to talk to me. And
25 I think, well, they're taking their medication, they'll

81

1 is to acknowledge what the problem is, and then we need
2 to educate people, post-registration. We know that
3 nurses coming out of university now really aren't --
4 they're not up to speed with all the things that they
5 need to to be a functioning, qualified nurse. They
6 still need further development. You'll get nurses who
7 have newly qualified, they don't get much support,
8 they've got to manage the ward and they've got to do all
9 sorts of things with very little experience.

10 So we need to address these things. We need to give
11 them better support right from the outset, but we need
12 ongoing developmental programmes. Nurse development
13 is -- it should never be a fixed thing. It should be an
14 ongoing part of the work. But we have to establish
15 standards that everybody adheres to, everybody
16 understands, and they know the purpose of them and they
17 can meet them. So there's a huge resource issue.

18 **MS CARTWRIGHT:** Thank you, Mr Hart.

19 **THE CHAIR:** Yes, Mr Straw.

Questioned by MR STRAW

21 **MR STRAW:** Mr Hart, I ask questions on behalf of VC's
22 family.

23 Firstly, I'd like to ask you about the financial
24 costs of mental ill health which you describe in your
25 statement at paragraph 192 and to leave aside the human

83

1 probably be asymptomatic fairly soon, I won't push, I
2 won't ask these questions. I might think there's
3 something that poses a risk to other people, but they'll
4 be going home or they'll be going out of here and then
5 another team will pick this up.

6 This is not necessarily a conscious process, but if
7 I ask this question, how will this person react? Will
8 I be safe? That's always a question, I think, at the
9 back of people's minds.

10 Plus, I've got 15 other things to do. If I sit and
11 have this conversation it's going to take time. What
12 will I do, you know, how will I make that time? What
13 will my manager say if I don't do this audit or do that
14 thing?

15 You know, we take away from our clinical arenas our
16 most experienced nurses: the ward managers. They get to
17 spend very, very little time clinically with the
18 patients. So people don't see them modelling good
19 practice.

20 So the way in which you may have those
21 conversations, those difficult, challenging
22 conversations, is not modelled for people, and then we
23 just expect them to get on with it.

24 **Q.** So a problem, but how -- what's the solution to that?

25 **A.** It's not a quick fix. It's a slow fix. The first thing

82

1 cost, which is obviously of huge importance, just look
2 at the financial cost.

3 Now, is it right that what you're identifying in
4 paragraph 192 is that if one takes away funding from
5 mental health services, particularly around high-risk
6 patients, and thereby one doesn't provide the mental
7 health care that's required to keep people safe, that
8 can have huge knock-on costs?

9 **A.** Mm-hm.

10 **Q.** Second issue, there's just three short issues I'd like
11 to ask you about. The second issue is about CCOs, care
12 coordinators. You discussed earlier training for nurses
13 generally. We've heard that the care coordinator role
14 is an important one, and has a number of sort of
15 specific requirements. Do you think there should be
16 training for care coordinators?

17 **A.** Yeah, I think, again, though, the notion of a care
18 coordinator implies that they've got this huge amount of
19 authority and they can coordinate and shift things
20 around. That's not the case at all. What essentially
21 it means is that they're the person who are the main
22 port of call. In some cases, the care coordinator may
23 not have much face-to-face contact but generally it will
24 be that person who has that responsibility, but again,
25 they've got very little authority.

84

1 If I was a care coordinator and I said, "Well
2 actually, you know, I think we should do A, B and C, but
3 the cost is going to be this," I've got no way of
4 implementing that.

5 The fundamental thing, and again this is about the
6 fragmentation of our services now, is nurses need to be
7 trained for all the things that they're expected to do.

8 So what is the role of -- the first thing is: what is
9 the role of a care coordinator? This involves Assertive
10 Outreach, it involves communication skills, it involves
11 decision-making, it involves knowledge of the Mental
12 Health Act, and it involves knowledge about medication.
13 Fundamentally, though, it involves maintaining this very
14 difficult relationship.

15 **Q.** You talked about training. Another aspect of
16 maintaining quality could be supervision or assessment.
17 So in particular in the context of care coordinator,
18 supervision of whether the care coordinator is
19 performing their role properly or some means of
20 assessment to make sure they're doing that. What's your
21 view on that? Should there be some process involved
22 which ensures that happens?

23 **A.** And you can't really function effectively as a mental
24 health nurse without two things: clinical supervision,
25 which is slightly different to managerial supervision;

85

1 **Q.** Thank you. And the final topic is about race
2 discrimination. In your witness statement, on page 52,
3 between paragraphs 179 and 183 you discuss race
4 discrimination, so in particular against black patients
5 in mental health services.

6 And is it right you set out the evidence to show
7 that there's persistent discrimination against black
8 patients in mental health services in your statement.

9 **A.** Yes, and I think this is very well known, very well
10 established. However, I think it's equally
11 discriminatory, then, to ignore the circumstances that
12 somebody from a different background has when they're in
13 crisis. People have a right to be treated. I don't
14 think people retrospectively would thank us for ignoring
15 their needs at their point of crisis simply because of
16 how we identified them.

17 **Q.** In your statement at paragraph 185 you indicate that
18 it's important that clinicians are aware of this and try
19 to reduce discrimination against black patients.

20 **A.** Well, I would say, a lot of clinicians are and I think
21 it does influence some people's decision making.
22 I think some aren't aware of it. It's, again, it's an
23 area that we need to have much more thought about and
24 have much more discussion, and again, people do need
25 training around this, this process.

87

1 but reflective practice. Reflective practice enables
2 a team, including nurses, to think about what they're
3 doing, what difficulties they're encountering, how it's
4 affecting them, and then how that plays into the
5 relationship. It enables better decision-making. It
6 enables better working relationships. So all of the --
7 supervision is absolutely essential. I keep coming back
8 to this. But it's a fundamental. This is complicated
9 work. You're often working with people who don't want
10 to work with you. If they do want to work with you,
11 you've got to take them to psychological and emotional
12 places they don't want to go.

13 If you look at all of the things around least
14 restrictive practice and phrases like "positive risk
15 taking", it's as if people have never gone through some
16 kind of psychological disaster because that's often what
17 this means. Your whole life has been derailed by
18 a psychotic episode. You've got to rebuild that. But
19 you've got to be able to understand it; you've got to be
20 able to revisit it. You've got to be able to figure out
21 how did this happen? What can I do to prevent it?
22 That's difficult work and the people doing this work
23 have to be supported. You have to have forums to think
24 and not be rushing around from one thing to another
25 without pause.

86

1 **Q.** One example for that, this may be obvious, but there's
2 a difference, isn't there, between avoiding
3 discrimination against black patients, so not treating
4 them less favourably, but on the other hand, not
5 discriminating in favour of them. So not discriminating
6 against white patients. There's a difference, isn't
7 there?

8 **A.** Can you say a little bit more about that?

9 **Q.** Sure. So what we're trying to avoid is discrimination
10 against black patients, isn't it? We're not saying they
11 should be treated more favourably than other people;
12 we're trying to avoid this problem, this persistent
13 problem with discrimination against them?

14 **A.** Yeah, we are. I think we also, though, have to
15 recognise that, within black communities, mental health
16 services have very often got a very poor reputation.
17 We're often viewed very negatively, and often with good
18 reason. So that's work that we have to do. We have to
19 address that. But when we have an individual person
20 that we are working with and we're trying to relate to,
21 we have to find ways to do that, always mindful of their
22 safety and the safety of others.

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

24 Thank you, Chair.

25

Questioned by THE CHAIR

88

1 **THE CHAIR:** Yes, I just want to ask you about training or
 2 education.
 3 Just as far as you're aware, when nurses are
 4 training, are they trained in note taking as to what,
 5 and to recording the important things that are necessary
 6 on a --
 7 **A.** Yeah, I think there's some attention paid to that,
 8 Chair, but not hugely.
 9 **THE CHAIR:** Do you think that would be helpful?
 10 **A.** I think it would be extremely useful.
 11 **THE CHAIR:** Yes. And as far as the difficult aspects, so
 12 difficult conversations you might have to have with the
 13 patient, of the kind that you've dealt with, so, for
 14 example, going back through the causes of the psychotic
 15 episode and so on, is there any training on, for
 16 example, scenarios where more experienced people do act
 17 up, if you like, the way that a difficult conversation
 18 might be held?
 19 **A.** That's where clinical simulations are invaluable because
 20 actually you can have an actor who's briefed and can
 21 take the role of the patient. The clinician is then
 22 just being themselves. They're not acting. They've got
 23 to have that -- I was doing this yesterday with a group
 24 of staff, so --
 25 **THE CHAIR:** How often does that happen?

89

1 there's -- we do have a fragmented health system.
 2 As far as the computer systems are concerned, they
 3 do have search functions, don't they?
 4 **A.** They do.
 5 **THE CHAIR:** Is it generally possible for nurses to find out
 6 what was happening, you know, if you put in a search
 7 term --
 8 **A.** Yeah.
 9 **THE CHAIR:** -- to last MDT, to bring that up?
 10 **A.** Mm-hm, yeah. Yeah, and there are pretty easy ways to
 11 navigate one's way around that. One of the things that
 12 people say is "I just haven't got time". I disagree
 13 with that. I do think they have time. And again, it's
 14 a way of thinking. It goes back to this issue of the
 15 culture within an organisation, the way that culture
 16 gets embedded and the way people behave within a certain
 17 context.
 18 If risk assessments aren't being written and
 19 documented, why is that? We spend all of our time
 20 talking about risk, so what's going on culturally that
 21 that's not happening? How do we address that? These
 22 are -- the question of how we make these changes is the
 23 essential thing.
 24 **THE CHAIR:** Yes.
 25 **A.** We talk a lot about what we're going to do; we never

91

1 **A.** In our -- in the work I do with my colleagues, we do
 2 this all the time, but it depends on the organisation,
 3 whether they want to engage in that or not. So we just
 4 have arrangements. At the moment we're doing a lot of
 5 this with Oxleas NHS Foundation Trust, so they
 6 commission this type of training which is built around
 7 simulation work.
 8 Some universities do use it, but very few Trusts use
 9 it in the way that I'm describing where they bring in
 10 actors to do this type of work. But it's invaluable.
 11 And then just going back, though, to the issue of
 12 documentation, if you do an audit of what many nurses
 13 write, they'll talk about monitoring somebody's mental
 14 state. If you think about that, it's nonsensical. How
 15 can I monitor somebody's mental state? I can't read
 16 their mind. What essentially they're talking about is
 17 looking at the person's behaviour.
 18 If I'm going to work as a nurse, I'm assessing that
 19 person's mental state, and I'm looking to help them
 20 develop better coping skills, better problem solving
 21 techniques. I'm helping them to try and understand
 22 what's happening. Then that's what I should be
 23 documenting.
 24 **THE CHAIR:** You've mentioned that there are different
 25 systems in different health authorities and obviously

90

1 talk about how we're going to do it.
 2 **THE CHAIR:** Thank you. Right. We'll finish there and we'll
 3 start again on Monday.
 4 **(4.23 pm)**

**(The hearing adjourned until 10.00 am on
 Monday, 1 June 2026)**

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

92

INDEX

	Page
1	
2	
3 PROFESSOR TIMOTHY KENDALL (affirmed)	1
4 Questioned by MR CARR	1
5 Questioned by MR MOLONEY	32
6 Questioned by MS CARTWRIGHT	37
7 Questioned by MR STRAW	42
8 Questioned by THE CHAIR	45
9	
10 CHRISTOPHER DAVID HART (sworn)	47
11 Questioned by MS LANGDALE	47
12 Questioned by MR MOLONEY	78
13 Questioned by MS CARTWRIGHT	80
14 Questioned by MR STRAW	83
15 Questioned by THE CHAIR	88
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	

<p>MR CARR: [5] 1/4 1/11 32/8 47/15 47/17</p> <p>MR MOLONEY: [4] 32/13 37/3 78/21 80/14</p> <p>MR STRAW: [4] 42/20 45/20 83/21 88/23</p> <p>MS CARTWRIGHT: [4] 37/7 42/16 80/17 83/18</p> <p>MS LANGDALE: [4] 47/21 48/2 76/8 78/17</p> <p>THE CHAIR: [28] 1/3 1/5 1/8 32/11 37/5 42/18 45/21 45/23 46/6 46/8 46/11 46/13 47/12 47/16 47/22 47/25 78/19 80/15 83/19 89/1 89/9 89/11 89/25 90/24 91/5 91/9 91/24 92/2</p> <p>THE WITNESS: [3] 1/10 37/4 42/17</p> <p>'</p> <p>'dangerousness' [1] 15/12</p> <p>'Neighbourhood' [1] 11/11</p> <p>'risk' [1] 15/11</p> <p>'tool' [1] 50/3</p> <p>'what' [1] 63/1</p>	<p>183 [1] 87/3</p> <p>185 [1] 87/17</p> <p>19 [2] 17/21 30/12</p> <p>192 [2] 83/25 84/4</p> <p>194 [1] 63/8</p> <p>195 [2] 63/9 64/13</p> <hr/> <p>2</p> <p>2.00 [1] 1/2</p> <p>20 years [3] 38/6 66/25 71/8</p> <p>2000s [1] 68/2</p> <p>2002 [1] 49/23</p> <p>2005 [1] 44/18</p> <p>2009 [1] 49/23</p> <p>2010 [1] 67/13</p> <p>2013 [2] 49/8 73/2</p> <p>2016 [1] 2/13</p> <p>2020 [1] 3/8</p> <p>2023 [1] 2/13</p> <p>2024 [1] 64/14</p> <p>2025 [1] 1/14</p> <p>2026 [4] 1/1 31/7 48/3 92/6</p> <p>209 [1] 52/6</p> <p>21 [1] 10/7</p> <p>22 [2] 10/7 11/2</p> <p>221 [2] 61/4 61/9</p> <p>226 [1] 65/9</p> <p>229 [1] 67/4</p> <p>230 [2] 67/4 67/5</p> <p>235 [1] 69/21</p> <p>236 [2] 69/22 70/1</p> <p>237 [2] 69/22 70/5</p> <p>238 [1] 71/14</p> <p>24 [1] 43/21</p> <p>24 hours [2] 9/2 9/3</p> <p>24/7 [5] 2/19 4/25 5/12 5/25 31/1</p> <p>242 [1] 72/17</p> <p>245 [1] 74/17</p> <p>248 [1] 75/9</p> <p>249 [1] 75/9</p> <p>25 [1] 26/16</p> <p>29 [1] 1/1</p> <hr/> <p>3</p> <p>3.08 [1] 47/18</p> <p>3.25 [2] 47/16 47/20</p> <p>30 [1] 2/5</p> <p>30 January [1] 48/3</p> <p>30 years [1] 78/2</p> <p>316 million [1] 31/12</p> <p>36 [2] 39/24 50/1</p> <p>37 [3] 11/25 40/18 42/8</p> <p>38 [2] 15/8 42/2</p> <hr/> <p>4</p> <p>4.23 [1] 92/4</p> <p>41 [1] 5/3</p> <p>44 [1] 5/11</p> <p>45 [1] 58/24</p> <p>46 [2] 11/10 17/1</p> <p>47 [1] 5/21</p> <p>48 [1] 17/4</p>	<p>49 [2] 5/21 9/5</p> <hr/> <p>5</p> <p>50 [1] 6/18</p> <p>52 [1] 87/2</p> <p>54 [1] 5/16</p> <p>57 [1] 63/6</p> <p>58 [2] 29/10 29/18</p> <p>59 [1] 67/13</p> <hr/> <p>6</p> <p>6 miles [1] 38/24</p> <p>61 [1] 22/15</p> <p>66 [1] 30/12</p> <p>67 [1] 31/4</p> <p>68 [1] 31/4</p> <hr/> <p>7</p> <p>70 [1] 43/22</p> <p>71 [1] 65/6</p> <p>72 [2] 65/6 67/3</p> <p>73 [2] 69/19 72/22</p> <p>74 [2] 69/19 72/17</p> <p>75 [1] 72/22</p> <p>77 [1] 74/15</p> <hr/> <p>8</p> <p>8.00 [3] 9/4 31/19 31/19</p> <p>80 [1] 54/22</p> <hr/> <p>A</p> <p>able [21] 7/19 7/21 10/21 14/9 20/10 30/2 30/22 31/18 38/17 42/25 45/15 53/10 54/17 59/22 69/14 73/19 77/3 81/2 86/19 86/20 86/20</p> <p>abolish [2] 13/11 14/7</p> <p>abolished [1] 14/21</p> <p>about [107]</p> <p>abroad [1] 16/14</p> <p>absolutely [19] 14/11 17/12 18/24 27/11 27/16 35/5 38/6 40/24 41/8 41/14 42/1 42/10 47/7 50/10 53/9 58/1 63/15 75/8 86/7</p> <p>absorb [1] 35/2</p> <p>accept [2] 24/3 27/14</p> <p>acceptable [1] 44/6</p> <p>acceptance [1] 6/17</p> <p>accepted [1] 64/16</p> <p>access [11] 8/22 10/16 10/21 21/11 21/23 22/20 44/3 44/4 44/7 66/24 74/2</p> <p>accommodated [1] 76/23</p> <p>accommodation [10] 37/21 37/24 38/3 38/5 38/13 39/1 39/8 39/12 41/6 41/6</p> <p>accordingly [1] 15/6</p>	<p>accuracy [2] 53/16 53/16</p> <p>accurate [3] 48/4 53/7 53/11</p> <p>accurately [1] 79/9</p> <p>acknowledge [2] 20/2 83/1</p> <p>acknowledging [1] 34/22</p> <p>across [1] 68/1</p> <p>act [18] 8/24 13/9 15/6 16/4 16/20 16/21 22/14 25/20 33/22 52/16 52/16 52/20 52/20 52/24 57/7 63/17 85/12 89/16</p> <p>acting [1] 89/22</p> <p>action [1] 72/6</p> <p>actions [1] 12/9</p> <p>actively [2] 33/7 33/14</p> <p>actor [1] 89/20</p> <p>actors [1] 90/10</p> <p>actually [9] 20/12 35/11 36/7 40/8 58/16 70/25 76/4 85/2 89/20</p> <p>acute [4] 48/16 66/13 74/25 75/5</p> <p>add [1] 76/11</p> <p>additional [1] 56/15</p> <p>address [9] 3/11 12/9 12/19 18/2 52/2 81/8 83/10 88/19 91/21</p> <p>addressed [2] 39/12 69/4</p> <p>addresses [1] 2/24</p> <p>adhered [2] 60/13 60/20</p> <p>adheres [1] 83/15</p> <p>adjourned [1] 92/5</p> <p>administering [1] 12/16</p> <p>admission [2] 12/15 66/13</p> <p>admit [1] 32/19</p> <p>admitted [3] 32/21 55/14 74/25</p> <p>adopt [1] 61/5</p> <p>adult [1] 48/10</p> <p>advanced [2] 11/14 70/3</p> <p>advantage [1] 24/12</p> <p>advantages [2] 19/7 59/9</p> <p>advice [1] 29/25</p> <p>advisory [7] 35/24 36/2 36/3 36/13 36/14 36/23 37/1</p> <p>affected [1] 62/9</p> <p>affecting [1] 86/4</p> <p>affirmed [2] 1/6 93/3</p> <p>Afiya [1] 17/2</p> <p>afraid [2] 26/7 71/22</p> <p>after [3] 6/9 48/11 48/23</p> <p>aftercare [1] 37/21</p>	<p>afternoon [4] 4/12 37/7 37/8 80/17</p> <p>afterwards [1] 19/13</p> <p>again [35] 11/7 12/14 18/4 38/9 41/5 42/7 51/16 53/24 55/21 58/1 59/21 59/23 60/15 60/20 61/1 61/16 61/20 61/24 62/20 63/2 66/24 67/15 68/18 71/22 72/12 74/5 77/11 79/2 84/17 84/24 85/5 87/22 87/24 91/13 92/3</p> <p>against [8] 46/17 87/4 87/7 87/19 88/3 88/6 88/10 88/13</p> <p>agencies [2] 73/15 75/14</p> <p>agency [4] 13/6 75/10 75/24 76/4</p> <p>agenda [2] 54/11 54/12</p> <p>aggression [1] 58/9</p> <p>aggressive [1] 58/15</p> <p>ago [2] 38/6 73/2</p> <p>agree [16] 3/25 4/21 4/22 15/17 25/7 32/17 36/19 36/21 40/8 40/23 41/5 41/10 41/22 42/1 42/7 47/7</p> <p>agreeable [1] 23/5</p> <p>agreed [1] 73/13</p> <p>agreement [1] 58/1</p> <p>aim [3] 8/7 9/1 21/11</p> <p>aimed [1] 29/14</p> <p>airing [1] 5/4</p> <p>akin [1] 45/11</p> <p>alarming [1] 80/23</p> <p>alcohol [1] 41/1</p> <p>aligned [1] 10/24</p> <p>all [57] 6/4 6/11 6/22 7/23 8/9 8/17 8/19 8/21 8/22 9/16 15/3 15/3 16/10 16/12 16/23 17/6 18/11 20/22 21/15 24/14 24/24 30/2 32/22 35/6 35/9 36/8 36/9 36/14 36/22 40/14 41/10 41/12 51/8 53/18 55/4 57/7 59/1 60/22 63/5 64/3 64/25 66/15 68/7 69/4 70/6 71/15 73/19 75/8 75/23 83/4 83/8 84/20 85/7 86/6 86/13 90/2 91/19</p> <p>allow [2] 52/8 78/15</p> <p>allows [1] 74/2</p> <p>almost [2] 12/21 70/18</p> <p>along [2] 46/1 65/24</p> <p>alongside [2] 30/24 43/17</p> <p>already [5] 3/9 9/16</p>
--	--	---	---	---

A	appointments [2] 49/21 76/22 appreciate [1] 39/3 approach [16] 10/25 11/9 11/16 16/7 17/9 17/10 18/1 18/7 21/21 22/4 22/8 24/2 28/6 39/6 56/18 76/7 approaches [2] 17/20 34/23 approaching [1] 52/18 appropriate [6] 17/12 27/8 39/8 40/19 47/15 73/15 are [132] area [5] 32/24 40/3 51/13 65/24 87/23 areas [3] 38/19 52/24 68/4 aren't [9] 20/2 20/3 20/25 49/15 50/7 59/13 83/3 87/22 91/18 arenas [2] 56/1 82/15 argument [1] 70/12 arises [2] 9/13 14/18 arising [1] 45/23 around [16] 16/24 39/12 57/12 57/12 65/2 66/1 71/23 75/23 76/15 84/5 84/20 86/13 86/24 87/25 90/6 91/11 arrangement [1] 43/19 arrangements [1] 90/4 arrested [1] 75/16 arrive [1] 80/4 as [100] aside [1] 83/25 ask [11] 37/9 41/19 45/23 77/13 80/17 82/2 82/7 83/21 83/23 84/11 89/1 asked [7] 16/10 30/18 36/4 49/2 66/16 70/13 73/21 asking [2] 9/10 81/6 asks [1] 65/5 aspect [3] 53/24 54/1 85/15 aspects [2] 55/22 89/11 assault [1] 63/18 assaulted [1] 62/10 assertive [30] 20/16 25/4 25/8 25/10 25/11 25/17 25/18 25/19 25/20 26/1 26/3 26/4 26/6 26/8 26/17 27/10 27/10 27/14 28/1 28/15 28/17 28/19 28/23 29/7 48/21 67/12 76/15 76/17	76/17 85/9 assertively [4] 22/22 23/2 24/10 24/19 assess [1] 54/3 assessed [1] 52/23 assessing [5] 41/11 42/8 56/20 59/7 90/18 assessment [27] 23/6 49/18 53/22 58/12 58/25 59/20 60/11 60/11 61/6 61/10 61/12 61/14 64/14 64/18 64/22 65/22 69/25 71/15 71/17 71/23 71/25 72/4 72/11 72/13 76/9 85/16 85/20 assessments [3] 52/4 52/9 91/18 assist [2] 37/21 73/19 associate [1] 76/25 associated [1] 26/23 associates [1] 53/4 Association [1] 49/22 Associations [1] 39/11 asymptomatic [1] 82/1 at [103] attached [1] 11/19 attend [1] 27/7 attend-when-you-wis h [1] 27/7 attended [1] 70/8 attention [2] 4/22 89/7 attitudes [1] 18/2 attractive [1] 47/1 audit [2] 82/13 90/12 audits [2] 36/9 36/25 authorities [2] 38/10 90/25 authority [3] 54/24 84/19 84/25 authors [1] 3/10 autonomy [4] 10/25 11/4 11/7 21/25 autumn [1] 30/18 available [10] 7/13 7/14 19/14 19/14 31/12 38/5 39/5 41/5 56/19 56/22 avenues [1] 66/23 avoid [5] 23/17 33/11 33/15 88/9 88/12 avoidant [4] 33/7 33/8 33/10 34/9 avoiding [1] 88/2 aware [8] 14/17 42/15 59/14 61/7 81/4 87/18 87/22 89/3 awareness [1] 26/20 away [4] 19/21 21/13 82/15 84/4	awry [1] 73/22 B back [20] 5/19 23/1 36/12 48/17 50/24 59/8 65/22 66/1 67/11 68/1 68/5 70/13 75/20 78/2 79/10 82/9 86/7 89/14 90/11 91/14 background [2] 1/19 87/12 backgrounds [1] 71/10 bandied [1] 76/16 bare [1] 71/13 barely [1] 12/20 base [3] 6/3 20/6 44/9 based [14] 6/11 11/14 12/10 17/19 17/25 18/9 18/9 21/2 48/19 57/14 58/5 69/24 70/3 79/17 basis [8] 11/9 14/18 15/11 23/19 23/22 54/14 61/7 80/11 be [191] became [1] 25/11 because [31] 6/8 6/20 9/11 14/1 20/6 23/7 26/3 28/4 30/25 36/4 40/20 50/15 55/4 55/8 56/3 56/9 56/13 59/6 61/1 65/4 65/24 68/19 73/23 74/12 78/9 80/24 81/1 81/18 86/16 87/15 89/19 become [9] 7/7 14/2 15/5 23/21 45/1 46/14 54/18 56/3 65/16 becomes [5] 6/3 7/3 23/23 53/18 63/14 becoming [1] 48/14 bed [7] 10/19 21/24 22/22 23/4 23/8 31/3 51/13 beds [5] 6/6 6/9 51/13 55/9 55/18 been [35] 24/25 25/1 25/2 26/11 27/22 28/13 34/11 34/21 35/7 37/10 37/17 37/19 43/3 43/10 43/13 43/14 44/19 49/3 57/20 58/15 58/15 66/2 67/11 67/17 67/20 70/15 71/8 74/24 75/22 78/1 78/3 79/1 79/1 79/3 86/17 before [5] 29/15 29/21 49/11 73/16 78/3 behalf [4] 37/9 78/21 80/18 83/21 behave [1] 91/16	behaviour [2] 53/3 90/17 behavioural [1] 44/4 behind [1] 6/22 being [25] 5/3 5/8 10/21 10/24 15/16 21/9 23/4 23/10 29/22 30/13 37/18 39/5 39/15 42/5 53/11 53/17 53/18 54/24 58/7 66/16 67/16 70/25 79/24 89/22 91/18 belief [1] 1/17 beliefs [1] 46/14 believe [1] 45/12 believed [1] 16/11 bench [1] 20/21 beneficial [1] 76/5 benefit [3] 69/12 70/11 72/25 benefits [2] 34/22 75/23 bereaved [1] 78/22 best [16] 1/16 16/16 28/11 33/21 57/17 57/17 61/5 61/11 61/18 63/7 65/7 65/10 65/15 66/14 66/19 68/15 better [12] 28/4 28/14 29/1 43/19 46/25 58/20 80/12 83/11 86/5 86/6 90/20 90/20 between [8] 37/1 49/23 52/15 64/22 66/4 72/10 87/3 88/2 beyond [4] 6/7 9/4 30/5 56/12 bias [1] 15/13 bigger [1] 67/18 biggest [1] 38/2 bipolar [1] 21/17 Birmingham [1] 28/17 bit [10] 5/23 11/22 22/8 22/9 31/5 49/11 57/6 63/10 70/16 88/8 bits [1] 30/24 black [6] 87/4 87/7 87/19 88/3 88/10 88/15 board [2] 16/9 16/11 bodies [2] 66/6 66/21 body [6] 55/1 61/23 69/11 71/6 74/8 74/12 book [1] 64/16 both [1] 74/14 bottom [1] 17/22 brain [1] 45/10 break [6] 39/2 47/13 47/15 47/19 50/22 51/14 breakdown [2] 19/11 19/14
----------	--	--	--	---

<p>B</p> <p>bridge [2] 54/13 65/1 briefed [1] 89/20 briefly [3] 1/20 39/21 76/14 bring [4] 54/17 63/5 90/9 91/9 bringing [5] 29/12 29/19 30/5 30/8 76/4 broad [2] 24/24 66/12 broaden [1] 18/2 broader [2] 22/24 40/3 build [4] 31/13 61/22 76/19 77/9 building [1] 34/10 built [4] 19/24 35/6 35/7 90/6 bulk [1] 9/21 burden [1] 34/25 business [1] 43/14 but [125]</p>	<p>52/8 52/16 52/18 52/20 52/21 capital [2] 31/13 32/5 captured [1] 26/3 car [1] 75/1 care [48] 8/23 9/8 9/18 9/25 10/3 10/9 11/5 11/12 11/14 11/17 15/2 21/16 22/1 28/23 29/12 31/15 33/7 33/8 33/10 34/7 34/9 35/1 35/8 35/11 44/11 49/6 50/22 51/2 51/3 51/5 51/8 54/1 73/16 73/17 74/21 74/25 75/6 81/6 84/7 84/11 84/13 84/16 84/17 84/22 85/1 85/9 85/17 85/18 care-avoidant [1] 33/7 career [1] 48/9 carefully [1] 41/23 Carr [3] 1/3 1/7 93/4 carried [1] 49/8 carry [3] 32/2 40/25 67/14 carrying [2] 56/10 81/1 Cartwright [6] 37/5 37/6 80/15 80/16 93/6 93/13 case [11] 3/8 8/24 20/25 22/17 25/21 26/2 26/8 35/5 35/19 53/10 84/20 caseload [5] 24/23 25/2 26/16 26/18 55/9 caseloads [1] 67/18 cases [5] 19/2 43/3 46/15 55/11 84/22 catastrophes [1] 23/17 catastrophic [3] 4/2 4/12 4/17 category [1] 27/25 cause [1] 33/25 causes [1] 89/14 CBT [1] 7/5 CCOs [1] 84/11 cease [1] 36/1 central [1] 11/13 centrally [1] 8/20 centre [35] 2/20 6/2 7/12 7/18 7/21 8/8 8/17 8/23 9/24 10/1 18/25 19/20 20/4 20/6 20/18 21/3 21/14 21/15 22/20 22/23 24/14 24/22 27/6 28/8 30/23 33/2 33/12 33/13 38/21 38/22 41/15 43/6 46/18 47/3 48/19 centred [2] 17/19 17/25</p>	<p>centres [21] 5/20 5/25 6/22 7/10 7/17 8/17 10/12 19/7 20/12 21/7 21/16 22/7 23/22 24/19 29/2 31/13 31/18 35/5 39/9 39/10 39/11 certain [5] 13/21 62/14 63/19 64/7 91/16 certainly [2] 15/21 66/9 cetera [1] 61/15 chair [11] 1/4 1/8 32/9 45/22 47/21 49/22 88/24 88/25 89/8 93/8 93/15 challenging [2] 61/2 82/21 chance [2] 28/14 80/12 change [16] 18/1 23/7 33/18 60/23 62/12 62/13 62/18 62/20 64/11 64/12 66/25 70/22 77/25 78/8 78/9 78/11 changed [3] 33/19 54/21 64/9 changes [2] 56/6 91/22 changing [2] 50/16 77/11 charity [1] 4/14 charting [1] 80/12 chasm [1] 54/13 Chief [2] 43/13 68/10 children [1] 2/9 choice [2] 10/24 11/4 choices [2] 11/5 22/1 chopping [1] 77/11 CHRISTOPHER [3] 47/23 78/2 93/10 chronic [1] 43/23 circumstances [6] 14/19 41/4 62/14 63/19 64/7 87/11 cite [1] 3/7 city [8] 8/10 8/18 8/19 24/20 28/19 29/6 38/20 38/22 city-wide [1] 28/19 claimed [1] 25/23 clarity [1] 40/8 clear [7] 7/9 15/21 50/7 58/7 59/1 60/10 80/6 clinical [28] 2/13 2/16 21/12 40/10 48/17 54/23 60/14 60/16 65/8 65/12 65/19 66/4 67/20 68/13 69/1 70/3 71/1 71/7 71/9 74/6 79/20 79/22 80/5 80/21 81/6 82/15 85/24 89/19</p>	<p>clinically [2] 69/9 82/17 clinician [4] 41/23 53/10 53/15 89/21 clinicians [7] 34/7 41/11 54/21 57/19 58/8 87/18 87/20 close [2] 10/3 49/11 clothing [2] 34/15 38/23 Clunis [1] 78/2 co [2] 2/11 51/5 co-existing [1] 2/11 co-ordinator [1] 51/5 Code [2] 53/2 66/9 coercion [8] 12/9 12/22 14/20 15/20 15/22 15/24 16/1 39/16 coercive [9] 12/2 12/6 14/21 15/10 17/4 17/9 17/10 18/3 22/13 cognitive [1] 44/3 cohesive [1] 76/6 cohort [2] 19/25 20/2 collating [1] 59/15 colleague [1] 64/19 colleagues [2] 49/10 90/1 collection [1] 36/1 College [2] 2/1 66/21 column [1] 3/13 combine [1] 72/15 come [24] 2/23 4/24 7/21 9/24 10/22 20/4 20/9 20/14 23/1 28/6 34/23 35/11 44/13 46/18 50/24 52/3 53/20 64/11 66/1 68/4 73/24 74/4 75/18 75/20 comes [2] 42/12 74/3 comfortable [2] 49/12 49/13 coming [7] 31/6 35/20 47/3 63/12 77/12 83/3 86/7 comment [1] 65/9 commission [1] 90/6 committed [2] 3/15 3/17 committee [1] 13/10 committees [1] 13/21 common [4] 19/5 34/4 47/11 78/24 commonly [4] 6/18 7/23 14/1 42/25 communicate [2] 60/21 60/22 communicated [1] 57/25 communication [2] 70/4 85/10 communities [1] 88/15</p>	<p>community [47] 5/1 6/13 6/15 7/19 7/20 7/20 7/21 9/13 9/14 9/19 11/14 11/17 11/24 14/14 16/8 16/17 16/24 18/8 20/8 20/9 20/24 24/25 25/20 26/4 26/22 27/10 28/19 29/11 29/12 29/20 31/15 32/16 35/7 37/10 47/3 48/17 48/18 48/20 50/20 54/9 55/10 55/13 56/4 75/13 77/17 77/18 81/12 community-based [1] 11/14 compassion [1] 18/9 compelled [1] 13/17 competences [1] 53/5 competency [1] 69/24 competency-based [1] 69/24 Completely [1] 32/17 complex [6] 37/15 51/23 51/23 61/1 71/13 71/13 compliance [1] 26/21 complicated [2] 51/16 86/8 component [1] 73/6 comprehensive [3] 17/18 35/25 36/1 compulsory [4] 13/12 14/8 15/16 18/13 computer [1] 91/2 concern [5] 21/15 34/24 35/3 35/13 35/14 concerned [4] 23/24 48/5 81/15 91/2 concerning [1] 80/23 concerns [3] 15/12 65/10 77/6 concordant [2] 18/17 22/5 Conduct [1] 66/10 conducts [1] 72/14 conferences [1] 68/17 Confidential [2] 36/9 36/24 confirm [1] 48/3 conscious [2] 76/9 82/6 consciously [2] 81/21 81/21 consensus [1] 58/4 consequence [1] 39/1 consequences [1] 38/19 consequently [1]</p>
--	---	--	--	---

<p>C</p> <p>consequently... [1] 26/21</p> <p>consider [1] 52/7</p> <p>considered [1] 57/24</p> <p>consistent [3] 58/8 76/7 77/9</p> <p>consistently [1] 60/13</p> <p>conspiracy [2] 46/16 46/19</p> <p>Constables [1] 43/13</p> <p>consultant [7] 1/20 19/1 26/17 48/25 49/10 53/15 68/8</p> <p>consultants [3] 49/23 68/1 68/3</p> <p>contact [4] 27/1 53/13 68/7 84/23</p> <p>content [1] 63/22</p> <p>contents [1] 48/4</p> <p>context [5] 14/13 37/14 62/23 85/17 91/17</p> <p>contextual [1] 30/21</p> <p>continue [2] 40/22 49/11</p> <p>continuity [5] 10/9 15/1 50/22 51/14 54/15</p> <p>contradiction [1] 23/19</p> <p>control [3] 3/8 11/5 21/25</p> <p>Convention [2] 12/25 13/4</p> <p>conventionally [1] 64/15</p> <p>conversation [8] 54/17 70/18 79/6 79/6 81/13 81/18 82/11 89/17</p> <p>conversations [3] 82/21 82/22 89/12</p> <p>coordinate [1] 84/19</p> <p>coordinating [1] 34/25</p> <p>coordinator [8] 51/2 84/13 84/18 84/22 85/1 85/9 85/17 85/18</p> <p>coordinators [2] 84/12 84/16</p> <p>coping [1] 90/20</p> <p>copy [1] 26/11</p> <p>core [2] 9/18 50/10</p> <p>correct [12] 2/4 2/7 2/12 2/15 2/18 2/22 5/9 5/13 5/18 21/6 40/6 40/7</p> <p>cost [5] 30/25 31/1 84/1 84/2 85/3</p> <p>costs [3] 70/10 83/24 84/8</p> <p>could [15] 23/17 31/20 33/23 46/15</p> <p>54/23 55/15 55/20 64/3 65/14 66/7 66/7 66/9 68/3 78/13 85/16</p> <p>couldn't [2] 32/25 39/12</p> <p>council [1] 38/4</p> <p>countries [1] 18/1</p> <p>couple [2] 17/3 76/14</p> <p>course [2] 17/3 70/10</p> <p>cover [3] 32/22 45/5 71/24</p> <p>coverage [1] 31/23</p> <p>covered [1] 64/25</p> <p>covering [1] 28/21</p> <p>Covid [3] 68/21 68/22 68/23</p> <p>CPD [2] 8/10 8/19</p> <p>crash [1] 75/2</p> <p>crashes [1] 4/20</p> <p>CRDP [1] 12/14</p> <p>create [1] 81/9</p> <p>creation [1] 15/19</p> <p>credited [1] 51/24</p> <p>crisis [9] 9/20 25/2 31/16 48/21 51/9 75/19 75/19 87/13 87/15</p> <p>criteria [2] 6/17 10/18</p> <p>CRPD [2] 12/8 12/24</p> <p>crucial [1] 64/9</p> <p>cultural [2] 81/8 81/9</p> <p>culturally [1] 91/20</p> <p>culture [3] 81/9 91/15 91/15</p> <p>curiosity [5] 79/20 79/22 79/24 80/6 80/21</p> <p>curious [1] 79/24</p> <p>current [3] 62/5 62/8 80/10</p> <p>currently [2] 1/23 2/16</p> <p>curriculum [1] 70/3</p> <p>cut [9] 36/10 36/13 36/18 36/18 36/19 36/22 36/25 65/22 67/11</p> <p>cuts [2] 36/20 67/4</p> <p>cutting [1] 36/16</p> <p>cynical [1] 15/16</p> <hr/> <p>D</p> <p>damage [1] 37/2</p> <p>damaging [1] 36/15</p> <p>danger [4] 14/2 15/5 24/2 35/19</p> <p>dangerous [2] 23/21 23/24</p> <p>data [4] 31/2 36/1 40/2 40/9</p> <p>date [1] 53/12</p> <p>dated [2] 1/14 48/2</p> <p>DAVID [2] 47/23 93/10</p> <p>day [8] 9/1 9/2 9/3</p>	<p>54/14 54/14 69/24 70/6 70/8</p> <p>days [3] 31/19 65/14 71/12</p> <p>deal [12] 6/20 8/5 12/22 12/24 25/12 28/4 29/2 29/8 31/5 32/25 69/21 75/9</p> <p>dealing [3] 3/24 4/11 9/13</p> <p>dealt [2] 39/14 89/13</p> <p>debate [1] 76/15</p> <p>debt [1] 29/25</p> <p>decades [1] 74/10</p> <p>decided [1] 36/22</p> <p>decision [15] 36/5 36/5 36/6 36/7 36/8 50/5 55/15 55/20 55/23 56/1 77/5 79/17 85/11 86/5 87/21</p> <p>decision-making [6] 55/23 56/1 77/5 79/17 85/11 86/5</p> <p>decisions [5] 52/5 55/5 57/16 79/7 79/7</p> <p>dedicated [6] 25/8 27/14 28/1 28/23 29/7 41/3</p> <p>deeply [1] 78/9</p> <p>defer [1] 55/11</p> <p>deferral [1] 80/22</p> <p>deferring [1] 56/3</p> <p>definition [2] 58/7 58/9</p> <p>defragmented [1] 14/14</p> <p>degree [1] 19/24</p> <p>delighted [1] 31/25</p> <p>delivering [2] 74/1 75/7</p> <p>delivery [1] 10/2</p> <p>delusional [1] 63/22</p> <p>delusions [1] 40/21</p> <p>demand [1] 67/2</p> <p>demands [1] 67/1</p> <p>demonstrate [1] 26/19</p> <p>Department [1] 73/4</p> <p>depend [4] 51/16 51/17 54/6 57/4</p> <p>depended [1] 36/23</p> <p>depending [1] 44/6</p> <p>depends [1] 90/2</p> <p>depot [1] 22/24</p> <p>depressive [1] 40/12</p> <p>deprivation [1] 12/10</p> <p>depth [2] 56/8 80/24</p> <p>derailed [1] 86/17</p> <p>derive [1] 54/24</p> <p>describe [10] 5/2 5/3 17/3 24/10 30/12 30/22 45/4 58/21 59/19 83/24</p> <p>described [4] 10/23 24/14 27/25 37/11</p> <p>describing [8] 26/16</p>	<p>26/18 27/5 29/19 29/21 30/6 37/14 90/9</p> <p>description [1] 28/7</p> <p>desire [1] 78/11</p> <p>deskill [1] 56/2</p> <p>detailed [2] 71/18 76/10</p> <p>details [1] 2/19</p> <p>detain [1] 75/17</p> <p>detained [1] 51/20</p> <p>detect [1] 60/7</p> <p>detention [3] 13/18 37/19 50/14</p> <p>deteriorating [1] 37/23</p> <p>determine [2] 4/9 36/25</p> <p>develop [5] 14/14 50/11 68/15 69/13 90/20</p> <p>developed [4] 59/25 64/19 64/20 69/9</p> <p>developing [3] 23/13 65/19 71/3</p> <p>development [5] 2/5 5/12 72/20 83/6 83/12</p> <p>developmental [1] 83/12</p> <p>diagnosis [5] 40/9 57/2 57/13 57/20 62/17</p> <p>dial [1] 74/11</p> <p>did [17] 16/15 25/14 25/16 25/17 34/6 36/5 36/14 36/19 46/3 46/5 46/6 49/1 60/1 64/10 78/11 78/14 86/21</p> <p>didn't [1] 55/19</p> <p>difference [4] 21/6 21/7 88/2 88/6</p> <p>differences [1] 52/15</p> <p>different [27] 16/23 17/6 22/8 22/9 24/6 25/25 26/5 29/12 30/19 51/8 51/21 56/25 56/25 58/17 60/14 60/16 60/17 68/4 71/9 71/10 75/20 77/12 78/14 85/25 87/12 90/24 90/25</p> <p>differently [2] 57/11 68/11</p> <p>difficult [17] 24/13 28/2 32/18 43/15 44/25 47/8 50/24 51/11 75/13 75/14 80/13 82/21 85/14 86/22 89/11 89/12 89/17</p> <p>difficulties [4] 37/13 37/16 71/2 86/3</p> <p>difficulty [3] 33/10 40/2 46/20</p> <p>dilemma [1] 66/16</p> <p>diluted [2] 70/16 73/3</p> <p>direct [1] 77/19</p>	<p>direction [1] 79/13</p> <p>directions [1] 74/14</p> <p>directly [1] 71/25</p> <p>Director [5] 2/14 68/12 72/18 72/23 73/18</p> <p>directorate [2] 72/20 73/3</p> <p>directs [1] 73/8</p> <p>Disabilities [2] 12/25 13/10</p> <p>disability [1] 12/11</p> <p>disadvantaged [2] 30/10 41/4</p> <p>disadvantages [1] 59/10</p> <p>disagree [5] 18/5 18/6 27/9 28/22 91/12</p> <p>disagreed [1] 13/13</p> <p>disaster [1] 86/16</p> <p>discharge [1] 66/17</p> <p>discharged [2] 22/21 75/18</p> <p>disciplinary [2] 58/3 75/9</p> <p>disclosing [3] 41/21 41/24 64/2</p> <p>disclosure [1] 57/12</p> <p>discrepancies [1] 57/9</p> <p>discriminating [2] 88/5 88/5</p> <p>discrimination [7] 87/2 87/4 87/7 87/19 88/3 88/9 88/13</p> <p>discriminatory [1] 87/11</p> <p>discuss [2] 55/14 87/3</p> <p>discussed [1] 84/12</p> <p>discussion [4] 57/13 67/23 67/24 87/24</p> <p>disengage [1] 26/2</p> <p>disengaged [4] 18/16 22/5 23/10 34/18</p> <p>disengagement [1] 26/22</p> <p>disengaging [2] 25/3 59/18</p> <p>disorder [3] 21/18 40/5 62/17</p> <p>disposal [1] 69/18</p> <p>Dissanayaka [2] 26/12 28/1</p> <p>disseminating [1] 60/25</p> <p>distracted [1] 65/17</p> <p>distressed [1] 75/6</p> <p>distrustful [1] 46/22</p> <p>disturbed [2] 55/18 75/5</p> <p>divorced [1] 20/24</p> <p>do [112]</p> <p>document [10] 11/25 12/18 14/16 15/8 16/22 17/2 17/15</p>
---	---	---	---

D	duty [1] 38/12 dynamic [5] 61/14 62/22 72/16 80/8 80/10	engaged [3] 22/22 24/10 77/5 engagement [1] 25/5 engaging [3] 23/2 28/14 45/17 England [11] 2/14 2/17 2/21 3/17 6/14 16/9 19/9 31/12 36/8 36/21 68/1 English [2] 14/13 16/19 enormous [3] 57/10 60/21 76/1 enormously [1] 62/18 ensures [1] 85/22 ensuring [1] 39/6 entirely [2] 16/1 60/18 entirety [1] 17/8 entitles [1] 37/20 entry [1] 27/4 envisaged [1] 18/8 episode [3] 8/6 86/18 89/15 equally [1] 87/10 equip [1] 78/5 equipped [2] 25/13 52/13 eradicated [1] 55/16 escalate [1] 77/6 essence [1] 53/6 essential [12] 27/11 27/23 35/5 53/9 62/16 73/20 79/16 79/25 80/5 80/20 86/7 91/23 essentially [10] 5/20 29/23 32/3 34/4 39/6 71/23 81/5 81/6 84/20 90/16 essentials [1] 71/24 Essex [1] 5/5 establish [3] 50/4 72/18 83/14 established [2] 19/12 87/10 establishing [1] 72/24 et [1] 61/15 et cetera [1] 61/15 ethical [2] 66/16 66/20 evaluate [1] 30/19 evaluation [2] 30/13 31/22 even [13] 4/15 4/15 22/24 32/14 32/18 32/25 41/23 55/24 67/19 68/21 68/22 71/12 78/3 evening [1] 6/6 event [2] 3/16 4/12 events [2] 4/2 4/17 eventually [2] 48/13 48/17 ever [1] 77/25	every [8] 6/14 24/14 32/16 45/5 53/20 60/12 70/8 79/1 everybody [8] 33/1 36/12 46/17 46/19 60/18 60/25 83/15 83/15 everyone [3] 8/1 18/10 21/21 everything [1] 14/15 evidence [19] 3/9 4/13 4/15 11/19 21/1 25/9 26/10 34/6 35/24 36/17 44/9 52/3 54/20 56/25 71/7 76/12 80/23 81/3 87/6 evident [1] 67/6 evolve [3] 62/19 79/10 79/11 exactly [3] 44/16 58/21 67/14 example [14] 7/3 19/11 32/19 45/25 59/17 60/4 61/10 61/13 62/1 62/3 65/20 88/1 89/14 89/16 examples [4] 16/22 17/6 35/17 61/18 excellence [1] 65/19 excessive [2] 16/13 41/2 execs [1] 16/11 Executive [1] 68/10 exercise [1] 12/22 exert [2] 54/23 62/22 exist [2] 8/14 12/20 existential [1] 65/17 existing [2] 2/11 8/12 expand [2] 32/2 63/9 expect [2] 41/15 82/23 expected [5] 29/2 52/13 67/14 67/18 85/7 expecting [1] 20/13 experience [13] 23/9 23/11 42/22 42/25 43/10 44/11 50/23 51/20 61/22 69/5 69/12 78/24 83/9 experienced [4] 69/7 69/16 82/16 89/16 experiences [1] 68/5 expert [1] 74/2 expertise [3] 3/2 3/3 34/3 explain [1] 5/24 explained [1] 11/9 explaining [1] 58/16 explanation [2] 16/25 64/11 explore [8] 5/19 33/4 33/9 33/23 34/6 51/10 56/7 80/24 exploring [1] 21/20 expressed [1] 35/3	extensive [1] 70/10 extensively [1] 76/9 extent [1] 21/1 external [1] 30/13 extract [4] 14/12 16/16 26/11 53/2 extracted [1] 15/3 extremely [4] 50/23 51/23 69/16 89/10
	E		F	
document... [3] 17/21 59/1 80/6 documentaries [1] 5/4 documentation [6] 52/10 54/19 58/20 79/14 79/16 90/12 documented [7] 53/17 78/25 79/2 79/5 79/8 79/8 91/19 documenting [1] 90/23 does [16] 6/20 7/9 10/21 14/4 24/11 26/4 28/8 31/23 43/25 50/22 51/14 56/2 74/3 76/16 87/21 89/25 does it [2] 56/2 76/16 doesn't [18] 2/19 2/24 8/4 8/11 8/12 23/23 24/3 42/14 50/11 60/12 66/10 66/12 66/12 66/15 66/18 72/2 80/24 84/6 doing [16] 19/9 25/14 26/6 26/7 27/22 49/5 64/1 71/8 73/8 73/9 81/5 85/20 86/3 86/22 89/23 90/4 don't [38] 3/21 4/6 4/9 6/7 12/23 15/14 15/25 16/20 20/17 31/20 34/17 35/4 38/14 38/18 43/16 51/7 52/6 52/12 52/19 59/7 63/1 65/15 68/25 76/18 76/21 76/21 77/5 80/25 81/14 81/23 81/24 82/13 82/18 83/7 86/9 86/12 87/13 91/3 done [7] 13/16 30/23 31/14 37/1 39/5 53/18 77/16 doors [1] 9/4 doubt [5] 13/16 14/23 33/2 46/10 46/11 down [17] 1/8 3/12 3/13 4/24 5/10 9/24 19/20 31/5 39/2 45/18 47/25 52/3 58/19 63/9 72/22 74/3 74/4 Dr [2] 26/12 28/1 Dr Dissanayaka [2] 26/12 28/1 dramatic [1] 67/20 draw [1] 61/21 dream [1] 45/11 drop [1] 10/5 drugs [1] 41/2 due [1] 30/15 during [2] 46/8 46/23 duties [2] 38/15 38/17	each [9] 6/2 6/10 6/16 8/18 22/7 30/22 58/5 60/18 75/13 earlier [4] 18/19 42/20 45/16 84/12 early [8] 7/3 7/4 8/11 9/20 31/17 44/17 68/1 75/21 easily [1] 59/11 easy [7] 10/19 10/19 21/11 21/23 21/24 64/24 91/10 educate [1] 83/2 education [4] 61/19 61/21 77/1 89/2 effect [1] 70/22 effective [3] 39/13 44/2 75/25 effectively [6] 6/8 7/1 20/16 43/16 71/6 85/23 efficacy [1] 50/3 EIP [15] 7/9 7/11 7/11 7/16 8/5 8/7 8/12 8/14 8/16 8/18 9/11 21/2 25/1 25/9 44/14 either [9] 9/25 14/2 17/9 36/23 44/5 66/17 66/20 81/11 81/21 elaborate [1] 54/5 elective [1] 35/1 electronic [3] 59/9 71/16 72/2 element [1] 58/4 elements [2] 51/8 64/25 eliminate [1] 18/3 elimination [1] 12/5 else [2] 8/15 55/20 else's [1] 58/18 elsewhere [1] 16/14 embedded [1] 91/16 emotional [1] 86/11 employment [1] 44/8 enable [1] 76/6 enables [4] 71/5 86/1 86/5 86/6 enact [2] 54/16 63/17 encountering [1] 86/3 encouragement [1] 18/10 end [4] 31/6 39/1 46/5 46/22 endorsed [1] 11/16 endorses [1] 15/19 endorsing [1] 14/11 engage [7] 19/25 20/3 24/1 32/18 46/18 77/4 90/3	engaged [3] 22/22 24/10 77/5 engagement [1] 25/5 engaging [3] 23/2 28/14 45/17 England [11] 2/14 2/17 2/21 3/17 6/14 16/9 19/9 31/12 36/8 36/21 68/1 English [2] 14/13 16/19 enormous [3] 57/10 60/21 76/1 enormously [1] 62/18 ensures [1] 85/22 ensuring [1] 39/6 entirely [2] 16/1 60/18 entirety [1] 17/8 entitles [1] 37/20 entry [1] 27/4 envisaged [1] 18/8 episode [3] 8/6 86/18 89/15 equally [1] 87/10 equip [1] 78/5 equipped [2] 25/13 52/13 eradicated [1] 55/16 escalate [1] 77/6 essence [1] 53/6 essential [12] 27/11 27/23 35/5 53/9 62/16 73/20 79/16 79/25 80/5 80/20 86/7 91/23 essentially [10] 5/20 29/23 32/3 34/4 39/6 71/23 81/5 81/6 84/20 90/16 essentials [1] 71/24 Essex [1] 5/5 establish [3] 50/4 72/18 83/14 established [2] 19/12 87/10 establishing [1] 72/24 et [1] 61/15 et cetera [1] 61/15 ethical [2] 66/16 66/20 evaluate [1] 30/19 evaluation [2] 30/13 31/22 even [13] 4/15 4/15 22/24 32/14 32/18 32/25 41/23 55/24 67/19 68/21 68/22 71/12 78/3 evening [1] 6/6 event [2] 3/16 4/12 events [2] 4/2 4/17 eventually [2] 48/13 48/17 ever [1] 77/25	every [8] 6/14 24/14 32/16 45/5 53/20 60/12 70/8 79/1 everybody [8] 33/1 36/12 46/17 46/19 60/18 60/25 83/15 83/15 everyone [3] 8/1 18/10 21/21 everything [1] 14/15 evidence [19] 3/9 4/13 4/15 11/19 21/1 25/9 26/10 34/6 35/24 36/17 44/9 52/3 54/20 56/25 71/7 76/12 80/23 81/3 87/6 evident [1] 67/6 evolve [3] 62/19 79/10 79/11 exactly [3] 44/16 58/21 67/14 example [14] 7/3 19/11 32/19 45/25 59/17 60/4 61/10 61/13 62/1 62/3 65/20 88/1 89/14 89/16 examples [4] 16/22 17/6 35/17 61/18 excellence [1] 65/19 excessive [2] 16/13 41/2 execs [1] 16/11 Executive [1] 68/10 exercise [1] 12/22 exert [2] 54/23 62/22 exist [2] 8/14 12/20 existential [1] 65/17 existing [2] 2/11 8/12 expand [2] 32/2 63/9 expect [2] 41/15 82/23 expected [5] 29/2 52/13 67/14 67/18 85/7 expecting [1] 20/13 experience [13] 23/9 23/11 42/22 42/25 43/10 44/11 50/23 51/20 61/22 69/5 69/12 78/24 83/9 experienced [4] 69/7 69/16 82/16 89/16 experiences [1] 68/5 expert [1] 74/2 expertise [3] 3/2 3/3 34/3 explain [1] 5/24 explained [1] 11/9 explaining [1] 58/16 explanation [2] 16/25 64/11 explore [8] 5/19 33/4 33/9 33/23 34/6 51/10 56/7 80/24 exploring [1] 21/20 expressed [1] 35/3	extensive [1] 70/10 extensively [1] 76/9 extent [1] 21/1 external [1] 30/13 extract [4] 14/12 16/16 26/11 53/2 extracted [1] 15/3 extremely [4] 50/23 51/23 69/16 89/10

<p>F</p> <p>find... [2] 88/21 91/5</p> <p>finding [1] 76/18</p> <p>finish [2] 47/13 92/2</p> <p>first [14] 7/25 8/6 10/8 17/1 19/11 24/1 44/23 48/10 70/13 70/14 73/20 76/21 82/25 85/8</p> <p>Firstly [1] 83/23</p> <p>fit [1] 9/11</p> <p>five [3] 7/24 38/20 69/24</p> <p>five miles [1] 7/24</p> <p>fix [2] 82/25 82/25</p> <p>Fixations [2] 63/21 63/22</p> <p>fixed [3] 46/14 46/14 83/13</p> <p>flippant [1] 70/17</p> <p>focus [3] 14/19 73/11 73/11</p> <p>follow [2] 14/7 44/19</p> <p>followed [2] 14/15 21/1</p> <p>following [1] 75/1</p> <p>follows [2] 12/13 40/20</p> <p>food [2] 34/15 38/23</p> <p>force [1] 27/3</p> <p>forced [1] 12/15</p> <p>forensic [3] 41/19 49/2 74/21</p> <p>form [1] 58/19</p> <p>formulation [4] 63/8 64/23 71/17 71/25</p> <p>forum [1] 68/16</p> <p>forums [4] 67/25 68/3 68/3 86/23</p> <p>forward [1] 1/9</p> <p>found [1] 76/18</p> <p>foundation [2] 17/16 90/5</p> <p>four [5] 7/24 28/18 31/24 70/6 71/12</p> <p>four days [1] 71/12</p> <p>four months [1] 28/18</p> <p>fragmentation [2] 6/21 85/6</p> <p>fragmented [2] 16/12 91/1</p> <p>framed [1] 70/17</p> <p>framework [2] 73/7 74/1</p> <p>free [2] 15/20 38/13</p> <p>freedom [2] 11/4 21/25</p> <p>frequent [1] 26/23</p> <p>frequently [2] 27/20 56/16</p> <p>Friday [1] 1/1</p> <p>friend [1] 70/19</p> <p>frightened [1] 28/10</p> <p>front [1] 73/12</p>	<p>frustrated [1] 77/15</p> <p>fulfil [2] 38/16 38/18</p> <p>full [3] 25/17 44/12 69/11</p> <p>fully [1] 9/16</p> <p>function [3] 58/2 67/14 85/23</p> <p>functioning [1] 83/5</p> <p>functions [2] 48/20 91/3</p> <p>fundamental [10] 50/8 52/2 53/24 60/19 65/5 78/5 79/5 79/14 85/5 86/8</p> <p>fundamentally [3] 65/16 77/23 85/13</p> <p>fundamentals [1] 66/11</p> <p>funding [12] 31/5 31/9 32/2 32/5 39/4 44/15 67/4 67/10 67/13 67/17 68/20 84/4</p> <p>further [6] 5/10 19/14 31/5 41/23 71/19 83/6</p> <p>future [5] 31/10 45/15 61/15 62/6 63/4</p> <p>G</p> <p>gain [1] 58/4</p> <p>gained [1] 58/6</p> <p>gap [7] 54/13 64/22 65/1 69/3 72/3 72/7 72/10</p> <p>gather [1] 79/24</p> <p>gave [5] 4/14 35/24 36/17 45/25 80/22</p> <p>general [8] 24/25 34/20 35/1 40/2 42/4 45/5 48/10 63/18</p> <p>generally [5] 52/18 79/2 84/13 84/23 91/5</p> <p>generation [3] 68/22 69/3 69/16</p> <p>genuinely [1] 4/9</p> <p>geography [2] 6/14 8/22</p> <p>George's [2] 48/23 48/24</p> <p>get [24] 8/8 9/24 10/17 10/19 15/2 15/14 21/24 38/7 38/19 38/22 64/11 68/19 71/5 75/18 76/5 76/16 77/14 77/18 77/19 78/12 82/16 82/23 83/6 83/7</p> <p>gets [7] 7/1 51/2 67/8 72/5 79/4 79/8 91/16</p> <p>getting [3] 9/25 38/3 38/8</p> <p>give [2] 29/25 83/10</p> <p>given [12] 15/12 15/15 15/21 16/22 16/25 17/8 18/4 26/11 39/4 71/19 76/10 81/3</p>	<p>gives [3] 2/19 63/3 79/12</p> <p>giving [1] 26/10</p> <p>glad [1] 37/25</p> <p>go [47] 3/4 3/12 5/19 7/20 8/25 10/22 11/2 11/25 16/14 16/23 19/20 19/21 20/4 20/9 20/10 21/13 22/9 24/4 24/7 24/14 32/7 34/19 35/9 36/12 38/22 40/16 46/23 49/2 49/16 49/25 50/21 51/19 61/9 70/13 71/1 74/14 75/19 75/20 76/22 76/24 77/8 77/14 78/2 78/3 79/19 81/23 86/12</p> <p>goes [6] 4/19 17/2 30/5 45/14 72/13 91/14</p> <p>going [75] 1/19 3/4 3/6 4/18 18/10 18/13 19/3 19/18 19/18 19/19 19/23 19/25 19/25 20/2 20/3 20/13 21/21 22/4 23/1 23/3 23/5 23/7 24/5 27/8 29/25 33/14 34/5 34/16 35/20 36/22 45/15 46/22 51/4 51/16 51/17 51/18 51/21 53/13 54/12 55/23 56/8 56/10 56/14 56/15 56/16 60/23 60/25 61/9 62/11 62/18 68/1 73/25 75/2 77/8 77/13 77/25 78/8 78/8 79/13 80/9 81/1 81/2 81/14 81/19 81/20 82/4 82/4 82/11 85/3 89/14 90/11 90/18 91/20 91/25 92/1</p> <p>gone [8] 12/19 55/2 55/21 56/23 68/16 68/19 73/22 86/15</p> <p>good [14] 21/16 28/9 37/7 37/8 43/10 44/9 44/11 67/24 68/5 70/18 72/4 80/17 82/18 88/17</p> <p>got [48] 6/9 9/12 16/11 16/19 22/9 28/13 28/15 35/7 35/10 36/13 37/23 39/18 47/3 56/11 60/12 61/13 63/23 66/11 68/12 68/22 71/6 73/2 73/5 75/24 77/11 77/15 77/19 77/22 80/6 80/7 80/10 80/12 81/10 81/18 82/10 83/8 83/8 84/18 84/25 85/3 86/11 86/18 86/19 86/19</p>	<p>86/20 88/16 89/22 91/12</p> <p>governing [1] 55/1</p> <p>GP [2] 35/20 35/21</p> <p>GPs [2] 35/3 35/9</p> <p>great [4] 12/22 56/7 76/2 80/24</p> <p>greatly [1] 12/23</p> <p>Grey [1] 45/21</p> <p>ground [1] 74/4</p> <p>group [18] 27/13 27/21 35/25 36/2 36/3 36/14 36/15 37/1 37/1 49/10 55/7 57/7 63/25 68/2 75/12 75/25 78/5 89/23</p> <p>groups [4] 36/13 36/23 40/4 77/16</p> <p>guess [1] 46/20</p> <p>guidance [3] 11/21 11/24 71/18</p> <p>Guide [1] 49/17</p> <p>guideline [4] 2/10 25/15 26/7 44/1</p> <p>Guidelines [2] 2/6 44/12</p> <p>H</p> <p>had [19] 8/17 13/10 19/10 22/20 25/25 31/25 33/17 36/12 37/19 38/5 46/9 49/3 49/21 68/23 69/17 74/9 74/24 75/3 75/17</p> <p>half [2] 3/12 12/1</p> <p>hallucinations [1] 40/21</p> <p>hand [1] 88/4</p> <p>happen [7] 42/14 44/16 63/4 72/2 78/16 86/21 89/25</p> <p>happened [9] 43/3 58/21 58/21 59/23 62/8 73/21 78/10 78/12 78/13</p> <p>happening [8] 32/20 45/10 64/5 64/9 81/4 90/22 91/6 91/21</p> <p>happens [5] 44/17 62/14 66/4 74/13 85/22</p> <p>happy [1] 19/19</p> <p>hard [1] 51/10</p> <p>harder [2] 45/2 45/2</p> <p>harm [1] 39/20</p> <p>harming [1] 13/18</p> <p>Hart [16] 47/21 47/23 48/2 48/8 49/11 53/2 64/14 65/9 69/20 76/8 78/18 80/14 80/17 83/18 83/21 93/10</p> <p>has [45] 6/2 6/17 8/1 13/11 17/4 19/10 21/18 25/9 28/16 28/18 30/23 30/23 38/4 40/11 41/3 41/22</p>	<p>43/3 43/14 44/22 47/3 53/5 54/12 54/21 56/11 57/14 57/20 58/5 58/15 58/15 60/12 62/10 64/12 66/2 68/16 69/9 70/15 71/23 71/24 78/12 79/1 81/18 84/14 84/24 86/17 87/12</p> <p>hasn't [1] 30/23</p> <p>have [166]</p> <p>haven't [6] 1/12 14/15 26/11 30/17 65/3 91/12</p> <p>having [15] 7/18 19/21 24/25 28/19 35/1 35/15 40/8 41/5 41/18 41/20 56/22 56/23 60/23 78/23 81/13</p> <p>he [7] 4/14 23/5 26/16 27/5 43/9 46/3 46/8</p> <p>He'd [1] 46/7</p> <p>he's [3] 4/13 26/17 26/17</p> <p>heading [3] 12/1 12/3 17/22</p> <p>health [93] 1/23 2/14 2/17 2/20 5/1 8/23 8/24 9/14 9/18 9/19 9/23 10/15 11/12 11/13 11/14 11/17 11/20 11/24 12/7 12/20 13/9 14/15 14/24 15/23 16/4 16/6 16/18 16/20 16/21 16/24 17/18 18/1 19/8 20/24 21/14 21/19 22/13 22/20 22/23 24/22 25/1 28/8 29/2 31/16 32/15 32/24 33/1 33/22 34/25 35/2 35/4 37/13 37/16 37/23 39/9 41/15 43/14 46/16 47/2 48/11 48/16 48/25 49/18 50/2 52/16 52/20 52/23 57/9 65/8 65/11 67/9 67/21 70/2 70/7 70/7 71/10 71/11 72/19 72/23 73/4 73/6 73/18 74/10 83/24 84/5 84/7 85/12 85/24 87/5 87/8 88/15 90/25 91/1</p> <p>healthcare [2] 63/24 73/15</p> <p>hear [5] 1/9 45/13 56/9 72/15 80/25</p> <p>heard [5] 3/9 4/13 25/9 43/12 84/13</p> <p>hearing [1] 92/5</p> <p>held [1] 89/18</p> <p>help [22] 9/22 10/17 14/23 15/2 15/25</p>
--	---	---	---	---

<p>H</p> <p>help... [17] 21/17 23/20 23/21 30/1 30/1 43/1 44/25 45/15 45/25 47/6 56/15 64/25 66/12 66/13 66/15 70/19 90/19</p> <p>helpful [2] 38/25 89/9</p> <p>helpfully [1] 39/19</p> <p>helping [4] 38/2 68/15 70/21 90/21</p> <p>helpline [1] 66/20</p> <p>Hendy [1] 4/13</p> <p>here [8] 4/11 13/16 15/16 29/19 65/6 75/5 75/11 82/4</p> <p>hierarchy [2] 54/21 55/24</p> <p>high [4] 26/23 42/11 60/3 84/5</p> <p>high-risk [1] 84/5</p> <p>higher [3] 40/1 40/14 55/24</p> <p>highly [3] 40/9 42/8 74/20</p> <p>him [3] 25/12 34/8 46/4</p> <p>his [6] 26/14 26/16 26/18 28/22 34/7 46/9</p> <p>history [12] 23/10 26/24 41/9 41/17 41/19 41/20 41/21 43/6 46/1 62/5 62/17 81/19</p> <p>hm [5] 49/24 50/13 59/5 84/9 91/10</p> <p>holding [1] 64/1</p> <p>holistic [2] 9/8 39/6</p> <p>home [13] 9/19 9/25 19/3 27/17 31/16 33/12 33/15 34/7 43/7 43/8 77/7 81/12 82/4</p> <p>homeless [16] 20/15 20/17 20/20 22/12 24/6 27/12 27/18 27/19 27/24 29/5 34/12 34/14 37/13 38/21 42/21 42/23</p> <p>homelessness [1] 28/25</p> <p>homely [1] 21/8</p> <p>homes [6] 8/2 10/3 20/11 20/13 24/14 27/20</p> <p>hometown [1] 38/3</p> <p>homicide [5] 3/15 18/23 36/2 42/9 49/3</p> <p>homicides [2] 3/17 4/16</p> <p>honest [1] 36/21</p> <p>Honorary [1] 2/2</p> <p>hope [1] 19/16</p> <p>hopefully [1] 63/14</p> <p>hospital [18] 19/21 20/18 20/25 21/3 23/5</p>	<p>27/1 35/2 48/12 48/16 48/23 50/14 51/18 51/19 56/13 66/18 74/25 75/18 75/19</p> <p>hospital-level [1] 35/2</p> <p>hospitals [1] 7/24</p> <p>hours [5] 6/5 9/1 9/2 9/3 68/14</p> <p>house [4] 17/2 46/3 76/23 77/8</p> <p>housing [5] 29/5 30/1 30/8 39/10 75/23</p> <p>how [65] 4/9 5/7 9/10 17/3 24/1 24/11 30/22 39/13 43/19 46/6 46/17 49/14 51/18 52/19 52/22 53/17 54/7 57/10 58/21 59/25 60/20 60/21 61/2 61/13 62/3 62/6 63/15 63/17 63/20 64/5 64/10 64/14 65/10 66/14 70/17 71/12 72/5 72/14 72/15 73/8 74/4 76/18 77/9 78/11 78/24 79/7 79/9 79/11 79/23 80/7 81/8 81/17 81/20 82/7 82/12 82/24 86/3 86/4 86/21 87/16 89/25 90/14 91/21 91/22 92/1</p> <p>However [3] 39/25 42/5 87/10</p> <p>Howsoever [1] 57/24</p> <p>hubs [1] 16/24</p> <p>huge [15] 24/12 24/15 24/17 28/21 66/24 67/17 68/18 69/2 69/17 72/3 72/7 83/17 84/1 84/8 84/18</p> <p>hugely [1] 89/8</p> <p>human [1] 83/25</p> <p>Hundred [1] 4/14</p> <p>hypothetical [2] 61/9 62/3</p> <p>I</p> <p>I absolutely [1] 47/7</p> <p>I actually [1] 35/11</p> <p>I also [2] 38/6 47/1</p> <p>I appreciate [1] 39/3</p> <p>I ask [4] 37/9 80/17 82/7 83/21</p> <p>I be [1] 82/8</p> <p>I call [2] 1/4 47/21</p> <p>I can [2] 48/6 54/5</p> <p>I can't [4] 35/18 45/4 45/4 90/15</p> <p>I couldn't [1] 39/12</p> <p>I developed [1] 64/19</p> <p>I did [2] 25/14 46/5</p> <p>I disagree [2] 27/9 91/12</p> <p>I do [8] 3/20 18/6</p>	<p>27/22 66/1 82/12 86/21 90/1 91/13</p> <p>I don't [9] 4/6 31/20 34/17 35/4 43/16 52/12 52/19 82/13 87/13</p> <p>I form [1] 58/19</p> <p>I genuinely [1] 4/9</p> <p>I go [2] 35/9 81/23</p> <p>I have [2] 1/13 33/17</p> <p>I just [9] 33/4 33/9 33/23 34/5 37/17 45/23 79/19 80/19 89/1</p> <p>I keep [1] 86/7</p> <p>I know [2] 22/6 39/9</p> <p>I left [1] 49/8</p> <p>I may [1] 35/23</p> <p>I mean [7] 24/5 34/2 35/17 37/25 44/15 47/4 53/13</p> <p>I might [1] 82/2</p> <p>I monitor [1] 90/15</p> <p>I moved [1] 48/23</p> <p>I must [1] 42/10</p> <p>I personally [1] 29/1</p> <p>I probe [1] 81/18</p> <p>I refer [1] 44/20</p> <p>I referred [1] 50/18</p> <p>I say [6] 6/13 15/24 22/9 24/12 28/12 32/17</p> <p>I see the [1] 58/18</p> <p>I should [2] 29/24 90/22</p> <p>I sit [1] 82/10</p> <p>I started [1] 48/13</p> <p>I suggest [1] 79/12</p> <p>I suspect [2] 40/11 40/14</p> <p>I talk [1] 79/2</p> <p>I then [1] 48/14</p> <p>I think [61] 4/2 6/13 14/3 14/23 15/20 17/1 17/10 17/12 19/8 26/5 27/9 27/9 27/11 27/12 27/21 28/4 28/7 29/6 31/1 31/25 37/11 40/16 40/19 41/10 43/9 43/18 47/8 47/13 50/22 51/2 51/9 51/22 52/1 52/10 52/19 52/24 55/9 56/18 60/15 61/16 65/16 66/24 67/6 67/7 70/13 72/12 73/2 74/9 76/13 76/14 81/25 82/8 84/17 85/2 87/9 87/10 87/20 87/22 88/14 89/7 89/10</p> <p>I trained [1] 48/10</p> <p>I want [2] 11/21 61/12</p> <p>I was [8] 9/10 25/14 36/3 36/7 48/18 76/14 85/1 89/23</p>	<p>I went [2] 43/7 48/12</p> <p>I will [1] 43/11</p> <p>I worked [1] 48/15</p> <p>I would [9] 14/22 20/11 32/18 34/15 41/15 44/1 46/10 46/20 87/20</p> <p>I wouldn't [1] 21/12</p> <p>I'd [6] 4/22 31/25 35/17 35/18 83/23 84/10</p> <p>I'm [28] 1/19 3/4 3/6 6/15 14/11 20/21 20/25 21/6 21/20 23/1 26/6 28/7 32/6 34/11 37/25 49/13 56/14 56/15 61/9 65/2 71/22 75/25 76/8 90/9 90/18 90/18 90/19 90/21</p> <p>I've [15] 3/3 14/22 20/15 24/5 27/22 27/25 34/11 35/9 43/11 47/8 76/11 79/1 79/3 82/10 85/3</p> <p>idea [7] 9/23 10/11 10/21 20/22 21/10 21/13 63/3</p> <p>ideal [2] 27/21 27/24</p> <p>ideas [3] 67/24 68/5 68/18</p> <p>identified [7] 16/25 18/19 22/3 39/7 40/18 41/17 87/16</p> <p>identifying [2] 59/16 84/3</p> <p>if [109]</p> <p>if' [1] 63/1</p> <p>if' factor [1] 63/1</p> <p>ignore [1] 87/11</p> <p>ignoring [1] 87/14</p> <p>ill [9] 13/17 13/24 14/2 15/4 19/19 20/3 28/13 47/10 83/24</p> <p>ill health [1] 83/24</p> <p>illegally [1] 64/1</p> <p>illness [4] 26/19 26/20 59/3 59/3</p> <p>imagine [1] 81/11</p> <p>immediate [3] 63/20 64/5 73/11</p> <p>impact [3] 51/14 67/22 69/9</p> <p>impetus [1] 5/3</p> <p>implement [4] 14/5 61/1 61/5 61/11</p> <p>implementation [1] 12/6</p> <p>implemented [1] 7/12</p> <p>implementing [2] 25/4 85/4</p> <p>implication [1] 33/24</p> <p>implies [1] 84/18</p> <p>importance [2] 52/4 84/1</p> <p>important [32] 7/22</p>	<p>8/21 13/24 14/17 14/25 18/25 20/14 27/13 30/4 31/21 35/21 40/9 44/17 53/7 53/22 54/1 57/19 58/25 59/6 59/18 59/20 60/3 62/7 62/14 62/15 62/21 62/21 63/1 63/13 84/14 87/18 89/5</p> <p>improve [1] 77/23</p> <p>incidents [2] 64/21 79/3</p> <p>includes [1] 2/8</p> <p>including [7] 32/24 40/18 41/1 48/21 49/22 69/23 86/2</p> <p>inconsistent [1] 12/15</p> <p>increase [2] 18/22 18/23</p> <p>increased [4] 35/14 40/17 59/17 67/2</p> <p>increases [1] 41/7</p> <p>increasing [1] 41/24</p> <p>incredibly [3] 53/19 65/3 67/1</p> <p>indeed [4] 13/20 14/20 33/23 52/15</p> <p>independent [4] 13/8 35/15 36/12 49/9</p> <p>indicate [1] 87/17</p> <p>individual [3] 44/7 50/3 88/19</p> <p>individuals [3] 3/18 28/24 37/15</p> <p>influence [2] 62/23 87/21</p> <p>inform [1] 40/9</p> <p>information [11] 30/25 39/4 39/20 57/4 57/24 59/2 59/15 60/22 79/18 79/23 80/4</p> <p>ingredients [1] 30/20</p> <p>initiative [1] 39/5</p> <p>injection [1] 22/24</p> <p>injuries [1] 75/2</p> <p>inpatient [11] 5/4 8/25 16/13 46/23 50/20 51/5 54/9 55/17 73/17 77/20 81/13</p> <p>input [2] 53/25 73/25</p> <p>Inquiries [3] 36/10 36/24 78/8</p> <p>inquiry [9] 1/12 4/12 17/16 23/18 25/9 36/1 48/3 69/21 78/3</p> <p>insight [3] 18/17 22/5 28/3</p> <p>instability [1] 33/25</p> <p>instance [7] 4/19 9/11 11/10 21/2 44/23 76/16 81/11</p> <p>instances [2] 15/10 33/8</p>
---	--	--	--	---

<p>I</p> <p>instead [4] 7/11 20/19 24/16 26/2</p> <p>institutional [1] 12/21</p> <p>integral [2] 54/18 64/18</p> <p>integrate [2] 9/15 17/24</p> <p>integrated [6] 9/7 9/16 24/24 29/15 29/22 65/11</p> <p>integrating [2] 9/16 65/7</p> <p>intensive [8] 25/21 26/2 26/6 26/8 28/23 49/6 74/21 74/25</p> <p>interaction [1] 53/20</p> <p>interchangeability [1] 58/10</p> <p>interchangeably [1] 58/13</p> <p>interests [1] 66/19</p> <p>interface [1] 66/4</p> <p>interpretation [1] 58/17</p> <p>intervention [6] 7/3 7/5 8/11 9/20 31/17 75/21</p> <p>interventions [3] 7/4 7/6 44/5</p> <p>into [34] 4/18 4/19 5/21 7/20 7/21 9/11 20/7 20/13 23/5 24/14 27/25 31/18 34/16 38/22 43/8 44/13 45/11 45/12 46/18 48/11 48/17 51/18 53/25 54/17 54/17 62/6 65/7 65/11 72/5 72/13 73/25 75/18 79/19 86/4</p> <p>intoxication [1] 41/2</p> <p>introduce [2] 70/2 74/18</p> <p>invaluable [2] 89/19 90/10</p> <p>investigating [1] 79/3</p> <p>inviting [1] 21/10</p> <p>involuntary [2] 13/12 14/8</p> <p>involve [7] 7/9 8/4 24/8 25/2 33/22 44/2 44/3</p> <p>involved [12] 19/1 39/11 43/4 43/5 46/19 52/1 73/16 75/15 75/22 79/3 79/6 85/21</p> <p>involves [6] 85/9 85/10 85/10 85/11 85/12 85/13</p> <p>Ipsos [1] 30/14</p> <p>Ipsos Mori [1] 30/14</p> <p>is [305]</p>	<p>is: [1] 79/23</p> <p>is: how [1] 79/23</p> <p>isn't [31] 4/1 4/7 4/8 11/7 12/4 13/2 13/6 13/21 14/17 16/5 17/8 17/11 19/5 20/5 21/10 21/13 23/6 24/1 25/7 29/14 30/4 34/4 34/9 35/3 53/7 54/1 59/4 59/20 88/2 88/6 88/10</p> <p>isolated [1] 81/22</p> <p>issue [15] 4/23 4/25 8/21 20/14 23/1 39/7 52/18 53/23 81/8 81/9 83/17 84/10 84/11 90/11 91/14</p> <p>issues [2] 75/23 84/10</p> <p>it [237]</p> <p>it's [114]</p> <p>iterations [1] 25/15</p> <p>itinerant [3] 27/12 27/24 29/4</p> <p>itinerants [1] 27/19</p> <p>its [4] 35/24 36/1 60/23 79/22</p> <p>itself [1] 34/11</p> <p>J</p> <p>January [1] 48/3</p> <p>job [4] 32/20 33/20 43/16 49/6</p> <p>join [1] 81/23</p> <p>journey [2] 10/15 40/10</p> <p>judgement [3] 4/6 80/4 80/5</p> <p>Julian [1] 4/13</p> <p>Julian Hendy [1] 4/13</p> <p>June [1] 92/6</p> <p>June 2026 [1] 92/6</p> <p>junior [1] 69/13</p> <p>just [56] 1/8 3/5 3/24 5/10 5/19 5/22 5/24 6/20 7/9 9/12 15/7 17/15 23/3 23/7 24/4 24/4 27/25 30/5 31/4 33/4 33/9 33/23 34/5 34/20 35/23 36/18 37/17 38/14 39/18 39/18 39/21 41/20 44/5 45/23 46/13 53/16 54/5 56/3 66/2 67/12 76/13 78/21 78/23 79/19 80/19 80/19 81/11 82/23 84/1 84/10 89/1 89/3 89/22 90/3 90/11 91/12</p> <p>justified [1] 15/10</p> <p>Justin [2] 64/19 72/9</p> <p>Justin O'Brien [1] 72/9</p>	<p>K</p> <p>KC [1] 80/22</p> <p>keen [2] 32/6 35/18</p> <p>keep [6] 7/2 7/2 7/7 19/12 84/7 86/7</p> <p>keeping [1] 26/24</p> <p>Kendall [13] 1/4 1/6 1/11 3/10 5/24 18/7 32/13 35/23 37/3 37/7 42/16 42/20 93/3</p> <p>kept [1] 53/7</p> <p>key [12] 7/4 17/22 30/19 41/19 51/6 51/7 53/5 54/1 58/22 58/23 59/1 62/3</p> <p>kill [1] 42/4</p> <p>killed [1] 42/5</p> <p>kind [16] 4/2 9/13 16/21 20/3 22/4 27/6 29/16 30/21 38/23 44/8 54/5 57/13 61/16 66/11 86/16 89/13</p> <p>kinds [1] 77/22</p> <p>knock [1] 84/8</p> <p>knock-on [1] 84/8</p> <p>know [63] 4/9 15/2 15/25 19/2 19/4 20/17 20/19 21/15 22/6 22/11 23/18 24/16 28/15 31/21 33/18 33/20 34/15 35/10 35/21 38/20 38/24 39/9 41/15 42/11 42/13 43/9 46/8 53/2 56/4 56/16 57/5 57/7 57/8 59/11 60/16 63/1 63/15 64/14 65/17 67/6 68/24 69/15 69/17 73/21 73/22 73/24 75/1 75/12 75/25 76/20 77/1 77/6 77/17 77/18 77/19 79/3 81/10 82/12 82/15 83/2 83/16 85/2 91/6</p> <p>knowing [1] 62/13</p> <p>knowledge [11] 1/16 54/16 58/5 61/23 69/2 69/18 70/22 77/24 78/7 85/11 85/12</p> <p>known [2] 41/11 87/9</p> <p>L</p> <p>labelled [1] 25/24</p> <p>lack [3] 22/5 28/2 67/1</p> <p>lacking [1] 18/17</p> <p>LANGDALE [3] 47/24 80/22 93/11</p> <p>large [7] 12/19 28/19 32/14 32/14 60/13 67/8 73/22</p> <p>largely [2] 55/8 66/25</p> <p>largest [2] 66/2 73/5</p> <p>last [5] 20/15 27/22</p>	<p>66/25 78/1 91/9</p> <p>late [1] 6/6</p> <p>later [1] 50/18</p> <p>lead [3] 2/16 35/15 72/20</p> <p>leader [1] 48/18</p> <p>leadership [2] 67/21 73/7</p> <p>learn [3] 61/2 71/3 71/12</p> <p>learned [1] 69/16</p> <p>least [10] 6/5 9/18 10/25 12/18 36/15 37/2 39/10 56/23 57/13 86/13</p> <p>leave [5] 10/19 21/24 45/17 74/16 83/25</p> <p>leaves [1] 73/17</p> <p>lecture [1] 68/25</p> <p>lecturer [2] 49/7 49/8</p> <p>lectures [2] 68/23 68/24</p> <p>led [4] 2/5 5/6 30/13 49/5</p> <p>left [3] 3/13 46/7 49/8</p> <p>legal [2] 38/15 38/17</p> <p>less [7] 21/12 34/24 38/4 45/7 45/14 67/19 88/4</p> <p>let [1] 35/21</p> <p>let's [1] 12/24</p> <p>level [6] 35/2 44/15 55/24 57/4 67/10 72/19</p> <p>levels [1] 68/7</p> <p>liaison [1] 48/25</p> <p>liberty [2] 12/8 12/10</p> <p>life [1] 86/17</p> <p>light [1] 37/17</p> <p>like [21] 18/24 19/1 20/23 22/6 28/6 31/24 33/20 42/13 43/1 45/9 46/18 49/14 51/19 57/6 72/25 76/11 78/16 83/23 84/10 86/14 89/17</p> <p>likely [3] 42/3 45/8 45/14</p> <p>limitation [1] 24/2</p> <p>limiting [1] 38/2</p> <p>line [2] 29/21 45/18</p> <p>lines [1] 3/13</p> <p>link [3] 62/7 71/24 77/20</p> <p>linked [1] 59/3</p> <p>linking [3] 62/5 71/16 74/12</p> <p>links [1] 2/25</p> <p>list [2] 10/4 28/16</p> <p>listening [1] 76/15</p> <p>literature [1] 2/24</p> <p>little [8] 5/23 31/4 70/16 73/25 82/17 83/9 84/25 88/8</p> <p>live [1] 29/3</p> <p>lives [2] 33/25 47/10</p>	<p>living [1] 41/4</p> <p>loads [1] 71/8</p> <p>local [4] 23/8 38/10 48/19 68/6</p> <p>locally [2] 74/4 74/13</p> <p>London [3] 2/2 48/14 48/24</p> <p>long [10] 23/12 44/20 44/24 46/6 55/1 55/16 55/21 59/12 71/22 80/9</p> <p>longer [3] 44/22 44/23 45/13</p> <p>look [26] 3/12 5/21 6/9 15/7 15/8 16/14 17/1 17/21 22/15 26/14 29/9 30/18 31/2 39/18 39/22 49/21 52/10 56/22 63/21 66/9 67/3 70/17 73/12 79/10 84/1 86/13</p> <p>looked [3] 21/23 25/22 41/23</p> <p>looking [13] 11/22 12/2 17/15 23/12 57/14 61/18 62/4 63/16 64/21 72/9 74/8 90/17 90/19</p> <p>losing [2] 8/3 27/20</p> <p>loss [3] 67/17 67/20 69/8</p> <p>lost [5] 55/25 67/13 68/20 72/24 73/4</p> <p>lot [15] 7/23 29/6 34/15 37/11 52/10 54/6 59/12 61/16 65/21 74/3 79/18 79/19 87/20 90/4 91/25</p> <p>lots [2] 55/22 65/25</p> <p>Louis [3] 3/10 35/24 36/17</p> <p>Louis's [2] 36/14 37/1</p> <p>low [3] 42/6 42/11 42/14</p> <p>M</p> <p>made [7] 9/6 31/12 36/20 55/15 57/20 67/7 79/7</p> <p>magical [1] 60/24</p> <p>main [3] 51/1 78/5 84/21</p> <p>maintain [1] 53/8</p> <p>maintaining [2] 85/13 85/16</p> <p>major [1] 75/1</p> <p>majority [2] 17/13 29/3</p> <p>make [15] 8/21 11/5 21/11 22/1 39/7 44/11 45/4 51/25 54/2 55/4 57/16 69/21 82/12 85/20 91/22</p> <p>makes [3] 50/23 75/8</p>
--	---	---	---	--

<p>M makes... [1] 79/7 making [11] 30/20 50/6 52/5 55/23 55/25 56/1 77/5 79/17 85/11 86/5 87/21 male [1] 41/9 man [1] 69/15 manage [2] 56/11 83/8 managed [1] 74/11 management [15] 2/8 2/9 25/21 26/2 26/8 35/3 49/18 61/6 63/7 64/23 69/25 71/17 72/1 72/11 73/13 manager [3] 48/14 48/15 82/13 managerial [2] 68/8 85/25 managers [1] 82/16 Manchester [1] 5/5 mandatory [1] 70/6 manic [1] 40/13 manifestation [1] 33/9 many [22] 12/5 20/24 33/8 41/13 52/13 56/1 59/6 59/8 60/16 64/21 64/21 64/21 65/2 65/14 65/17 65/20 68/24 71/9 71/9 78/13 78/13 90/12 marks [1] 15/15 Marshall [1] 44/18 masking [1] 60/5 massive [3] 38/1 69/9 75/1 matter [4] 34/3 42/15 63/21 63/22 matters [1] 63/22 Maudsley [1] 48/12 Max [1] 44/18 may [48] 1/1 1/4 13/23 22/12 22/22 23/19 31/1 32/14 32/25 33/14 34/2 34/23 34/24 35/23 47/21 50/17 50/17 51/15 52/23 54/11 54/11 56/12 56/22 57/3 57/15 58/1 59/14 59/23 60/18 63/22 69/6 69/11 69/21 70/16 72/4 72/4 74/21 75/15 75/16 75/20 76/3 76/4 77/20 77/20 81/21 82/20 84/22 88/1 maybe [1] 63/3 MDT [3] 78/24 79/1 91/9 MDTs [1] 32/22 me [11] 19/1 19/3</p>	<p>21/6 43/7 56/12 79/25 80/1 80/1 80/2 81/20 81/24 mean [14] 20/20 23/23 24/5 34/2 34/2 35/17 37/25 43/25 44/15 47/4 53/13 58/16 60/12 76/17 means [10] 7/19 14/16 29/24 45/6 58/20 76/17 79/22 84/21 85/19 86/17 medical [1] 30/6 medication [7] 12/17 40/19 45/6 46/9 59/18 81/25 85/12 meet [5] 34/12 34/13 43/7 46/24 83/17 meeting [3] 16/9 34/7 79/1 meetings [5] 24/17 35/10 53/25 78/24 79/15 member [1] 36/3 members [1] 55/14 memberships [1] 49/22 mental [90] 1/23 2/14 2/17 2/20 5/1 8/23 8/24 9/14 9/18 9/19 9/23 10/15 11/11 11/14 11/17 11/24 12/7 12/20 13/9 14/14 14/24 15/23 16/3 16/18 16/20 16/21 17/18 18/1 19/8 21/14 21/19 22/13 22/20 22/23 24/22 25/1 28/8 29/2 31/16 32/15 32/23 33/1 33/22 34/25 35/2 35/4 37/13 37/15 37/23 39/9 41/14 43/14 47/2 48/11 48/16 48/24 49/18 50/2 52/16 52/16 52/20 52/20 52/23 56/7 57/9 65/8 65/11 67/9 67/21 70/2 70/6 70/7 71/10 71/11 72/18 72/23 73/6 73/18 74/10 83/24 84/5 84/6 85/11 85/23 87/5 87/8 88/15 90/13 90/15 90/19 mentioned [2] 42/20 90/24 mentor [1] 69/13 merge [1] 35/15 message [1] 62/3 met [1] 35/9 mid [1] 6/5 middle [4] 6/3 7/18 20/8 24/12 midwives [1] 53/4 might [36] 7/24 20/20 22/13 32/16 32/24</p>	<p>33/12 33/24 35/14 39/15 45/13 55/4 55/6 56/4 56/9 58/17 59/12 60/1 60/4 62/6 62/19 62/19 63/18 63/23 63/25 64/3 68/9 76/24 76/24 77/2 77/2 79/13 80/25 81/15 82/2 89/12 89/18 miles [3] 7/24 38/20 38/24 million [1] 31/12 mind [3] 45/12 81/15 90/16 mindful [1] 88/21 minds [1] 82/9 mindsets [1] 18/2 mine [1] 64/19 minimal [1] 16/2 minimalist [1] 17/10 minimum [1] 71/13 mirrored [1] 55/23 misleading [1] 51/3 misplaced [1] 35/13 miss [1] 42/12 missed [1] 69/1 misuse [3] 2/11 30/2 41/1 mixed [1] 34/21 Mm [5] 49/24 50/13 59/5 84/9 91/10 Mm-hm [5] 49/24 50/13 59/5 84/9 91/10 model [17] 5/12 6/1 8/4 9/8 11/12 24/11 27/7 29/15 29/15 29/22 30/21 31/8 31/11 32/14 37/10 64/14 72/8 modelled [1] 82/22 modelling [1] 82/18 models [5] 2/17 14/18 17/17 18/8 75/24 module [2] 69/24 70/6 modules [2] 65/23 70/3 Moloney [8] 32/11 32/12 39/14 78/19 78/20 80/20 93/5 93/12 moment [6] 2/23 56/14 61/10 64/6 72/1 90/4 Monday [2] 92/3 92/6 money [3] 32/5 32/6 67/8 monitor [1] 90/15 monitoring [1] 90/13 months [2] 28/17 28/18 more [40] 2/5 4/22 21/8 21/10 22/12 23/8 24/18 33/25 35/2 35/19 42/3 43/15</p>	<p>43/19 44/24 45/1 45/11 45/16 45/16 46/14 47/1 51/23 53/13 56/16 59/16 66/7 66/9 67/18 68/11 71/6 71/18 76/6 79/2 79/5 79/12 80/5 87/23 87/24 88/8 88/11 89/16 Mori [1] 30/14 morning [1] 6/5 most [20] 6/10 11/13 17/13 20/1 20/1 20/11 20/11 20/12 25/16 32/18 38/23 44/11 47/10 55/11 68/18 72/2 75/5 75/6 77/16 82/16 motive [1] 64/2 move [5] 31/7 33/12 33/15 55/19 66/17 moved [6] 33/18 48/11 48/13 48/23 73/3 73/3 moving [5] 27/20 29/6 33/24 34/1 65/2 32/12 39/14 42/18 42/19 45/24 47/21 48/2 48/8 49/11 53/2 65/9 69/20 76/8 78/18 78/19 78/20 80/14 80/17 80/20 83/18 83/19 83/20 83/21 93/4 93/5 93/7 93/12 93/14 Mr Carr [3] 1/3 1/7 93/4 Mr Hart [12] 47/21 48/2 48/8 53/2 65/9 69/20 76/8 78/18 80/14 80/17 83/18 83/21 Mr Moloney [8] 32/11 32/12 39/14 78/19 78/20 80/20 93/5 93/12 Mr Straw [5] 42/18 45/24 83/19 83/20 93/14 Ms [10] 37/5 37/6 45/21 47/24 80/15 80/16 80/22 93/6 93/11 93/13 Ms Cartwright [6] 37/5 37/6 80/15 80/16 93/6 93/13 Ms Grey [1] 45/21 MS LANGDALE [3] 47/24 80/22 93/11 much [25] 4/22 5/23 6/7 14/19 21/8 21/9 24/18 28/13 32/8 35/19 37/3 40/3 45/20 58/20 66/3 71/6 79/23 80/5 80/12 80/14 83/7</p>	<p>84/23 87/23 87/24 88/23 multi [5] 58/3 75/9 75/10 75/24 76/4 multi-agency [2] 75/10 75/24 multi-disciplinary [2] 58/3 75/9 multidimensional [1] 52/22 multidisciplinary [3] 34/23 53/25 54/4 multiple [3] 50/14 75/2 75/14 murder [2] 41/22 41/25 must [2] 18/1 42/10 my [20] 6/13 13/23 20/22 21/15 23/9 23/11 32/9 35/8 38/3 43/9 44/21 47/8 50/18 58/17 58/19 69/15 76/8 81/20 82/13 90/1 myself [1] 72/8</p> <hr/> <p>N name [2] 33/18 33/19 narrative [3] 79/9 79/10 80/7 national [18] 2/13 2/16 31/9 31/23 35/25 36/9 36/24 55/24 67/25 68/17 69/23 72/19 73/7 73/7 74/2 74/8 74/12 75/4 nature [4] 51/17 52/19 52/21 52/22 navigate [2] 50/19 91/11 near [1] 17/8 nearly [1] 28/17 necessarily [4] 34/18 40/19 51/24 82/6 necessary [4] 39/16 73/13 74/23 89/5 need [37] 4/17 4/22 10/17 10/18 10/19 18/13 21/24 27/14 28/24 29/6 32/1 38/14 38/16 44/10 56/13 56/14 57/15 63/9 63/15 64/11 70/22 74/5 74/13 75/6 77/4 77/21 78/7 80/21 83/1 83/5 83/6 83/10 83/10 83/11 85/6 87/23 87/24 needed [7] 9/22 10/18 16/3 16/13 32/19 55/13 81/2 needs [7] 43/18 56/21 57/24 67/15 74/6 74/14 87/15 negatively [1] 88/17 neglected [1] 66/3 negotiate [1] 54/13</p>
---	---	--	--	--

<p>N</p> <p>neighbour's [2] 43/8 46/3</p> <p>neighbourhood [30] 1/23 2/20 5/1 5/12 6/1 6/3 6/22 7/8 7/25 9/8 10/1 18/25 19/20 20/4 20/6 21/7 24/11 24/13 27/6 28/8 29/2 31/13 33/1 33/12 33/13 35/4 39/9 41/14 43/5 47/2</p> <p>networks [1] 17/18</p> <p>never [7] 3/3 23/4 27/8 36/21 83/13 86/15 91/25</p> <p>nevertheless [1] 57/19</p> <p>new [2] 2/16 71/18</p> <p>newly [1] 83/7</p> <p>next [5] 15/8 15/19 29/8 29/11 29/18</p> <p>NHS [10] 2/14 2/21 16/9 31/12 36/8 36/21 61/5 67/8 70/7 90/5</p> <p>NHSE0002413 [1] 3/7</p> <p>NHSE0002421 [1] 17/17</p> <p>NHSE0002422 [1] 11/23</p> <p>nice [6] 2/5 25/14 25/15 44/1 44/12 70/18</p> <p>night [2] 6/9 9/4</p> <p>nine [1] 49/1</p> <p>nine years [1] 49/1</p> <p>NMC [4] 55/1 66/9 66/22 81/5</p> <p>no [36] 7/10 7/13 7/18 8/13 8/16 10/4 10/4 10/18 13/16 14/23 15/22 18/12 19/6 20/6 21/5 21/22 23/9 24/6 27/19 31/24 33/2 36/18 39/3 45/21 52/19 55/18 58/7 58/8 64/19 68/19 73/6 73/7 75/3 75/7 75/8 85/3</p> <p>non [9] 12/2 14/14 16/11 17/4 17/9 18/17 22/5 26/21 71/10</p> <p>non-coercive [2] 12/2 17/4</p> <p>non-compliance [1] 26/21</p> <p>non-concordant [2] 18/17 22/5</p> <p>non-execs [1] 16/11</p> <p>non-mental [1] 71/10</p> <p>none [2] 74/10 77/25</p> <p>nonsensical [1] 90/14</p> <p>north [1] 48/14</p> <p>north London [1] 48/14</p>	<p>not [114]</p> <p>note [2] 14/17 89/4</p> <p>notes [4] 53/11 53/16 53/17 53/22</p> <p>nothing [3] 31/24 79/22 79/23</p> <p>noticed [1] 8/1</p> <p>noting [1] 38/9</p> <p>notion [1] 84/17</p> <p>Nottingham [1] 78/13</p> <p>notwithstanding [1] 25/10</p> <p>November [1] 1/14</p> <p>now [27] 4/25 6/11 6/14 7/22 9/22 10/21 12/5 13/8 23/1 25/22 27/5 28/15 31/13 39/13 39/14 47/14 49/9 55/8 64/5 64/8 64/10 64/16 70/17 70/24 83/3 84/3 85/6</p> <p>number [11] 4/15 8/16 10/16 16/22 28/20 35/10 43/3 43/13 48/20 78/23 84/14</p> <p>number 4 [1] 10/16</p> <p>numbers [1] 55/9</p> <p>numerous [1] 79/4</p> <p>nurse [35] 43/8 48/10 48/13 48/25 49/9 49/23 50/8 51/1 51/3 51/4 51/5 51/6 51/7 51/15 53/5 54/6 54/7 54/12 54/20 54/23 55/4 55/13 55/17 55/20 66/13 66/18 67/25 68/3 68/8 74/6 80/23 83/5 83/12 85/24 90/18</p> <p>nursed [1] 75/3</p> <p>nurses [45] 24/22 50/2 52/1 52/7 52/12 52/25 53/4 53/13 55/21 55/25 56/18 57/6 57/8 58/14 59/6 60/10 66/4 67/17 68/7 68/9 68/13 68/23 69/3 69/6 69/10 69/13 69/17 70/7 73/24 74/19 75/6 77/11 77/12 77/17 80/22 81/5 82/16 83/3 83/6 84/12 85/6 86/2 89/3 90/12 91/5</p> <p>nurses' [1] 53/25</p> <p>nursing [21] 49/4 50/16 52/17 53/4 54/2 65/8 65/12 66/1 66/11 66/21 67/21 68/10 68/12 69/8 70/2 72/19 72/19 72/20 72/24 73/18 74/10</p> <p>O</p> <p>O'Brien [2] 64/20</p>	<p>72/9</p> <p>objectives [1] 60/17</p> <p>observations [1] 54/2</p> <p>obvious [2] 74/22 88/1</p> <p>obviously [11] 37/9 37/14 37/22 39/3 39/23 41/17 45/3 51/20 81/3 84/1 90/25</p> <p>occasions [1] 75/16</p> <p>occupy [1] 30/2</p> <p>occur [1] 64/6</p> <p>occurred [1] 64/12</p> <p>odd [4] 4/3 7/23 34/17 59/12</p> <p>odds [3] 13/21 13/23 16/5</p> <p>off [3] 68/19 70/10 77/13</p> <p>offer [1] 23/8</p> <p>offered [3] 22/22 22/24 23/4</p> <p>offering [1] 16/17</p> <p>officers [1] 46/2</p> <p>often [19] 20/1 25/24 27/1 38/7 50/11 51/11 51/24 58/14 67/18 69/10 72/3 72/7 76/2 86/9 86/16 88/16 88/17 88/17 89/25</p> <p>Oh [1] 58/14</p> <p>Okay [8] 1/10 6/2 8/7 16/9 25/14 37/3 44/1 44/18</p> <p>old [1] 69/15</p> <p>omitted [1] 76/11</p> <p>on [130]</p> <p>on year [1] 78/4</p> <p>once [3] 19/11 19/23 79/8</p> <p>one [60] 3/5 3/6 3/10 3/11 4/9 5/5 5/5 6/16 6/23 6/24 7/10 7/17 9/12 10/12 11/3 11/22 15/14 17/1 19/7 24/4 24/19 25/16 25/20 29/15 29/22 29/22 30/9 30/25 33/4 33/9 33/23 34/3 34/13 35/8 37/22 38/18 42/23 43/5 45/5 50/17 50/21 51/22 52/1 52/14 53/5 54/11 59/10 60/12 60/18 67/12 72/14 76/13 78/21 79/19 84/4 84/6 84/14 86/24 88/1 91/11</p> <p>one's [2] 25/19 91/11</p> <p>ones [2] 62/22 62/22</p> <p>ongoing [5] 50/12 64/6 80/11 83/12 83/14</p> <p>online [1] 68/23</p> <p>only [3] 27/18 43/11 64/6</p>	<p>onto [1] 63/12</p> <p>open [10] 6/4 6/7 9/1 9/2 9/3 10/16 10/21 21/23 28/9 45/16</p> <p>operate [2] 9/3 31/19</p> <p>operates [1] 17/3</p> <p>operating [1] 7/17</p> <p>operational [1] 68/12</p> <p>opinion [2] 56/21 58/19</p> <p>opportunity [1] 79/12</p> <p>option [2] 18/14 28/10</p> <p>or [85] 4/15 6/7 7/10 8/6 8/15 9/4 9/15 9/25 10/18 13/11 13/18 13/19 14/2 14/24 15/5 15/11 16/17 17/9 20/18 20/18 22/11 23/24 24/22 25/20 26/11 26/24 27/10 27/19 29/4 29/5 31/20 36/24 39/13 40/12 40/13 40/13 41/2 41/6 41/12 42/14 44/5 45/13 45/13 46/9 51/4 51/5 51/13 51/25 52/12 53/15 54/9 55/7 55/18 56/5 56/14 57/2 58/15 60/18 62/17 63/18 63/19 64/6 66/17 66/21 71/20 74/9 74/21 75/1 75/21 76/11 76/11 76/23 77/1 77/20 81/2 81/12 81/13 81/17 81/21 82/4 82/13 85/16 85/19 89/1 90/3</p> <p>order [3] 17/24 33/11 33/12</p> <p>ordinarily [1] 9/17</p> <p>ordinator [1] 51/5</p> <p>organisation [4] 11/13 78/10 90/2 91/15</p> <p>organisationally [1] 65/19</p> <p>organisations [4] 34/14 60/14 65/16 78/7</p> <p>Organization [1] 16/7</p> <p>Organization's [1] 11/21</p> <p>oriented [1] 17/25</p> <p>original [1] 75/21</p> <p>other [22] 8/10 14/24 17/15 23/3 24/23 25/19 30/24 32/10 37/22 38/7 43/12 44/10 55/11 55/14 67/7 69/7 78/13 78/17 82/3 82/10 88/4 88/11</p> <p>others [13] 13/19 14/3 15/5 19/23 22/11 23/22 39/20 40/1 40/15 56/6 57/11</p>	<p>81/17 88/22</p> <p>otherwise [1] 77/24</p> <p>our [23] 16/2 16/16 20/11 32/20 32/22 32/23 33/20 35/10 36/7 43/14 43/16 48/19 49/5 57/17 62/19 75/5 80/3 80/12 82/15 82/15 85/6 90/1 91/19</p> <p>ourselves [1] 78/15</p> <p>out [36] 1/19 3/25 5/10 5/15 5/17 10/6 13/9 22/9 24/8 31/9 32/24 33/14 34/5 36/15 38/24 45/23 51/13 52/3 56/20 56/25 59/1 59/25 61/21 63/7 64/21 67/14 69/1 72/10 73/4 73/24 76/3 82/4 83/3 86/20 87/6 91/5</p> <p>outcry [2] 5/7 75/4</p> <p>outlets [1] 34/15</p> <p>outline [1] 61/12</p> <p>Outreach [22] 20/16 25/8 25/12 25/17 25/18 25/19 26/1 26/3 26/9 26/17 27/10 27/15 28/2 28/15 28/17 29/7 48/21 67/12 76/15 76/17 76/17 85/10</p> <p>outset [1] 83/11</p> <p>over [12] 8/18 17/2 19/7 31/24 44/20 45/1 62/19 62/23 66/25 70/16 72/14 74/10</p> <p>overall [1] 42/5</p> <p>overlap [1] 52/15</p> <p>overnight [2] 31/20 32/7</p> <p>overspeaking [2] 14/5 73/1</p> <p>own [12] 8/2 11/5 22/1 35/8 38/3 54/25 55/5 58/19 60/23 71/3 78/10 79/22</p> <p>Oxleas [1] 90/5</p> <p>P</p> <p>package [1] 44/13</p> <p>page [37] 3/13 5/2 5/11 5/15 5/15 5/21 11/2 11/10 11/25 12/1 15/7 15/8 15/8 17/1 17/4 17/21 17/23 22/15 26/15 30/12 31/5 39/22 49/16 49/21 49/25 50/1 53/1 58/24 63/6 65/6 67/3 72/17 72/22 74/15 74/16 87/2 93/2</p> <p>page 10 [1] 39/22</p> <p>page 12 [1] 5/2</p> <p>page 13 [4] 5/21</p>
---	--	---	---	--

<p>P</p> <p>page 13... [3] 11/10 26/15 53/1</p> <p>page 16 [2] 5/15 5/15</p> <p>page 18 [1] 22/15</p> <p>page 19 [2] 17/21 30/12</p> <p>page 22 [1] 11/2</p> <p>page 37 [1] 11/25</p> <p>page 38 [1] 15/8</p> <p>page 4 [1] 49/16</p> <p>page 45 [1] 58/24</p> <p>page 46 [1] 17/1</p> <p>page 48 [1] 17/4</p> <p>page 5 [1] 49/21</p> <p>page 52 [1] 87/2</p> <p>page 57 [1] 63/6</p> <p>Page 71 [1] 65/6</p> <p>page 72 [1] 67/3</p> <p>Page 74 [1] 72/17</p> <p>page 75 [1] 72/22</p> <p>Page 77 [1] 74/15</p> <p>page 9 [2] 49/25 50/1</p> <p>pages [5] 10/7 17/3 48/7 59/8 69/19</p> <p>pages 1 [1] 48/7</p> <p>pages 21 [1] 10/7</p> <p>pages 73 [1] 69/19</p> <p>paid [1] 89/7</p> <p>paper [1] 44/18</p> <p>papers [1] 3/7</p> <p>paradoxically [1] 33/25</p> <p>paragraph [35] 5/3 5/11 5/16 9/5 11/10 12/3 12/13 15/9 15/19 17/22 22/15 22/16 26/16 29/10 29/18 39/24 40/18 42/2 42/8 43/21 50/1 52/6 54/22 61/4 61/9 61/13 64/13 67/5 70/5 71/14 72/17 74/17 83/25 84/4 87/17</p> <p>paragraph 149 [1] 61/13</p> <p>paragraph 185 [1] 87/17</p> <p>paragraph 192 [2] 83/25 84/4</p> <p>paragraph 195 [1] 64/13</p> <p>paragraph 209 [1] 52/6</p> <p>paragraph 221 [2] 61/4 61/9</p> <p>paragraph 230 [1] 67/5</p> <p>paragraph 237 [1] 70/5</p> <p>Paragraph 238 [1] 71/14</p> <p>paragraph 24 [1] 43/21</p> <p>paragraph 242 [1]</p>	<p>72/17</p> <p>Paragraph 245 [1] 74/17</p> <p>paragraph 25 [1] 26/16</p> <p>paragraph 36 [2] 39/24 50/1</p> <p>paragraph 37 [2] 40/18 42/8</p> <p>paragraph 38 [1] 42/2</p> <p>paragraph 41 [1] 5/3</p> <p>paragraph 44 [1] 5/11</p> <p>paragraph 46 [1] 11/10</p> <p>paragraph 49 [1] 9/5</p> <p>paragraph 54 [1] 5/16</p> <p>paragraph 58 [2] 29/10 29/18</p> <p>paragraph 61 [1] 22/15</p> <p>paragraph 80 [1] 54/22</p> <p>paragraphs [7] 5/21 30/12 31/4 57/3 69/21 75/9 87/3</p> <p>paragraphs 159-164 [1] 57/3</p> <p>paragraphs 179 [1] 87/3</p> <p>Paragraphs 248 [1] 75/9</p> <p>paragraphs 65-66 [1] 30/12</p> <p>paragraphs 67 [1] 31/4</p> <p>park [1] 20/21</p> <p>part [35] 5/10 5/11 6/12 7/4 7/8 7/19 8/7 8/9 8/15 8/17 8/19 11/19 12/18 21/3 21/10 23/16 26/25 31/21 36/2 36/5 36/7 39/3 48/24 49/6 57/13 59/20 59/21 60/15 60/19 66/2 66/7 72/12 73/20 73/22 83/14</p> <p>particular [8] 14/25 37/11 49/16 49/17 58/8 59/17 85/17 87/4</p> <p>particularly [16] 15/15 18/16 32/6 33/5 37/12 39/20 50/21 51/1 51/9 52/5 55/18 59/3 60/3 65/25 69/8 84/5</p> <p>partly [2] 60/15 72/7</p> <p>parts [3] 8/18 12/19 14/11</p> <p>passed [1] 73/14</p> <p>past [4] 62/7 62/9 62/10 64/8</p> <p>patch [6] 6/15 6/16 9/17 29/4 31/17 32/23</p>	<p>pathway [1] 8/6</p> <p>patient [29] 9/14 10/11 10/22 22/19 24/3 25/12 32/16 33/4 33/7 33/10 41/24 44/5 50/5 50/5 50/8 50/23 53/21 54/11 55/7 57/1 57/4 57/22 57/25 59/7 59/17 73/14 73/17 89/13 89/21</p> <p>patient's [4] 40/10 59/2 60/3 66/19</p> <p>patient-nurse [1] 50/8</p> <p>patients [39] 5/8 8/2 14/9 18/24 20/9 22/3 24/16 25/3 26/18 27/5 28/2 28/4 32/15 32/17 32/19 33/17 37/12 37/18 38/14 39/21 41/12 41/16 41/20 42/23 46/13 50/18 55/7 57/11 66/5 77/18 77/19 82/18 84/6 87/4 87/8 87/19 88/3 88/6 88/10</p> <p>pause [1] 86/25</p> <p>pay [1] 4/22</p> <p>people [110]</p> <p>people's [6] 10/3 20/11 20/13 24/14 82/9 87/21</p> <p>percentage [1] 32/15</p> <p>performing [1] 85/19</p> <p>perhaps [3] 5/20 33/23 47/14</p> <p>Perinatal [1] 9/22</p> <p>period [4] 31/25 44/23 45/14 68/16</p> <p>periods [2] 44/20 50/14</p> <p>persistent [2] 87/7 88/12</p> <p>person [36] 3/15 4/13 10/12 12/8 17/19 17/25 24/9 44/22 51/7 51/9 51/11 51/18 53/14 54/10 56/9 56/11 56/13 56/21 57/14 57/18 58/5 58/14 58/15 59/23 63/19 75/16 76/20 77/10 77/13 79/25 81/1 81/16 82/7 84/21 84/24 88/19</p> <p>person's [4] 12/10 73/16 90/17 90/19</p> <p>person-centred [1] 17/19</p> <p>personally [1] 29/1</p> <p>Persons [2] 12/25 13/10</p> <p>persuade [2] 46/24 47/5</p> <p>persuaded [1] 22/23</p> <p>pertinent [2] 33/5</p>	<p>53/19</p> <p>philosophical [1] 16/6</p> <p>phone [1] 35/10</p> <p>phrases [1] 86/14</p> <p>physical [1] 6/2</p> <p>pick [2] 80/19 82/5</p> <p>pilot [3] 5/14 5/17 31/6</p> <p>pilots [1] 29/9</p> <p>pioneering [1] 2/21</p> <p>place [6] 15/22 15/24 20/9 24/1 44/13 46/25</p> <p>placed [2] 38/19 70/25</p> <p>placement [1] 44/7</p> <p>placements [2] 51/13 69/2</p> <p>places [6] 16/20 34/13 34/14 34/17 65/2 86/12</p> <p>plainly [2] 41/18 80/20</p> <p>plan [13] 31/7 54/15 54/16 56/21 64/23 72/1 72/5 72/6 73/13 80/8 80/8 80/9 80/10</p> <p>plane [1] 4/20</p> <p>plans [2] 63/7 71/18</p> <p>play [2] 36/5 66/7</p> <p>plays [1] 86/4</p> <p>please [19] 1/4 1/8 11/23 22/15 26/14 39/18 47/21 47/25 48/7 48/8 49/25 52/3 53/1 63/9 65/6 69/19 72/22 74/15 78/21</p> <p>pleases [1] 10/22</p> <p>Plus [1] 82/10</p> <p>pm [4] 1/2 47/18 47/20 92/4</p> <p>Pocket [1] 49/17</p> <p>point [20] 3/6 3/11 6/20 7/18 9/5 10/10 11/2 13/23 21/20 26/5 30/4 42/12 64/13 67/7 68/7 76/12 78/15 80/7 80/7 87/15</p> <p>points [2] 62/4 64/15</p> <p>police [9] 19/4 24/8 42/22 42/25 43/8 43/18 45/24 46/16 75/15</p> <p>policies [1] 73/24</p> <p>policy [7] 51/25 55/25 60/10 60/23 60/25 72/21 73/7</p> <p>poor [3] 26/20 32/15 88/16</p> <p>pop [1] 45/12</p> <p>population [2] 40/2 42/4</p> <p>port [1] 84/22</p> <p>poses [1] 82/3</p> <p>position [4] 32/3 72/18 72/23 78/12</p>	<p>positions [2] 69/13 74/23</p> <p>positive [3] 34/21 34/24 86/14</p> <p>possibility [3] 19/5 33/16 33/17</p> <p>possible [7] 10/3 17/14 23/13 32/13 33/9 56/17 91/5</p> <p>post [6] 65/23 68/21 68/22 68/23 74/19 83/2</p> <p>post-Covid [3] 68/21 68/22 68/23</p> <p>post-reg [1] 65/23</p> <p>post-registration [1] 83/2</p> <p>potential [1] 15/13</p> <p>potentially [1] 34/8</p> <p>practice [23] 28/12 35/1 53/3 61/6 61/12 63/7 65/7 65/8 65/11 65/12 66/14 67/24 68/6 68/10 68/14 68/15 69/2 71/5 81/4 82/19 86/1 86/1 86/14</p> <p>practices [9] 12/2 12/6 12/19 14/21 15/10 17/5 18/3 35/15 61/19</p> <p>practise [3] 57/10 71/1 74/4</p> <p>practitioner [2] 54/25 55/5</p> <p>practitioners [3] 34/20 71/11 71/11</p> <p>prematurely [1] 69/11</p> <p>premises [2] 21/4 21/9</p> <p>preparation [1] 67/19</p> <p>prepared [2] 1/11 48/2</p> <p>presence [1] 6/2</p> <p>present [2] 22/10 32/4</p> <p>pressure [1] 66/15</p> <p>pressures [1] 55/10</p> <p>presumably [1] 68/21</p> <p>pretty [2] 15/15 91/10</p> <p>prevent [3] 13/18 60/2 86/21</p> <p>prevention [4] 4/18 4/19 19/10 28/12</p> <p>previous [1] 26/25</p> <p>previously [1] 18/17</p> <p>primary [8] 9/18 21/15 31/15 35/8 35/11 51/3 51/3 51/5</p> <p>principal [1] 49/7</p> <p>principle [3] 29/21 71/20 78/5</p> <p>principles [14] 5/19 7/11 10/6 10/8 11/3 15/3 21/23 22/17 25/4</p>
---	---	--	--	---

<p>P</p> <p>principles... [5] 25/10 60/19 65/7 65/10 66/12</p> <p>private [1] 51/13</p> <p>probably [3] 12/23 46/22 82/1</p> <p>probe [1] 81/18</p> <p>problem [9] 28/18 38/1 41/1 60/15 82/24 83/1 88/12 88/13 90/20</p> <p>problematic [4] 34/8 34/11 34/18 50/25</p> <p>problems [6] 14/25 21/19 30/2 39/11 50/17 52/2</p> <p>proceedings [1] 33/5</p> <p>process [11] 9/15 52/11 56/24 59/24 59/25 69/1 77/14 78/1 82/6 85/21 87/25</p> <p>produced [1] 11/19</p> <p>profession [1] 66/8</p> <p>professional [5] 1/19 53/3 66/6 66/21 70/19</p> <p>professionals [1] 73/15</p> <p>Professor [17] 1/4 1/6 1/11 2/1 2/2 3/10 5/24 18/7 32/13 35/23 35/23 36/4 37/3 37/7 42/16 42/20 93/3</p> <p>Professor Appleby [1] 36/4</p> <p>Professor at [1] 2/1</p> <p>Professor Kendall [10] 1/11 3/10 5/24 18/7 32/13 35/23 37/3 37/7 42/16 42/20</p> <p>Professor Sir [1] 35/23</p> <p>Professor Tim [1] 1/4</p> <p>profile [2] 59/19 76/19</p> <p>prognosis [1] 44/24</p> <p>programme [3] 2/20 10/24 11/11</p> <p>programmes [1] 83/12</p> <p>prohibiting [1] 12/9</p> <p>project [1] 62/6</p> <p>promote [1] 30/21</p> <p>promoted [1] 69/11</p> <p>promoting [4] 11/4 11/7 17/19 21/25</p> <p>prompts [1] 71/18</p> <p>proper [3] 14/3 80/8 81/6</p> <p>properly [5] 52/12 57/20 58/3 59/13 85/19</p> <p>property [2] 38/9 38/15</p>	<p>proportionate [1] 67/10</p> <p>proposed [2] 13/11 13/11</p> <p>protect [2] 13/25 23/16</p> <p>protecting [1] 43/17</p> <p>proved [1] 39/24</p> <p>provide [12] 6/12 15/1 21/16 24/25 34/14 38/13 65/23 67/2 67/11 76/6 81/6 84/6</p> <p>provided [5] 17/16 39/19 48/20 52/7 67/16</p> <p>provides [1] 74/18</p> <p>providing [2] 11/17 17/16</p> <p>psychiatric [3] 21/14 49/6 74/21</p> <p>psychiatrist [2] 1/21 53/15</p> <p>psychiatrists [4] 19/1 24/23 43/12 47/5</p> <p>psychiatry [1] 49/1</p> <p>psychological [4] 22/24 45/7 86/11 86/16</p> <p>psychosis [12] 2/9 2/10 7/5 7/6 8/6 25/16 40/12 40/12 40/13 40/14 44/4 44/22</p> <p>psychotic [5] 26/19 45/9 62/17 86/18 89/14</p> <p>public [5] 5/7 23/16 23/18 43/17 74/24</p> <p>publications [1] 49/16</p> <p>published [2] 44/18 49/15</p> <p>pull [1] 1/8</p> <p>purpose [1] 83/16</p> <p>purposes [2] 1/12 26/10</p> <p>push [1] 82/1</p> <p>put [5] 31/18 52/6 64/3 75/5 91/6</p> <p>puts [3] 45/10 81/16 81/17</p> <p>putting [1] 38/24</p> <hr/> <p>Q</p> <p>qualification [2] 28/25 74/19</p> <p>qualifications [1] 48/9</p> <p>qualified [2] 83/5 83/7</p> <p>qualifying [1] 48/12</p> <p>quality [4] 50/15 79/5 79/16 85/16</p> <p>quantitative [1] 31/2</p> <p>question [12] 29/17 45/23 60/21 64/9</p>	<p>65/18 70/13 78/21 79/4 79/23 82/7 82/8 91/22</p> <p>Questioned [20] 1/7 32/12 37/6 42/19 45/22 47/24 78/20 80/16 83/20 88/25 93/4 93/5 93/6 93/7 93/8 93/11 93/12 93/13 93/14 93/15</p> <p>questions [17] 9/10 32/9 32/10 37/9 56/8 63/13 65/5 76/8 77/12 78/17 80/17 80/21 80/25 81/7 81/20 82/2 83/21</p> <p>quick [1] 82/25</p> <p>quickly [4] 44/25 59/11 77/6 77/13</p> <p>quite [13] 6/18 7/22 10/2 14/1 20/21 24/24 37/15 43/10 47/10 51/10 59/11 61/16 73/2</p> <p>quotation [1] 15/15</p> <hr/> <p>R</p> <p>race [2] 87/1 87/3</p> <p>radical [2] 10/2 13/14</p> <p>raised [1] 37/25</p> <p>raises [1] 15/12</p> <p>range [1] 44/10</p> <p>rare [10] 3/16 3/24 3/25 4/2 4/4 4/4 4/7 4/16 19/8 68/9</p> <p>rarely [1] 65/11</p> <p>rate [1] 38/2</p> <p>rate-limiting [1] 38/2</p> <p>rather [7] 19/21 22/21 40/5 56/19 68/24 75/10 77/7</p> <p>ratified [1] 13/2</p> <p>re [3] 28/14 72/18 72/24</p> <p>re-engaging [1] 28/14</p> <p>Re-establish [1] 72/18</p> <p>re-establishing [1] 72/24</p> <p>reach [5] 33/11 33/15 33/21 75/13 78/15</p> <p>reached [1] 78/16</p> <p>react [1] 82/7</p> <p>reaction [2] 34/20 34/21</p> <p>read [4] 59/8 63/14 70/24 90/15</p> <p>reads [2] 15/9 15/14</p> <p>real [2] 39/7 78/11</p> <p>realistically [1] 27/7</p> <p>reality [2] 18/7 38/12</p> <p>really [34] 13/24 18/25 20/14 21/16 23/20 27/13 28/9 31/21 37/15 41/22</p>	<p>42/14 47/7 49/4 51/10 53/22 56/5 56/12 57/17 59/21 61/20 62/7 62/21 63/1 66/10 68/25 75/13 75/14 76/13 77/14 77/22 81/15 81/23 83/3 85/23</p> <p>reason [4] 6/7 7/22 36/18 88/18</p> <p>reasonably [1] 31/14</p> <p>reasons [4] 36/17 36/17 36/19 36/20</p> <p>reassuring [1] 4/16</p> <p>rebuild [2] 49/4 86/18</p> <p>receive [2] 13/18 67/9</p> <p>receiving [1] 40/20</p> <p>recent [1] 25/16</p> <p>recently [1] 43/5</p> <p>recognise [2] 19/19 88/15</p> <p>recognised [1] 11/12</p> <p>recognising [2] 26/20 34/22</p> <p>recommend [2] 25/16 56/23</p> <p>recommendation [2] 25/25 28/22</p> <p>recommendations [2] 17/22 69/20</p> <p>recommended [1] 35/25</p> <p>recommending [1] 16/7</p> <p>recommends [1] 26/7</p> <p>record [3] 59/9 71/16 72/2</p> <p>recorded [1] 73/14</p> <p>recording [1] 89/5</p> <p>recordkeeping [1] 53/6</p> <p>records [3] 53/7 53/22 59/8</p> <p>recover [3] 15/25 21/17 23/21</p> <p>recovery [1] 17/25</p> <p>recovery-oriented [1] 17/25</p> <p>recurrent [2] 32/5 32/6</p> <p>reduce [1] 87/19</p> <p>reduced [1] 65/21</p> <p>refer [7] 3/21 4/11 44/1 44/20 50/1 58/7 67/3</p> <p>reference [3] 12/3 25/10 27/3</p> <p>referenced [3] 23/2 37/11 80/20</p> <p>referral [2] 24/17 44/14</p> <p>referrals [1] 10/18</p> <p>referred [3] 6/19 50/18 64/13</p>	<p>referring [1] 14/9</p> <p>refers [2] 3/14 12/13</p> <p>reflect [1] 79/13</p> <p>reflected [1] 54/19</p> <p>reflective [2] 86/1 86/1</p> <p>reflects [1] 53/18</p> <p>refresher [1] 70/8</p> <p>reg [1] 65/23</p> <p>registered [3] 54/24 55/5 55/20</p> <p>registration [2] 74/19 83/2</p> <p>regulatory [1] 53/8</p> <p>rejecting [1] 6/18</p> <p>rejection [1] 6/17</p> <p>relapse [2] 59/16 59/19</p> <p>relapses [2] 26/23 26/25</p> <p>relate [2] 71/4 88/20</p> <p>related [3] 12/7 42/21 55/6</p> <p>relation [5] 33/10 46/13 52/22 53/6 53/23</p> <p>relationship [21] 19/12 19/24 23/13 34/10 50/4 50/8 50/12 50/15 50/25 51/10 51/15 51/17 54/18 59/21 70/14 70/15 70/20 70/21 77/9 85/14 86/5</p> <p>relationships [3] 15/1 18/9 86/6</p> <p>relative [1] 74/24</p> <p>relevant [5] 14/13 39/15 42/8 53/21 59/2</p> <p>reliance [1] 16/13</p> <p>rely [1] 53/11</p> <p>relying [1] 16/1</p> <p>remain [1] 47/10</p> <p>remains [1] 42/6</p> <p>remotely [1] 80/10</p> <p>repeated [1] 17/6</p> <p>report [4] 13/8 14/12 30/15 30/17</p> <p>reported [2] 30/15 30/17</p> <p>reporting [1] 3/16</p> <p>represent [1] 9/7</p> <p>reputation [1] 88/16</p> <p>require [1] 24/21</p> <p>required [5] 25/8 69/23 71/21 81/5 84/7</p> <p>requirements [1] 84/15</p> <p>requires [2] 19/3 50/11</p> <p>research [1] 39/23</p> <p>researched [1] 3/3</p> <p>residential [2] 21/9 48/19</p> <p>resolve [1] 66/16</p> <p>resource [5] 28/23</p>
---	---	--	---	---

<p>R</p> <p>resource... [4] 55/8 67/1 76/2 83/17</p> <p>respect [1] 60/11</p> <p>respond [2] 45/8 81/20</p> <p>response [3] 5/10 5/11 45/24</p> <p>responsibility [3] 48/15 55/1 84/24</p> <p>responsible [4] 53/10 53/15 59/7 75/7</p> <p>responsiveness [2] 45/6 45/7</p> <p>restraint [1] 12/16</p> <p>restrictive [3] 10/25 27/1 86/14</p> <p>rests [1] 50/4</p> <p>result [3] 16/12 56/6 78/8</p> <p>results [1] 76/2</p> <p>retrospectively [2] 51/12 87/14</p> <p>review [2] 13/8 80/9</p> <p>reviewing [1] 80/11</p> <p>reviews [1] 74/10</p> <p>revisit [1] 86/20</p> <p>rid [1] 7/1</p> <p>right [24] 6/24 12/8 14/3 18/15 20/8 29/24 30/21 35/13 36/11 43/22 43/25 44/15 45/1 46/8 47/13 49/19 54/25 55/6 64/5 83/11 84/3 87/6 87/13 92/2</p> <p>rights [5] 12/14 12/25 13/10 17/19 17/25</p> <p>rights-based [2] 17/19 17/25</p> <p>risk [86] 8/3 18/19 18/22 18/23 20/5 22/3 22/10 37/22 39/15 39/20 40/1 40/14 40/22 41/7 41/10 41/11 41/24 42/5 42/7 42/8 42/14 49/17 53/21 58/12 58/25 59/2 59/4 59/17 59/20 60/4 60/10 60/11 61/6 61/6 61/10 61/12 61/14 61/15 62/4 62/5 62/7 62/8 62/9 62/11 62/15 62/21 62/24 62/24 63/7 63/8 63/15 63/16 63/17 64/3 64/6 64/8 64/8 64/13 64/18 64/22 64/23 64/23 65/22 69/25 69/25 71/15 71/17 71/23 71/24 71/25 72/1 72/4 72/11 72/11 72/13 72/16 73/13 76/9 80/11 81/16 81/17 82/3 84/5 86/14 91/18</p>	<p>91/20</p> <p>risk factor [1] 40/22</p> <p>risk factors [12] 18/19 37/22 39/15 41/10 42/7 62/7 62/8 62/15 62/21 62/24 62/24 72/16</p> <p>risks [4] 26/23 40/16 41/24 53/20</p> <p>risky [2] 20/1 56/14</p> <p>road [1] 19/20</p> <p>role [14] 2/21 49/3 54/2 54/7 54/20 68/8 68/12 69/7 75/10 84/13 85/8 85/9 85/19 89/21</p> <p>roles [5] 53/5 67/21 69/8 69/9 78/23</p> <p>roll [1] 31/9</p> <p>roll-out [1] 31/9</p> <p>roof [2] 6/23 29/22</p> <p>routes [1] 66/23</p> <p>routine [1] 8/2</p> <p>Royal [1] 66/21</p> <p>run [1] 44/24</p> <p>rushing [1] 86/24</p>	<p>71/20 88/10</p> <p>says [1] 64/7</p> <p>scenarios [1] 89/16</p> <p>scheme [2] 5/1 31/6</p> <p>schizoaffective [1] 40/13</p> <p>schizophrenia [24] 2/8 2/9 2/25 3/15 13/25 14/24 15/25 21/17 23/11 23/20 25/15 26/19 39/21 39/25 40/4 40/5 40/13 41/12 42/3 42/6 43/23 44/9 44/20 47/9</p> <p>schizophrenic [1] 19/11</p> <p>schools [1] 57/1</p> <p>screen [16] 5/17 5/22 5/22 5/24 9/5 48/7 52/6 53/1 58/24 62/1 63/6 63/9 65/6 67/3 69/19 74/15</p> <p>search [2] 91/3 91/6</p> <p>seclusion [1] 12/15</p> <p>second [6] 3/12 12/1 12/2 15/9 84/10 84/11</p> <p>secondary [2] 19/10 28/12</p> <p>secondly [1] 31/2</p> <p>section [6] 17/4 27/3 37/19 37/20 38/13 75/17</p> <p>Section 117 [2] 37/20 38/13</p> <p>Section 135 [1] 27/3</p> <p>sector [1] 34/14</p> <p>security [1] 12/8</p> <p>see [27] 3/19 4/19 5/14 10/7 11/2 16/14 19/3 20/17 20/19 22/10 24/16 34/5 35/11 35/18 35/18 45/13 51/8 53/5 56/15 58/18 61/14 62/23 72/14 79/9 79/10 81/2 82/18</p> <p>seeing [6] 8/2 20/21 32/7 34/17 72/9 81/12</p> <p>seem [3] 23/19 37/14 74/22</p> <p>seems [3] 4/3 9/12 45/9</p> <p>seen [4] 35/22 44/12 64/16 65/3</p> <p>sees [2] 10/11 54/7</p> <p>self [2] 67/6 81/22</p> <p>self-evident [1] 67/6</p> <p>self-isolated [1] 81/22</p> <p>sending [1] 65/24</p> <p>senior [2] 68/9 69/8</p> <p>sense [3] 15/14 34/4 75/8</p> <p>sentinel [2] 36/9 36/24</p> <p>separate [2] 21/4</p>	<p>54/12</p> <p>series [1] 32/9</p> <p>serious [4] 14/24 18/22 21/19 63/15</p> <p>seriously [1] 4/17</p> <p>serve [1] 6/16</p> <p>served [1] 9/17</p> <p>service [19] 1/24 17/18 20/16 22/12 25/8 42/22 44/14 48/15 48/21 48/22 49/2 49/4 54/8 60/19 67/2 67/11 67/16 68/6 75/21</p> <p>services [33] 5/5 6/12 6/23 11/21 11/25 12/7 12/20 14/15 15/19 16/18 16/25 19/9 23/11 23/20 26/22 27/1 29/13 29/20 30/8 41/3 48/16 55/10 67/9 70/7 74/20 75/22 76/6 77/20 84/5 85/6 87/5 87/8 88/16</p> <p>set [10] 4/14 5/10 5/14 5/17 10/6 13/9 25/18 56/25 63/7 87/6</p> <p>sets [3] 1/19 52/3 59/1</p> <p>setting [4] 54/4 56/20 68/13 74/6</p> <p>settings [4] 60/14 60/16 71/9 79/4</p> <p>seven [3] 10/8 31/19 38/20</p> <p>seven days [1] 31/19</p> <p>seven miles [1] 38/20</p> <p>several [4] 44/19 46/7 74/9 75/16</p> <p>severe [1] 13/25</p> <p>share [2] 54/2 68/5</p> <p>sharing [1] 68/18</p> <p>Sheffield [6] 1/24 2/3 28/16 35/9 38/4 46/7</p> <p>shift [6] 9/7 10/2 13/14 34/24 74/11 84/19</p> <p>shop [2] 30/9 34/8</p> <p>short [3] 47/19 50/14 84/10</p> <p>shortage [1] 55/9</p> <p>shortcuts [1] 59/14</p> <p>shortly [1] 53/20</p> <p>should [37] 13/11 13/17 14/4 15/6 16/2 16/3 16/14 16/16 16/18 20/22 20/22 26/1 29/24 36/25 38/7 41/11 42/15 44/2 44/3 44/4 44/7 44/13 44/16 53/10 54/19 57/1 71/19 73/8 73/9 73/14 83/13 83/13 84/15 85/2 85/21 88/11 90/22</p>	<p>shouldn't [3] 4/4 16/19 53/11</p> <p>show [1] 87/6</p> <p>shown [1] 44/21</p> <p>sic [1] 35/25</p> <p>significance [1] 58/11</p> <p>significant [6] 4/1 4/8 4/10 40/22 41/6 67/1</p> <p>significantly [1] 74/11</p> <p>signs [3] 19/13 59/16 60/4</p> <p>similar [3] 22/19 25/19 25/24</p> <p>simple [5] 51/22 52/11 61/25 64/24 65/4</p> <p>simply [2] 33/15 87/15</p> <p>simulation [2] 70/3 90/7</p> <p>simulation-based [1] 70/3</p> <p>simulations [3] 71/1 71/7 89/19</p> <p>since [3] 43/12 44/19 67/13</p> <p>single [2] 9/7 57/7</p> <p>Sir [2] 35/23 36/17</p> <p>sit [4] 1/8 47/25 68/25 82/10</p> <p>sited [1] 7/23</p> <p>sites [4] 5/14 5/17 30/19 35/6</p> <p>situation [4] 22/19 56/20 62/6 70/25</p> <p>situations [1] 42/12</p> <p>six [12] 3/13 3/25 5/14 5/17 6/9 28/17 29/9 35/6 38/20 64/13 64/15 72/8</p> <p>six months [1] 28/17</p> <p>six-factor [1] 72/8</p> <p>skills [9] 54/16 69/18 70/4 70/22 77/4 77/24 78/6 85/10 90/20</p> <p>slightly [3] 16/5 54/6 85/25</p> <p>slow [1] 82/25</p> <p>small [3] 8/16 8/18 75/12</p> <p>smarter [1] 77/16</p> <p>so [146]</p> <p>social [3] 22/25 30/8 75/22</p> <p>solely [1] 40/5</p> <p>solution [1] 82/24</p> <p>solving [1] 90/20</p> <p>some [32] 3/3 3/9 7/11 9/16 10/6 11/20 12/22 16/10 16/20 19/18 23/3 29/8 32/17 34/21 34/24 35/3 39/19 44/21 46/15 46/20 57/10 58/4</p>
--	---	---	---	--

<p>S</p> <p>some... [10] 66/12 80/22 84/22 85/19 85/21 86/15 87/21 87/22 89/7 90/8</p> <p>somebody [26] 8/5 10/11 15/4 28/13 34/9 38/21 38/24 52/23 55/13 55/19 56/5 58/18 62/10 62/10 63/2 63/17 64/7 66/17 70/21 76/18 77/4 80/9 81/12 81/18 81/22 87/12</p> <p>somebody's [3] 77/8 90/13 90/15</p> <p>somehow [1] 21/13</p> <p>someone [13] 13/24 14/1 19/10 23/23 34/18 42/4 42/5 43/1 43/6 45/9 46/1 46/18 46/21</p> <p>something [20] 8/3 10/22 23/6 23/7 23/25 25/24 45/10 47/4 48/9 62/20 63/23 63/24 64/17 65/20 74/7 78/16 80/2 81/3 81/16 82/3</p> <p>sometimes [9] 6/7 14/4 17/14 19/3 19/4 24/7 33/21 47/7 52/24</p> <p>somewhere [2] 8/14 38/18</p> <p>soon [1] 82/1</p> <p>sorry [4] 14/6 29/17 61/8 79/18</p> <p>sort [3] 43/18 69/13 84/14</p> <p>sorts [6] 55/4 64/3 66/15 68/7 75/23 83/9</p> <p>sound [2] 59/12 70/16</p> <p>south [1] 48/24</p> <p>south-west [1] 48/24</p> <p>space [1] 30/3</p> <p>speak [2] 21/12 65/6</p> <p>specialism [1] 8/4</p> <p>specialisms [1] 7/2</p> <p>specialist [7] 9/22 74/18 74/20 74/22 75/3 75/7 76/5</p> <p>specialities [1] 29/16</p> <p>specialty [1] 68/3</p> <p>specific [3] 63/13 63/18 84/15</p> <p>specifically [2] 27/16 59/16</p> <p>specifics [1] 63/21</p> <p>spectrum [1] 40/4</p> <p>speed [1] 83/4</p> <p>spend [5] 11/22 34/15 65/21 82/17 91/19</p> <p>spent [1] 20/12</p>	<p>spoken [1] 10/10</p> <p>St [2] 48/23 48/24</p> <p>St George's [2] 48/23 48/24</p> <p>stable [6] 37/23 41/6 61/14 62/18 62/24 72/15</p> <p>staff [16] 6/4 6/8 6/11 6/12 7/12 20/7 20/10 24/23 48/13 59/6 60/22 61/17 64/3 66/13 78/6 89/24</p> <p>stage [3] 29/11 29/18 45/16</p> <p>stakeholders [1] 12/5</p> <p>standard [1] 69/23</p> <p>Standardise [1] 71/15</p> <p>standards [3] 53/3 53/8 83/15</p> <p>stark [1] 65/9</p> <p>start [6] 14/14 19/9 26/15 56/7 80/24 92/3</p> <p>started [1] 48/13</p> <p>state [5] 46/21 56/7 90/14 90/15 90/19</p> <p>statement [39] 1/11 1/16 2/19 2/23 3/4 3/5 3/21 5/2 5/15 6/13 6/20 10/7 10/23 11/10 11/20 18/20 22/16 26/12 26/14 26/15 29/8 31/8 39/19 43/21 44/21 47/9 48/2 49/17 49/25 50/7 50/18 58/24 63/6 74/15 76/10 83/25 87/2 87/8 87/17</p> <p>states [1] 31/7</p> <p>static [6] 61/14 62/9 62/11 62/15 62/24 72/15</p> <p>statistical [3] 4/5 4/7 45/3</p> <p>statistical way [1] 4/7</p> <p>statistically [3] 4/1 4/8 4/10</p> <p>statistics [1] 42/11</p> <p>statutory [1] 38/12</p> <p>stay [2] 32/20 33/2</p> <p>stays [3] 10/12 62/15 62/16</p> <p>steps [2] 29/8 60/1</p> <p>stigmatizing [1] 18/2</p> <p>still [8] 8/14 8/19 9/24 32/18 32/20 41/24 76/2 83/6</p> <p>stock [1] 38/10</p> <p>Stonebridge [1] 21/3</p> <p>stop [3] 8/11 8/12 30/9</p> <p>stopped [1] 73/23</p> <p>straightforward [3] 24/18 61/25 65/4</p>	<p>strangers [1] 9/4</p> <p>Straw [7] 42/18 42/19 45/24 83/19 83/20 93/7 93/14</p> <p>street [2] 38/2 47/11</p> <p>strong [1] 43/6</p> <p>studies [2] 3/16 40/3</p> <p>study [1] 3/8</p> <p>stuff [3] 61/25 77/16 78/4</p> <p>sub [2] 8/4 29/16</p> <p>sub-specialism [1] 8/4</p> <p>sub-specialities [1] 29/16</p> <p>subject [1] 3/2</p> <p>subjectivity [1] 15/13</p> <p>subparagraphs [1] 5/16</p> <p>substance [3] 2/11 30/2 41/1</p> <p>substantive [1] 50/25</p> <p>subsumes [1] 26/8</p> <p>subtle [1] 60/4</p> <p>successful [1] 39/13</p> <p>successfully [2] 17/24 69/14</p> <p>such [3] 8/5 31/2 40/4</p> <p>suddenly [1] 45/12</p> <p>sufficient [3] 25/7 37/18 52/8</p> <p>sufficiently [1] 52/17</p> <p>suggest [3] 69/20 69/22 79/12</p> <p>suggested [2] 12/14 17/23</p> <p>suggesting [4] 9/12 16/17 64/17 75/11</p> <p>suggestion [2] 14/7 21/9</p> <p>suggestions [2] 14/20 70/12</p> <p>suicides [1] 49/3</p> <p>suit [1] 60/18</p> <p>suitable [2] 21/18 22/4</p> <p>sum [1] 31/12</p> <p>summarise [1] 1/20</p> <p>summarising [1] 39/23</p> <p>supersedes [1] 52/20</p> <p>supervision [7] 8/8 8/20 85/16 85/18 85/24 85/25 86/7</p> <p>support [10] 14/22 22/25 43/22 43/25 44/8 66/6 66/8 78/6 83/7 83/11</p> <p>supported [3] 44/8 81/10 86/23</p> <p>supportive [1] 36/6</p> <p>supports [2] 38/7 71/7</p> <p>sure [8] 8/21 20/25</p>	<p>31/14 33/6 34/11 39/7 85/20 88/9</p> <p>surgery [1] 75/1</p> <p>surprised [1] 35/17</p> <p>surrounding [1] 60/10</p> <p>survive [1] 65/18</p> <p>survivors [2] 37/9 80/18</p> <p>suspect [2] 40/11 40/14</p> <p>switch [1] 77/13</p> <p>sworn [2] 47/23 93/10</p> <p>system [6] 16/11 32/24 59/13 60/18 72/25 91/1</p> <p>systems [6] 11/14 59/9 71/16 72/2 90/25 91/2</p> <p>T</p> <p>tailor [1] 56/18</p> <p>take [13] 3/6 22/8 22/23 46/6 47/13 59/11 61/23 68/5 76/1 82/11 82/15 86/11 89/21</p> <p>taken [8] 4/17 15/16 17/9 17/10 36/8 37/10 60/2 70/10</p> <p>takes [3] 50/11 61/2 84/4</p> <p>taking [6] 6/11 40/18 59/18 81/25 86/15 89/4</p> <p>talented [1] 69/17</p> <p>talk [20] 51/12 57/6 58/3 65/14 65/20 66/10 68/4 68/11 68/11 70/24 79/2 79/18 79/19 80/2 81/14 81/23 81/24 90/13 91/25 92/1</p> <p>talked [1] 85/15</p> <p>talking [12] 29/14 59/22 61/21 68/10 68/13 68/14 68/15 69/15 76/1 78/3 90/16 91/20</p> <p>tasks [1] 52/13</p> <p>teaching [3] 65/2 69/23 69/25</p> <p>team [49] 6/24 7/3 7/5 7/8 7/10 7/11 7/12 7/16 7/19 8/5 8/7 8/9 8/12 8/14 8/16 9/8 9/11 9/12 9/19 9/19 9/20 9/20 9/21 9/23 20/16 21/2 24/20 25/9 27/15 28/15 28/18 29/7 48/18 48/18 54/11 55/15 58/2 58/3 58/5 63/24 73/17 75/19 75/19 75/20 75/21 76/5 79/10 82/5</p>	<p>86/2</p> <p>teams [32] 6/15 6/16 6/21 7/1 7/23 9/17 9/18 9/21 16/12 16/18 20/24 25/17 25/18 25/19 26/1 26/4 26/9 27/10 27/13 28/20 29/12 29/20 30/5 31/15 31/16 31/16 31/17 50/16 50/20 60/17 67/12 77/8</p> <p>techniques [1] 90/21</p> <p>tell [6] 36/13 39/13 48/8 62/1 63/12 75/11</p> <p>telling [3] 79/25 80/1 80/1</p> <p>tells [1] 62/20</p> <p>template [4] 71/15 71/19 71/23 77/12</p> <p>tend [2] 40/3 45/16</p> <p>tens [2] 25/22 25/23</p> <p>tenth [1] 38/4</p> <p>term [5] 3/24 23/12 51/1 51/3 91/7</p> <p>terminology [1] 61/17</p> <p>terms [10] 4/5 34/5 34/20 34/22 45/5 58/10 58/11 58/20 61/10 76/16</p> <p>terribly [1] 69/7</p> <p>tested [1] 76/3</p> <p>testing [1] 11/11</p> <p>than [17] 2/5 19/21 24/19 38/4 38/5 40/1 40/5 42/3 45/17 51/24 53/14 56/19 68/11 68/24 77/7 80/6 88/11</p> <p>thank [30] 1/9 4/24 32/8 32/11 37/3 37/4 39/14 40/16 42/2 42/16 42/17 45/20 45/21 45/21 46/13 47/12 47/16 47/17 47/22 47/25 63/11 78/17 78/19 80/14 83/18 87/1 87/14 88/23 88/24 92/2</p> <p>that [506]</p> <p>that's [86] 2/4 2/7 2/12 2/15 2/18 2/22 3/25 4/16 5/9 5/13 5/18 5/22 5/23 7/22 10/10 10/11 11/7 12/24 13/21 16/3 16/5 17/6 17/10 17/12 17/12 18/15 20/14 21/4 22/7 26/6 26/7 27/23 28/7 28/11 28/11 29/14 29/20 29/24 30/4 32/3 33/5 34/3 34/8 35/5 38/6 38/21 39/4 40/7 40/22 43/10 45/11 51/20 52/1 52/17 53/2 53/18 54/21 55/16 55/21</p>
---	---	--	---	--

<p>T</p> <p>that's... [27] 56/16 57/2 60/21 62/11 62/11 62/13 62/18 63/5 67/11 69/7 70/20 71/12 72/7 73/20 74/7 79/8 79/17 81/16 82/8 84/7 84/20 86/16 86/22 88/18 89/19 90/22 91/21</p> <p>their [75] 4/18 6/3 7/25 8/2 8/8 8/10 8/19 8/20 8/22 9/4 9/25 10/1 10/15 11/5 19/10 20/7 22/1 24/13 26/20 26/25 27/20 29/3 33/18 33/19 33/24 33/25 35/9 35/20 36/12 38/23 38/23 39/1 43/7 45/6 45/6 45/10 47/10 50/3 50/5 50/19 51/3 51/19 54/2 54/7 54/25 55/1 55/5 55/25 56/5 56/6 56/18 56/21 57/2 59/2 59/9 61/17 61/22 68/4 68/5 69/7 69/18 75/20 76/23 76/25 77/1 77/18 77/18 78/10 81/15 81/25 85/19 87/15 87/15 88/21 90/16</p> <p>them [92] 6/10 6/17 6/19 8/11 10/13 13/18 13/25 15/11 16/23 17/8 19/2 19/12 19/13 20/13 20/19 20/21 21/9 22/10 22/17 23/14 23/16 23/21 23/24 24/1 24/5 24/13 25/3 25/11 28/14 30/18 32/19 32/21 33/3 33/14 33/21 34/5 34/12 34/19 35/1 35/18 36/13 37/2 37/20 37/21 40/14 44/21 45/10 45/15 46/17 46/24 46/24 52/8 52/14 54/3 54/3 56/2 56/15 56/19 59/23 59/24 63/25 64/1 64/1 66/16 66/17 68/14 68/15 68/20 70/19 70/19 70/20 74/7 74/11 75/17 77/3 77/19 81/2 81/12 81/23 82/18 82/23 83/11 83/16 83/17 86/4 86/11 87/16 88/4 88/5 88/13 90/19 90/21</p> <p>theme [1] 15/7</p> <p>themselves [9] 13/19 14/1 14/2 15/5 22/10 40/15 50/2 81/16</p>	<p>89/22</p> <p>then [59] 6/6 7/9 8/24 10/16 11/2 12/13 14/8 15/5 22/12 25/3 29/6 30/12 31/4 31/23 32/20 33/12 33/14 33/23 36/25 40/16 40/17 40/25 41/7 41/9 41/9 41/17 42/2 48/10 48/13 48/14 48/17 49/1 50/24 52/23 54/19 55/15 56/18 56/22 58/19 60/1 62/17 62/25 67/13 68/13 73/3 73/4 74/3 75/20 76/22 77/4 80/3 82/4 82/22 83/1 86/4 87/11 89/21 90/11 90/22</p> <p>therapeutic [7] 50/3 50/9 51/15 70/14 70/15 70/20 70/21</p> <p>therapies [2] 7/13 7/14</p> <p>therapy [1] 44/4</p> <p>there [98]</p> <p>there'd [1] 75/3</p> <p>there's [40] 3/5 3/11 4/6 10/3 10/4 12/3 13/16 14/23 15/22 16/22 17/9 19/24 20/5 21/8 25/18 25/22 32/5 33/2 34/21 35/14 46/16 51/22 66/3 66/24 67/17 67/20 67/23 68/19 69/2 72/3 72/7 79/14 82/2 83/17 84/10 87/7 88/1 88/6 89/7 91/1</p> <p>thereby [1] 84/6</p> <p>these [52] 3/17 4/2 5/20 5/25 6/22 7/10 7/17 7/23 9/2 10/12 11/21 14/11 14/18 14/22 16/12 16/20 17/17 18/8 19/7 21/6 21/7 21/16 23/3 23/22 24/19 25/23 29/9 30/25 33/5 35/6 41/10 41/13 41/16 42/11 42/13 51/8 52/24 57/16 58/4 63/12 66/11 67/24 70/12 72/15 73/23 76/16 77/22 80/13 82/2 83/10 91/21 91/22</p> <p>they [160]</p> <p>they'd [3] 8/9 31/18 69/12</p> <p>they'll [5] 65/18 81/25 82/3 82/4 90/13</p> <p>they're [56] 6/4 8/1 8/2 9/1 9/21 12/21 19/19 19/19 20/8 21/8 24/3 24/12 24/24 29/5 32/21 38/17 39/2 45/7</p>	<p>46/21 46/22 51/20 52/13 53/14 54/8 54/17 55/7 58/12 62/9 63/20 64/2 64/8 66/14 67/13 69/6 69/12 69/14 72/10 75/14 76/23 76/23 77/1 77/2 78/8 81/1 81/2 81/10 81/25 83/4 84/21 85/7 85/20 86/2 86/3 87/12 89/22 90/16</p> <p>they've [13] 6/9 24/15 24/16 33/18 35/7 35/10 44/21 75/17 83/8 83/8 84/18 84/25 89/22</p> <p>thing [22] 4/3 7/25 38/24 43/11 45/3 49/5 57/12 57/12 57/17 67/12 69/8 70/14 76/13 76/21 79/19 82/14 82/25 83/13 85/5 85/8 86/24 91/23</p> <p>things [36] 12/23 13/16 14/22 30/25 44/10 45/12 45/13 51/11 56/14 58/4 59/10 59/14 59/25 62/6 62/8 64/1 64/4 66/15 73/23 75/24 76/14 77/22 79/9 79/11 79/13 81/23 82/10 83/4 83/9 83/10 84/19 85/7 85/24 86/13 89/5 91/11</p> <p>think [97]</p> <p>thinking [14] 2/24 6/22 50/5 56/12 60/24 63/20 71/3 73/19 73/20 73/23 74/2 74/3 79/17 91/14</p> <p>third [1] 34/13</p> <p>thirds [1] 26/24</p> <p>this [150]</p> <p>those [35] 5/14 5/17 11/22 13/17 15/11 18/16 19/2 22/3 27/24 28/2 28/4 28/24 30/9 31/18 31/18 32/9 32/24 34/16 36/19 36/20 39/10 40/5 51/10 57/22 58/10 60/9 62/23 64/15 68/18 74/23 76/8 79/7 79/15 82/20 82/21</p> <p>though [8] 8/3 31/7 32/25 72/12 84/17 85/13 88/14 90/11</p> <p>thought [7] 26/3 55/13 57/1 64/23 66/3 71/20 87/23</p> <p>thoughts [2] 41/21 41/25</p> <p>thousands [2] 57/8 57/8</p> <p>threaten [1] 50/15</p>	<p>three [9] 7/24 25/14 39/10 45/17 49/9 70/8 74/9 74/9 84/10</p> <p>three years [3] 45/17 49/9 70/8</p> <p>through [23] 3/4 6/5 8/23 16/23 17/2 23/3 35/20 37/10 50/19 55/22 56/23 59/8 59/23 59/25 63/3 69/1 71/1 77/14 78/1 79/24 80/13 86/15 89/14</p> <p>throughout [2] 10/15 60/13</p> <p>Tim [1] 1/4</p> <p>time [39] 10/4 11/22 17/14 18/11 19/8 20/11 24/15 24/17 28/16 28/18 31/8 34/16 36/3 44/20 45/1 46/8 46/15 46/23 47/15 50/11 54/23 55/12 59/7 59/12 61/2 62/19 65/21 68/17 68/19 70/10 72/14 76/1 82/11 82/12 82/17 90/2 91/12 91/13 91/19</p> <p>times [1] 20/12</p> <p>TIMOTHY [2] 1/6 93/3</p> <p>today [2] 3/9 35/24</p> <p>together [8] 29/13 29/20 30/5 39/22 43/19 63/5 68/4 76/4</p> <p>told [1] 57/2</p> <p>too [3] 5/23 45/4 56/14</p> <p>took [2] 31/15 46/7</p> <p>top [1] 5/15</p> <p>topic [2] 56/25 87/1</p> <p>touch [3] 19/13 32/21 33/2</p> <p>towards [6] 9/7 31/8 35/1 40/1 40/15 40/15</p> <p>tragedies [1] 42/13</p> <p>trained [6] 48/10 52/12 59/13 61/17 85/7 89/4</p> <p>training [20] 52/7 60/11 61/18 61/20 65/22 67/15 69/22 74/18 74/22 75/3 75/8 76/5 84/12 84/16 85/15 87/25 89/1 89/4 89/15 90/6</p> <p>transformation [2] 29/11 29/19</p> <p>translated [1] 72/5</p> <p>traumatic [1] 27/2</p> <p>travel [1] 24/15</p> <p>travelling [1] 8/1</p> <p>treat [2] 14/9 45/2</p> <p>treated [5] 5/8 43/22 43/25 87/13 88/11</p> <p>treating [1] 88/3</p>	<p>treatment [24] 9/20 9/25 12/15 13/12 13/18 14/8 15/16 15/23 16/8 18/8 18/13 25/20 26/4 26/22 27/11 28/11 28/20 31/17 37/20 44/2 52/5 58/11 73/16 77/7</p> <p>treatments [1] 45/7</p> <p>trials [2] 25/22 25/23</p> <p>triggered [1] 16/9</p> <p>true [6] 1/16 15/4 22/7 28/11 38/6 48/4</p> <p>trust [5] 19/24 23/14 48/25 60/12 90/5</p> <p>trusted [1] 18/9</p> <p>trusting [1] 15/1</p> <p>trusts [9] 61/5 61/11 61/16 65/21 65/24 69/10 71/16 78/14 90/8</p> <p>try [8] 14/12 49/4 54/13 57/17 62/22 76/22 87/18 90/21</p> <p>trying [11] 52/2 54/7 54/9 56/19 59/10 60/5 69/12 72/10 88/9 88/12 88/20</p> <p>turn [4] 4/25 20/3 24/4 76/22</p> <p>two [12] 5/4 26/24 30/24 43/7 44/13 45/17 46/2 49/3 58/10 70/8 74/9 85/24</p> <p>two weeks [1] 44/13</p> <p>two years [1] 45/17</p> <p>two-thirds [1] 26/24</p> <p>type [8] 14/9 27/5 27/7 33/4 67/15 68/16 90/6 90/10</p> <hr/> <p>U</p> <p>UK [6] 12/23 13/2 13/11 14/5 14/7 14/13</p> <p>ulterior [1] 64/2</p> <p>ultimate [1] 54/25</p> <p>ultimately [1] 57/3</p> <p>UN [3] 13/4 13/6 13/22</p> <p>UN's [1] 13/9</p> <p>unable [1] 25/12</p> <p>uncomfortable [1] 59/24</p> <p>uncommon [2] 21/4 21/5</p> <p>under [10] 6/23 6/23 8/24 12/1 12/3 17/21 29/22 38/12 52/23 66/14</p> <p>underlying [1] 10/6</p> <p>underneath [1] 12/13</p> <p>underpinnings [1] 16/6</p> <p>underscores [1] 12/9</p> <p>understand [7] 22/17 57/20 64/18 64/24</p>
--	--	---	---	---

<p>U</p> <p>understand... [3] 71/4 86/19 90/21</p> <p>understanding [6] 41/18 61/11 62/19 70/15 72/13 78/9</p> <p>understands [1] 83/16</p> <p>understood [2] 51/25 52/17</p> <p>undertake [2] 52/8 52/14</p> <p>undertaking [1] 52/4</p> <p>unfortunately [1] 72/1</p> <p>unified [1] 9/8</p> <p>uniform [1] 58/1</p> <p>unit [7] 8/25 46/23 49/6 54/9 55/17 74/25 81/13</p> <p>units [2] 16/13 50/20</p> <p>universities [2] 65/22 90/8</p> <p>university [4] 2/1 2/2 49/7 83/3</p> <p>unless [1] 8/23</p> <p>unlikely [1] 22/21</p> <p>unstable [1] 29/5</p> <p>until [4] 6/5 31/19 47/14 92/5</p> <p>untreated [2] 44/22 45/14</p> <p>unwell [4] 24/3 26/21 60/4 75/5</p> <p>up [21] 4/14 7/23 20/3 23/5 24/4 35/6 35/7 35/11 44/19 46/22 46/23 53/11 55/24 71/24 76/1 76/22 80/19 82/5 83/4 89/17 91/9</p> <p>update [1] 31/10</p> <p>uploaded [1] 3/5</p> <p>upon [2] 48/11 50/4</p> <p>us [15] 14/12 20/14 35/11 35/20 46/23 48/8 62/1 62/20 63/3 63/12 73/12 74/2 75/11 76/10 87/14</p> <p>usable [1] 14/13</p> <p>use [14] 3/24 15/11 22/13 31/3 33/22 37/18 41/2 42/10 59/13 61/16 61/20 71/7 90/8 90/8</p> <p>used [12] 8/9 16/3 20/21 37/18 51/2 56/3 58/8 58/12 64/15 64/20 65/23 71/16</p> <p>useful [2] 65/4 89/10</p> <p>useless [1] 38/22</p> <p>using [2] 26/25 28/5</p> <p>usually [2] 6/4 26/19</p> <p>utilise [2] 61/24 66/14</p>	<p>V</p> <p>vague [1] 52/24</p> <p>value [1] 79/14</p> <p>variations [1] 57/9</p> <p>variety [1] 50/19</p> <p>various [4] 49/16 49/21 62/4 75/15</p> <p>vast [1] 29/3</p> <p>VC [5] 22/20 23/4 25/11 33/8 34/6</p> <p>VC's [4] 21/2 22/17 25/9 83/21</p> <p>versed [1] 69/17</p> <p>version [1] 16/19</p> <p>very [57] 13/24 14/1 14/19 14/25 17/9 19/1 25/19 25/24 32/8 32/14 34/21 35/12 35/21 37/3 38/7 39/7 39/19 42/6 43/5 43/23 45/20 51/11 51/16 51/21 57/10 59/18 59/24 60/13 62/20 64/24 64/24 65/4 65/16 66/11 68/9 72/3 72/4 73/24 75/25 76/2 76/14 77/13 77/19 80/13 80/14 82/17 82/17 83/9 84/25 85/13 87/9 87/9 88/16 88/16 88/17 88/23 90/8</p> <p>view [11] 13/23 15/16 15/22 16/2 16/10 16/16 20/22 22/18 44/14 57/3 85/21</p> <p>viewed [1] 88/17</p> <p>violence [16] 2/25 18/22 40/1 40/15 40/17 41/9 41/18 41/21 43/6 46/1 58/7 58/9 58/17 58/18 63/16 81/19</p> <p>violent [7] 18/17 20/1 23/10 28/2 58/15 63/17 81/19</p> <p>vision [1] 7/9</p> <p>visiting [2] 2/1 81/11</p> <p>visits [1] 34/7</p> <p>voice [1] 55/25</p> <p>voices [1] 45/13</p> <p>vulnerable [3] 5/8 27/20 30/9</p> <p>W</p> <p>waiting [6] 10/4 10/4 28/16 28/16 28/18 77/7</p> <p>walk [2] 59/22 63/2</p> <p>walking [1] 59/24</p> <p>want [36] 3/11 5/24 7/7 10/20 11/6 11/21 14/23 20/4 21/12 21/24 22/2 28/9 28/9 32/18 33/9 34/6 55/4</p>	<p>56/9 57/5 57/15 61/12 61/21 61/22 61/23 74/1 76/18 77/5 79/19 80/25 81/14 81/24 86/9 86/10 86/12 89/1 90/3</p> <p>wanted [1] 45/23</p> <p>ward [8] 48/14 50/21 55/17 56/2 66/13 81/22 82/16 83/8</p> <p>wards [1] 50/16</p> <p>warning [1] 59/16</p> <p>warrants [1] 27/3</p> <p>was [51] 4/10 5/11 5/22 9/10 14/5 14/7 14/12 16/16 21/2 23/4 23/5 25/14 25/23 25/24 25/25 33/8 36/3 36/4 36/7 36/8 36/14 36/15 36/18 36/19 36/21 37/1 41/20 43/5 48/18 48/19 49/1 49/4 49/6 55/12 55/18 55/19 64/7 64/9 64/22 64/24 68/2 68/16 72/10 72/24 73/2 73/2 73/4 76/14 85/1 89/23 91/6</p> <p>wasn't [5] 31/9 36/7 36/18 43/9 46/3</p> <p>watch [1] 68/25</p> <p>waters [1] 80/13</p> <p>way [22] 4/7 13/16 22/11 33/7 33/11 34/1 34/1 34/23 36/15 50/19 54/15 71/4 71/4 80/12 82/20 85/3 89/17 90/9 91/11 91/14 91/15 91/16</p> <p>ways [8] 26/5 33/21 59/15 65/25 71/3 75/15 88/21 91/10</p> <p>we [181]</p> <p>we'd [2] 16/11 33/2</p> <p>we'll [6] 26/14 35/19 47/13 53/20 92/2 92/2</p> <p>we're [19] 4/11 7/9 32/3 51/4 52/2 59/22 61/21 63/16 73/25 78/12 80/11 88/9 88/10 88/12 88/17 88/20 90/4 91/25 92/1</p> <p>we've [28] 3/9 16/19 22/3 28/13 28/15 30/18 31/14 35/6 35/22 39/18 44/12 64/16 68/20 68/22 69/3 71/6 71/8 73/22 73/23 74/9 75/24 77/15 77/22 78/3 80/6 80/10 80/11 84/13</p> <p>weapons [1] 26/25</p> <p>week [1] 31/19</p> <p>weeks [2] 44/13 46/7</p> <p>well [33] 6/6 12/24 19/16 20/6 22/6 34/2</p>	<p>34/3 34/9 39/23 41/11 43/23 47/13 50/20 56/2 62/5 63/14 67/3 67/6 67/23 69/6 69/16 71/11 73/20 74/24 75/12 76/13 76/13 79/1 81/25 85/1 87/9 87/9 87/20</p> <p>went [8] 43/7 43/8 46/1 46/2 48/12 48/14 48/17 60/1</p> <p>were [36] 2/13 5/8 6/18 6/23 7/16 8/4 8/14 10/12 11/16 16/5 16/10 16/17 25/4 25/11 25/12 25/13 29/14 29/21 30/9 33/4 34/7 35/2 35/17 36/2 36/5 36/19 36/20 36/22 55/12 55/18 63/12 67/25 68/2 68/17 72/9 75/2</p> <p>weren't [1] 65/24</p> <p>Wesley [1] 13/8</p> <p>west [1] 48/24</p> <p>what [117]</p> <p>what's [22] 29/17 39/5 44/6 55/23 56/22 58/9 58/9 58/10 58/21 62/3 62/7 64/9 70/12 71/21 73/21 78/10 79/5 81/14 82/24 85/20 90/22 91/20</p> <p>whatever [4] 20/18 45/13 51/4 75/22</p> <p>when [57] 10/5 10/17 10/19 10/20 13/24 14/1 15/14 17/13 18/24 19/10 19/13 20/4 20/20 21/24 21/24 23/5 24/5 24/10 25/11 25/22 27/7 28/6 30/4 30/15 32/21 34/11 38/1 39/15 41/11 42/12 43/22 45/9 47/2 47/2 50/18 51/9 51/19 52/5 52/18 54/23 57/20 59/3 60/4 65/2 66/14 66/18 67/6 67/25 68/17 72/24 73/3 76/18 77/4 77/6 87/12 88/19 89/3</p> <p>where [44] 4/16 6/21 10/11 10/17 12/20 12/21 14/19 15/2 15/9 16/2 16/14 16/23 24/7 24/8 42/13 42/23 43/6 45/11 46/1 46/18 48/12 48/15 48/18 48/20 49/2 55/25 60/3 63/5 64/21 68/17 69/20 70/25 71/1 72/7 72/8 72/10 73/13 75/24 76/23 76/24 78/16 89/16 89/19 90/9</p>	<p>wherever [2] 20/19 34/12</p> <p>whether [9] 31/20 40/12 42/14 46/8 54/8 57/1 65/18 85/18 90/3</p> <p>which [50] 5/6 7/24 8/4 8/24 9/5 9/10 11/12 12/14 15/12 16/15 18/8 19/20 20/16 21/1 23/2 23/7 23/14 30/13 32/20 37/2 37/20 37/21 38/17 44/8 44/11 44/19 46/14 46/23 48/19 50/17 51/11 54/18 55/6 56/22 57/15 58/2 59/1 59/11 59/23 62/9 66/25 68/9 71/8 73/8 82/20 83/24 84/1 85/22 85/25 90/6</p> <p>while [4] 5/23 25/14 58/25 73/2</p> <p>whilst [3] 5/22 32/13 39/18</p> <p>white [1] 88/6</p> <p>who [75] 4/13 8/5 8/10 8/22 11/16 11/24 12/18 13/6 13/17 15/11 17/15 18/16 19/18 19/23 20/2 23/9 23/10 24/3 24/23 25/3 26/2 27/12 27/16 27/19 27/24 28/2 28/24 29/3 29/4 29/25 30/1 30/1 30/9 32/24 33/17 34/9 37/13 37/19 38/14 38/21 40/11 41/15 43/13 46/13 46/21 51/1 51/25 51/25 56/9 56/11 57/7 59/7 63/23 68/23 69/6 69/14 69/17 72/9 73/25 75/3 75/6 75/13 76/24 76/25 77/17 77/17 77/18 77/19 78/6 79/7 80/24 83/6 84/21 84/24 86/9</p> <p>who's [7] 28/13 42/23 66/13 68/12 74/6 79/6 89/20</p> <p>whole [9] 12/18 23/18 58/2 63/8 68/25 69/3 71/6 74/16 86/17</p> <p>wholly [1] 12/21</p> <p>whose [2] 54/25 74/24</p> <p>why [18] 9/10 27/24 28/1 35/18 36/17 36/19 36/20 44/17 55/3 63/12 65/13 73/22 74/22 77/8 78/14 79/25 80/2 91/19</p> <p>wide [3] 24/20 28/19 29/6</p>
---	--	---	--	--

<p>W</p> <p>widely [1] 64/14</p> <p>will [29] 2/23 3/5 9/3 24/8 30/17 30/24 33/22 40/14 41/15 43/11 52/14 54/6 54/18 58/14 58/14 59/6 61/16 63/3 77/25 77/25 78/14 78/17 82/5 82/7 82/7 82/12 82/12 82/13 84/23</p> <p>wish [2] 10/5 27/7</p> <p>within [21] 7/10 7/17 10/1 13/22 44/13 52/17 54/3 54/7 58/5 67/9 68/2 68/6 68/13 74/5 75/12 77/17 78/10 78/11 88/15 91/15 91/16</p> <p>without [7] 28/24 29/15 35/20 58/16 68/8 85/24 86/25</p> <p>WITN0075001 [1] 48/8</p> <p>WITN0076001 [1] 39/22</p> <p>WITN0299002 [1] 53/1</p> <p>WITN0412001 [1] 26/15</p> <p>witness [3] 43/21 47/8 87/2</p> <p>won't [8] 16/23 24/4 24/4 61/17 61/18 80/2 82/1 82/2</p> <p>wondered [1] 37/17</p> <p>word [2] 58/18 61/20</p> <p>work [46] 4/18 18/10 20/7 20/7 21/21 24/11 24/19 25/14 26/6 30/20 32/14 32/16 36/14 36/23 37/12 43/19 48/18 49/2 49/9 50/4 50/9 51/23 53/18 53/24 56/11 56/20 57/10 61/1 64/20 71/13 74/13 75/14 77/2 77/17 78/6 83/14 86/9 86/10 86/10 86/22 86/22 88/18 90/1 90/7 90/10 90/18</p> <p>worked [5] 20/15 30/23 42/21 48/15 78/23</p> <p>workers [2] 24/21 46/17</p> <p>workforce [3] 66/2 73/6 77/24</p> <p>working [33] 6/4 6/15 17/13 20/23 23/9 24/6 24/8 30/22 34/12 38/1 42/22 43/17 49/7 51/7 53/14 54/8 54/10 55/7 55/12 56/4 57/22 58/3 63/24 69/6 70/7 74/6</p>	<p>74/19 75/10 75/10 75/24 86/6 86/9 88/20</p> <p>workload [1] 35/14</p> <p>world [7] 11/13 11/15 11/20 12/20 16/6 16/24 45/11</p> <p>worried [1] 56/5</p> <p>worse [3] 44/23 68/21 68/22</p> <p>would [90] 3/24 4/9 4/21 6/12 6/23 7/2 7/7 7/10 7/13 7/14 8/6 8/7 8/8 8/10 8/14 8/15 8/16 8/19 8/25 9/11 9/15 9/17 9/23 9/23 9/24 13/14 14/10 14/12 14/22 15/17 18/4 19/16 20/11 22/11 22/20 22/21 22/22 23/25 24/10 24/21 24/21 24/25 25/1 25/1 25/2 27/9 27/21 28/22 29/1 30/22 31/24 32/18 34/15 35/13 35/16 35/19 36/10 37/2 40/8 40/22 41/5 41/10 41/15 41/22 42/7 44/1 45/5 46/10 46/11 46/17 46/20 46/20 50/14 52/11 55/14 63/16 63/17 64/6 64/25 68/6 70/10 73/11 73/18 76/3 76/5 76/6 87/14 87/20 89/9 89/10</p> <p>wouldn't [7] 7/16 13/14 14/8 15/21 21/12 23/25 43/7</p> <p>write [2] 58/14 90/13</p> <p>writer [1] 49/15</p> <p>writing [1] 60/24</p> <p>written [3] 58/19 76/9 91/18</p> <p>wrong [1] 21/7</p> <p>wrongly [1] 64/1</p> <hr/> <p>Y</p> <p>yeah [47] 7/15 10/14 11/8 12/12 13/3 13/15 15/18 16/1 17/7 19/17 19/22 22/7 25/6 25/24 30/7 35/8 36/3 36/4 40/24 44/15 44/16 44/24 45/3 46/5 46/12 49/20 50/25 53/9 53/13 53/24 56/3 56/3 57/21 57/23 59/5 59/9 59/21 60/6 60/8 62/2 66/23 84/17 88/14 89/7 91/8 91/10 91/10</p> <p>year [7] 31/7 31/7 31/24 78/4 78/4 78/4 80/9</p> <p>years [14] 20/15 27/22 38/6 42/21</p>	<p>45/17 45/17 48/11 49/1 49/9 66/25 70/8 70/16 71/8 78/2</p> <p>yes [46] 1/3 1/5 1/8 1/15 1/22 1/25 3/1 3/23 4/23 5/13 6/25 9/15 11/1 11/18 13/1 13/5 13/7 18/18 18/21 26/13 28/8 30/11 32/8 37/5 38/11 39/17 40/11 42/18 42/24 43/2 43/9 43/24 44/15 45/19 45/21 47/12 47/22 48/1 49/13 78/19 79/21 83/19 87/9 89/1 89/11 91/24</p> <p>yesterday [2] 4/12 89/23</p> <p>yet [2] 30/16 30/17</p> <p>you [323]</p> <p>you took [1] 31/15</p> <p>you'd [5] 4/19 7/2 8/18 68/17 76/11</p> <p>you'll [2] 69/10 83/6</p> <p>you're [42] 1/9 1/20 1/23 2/1 2/16 2/20 14/9 15/21 17/13 19/14 19/18 23/12 23/13 24/5 24/5 28/20 29/19 30/4 30/6 38/1 40/20 41/14 44/25 45/14 48/4 55/17 56/8 56/9 56/10 61/7 62/4 64/10 74/7 75/11 81/4 81/11 81/12 81/13 81/15 84/3 86/9 89/3</p> <p>you've [50] 1/11 2/5 9/12 10/10 10/23 11/9 11/19 15/20 18/4 18/19 19/11 21/1 22/9 23/2 26/10 36/13 37/10 37/10 37/11 37/17 37/23 37/25 38/9 39/4 39/7 39/14 39/19 39/23 40/17 41/17 42/21 43/3 46/14 48/2 49/15 49/21 61/13 73/5 76/9 77/11 80/19 80/20 81/3 86/11 86/18 86/19 86/19 86/20 89/13 90/24</p> <p>young [1] 2/10</p> <p>your [61] 1/8 1/16 1/19 2/19 2/23 3/4 3/5 3/21 5/2 5/15 6/20 10/7 10/23 11/10 11/19 11/20 18/19 22/15 22/16 22/18 23/3 29/8 29/9 30/12 31/8 34/3 39/19 40/20 40/21 42/23 42/25 43/21 44/14 45/12 48/9 48/9 49/17 49/25 52/3 54/20 55/20 56/25 57/3 58/24 61/9</p>	<p>61/11 63/6 64/16 65/9 71/3 71/24 71/25 74/15 76/12 78/24 83/24 85/20 86/17 87/2 87/8 87/17</p> <hr/> <p>Z</p> <p>zoomed [1] 5/23</p>
---	---	--	---