Thursday, 28 May 2026

(1.30 pm)

THE CHAIR: Yes, Ms Langdale.

MS LANGDALE: Chair, may I call Mr Hendy, please.

JULIAN HENDY (affirmed)

Questioned by MS LANGDALE

MS LANGDALE: Mr Hendy, you've prepared a witness statement dated 2 November 2025 for the Inquiry. Can you confirm, subject to a few tweaks and updates we're going to make as you go through the statement, that it's accurate and true as far as you're concerned?

A. I can.

Q. It's a very warm day, Mr Hendy. If you want a break at any point, please do say.

A. Thank you.

Q. You set out at the beginning of your statement, at paragraph 4, your career, your background, both as a documentary film maker, an investigative journalist. Can you tell us more about that, please?

A. I was an investigative journalist with Yorkshire Television from 1986. I had a career up to 2017 making investigative documentary films throughout the world. I was in Bosnia during the war and Rwanda during the genocide.

I'd followed -- I'd made a number of films about

terrorists, people with war criminals, and a number of films about people with serious mental illness. So people who had schizophrenia who were detained in Brixton prison, people who had been detained inappropriately in America for the insurance money, and people who had received lobotomies whilst they were still awake while they were -- for their violent behaviour.

All those films affected me greatly and I had 25 years' experience as an investigative journalist and after my dad was killed, I found that it was very incredibly difficult to get any information at all about what happened and about the man who killed my dad.

Q. You received as well two Royal Television Society Awards for the quality of your work?

A. I did, one for a film about Germany after the war, and one for a film about my father and some other cases.

Q. You say that the cases, the experiences of making films about those with serious mental illness affected you greatly?

A. They did. I couldn't believe how awful a disease schizophrenia was. People were really, really troubled by it. They couldn't shut off the voices. It was very moving.

And we made a film about diversion schemes from

Horseferry Road Magistrates' Court away from prison into hospital care at that time.

Q. Tell us what happened to your own father in 2007.

A. My dad went out to pay his paper bill on a Sunday morning in late April 2007 and, as he was walking out of the shop, a man he'd never met before stabbed him in the back and stabbed him in the neck, and he died as I was holding his hand seven days later.

They were complete strangers to each other. I found that the man who had attacked him had a long history of contact with local mental health services, he had a history of serious mental illness, drug abuse and violence. His family had been raising concerns about his deterioration before the incident, four days before, and although mental health services actually went out to see him, and although he had vast, what was described as industrial, quantities of amphetamines in his possession, they decided not to detain him, and so he was free, dangerous, seriously unwell, and on the day that he killed my data.

He believed that my dad was involved in a conspiracy with the Royal Family, George Bush, and other people to clone his children and give them sex changes to make them look like Kylie Minogue, apparently. So he was a seriously disordered man.

Q. You tried to discover what had happened with his previous care and treatment, didn't you, in Bristol, and you alluded to it earlier, but what were you met with when you did so?

A. It was a wall of silence in a way. I soon discovered that after a patient had killed -- after a patient homicide there should be an investigation by the local Mental Health Trust and I rang the local Mental Health Trust to say who I was, and would there be an investigation and how could I be involved? And their first words to me were "Who told you there was going to be an investigation?"

Not -- and then I found that -- later I found out that the day after the offender had assaulted my dad, the Mental Health Trust had rang the offender's family to say how sorry they were, and it took me over a month to actually get a meeting with the Medical Director. And there was a complete imbalance between -- they were more concerned about the patient and the family rather than the victims, and that seems to have been an imbalance that has continued throughout my work.

Q. You say it felt cruel and unfair?

A. It was very cruel and very unfair.

Q. Was that recognised when you finally did communicate with them, that that was a grave error, and how it felt

to you?
A. I don't think they did recognise it, to some extent. I think they apologised that it had taken some time, but I don't think they really understood the gravity of the effect of a homicide of this on, you know, losing -- I loved my dad. My dad was -- he was a funny, kind, decent man, you know. And when it happened I was -- you know, he was killed in Bristol. I live in Leeds. I remember having to drive down and I remember not turning the radio on because I thought: oh gosh, I don't want to hear the news that a man was stabbed and they're waiting to hear and their families are due to be informed.

So it was very, very traumatic. Our families are scarred. We are -- were hit emotionally by, you know -- it's an emotional trainwreck, actually. We can't understand what's gone on. Suddenly all the systems that we had counted on to keep us safe and feel safe are suddenly gone, and so --
Q. Did you feel safe from that kind of event before it happened to your father?
A. No, I felt that --
Q. Was that something you thought about?
A. I did feel safe generally. I'm a reasonably well educated professional person so, you know, I relied on

public services to keep us safe, to the extent, and I soon discovered that quite a lot of public services were wanting, you know, and closed, and not easy to access and were closed off. And that seems to have continued ever since, really.
Q. And you learned, as you said earlier, that the offender, in relation to your father, was known to mental health services, his family had alerted health services to his drug use and it took you some time to get that information.
A. When I found out that they were going to do an internal investigation, a Trust internal investigation, I said I'd like to see it, and they said, "We can't share with you -- to you -- without his consent."

And I thought: he's just killed my dad and now he's able to control how much information I get. That's just bizarre. That is so unfair, and it seems to be completely the wrong way round. It shouldn't be down to an offender who has so gravely managed my family and our community to be able to decide how much information I get. And that is still going on today. I've got families last week who applied to get a Mental Health Trust investigation report and they said, "Well, the offender has not given consent."
Q. We'll come to that. Just in terms of following the

death of your father, the offender was convicted in October 2008 and that's when you were commissioned to make the documentary.
A. Yeah.
Q. And you made a film in relation to a number of cases.
A. Yeah.
Q. Were there similarities over those cases in the failings that were highlighted in the documentary?
A. They were not only similarities in the care of the offender but also in the very dismissive ways that the families were treated in the aftermath. They were all -- there were repeated problems in managing risk, monitoring compliance with medication, listening to families, doing proper care plans, keeping proper records, treating drug and alcohol problems.

These are all common problems around all the four cases I saw, and I took one from Sunderland and one from Aylesbury and one from, you know, Bristol and all around the country, one from Hull. They were all very, very similar problems in the care and treatment of seriously dangerous people who were unwell.

And I should say most of the cases we see, I mean most people with mental illness are not violent, but there are a small number who are, if they are unable or unwilling to get treatment, those are the ones that

cause most concern. So it's a small number of people that need more assertive care but I'm sure we'll come on to that.
Q. With massive impact on the lives of others.
A. Massive impact. And my father was married for over 50 years. He had three children, he had three grandchildren. He was the chairman of the local allotment society. So this is not just one incident and one case, this ripples out through families and communities for years.

There's no closure. We keep our grief, but we just put some distance to the grief and I think we try and -- we try and remember -- best remember how our loved ones lived and not how they died.
Q. And of generational impact?
A. Absolutely, and, I mean, that is one of the most difficult things is nobody told me how to tell my children what had happened. You know, you're left on your own. And I know that's a real problem for a lot of people.
Q. You set up the Hundred Families charity. Tell us why, and what the purpose of the charity is.
A. After my dad was killed, there was an organisation called the Zito Trust, which had been set up after Jonathan Zito had been killed by Christopher Clunis, by

Jonathan's widow, Jayne. And I contacted them and they were really the only people who actually spoke any sense to me. They'd had direct experience and they were very supportive, and they stopped work, I think, after the 2007 Act, so basically they stopped -- ceased working after 2009 and so there was no organisation to assist families afterwards.

And I thought there was a big gap in services, that there needs to be somebody or something to try and support families, and I did quite a bit of research to see, you know, how the charities had been managed before in the past, and I didn't want it just to be for families to complain about what had happened; I wanted to be proactive to make sure that we engaged with the health services or the criminal justice agencies to try and get some change, to try and influence policy, to try and make things better for, you know, better services for people with serious mental illness, but also for victims after these appalling situations.

And I thought that was, given the similarities that I'd found from the film, that that was a good place to start, really.

Q. So what information was available? You tell us in paragraph 19 how, in 1994, the Department of Health introduced a requirement to conduct independent

investigations. Here you are, you're an investigator by occupation.

A. Yeah.

Q. You've got experience of this. You know better than most, presumably, how to set about this. What information did you find was readily available at that time?

A. Very little. So I found -- so I wanted to find out how, you know, whether what had happened to us in Bristol was a one-off or whether it was happening all the time, and so I started digging into press reports and I'd found at that time there'd been at least 22 mental health-related homicides in the Avon and Wiltshire areas. There had been four Inquiry reports. I think two of the reports the Trust didn't even have. You know, some of them were available on a website. I had to write -- find the Chair of one of the Inquiry reports and say, "Please can you send it to me?"

Q. Do you mean they hadn't kept them after the report had been --

A. No, they hadn't kept them at all. And these were -- and all the four investigations had very similar recommendations: risk assessment, care planning, documentation, listening to families, treating drug problems. These are all very, very similar problems and

they were exactly the same when the Inquiry report came out into my father.

Q. You say at paragraph 21:

"Remarkably I found ... some mental health care trusts didn't even keep copies ... so couldn't demonstrate that they were learning anything."

Were you looking to see what the learning was from any reports, what lessons were -- *(overspeaking)* --

A. I wanted to see what they -- I wanted to see what they had learned, if anything, because are they -- I want to see any evidence of any learning, and the fact that four Inquiry reports had essentially said the same things said to me that they weren't learning from these terrible incidents.

Q. You decided to start putting together a database from press reports --

A. Yeah.

Q. -- and other reports --

A. Yeah.

Q. -- into mental health-related homicide cases?

A. Yes, initially I wanted to find out what happened in Bristol and that area, but then I wanted to find out nationally what the picture was and, you know, whether some Trusts were managing this better or others, and an update on my statement is that now there are, I think,

2,468 cases that we've documented.

Q. It's paragraph 26, you say at the time of writing you'd documented 2,396. Is it now 2,468?

A. Yeah.

Q. -- *(overspeaking)* -- 2,463 that you *(unclear)* --

A. 2,468.

Q. So 2,468 mental health-related killings since 1993, and how many available Inquiries? That's updated as well, hasn't it, from 1,032; is that now 1,084?

A. I think so, yes. So there are Inquiry reports, sentencing remarks, domestic homicide reviews, all where there's been a -- so they're not just Inquiry reports, there are other official documents.

Q. And you set out -- can we have on screen, please -- WITN0258006, page 1. On your website you have set out breakdown by regions, haven't you?

A. Yeah.

Q. We can perhaps enlarge that. And then we see on page 2, 135 known cases in the East Midlands?

A. In the East Midlands, yes.

Q. You say 75 official reports into those cases.

A. Yeah, that's correct.

Q. Do you know why there's 75 reports and not 135?

A. Because they don't always do an investigation into a patient homicide. Sometimes they decide that the

Trust internal investigation is sufficient and there's no requirement for an independent investigation. So Trust internal investigations are not routinely published, and there may be cases where somebody has either dropped out of services or not had any service at all, so they wouldn't qualify for an independent investigation.

Q. Conceivably might have been seen by other services in another region or something?

A. Possibly, yeah.

Q. That can come down, please. You say you know the cases you've been able to document are a clear underestimate of the total number, as every case --

A. Yeah.

Q. -- isn't reported. Why do you think that?

A. Because not every case is reported, and sometimes -- and I'm aware from my work with the NHS that sometimes -- so I know that sometimes Mental Health Trusts don't report all the homicides of patients in their area so -- and I know that from Freedom of Information requests that in some areas there might be X-number of I think -- I know a case where I think there was, if memory serves me right, 29 patient homicides in a ten-year period and only 19 were reported, so -- to NHS England, so for various reasons which are unclear.

And not all cases, sometimes if people are with drug and alcohol services, that's not considered as a mental health related homicide although they were patients.

Q. You've assisted around 300 families --

A. Yeah.

Q. -- through your charity, and you have several trustees also personally affected in this way.

A. Yes.

Q. You've already set out eloquently the impact of your father's death and the circumstances of the death on you. Is there anything you would like to add about that victim experience, or bereaved families' experience, in the knowledge of all the cases you've assisted with?

A. It's hard. It's really, really hard. Some families get stuck. Some families can't move on. The provision of information is really, really important to help families understand what has happened, and some accountability is really important, you know, to help people try and cope and recover.

I mean I remember when the -- for the film we interviewed a woman whose son had been killed, and she said in the days afterwards, the family would come round for dinner and she said, "How can they eat? How can you eat after such an awful trauma?"

And I -- the trauma stays with people, you know, and

it goes for a long -- there's no closure. I hate the term "closure" because there's no closure. I'm a different person now to the one I was before, you know, and I think that's true for an awful lot of families. You know, they struggle to understand how this can have happened, and they, you know, it's not right that a bereaved family should have to struggle so hard to get the information which should be readily supplied to them.

Q. You mention accountability and the importance of accountability. Why is that?

A. People want some form of justice. And I don't think that -- we will probably talk about it, but I don't think the criminal justice system sometimes gives justice to families bereaved *(unclear)*.

I think people want to know that if there have been failings, that there are consequences to those failings, you know, and the lack of any consequence, the NHS has a no-blame culture, you know, and that stops learning. You know, they have a funny attitude to learning, they have a funny attitude to patient safety. They talk about patient safety, there's any number of meetings, and I've been to lots of them, about patient safety but what actually happens as a result? It's very difficult to see.

The Head of Patient Safety at the NHS is on record as saying investigations are burdensome. That doesn't really bode very well for a learning organisation, really.

Q. Do you think there's protection of their own staff in that?

A. There's a clear hierarchy, it seems to me, of the patient comes first, and then their staff, and then maybe the families of the perpetrator and then very far down are the victims. There's a clear hierarchy of protection and, you know, and you'll see in a lot of reports they want to concentrate on good practice. It's like they want to hear some good news rather than actually "this has happened time and time again and we haven't learnt."

You know, I think one of the elements of the National Confidential Inquiry was saying that why they had stopped was they were saying, "Well, all the learning's happened". That's patently untrue because the investigation -- they blamed the lack of learning on the investigations, not the failure to implement the recommendations.

Q. Can we have page 7 of your statement on screen, please. So WITN0258001. We see here, Mr Hendy, a list of the numbers of advisory committees you have been on or are

a member of. A significant level of public service there, and you see, Mr Hendy, at the sixth bullet point, the Mental Health Act Review Group?

A. Yes.

Q. Can you tell us about your involvement in that? Was that the recent review group?

A. No, that was quite a few years ago. I was -- that was Sir Simon Wessely's review group looking at the review of the Mental Health Act. I only attended one or two meetings for that, but --

Q. What year are we talking about? When did you attend those, roughly, if you can remember?

A. Probably three years ago, but I can't, you know, it was --

Q. Don't worry --

A. It was during the discussions, but we were brought in -- I was raising concerns about tribunals and things, but -- which I don't think were listened to very well, but --

Q. Well, tell me about that, please. What concerns did you raise? What was the format?

A. Well, I don't know if we're going to go onto it, but the tribunal system considers the release of people on hospital orders, or people who have been detained under the Mental Health Act, and so they will consider the

release of people, "restricted patients", so that's patients who have been given hospital orders with restrictions, and essentially the Tribunal Service is basically looking at illegitimate detention. They're not looking at public safety. Generally. They will claim they are, but they don't. And essentially they are closed shops. They are the only form of judicial process that I know where we're not even allowed to know the names of the judges.

The victims are not considered interested parties, so we don't have an automatic right to understand what's been decided, on the basis of what evidence, and we can't appeal it. You know, we may come on to talk about the Maher case, where I gave some evidence, but actually these are closed shops, there is no public scrutiny whatsoever.

The -- if you look at the Family Court, which looks at the detention of or the -- what should happen to young children who have committed no offence, reporters can go along and report that. They can observe the hearings. They can't name people, but they can see that justice has been done.

Q. So they can be the eyes and ears of the public, if you like.

A. That doesn't happen in the tribunal system, and so can't

tell if the tribunal system is racist. We can't tell if the tribunal system acting lawfully. We don't know, because the only information we have are some statistics about the number of tribunal hearings they have, and we know that of the 500 or so restricted patients that are discharged each year, around 300 of them, so 60%, are recalled to hospital.

So it raises questions about the efficacy of the tribunal system and whether people are being appropriately released from tribunals. There's no independent voice in the tribunal system. So that needs to be reformed, there needs to be a lot more -- you know, in the Maher judgement the tribunal system was said it was an outlier to the criminal justice system because of the complete lack of transparency.

Q. You say at paragraph 190 of your statement:

"I would respectfully ask the Inquiry to make a recommendation for steps to be taken to ensure much greater openness and transparency in the tribunal system so that families and the public can be assured that safe, proportionate and lawful decisions are being made about the release of mentally ill offenders who have previously committed serious crimes. There needs to be open justice in the Tribunal system."

A. Absolutely.

Q. And you mention in that part of your statement, Mr Hendy, Mrs Maher's request for a copy of a tribunal decision. Would you like to summarise that case and what was said about that in the court.

A. So Kyle Maher was killed, I think, in 2017. I can't remember exactly but he was killed in Tooting by a mentally ill man who was released three and a half years later by a tribunal, and Mrs Maher -- I think he was being released to a location very close to where she lived and she asked for a copy of the decision, which was refused by the tribunal, and so she had to go to a judicial review to get that decision looked at, which she won, because they decided -- the judge in the judicial review found that the Deputy Chamber President of Tribunals was acting unlawfully where she had a blanket ban on sharing any information.

And you just -- it shouldn't be for families to have to go to judicial review to try to get any information about release of the person who killed their loved one, and particularly to an area close to where they lived.

Q. And you say in your statement, there was reference by the court as to the tribunal system being something of an outlier.

A. It is an outlier, yeah.

Q. At the beginning of your statement you tell us you have

been an invited speaker at both the Royal College of Psychiatrists' International Conference and a Forensic Conference in March 2020.

A. Yeah.

Q. What are your key messages at those conferences, and how are they received?

A. I speak -- so both -- so the International Conference I think this year or last year was -- I'm speaking about the victims' journey and what it was like to try to let them know that there are other people that they need to consider. At the Forensic Conference I was part of discussion on whether, from memory, whether there is a duty to victims by forensic psychiatrists.

Q. Legal duty or moral duty?

A. Moral duty I think we were talking about. I mean there is a legal duty under the Victims' Code of Practice, which will soon become statutory, but a lot of forensic psychiatrists do not seem to understand that.

Q. Do they understand the moral duty?

A. No, I don't think they do. And I must say there are some who certainly do, generally those who have been affected by homicide. They -- and there are -- when I talk about psychiatry, there are some notable and very good exceptions, but generally, I found forensic psychiatrists not to have a good understanding of

victims and the impact of what victims say, and we can talk about later on the involvement of forensic psychiatrists in the criminal justice system, but actually I know that a psychiatrist who I know wrote a paper on "Do forensic psychiatrists owe an ethical duty to victims?" which was published in an academic journal and she got hate mail for actually considering it.

So there's a huge resistance to actually considering victims by forensic psychiatrists who seem to be solely focused on their patients with a limited recognition that they have safeguarding duties and duties to the public to keep patients, their families, and the public, safe.

Most mental health-related homicides, as we heard this morning, happen within families and friends and neighbours. You know, 83%, I think, from the National Confidential Inquiry research, most people -- families are most at risk from people with untreated serious mental illness who are dangerous when unwell.

Q. You've contributed to academic research and also written a chapter on best practice in engaging families --

A. Yeah.

Q. -- in a book on patient safety investigations.

A. Yeah.

Q. Again, engaging families, what are your key tenets of that?

A. What are my key --

Q. Key messages around that?

A. Talk to families and treat them with decency and respect. You know, engage with them early, you know, and listen to the questions and answer them. Don't assume what the families will want, because that seems to be a common practice as they will assume what the families need to hear without actually talking to them.

I think after my dad was killed, you know, I was used to organising my life to some extent, you know, and working out what I wanted to do, and suddenly after my dad was killed, all these agencies were coming in making assumptions about what should happen, and not talking to me.

So I needed to -- it felt I needed to take some agency back, and work out, you know -- our families really want to have some accountability and an apology, to be treated with respect, and they want learning to happen. That's the three things -- the three basic elements that families want.

Q. You tell us at paragraph 41 that you're concerned many criminal justice and mental health professionals often claim that these killings are rare with the impression

that they are unavoidable and therefore unimportant.

Just dealing with rare first of all, what are the numbers and concerns? And I think you have an update again in relation to February 2026.

A. Well, I mean -- so the numbers are around 100 to 120 mental health-related homicides in the UK each and every year. So that's about 20-23% of the -- because the numbers -- the ONS figures for homicide have come down, so it's about 500 homicides in, I think, in England last year, that's about 20 -- up to 23% of the total number of homicides. That's not a rare occurrence. And even if it -- I say that even if it was rare, plane crashes are rare. You know, we wouldn't be reassured if after every plane crash, you know, the airline said, "Well, it doesn't happen very often."

You know, that's not a reassurance --

Q. It's -- *(overspeaking)* --

A. No, because these are catastrophic events. We need to treat these seriously, and the amount of work that goes into prevention of plane crashes doesn't seem to be replicated in mental health services to try and prevent serious untoward incidents in, you know, by their patients who when unwell.

Q. Do you think there's sufficient emphasis at all on safety culture?

A. No.
Q. Safety for the community?
A. No. I'm yet to see evidence. There's a lot of talk about it, but I don't see any evidence that there is -- they think they are, so they -- and one example of that is that -- one example of that is the Department of Health a couple of years ago did a call for evidence on the Duty of Candour, and they asked the -- they asked clinicians and medical staff, "Do you effect the Duty of Candour well?" And 73% of the staff said, "Yes, we adhere to the Duty of Candour, we do it well."

When they asked the patients, only 6% of the patients said the Duty of Candour had been met. So there was a huge disparity between work as imagined and work as done and I often think the mental health services think that they are considering safety and the welfare of the public, but the reality is, from my viewpoint, is that they don't do that.
Q. You refer us to research of the British Journal of Psychiatry in 2020 showing that whilst the rate of homicide in the general population has been declining, the relative contribution of mental disorders, the proportion of all homicide, has increased.
A. That's right. So mental health-related homicides are more important and proportionately more important.

Q. And getting worse?
A. It would appear so. I mean, because there is a delay in the number of cases coming to court, there's a backlog, so -- and I know certainly in London there was a big increase because of the pandemic.
Q. You also refer in the context of potentially under-reporting and maybe all cases not being brought to statistical attention. You refer to the work of the National Confidential Inquiry into Suicide and Homicide and how data counts to be included. What are your concerns there about whether it captures the whole picture?
A. I think they don't capture the whole. I think they offer a snapshot because the headline figures that they promote, you know, they will have graphs of what homicide is, but they only count convictions rather than the number of, you know -- so they miss out people who aren't convicted, so they will miss out suicides or people who died beforehand.

They will say that murder-suicides are described separately in their report. There's no global figure. So the information they put on about homicides is (a) for convictions, and that's of perpetrators not victims. So in this case, if, you know, VC killed three people, that would go down as one case in the National

Confidential Inquiry.

And I say that, you know, he killed three people, that's three homicides. That's not one homicide. So there's under-reporting, and they only count people who are in touch within one year of services. So they don't count people who are outside of that period or who are in touch with no service at all.

They used to do that up to 2014 on the basis of psychiatric reports, but after a court case in 2001, the availability of psychiatric reports pre-trial diminished rapidly. So in 2013, when they showed that 120 cases in the UK each year, 120 victims of mental health patients and those who were mentally unwell at the time of the offence, they changed the methodology in 2014 and they only counted people -- patients. So miraculously the numbers came down.
Q. How have you collected and entered your database on the website? What do you upload, what do you -- *(overspeaking)* --
A. So I try and monitor press reports, I try and monitor Coroners' Prevention of Future Deaths Reports. I get referrals from families, or from Victim Support or from the police about cases that are upcoming. So I try and maintain a -- I've got a database of cases that have been disposed of and also of forthcoming cases which it

looks likely that there may be a mental health element to it. So if somebody has been arrested and then subject to the Mental Health Act after arrest, that is likely to come to mind. So I've got to try and track that.

Or if a mentally unwell -- sorry, if a man, particularly a man in his forties, kills an elderly grandmother with multiple stab wounds, that's likely to be a mental health case.

So you can sort of tell which ones, so I try and monitor them, as best I can, to see whether there's been a component of mental health to the incident and whether there's a plea of diminished responsibility, or if there's been a transfer to psychiatric ward, if it's been known that they've -- that they were known to mental health services.
Q. You tell us that some forensic psychiatrists have contacted you to say that your database is a valuable resource for them.
A. Yes.
Q. In what context are they finding that a valuable resource?
A. One psychiatrist told me that he couldn't find the Inquiry report into his patient in the patient records and the only place he could find it was on my website,

which is funded by bereaved families.
Q. What was your response to that?
A. Well, I was pleased it worked but it showed a -- it showed a frightening lack of concern about somebody who in the past had killed. They couldn't even keep the records, you know, in his patient record. That seemed to be remarkably lax.
Q. You set out at paragraph 54:
"In general, all cases of recent patients ... mental health trusts who have committed a homicide should result in a Patient Safety internal investigation by that Trust ..."
You have made Freedom of Information requests, have you, around those?
A. Yes.
Q. Why do you think that it doesn't happen that all sources of information are collated for the purposes of those reports? You say sometimes they're missing or information isn't there as you'd like it to be, perhaps; why is that?
A. Because sometimes information is not shared. Because sometimes they don't talk to the families or engage with them. Sometimes there is a disparity of different agencies having different risk information, you know, which is not always shared. So that -- and sometimes

they -- sometimes the internal investigations are solely based on the medical notes without corroboration from other agencies or other -- *(overspeaking)* --
Q. But after the homicide, even if the information wasn't shared before, getting that information afterwards to really learn lessons is key, isn't it?
A. Well, sometimes the investigation reports don't even know what's been said at the trial, or they don't have access to the sentencing remarks. So they don't really know what's in the public domain already.
Q. From your experience, do they usually wait for the conclusion of the trial before conducting an investigation?
A. I encourage them to start as soon as they possibly can, and --
Q. Why is that?
A. Because memories fade, staff move on, records get lost. You know, if you only wait -- and there is a tension between the criminal justice process and the NHS investigations which have different purposes. And sometimes over-zealous senior officers or the CPS will try and stop an NHS investigation, as happened in this case, until the trial's concluded.
And my view, and what I tried to do is I try and facilitate contact so that there is contact between the

police and mental health services so that the investigation can at least start and there can be regular communication between the police and mental health services so that the trial is not prejudiced, but actually mental health services can get on. Because a lot of these cases are not complicated. A lot of the cases there is a guilty plea to manslaughter by diminished responsibility.
So -- and often, families and doctors are not required in evidence. So there's a limited reason why there should be a prejudice to the trial. It's a question about communication and talking to each other.
Q. You did, when you mentioned the police, in this case, contact the police, didn't you, about investigations and what was going on at the same time.
Can we have a look, please, at NHFT0019340, page 27, and this is a letter from you, Mr Hendy, to the Chief Constable on 27 October 2023. So we see page 27 and 28 -- perhaps have them alongside each other.
So we have at page 28, people can see that. As you, Mr Hendy tell us, how was it that you were contacting the Chief Constable Kate Meynell back in October?
A. So I'd been to see the Webbers and I think at that stage I'd been to see the O'Malley-Kumars, and I was aware --

I mean, it was known that VC had been a patient of Nottinghamshire Healthcare and that I knew that there should be a Trust Patient Safety Investigation as a result of that, and part of the requirement under NHS guidance is for the Trust to contact the families to see if they have any questions that need to be addressed in the Patient Safety Investigation, and that had not happened.
And I spoke, because I was a member of the NHS Independent Investigations Review Group I knew people at NHS England who would know that and so I wrote to them to say: the families have not been contacted by the Trust, is there a problem?
And they said -- they told me that NHS England had been trying to contact the families but had been told not to by the police because they'd been told that there'd be -- because they could -- it could potentially prejudice the trial. And I said to NHS England that actually I sat also on the Family Liaison Coordinators Committee, the FLACSS committee, of which Kate Meynell was the Chair, and I'd had some brief encounter with her before.
And so I thought: well, actually, if the NHS needs to talk to the police, let's talk to the Chief Constable to see if we can pragmatically sort it in a way that

doesn't prejudice the police and allows the investigation to continue. And this is the letter I wrote to Kate Meynell.

Q. And you say in the bottom third paragraph:

"Can I ... please [ask] to see if there is a pragmatic and proportionate way forward ... not only guarantees ... safety of the criminal investigation but .. [allowing] the NHS to contact the families and move forward ... in order to ... prevent similar tragedies in the future?"

We see the Chief Constable's response, NHFT0019340, page 26, please. 26 and 27 alongside each other.

Was that the answer you'd hoped for?

A. Yes. She said it was being sorted on 2 November, so I was reasonably assured that something was going to happen, and I let -- I let NHS England know that. And I think it took over a month for the Trust to eventually write to the families. I think Ifti Majid wrote to the families at the beginning of December. I didn't understand why it took so long.

Q. Say that again?

A. I didn't understand why it had taken so long when it was being sorted. And NHS England, in the minutes of the IRG, thanked me for facilitating the contact and allowing that to happen.

Q. We know just on the topic of reports that were conducted, we know of course the level 2 investigation commissioned by the Trust, carried out by Psychological Approaches, was commissioned 6 July 2023, report 7 February 2024, and a Theemis Report commissioned by NHS England reported in January 2025. That report was one, if we have on screen, please, WITN0390104, page 6. 0390104, page 6, please, at the bottom: "Victim's families". So WITN0390104, page 6. We see there under "Victim's families":

"A meeting ... representatives from each of the victim's family. ... full report has been shared as a paper copy ... victims families have requested to meet with Chief Medical Officer ... The main feedback from NHSE was ... families want accountability and are therefore requesting the names of all the consultants involved -- NHSE declined."

So your point earlier about accountability, it's important, isn't it, and that wasn't --

A. That's definitely what the families wanted. I remember this meeting because I was there to try and support the families, and I was sat next to the psychiatrist on the Theemis panel and she turned to me and said, "Oh I know you", and it turns out she was the psychiatrist on the Parole Board that was deciding the fate of the man who

killed my dad. And she mentioned that in the middle of the meeting, so I was very taken aback and I wasn't quite sure what I should do with that because my role was there to try and look after the families, but I felt that wasn't very helpful, really.

Q. That can come down, thank you. Going back to your statement at paragraph 63, you say:

"Since 2023 ... NHS England has stopped publishing Independent Investigations in full, citing patient confidentiality issues. [You] think this practice is wrong, ill-advised and hinders effective learning and improvement."

A. Yeah, I was very frustrated by that policy because they seemed to be more worried about the confidentiality of the patient who has killed, a criminal patient, rather than help learn from the terrible events that had happened and to be accountable for what happened, and they published -- and because I sat on the Publications Review Group, I saw the legal guidance, unusually, which to my mind was full of holes because it didn't quote all of the case law, and it didn't quote all the exemptions to GDPR, which it should do, and it didn't discuss the public interest. You know, and one of the exemptions, as I understood it, was that, you know, when a patient has killed, there is an overriding public interest in

knowing how that patient was killed.

I think Lady Hale has actually said this in a case in the Supreme Court, that, you know, when a patient who was unwell who is dangerous, then the public has a right to know how that person has been treated and looked at after, and this seemed to know against all of that out of the interests of the patient and a theoretical problem that, you know, is there unauthorised disclosure of that information? And I thought, well, there's plenty of reasons why this information can be disclosed to the families and published rather than a theoretical risk to patient confidentiality.

And to my knowledge, there has only been one case where a patient has gone to court to question the release of an independent investigation which was Michael Stone, and he lost. And because Michael -- the judge in Michael Stone's case said: the only reason we are interested in this patient information is because of his criminal acts.

And that's -- and the judge said: this will apply to other cases in advance. And the NHS guidance completely ignored that and I understand the current guidance still ignores that. Because there has been an update to the things, and essentially, I think there's -- the new guidance is problematic because it doesn't give NHS

bodies any steers on what is legitimate or what is, you know, how you can share information. It basically says, "Give this to your lawyers to decide."

Q. So in February 2026, it updated it's publication advice?

A. That's correct.

Q. But you still say there is not sufficient clarity around that?

A. No, there's not sufficient --

Q. The competing rights, even, between victims --

A. Yeah, and there's a balance to be held between Article 8 rights of privacy and Article 10 rights, the public's right to know. So there is a balance to it. And I've asked -- and I've had quite a few cases where we've had reports which have been completely redacted about the offender's care and treatment and we've said, "How have you done the balancing act?" And they said, "We've done it."

"Can we see how you've done it?"

"No we're not going to tell you."

So there's a lack of transparency and accountability about how they've reached these decisions because out of theoretical concerns that this might prejudice the patient's confidentiality.

Q. You, again, at paragraph 69 respectfully suggest the Inquiry could make a recommendation for greater openness

and transparency around the publication of Inquiry reports --

A. Indeed.

Q. -- as these incidents are always matters of significant public interest and concern.

A. The current position is that they will publish learning bulletins which, to my mind, are pretty useless because they don't even say where this has happened, where the incident has happened. So potentially a good Trust may be tarnished with the actions of a poor Trust, you know, and it doesn't say where and when it's happened because they think that this might lead to the identification of the perpetrator.

Well, we all know generally, we've been through a court case, we've been through an arrest process and there's been sentencing hearings. This is all in the public domain, so why is it suddenly necessary to redact everything and not name the person? I don't understand why, if everybody has known, why it should be different for mental health services.

Q. If we go to your witness statement and have it on screen, please, page 14, so it's WITN0258001, page 14, please, paragraph 66. You say there:

"In the Nottingham case, NHS England initially decided that only an executive summary of the

Independent investigation would be published (again citing legal advice about patient confidentiality concerns) which was only overturned after the complaints of the families, national press coverage, and the intervention of the Secretary of State."

A. So they didn't want to publish the full report, apparently based on legal advice. And then suddenly within three days after The Times article and intervention by the Secretary of State, it was suddenly that it appeared to be thrown out of the window and suddenly there was reasons why the full report could be published, because I think the Secretary of State said that it was a matter of, you know -- I think he said something like "Light is the best disinfectant" and, you know, transparency is the best disinfectant, and I think that's absolutely right.

Q. If that hadn't been pushed by the families, it wouldn't have happened, would it?

A. No, it wouldn't have happened.

Q. And we wouldn't be here?

A. No. And we would have -- we would have had a bland executive summary which would have missed out quite a lot of the detail, you know, and detail of concern.

Q. That can come down, please. You comment from paragraph 70 about structure and principles of Mental

Health Act and you're concerned about a main principle of least restriction, least restrictive principle. What are your concerns about that?

A. It seems to be, in the cases I see, often a tendency for clinicians to not deal assertively with people -- untreated, seriously unwell people. And that if there are opportunities to treat them more assertively they will say, "We need to adopt a process of least restriction that we hope this person can be managed well and monitored in the community", when often that seems to be an optimistic response.

And I think the -- and my understanding of the new Mental Health Act is there is a Section 118 in the new Mental Health Act which says that "least restriction in accordance with public safety", "patient and public safety".

So that's added, as I understand it, into the new Mental Health Act because there was a gap before, that people would just apply least restriction without considering public safety.

Q. When you attended, about three years ago, that consultation group, did you give any views about least restrictive principle, or not? You say you referred to mental health tribunals when you met with Sir Simon Wessely --

A. I can't -- no, I don't think I did. I don't think I did.
Q. So you --
A. I remember it was a big meeting with about 20 or 30 people there, and so the opportunities to speak were quite limited.
Q. That was your main concern at that time?
A. Yeah, absolutely, yeah.
Q. About tribunal secrecy-- *(overspeaking)* -- not knowing how decisions were being made.
A. Yeah.
Q. In terms of the Act itself, grounds for detention or the like, you didn't have a view about that at that meeting?
A. Not at that meeting, but I have since.
Q. You say at paragraph 75:

"[You're] ... concerned [the] ... current proposals for reform ... will make it more difficult for seriously unwell people to obtain effective care in hospital, as I understand there will be a requirement on clinicians to predict ... the patient will commit serious harm, and when that serious harm will occur."

A. Yeah, and "serious harm" is not defined, and I know the Inquiry has heard evidence that I think from at least one psychiatrist considered "serious" to be a subjective notion.

Q. And you say at paragraph 77:

"I ... suggest the Inquiry could usefully consider making a recommendation that for potentially dangerous patients or those with a history of previous violence, there should be clearer [Mental Health Act] guidance reminding staff of the need to safeguard and be cognisant of the needs of patients' families and for public protection generally, rather than have a sole fixed focus on the needs of the patient."

A. Absolutely.
Q. How would you express that in the Code if you were writing the Code? What would you say?
A. Well, I would say that they have to take cognisance of the need to safeguard family and the general public, and document how they've considered that and acted upon it.
Q. You refer in your statement to:

"The current system of delivering mental health care is largely based on an unwell patient recognising they are ill and wanting to be treated."

And significantly, of course, a number of seriously ill patients don't recognise that, do they?
A. No, absolutely. And I'm concerned that the proposals for neighbourhood hubs is not going to meet the needs of seriously unwell people who have no insight into their condition, because if you don't think you're unwell why

would you attend a hub?

You know, and I know there's a lot of emphasis currently within NHS England that these neighbourhood hubs are going to solve all the problems, but I don't think it's going to meet the needs of people with serious mental illness who are -- who decline care and disengage and they need a more Assertive Outreach Team, not an Assertive Outreach approach. Nobody really knows what an Assertive Outreach approach is. I know you've heard evidence from Dr Dissayanaka is that you need teams, you need dedicated teams that will do this, because the approach is like some people may have -- be only working one day a week or two days a week. So that's not sufficient to follow somebody up who is potentially dangerous when unwell, assertively.

Q. Did you find any evidence in cases that you have looked at or examined where patients didn't believe they were well? Any evidence that capacity assessments were being undertaken in respect of that patient having the ability to consent to decisions around treatment like depot or Community Treatment Orders?
A. No, I think we've heard this morning about one of the cases where capacity was an issue and they weren't -- capacity is always assumed and it's very rarely tested -- when it should be.

Q. You refer at paragraph 93 of your statement to:

"[The] ... severe shortage of psychiatric beds in the United Kingdom down from around 150,000 in 1954 to less than 18,000 today ..."

A. Yes.
Q. What do you say is the significance of that?
A. Twofold, really. One is that there's not enough beds. We did some research and there's supposed to be Section 140 beds for people in crisis. We did research to find that a third of then Clinical Commissioning Groups didn't know that they had a duty under Section 140 to provide crisis beds, and we know that the lack of beds means that people are being given out-of-area placements, so they're not being kept close to home, at great expense, because often in private providing hospitals; and we also know that the lack of psychiatric beds, if you plot the decline in psychiatric beds with the rise in the prison population, it goes like that [indicating] and cuts off at 50,000, you know.

So there is a question: are we de-institutionalising people from hospital and re-institutionalising them in prison? And that doesn't seem to be *(unclear)* -- it's what's they call the Penrose argument, but it doesn't seem to be -- and we know there's high psychiatric morbidity in prison.

So my view, if I had a magic wand -- would be that we need 50,000 beds, you know, that would be not just Psychiatric Intensive Care Units, which is what a lot of the hostels seem to be now, which can be unpleasant places. If you had a more -- place where people could recover properly.

Q. Establish treatment, therapeutic treatment.

A. And have therapeutic treatment, psychological treatment and occupational therapists and things like that, that wasn't -- they seem to have this focus on flow and getting people out as soon as they come in. Stabilise them. Give them some tablets. Do they seem to be okay? Chuck them back out to their own devices. That's in -- that's broad -- that's too general, but that seems to be the approach generally. There's focus on flow and getting people through the system because they think that hospital treatment is poor care and that best mental health care is in the community and I think that's not always the case.

Q. You also say that:

"In the cases I see many mental health staff have just appeared to accept what a seriously unwell patient tells them without sufficient challenge or corroboration."

A. Yeah.

Q. Why is that, do you think?

A. They say because they want to maintain a therapeutic relationship with them and if they challenge them to any extent, that that might lead them to disengage. But I think you need to have open and honest conversations with them to try and keep them and their families and the general public safe.

Q. Can we have page 20 of your statement on the screen, please. You say at paragraph 99, as you just have:

"... patients do need more assertive and regular contact and support from specialist mental health services to keep them safe and well and to safeguard their families and the public."

If we go to paragraph 101, can you tell us what you requested and at what point you requested this?

A. So there's an update to this. So after the NHS England made this -- made the -- asked in Integrated Care Boards to report on the state of their services for people with serious mental illness, they were due to report in September, I think, 2024, and nothing had happened. And so I did an FOI -- or I wrote -- did a Freedom of Information Request to NHS England to say, "Can I see the responses, please?"

And they replied:

"No, it's all confidential and that releasing the

information would be likely to generate extremely unhelpful discourse."

Which I thought was quite Stalinist, really.

You know, this is a matter of public concern and they were worried that people might comment on it. So I thought that was wrong.

And I kept pushing and in the end, I think, in January this year, they did publish the responses by the ICBs. They -- I think there's 42 responses. I've started to go through them and I know -- I've tried to do it on a regional basis and it's clear that large areas of the country don't have Assertive Outreach teams, you know, and there is a concern that they can't identify the people that might need the service.

So there is a big need for substantial amount of work around Assertive Outreach, and funding for it. I mean, we've seen a lot of money goes -- I think it's been mentioned before -- a lot of money goes into wellbeing services, it seems to me, and there's very little funding for people with serious mental illness who are unwell and untreated, and that needs to be addressed, in my view.

Q. Page 23, if we can have that on the screen as well of your statement next, please. "Risk assessment and public protection". You say at 121:

"Typically the risk will be assessed only to the patient, not the risk from them - ie, the risk they pose to others."

A. Yeah.

Q. Again, why do you think that is?

A. Because of the focus on the patient and the lack of regard for the families and the public safeguarding.

Q. You tell us at paragraph 130 you think sole focus on the needs of the patient is what's happening, effectively, and in your view:

"... Mental Health Services need to take public protection far more seriously."

A. They need to understand that they have a duty to the public. You know, there aren't -- I don't think the NHS understands the Victims' Code of Practice. I don't think they understand that the victims have rights under the Victims' Code of Practice to be informed and to receive information after conviction, and they don't seem to do that. You know, they don't seem to -- they need to be aware of the risks to protect the public.

Q. You refer, if we have page 25 on screen, 25 and 26 alongside each other, to the revolving door?

A. Yes.

Q. Patients becoming unwell, sent back to hospital, an almost revolving door. What role do you think, on the

cases that you have been involved with or seen, Community Treatment Orders and depot have played, if any, in the cases that you've seen?

A. I think Community Treatment Orders and depot medication keep people well, or keep people safe. I mean, I know there are problems with monitoring them, but they -- if somebody -- as I said before, it's people who are seriously unwell who are outside of treatments, who are not medicated, so not getting the medical care and treatment, that are -- cause the problems, either to themselves or to other people.

You know, so keeping people in treatment or keeping people on depot medication when you know they have taken their medication, keeps people safe, in my view. You know, and protects not only the patient but also their families and the other people. And I know there was research in Broadmoor a few years ago when they asked offenders in Broadmoor whether they wished that they'd been treated more assertively to take their medication, and half of them said yes, they did.

Q. If we look at paragraph 141 on page 26 you refer to the ability of the families to obtain a second opinion to escalate concerns?

A. Yeah.

Q. Can you elaborate on that, please.

A. We've had -- as I've said, 80% of these cases happen within families and friends and I've had a number of cases where families have been raising very serious concerns, and sometimes people have been very professional, you know. We've had people who have been Medical Directors of university health boards in Wales whose family member was seriously unwell, they kept asking for care and treatment for them which was disregarded, and some of our families have said if there was a Martha's Rule where people could ask for a second opinion for about the care and treatment, in mental health services, that would help. You know, and there is -- and I think under Martha's rule, there is a proposal that this may at some stage come to mental health services, but I've had lots -- I've had several people say for those family members who are concerned about the wellbeing of their loved one, who -- that that would really help. And the cases I've had, they -- the seriously unwell people when their family have been raising concerns, they've gone on to kill other members of their family in horrible, horrible circumstances.

Q. Can I have, please, page 27 of your statement on the screen:

"Criminal justice system and mental health related homicides."

Twenty-five can come down, thank you, just twenty-seven. You say:

"In several homicide cases I have been involved with there have been significant problems with the exchange of risk information between Police and mental health services before an incident."

In what respect?

A. So I've had several cases where the police have known information. There's the case relatively recently in Sheffield where a mentally unwell person was known to be threatening others and threatening a bloodbath and that information wasn't passed on to mental health services.

I've known other *(unclear)* cases in the south of England where a man was threatening to kill his neighbour. The mental health services knew of that and didn't pass that information to the police, so they couldn't issue an Osman warning, and so they asked his wife: "Will he do it?" And his wife said, "No, he's just being silly". And they didn't pass on the *(unclear)* that this was a named threat to his neighbour. They knew the person that was potentially -- and he went and killed him the next day.

So there is, this passing of information, and I've seen -- I've been following the Inquiry and I know this, there needs -- for people who are dangerous, when there

is a risk to public safety, there needs to be a lot more fluid sharing of information, because that keeps patients, the families, and the public safe.

Q. Paragraph 144, what are you describing there?

A. This was a case where a man who had a long history of threatening, phoning the police and threatening children who was going to -- he'd made a long history that he was going to run over children and kill them, and he kept phoning and was eventually detained, and the two doctors turned up to do a Mental Health Act Assessment with an AMHP. They didn't have the full information, they asked the Custody Sergeant if he was okay, and this was late at night and he'd been sleeping, and the Custody Sergeant said, "No, he's fine."

And the Custody Sergeant had only recently come on duty so didn't really have full information. And on the basis of a three-minute Mental Health Act Assessment they decided he was not detainable, and a month later he went and drove his car at a load of children leaving a school in Essex, killing one of them and injuring about a dozen more.

This was an eminently preventable incident, because he was warning to do exactly what he did, and they didn't have -- they didn't pass on information. And apparently, we took that to the GMC and the GMC said

that was perfectly acceptable behaviour by the doctors. It didn't inspire confidence.
Q. Sorry, I missed that.
A. Say again?
Q. It didn't inspire confidence?
A. It didn't inspire confidence.
Q. Paragraph 145, you say victims' rights, you've mentioned this earlier, are not understood properly.
Paragraph 145, please. How do you think --
A. -- *(overspeaking)* -- I don't --
Q. Can you see that?
Victims understand the Code but you don't think it's understood generally within prosecution?
A. I think it's a problem. I think sometimes victims don't understand the Code because it's not always well represented to them. But certainly I've seen it's an area where the CPS particularly seems to struggle about the giving of information.
Q. Can we have a look at some emails directly impacting on the case we're examining in detail. CPSE0002330, page 4. And this is an email from Emma Webber on 21 November, requesting that she would like your support at a meeting, a meeting with the CPS and with the police.
When we've all read that, can we go, please, to

CPSE0002105, page 3. Can you see that? Page 4, she's requesting that you should be present, and page 3 we see an email coming back to her, that the purpose of the meeting is CPS lawyers and prosecution counsel "to explain the court process", "some of the law involved, "not felt appropriate to have a third party involved in [the] ... meeting."
If we go to page 2, we see Emma Webber saying:
"I'm afraid I'm not prepared to accept this. We are entitled to appropriate support at important meetings and as such, I want Julian there."
If we go, please, to CPSE0002330, page 1, we see Mr Murphy's email from the CPS to the counsel involved. So CPSE0002330, page 1 at the bottom, "see ... email chain". And if we go to page 2:
"He's been offering support to them (and indeed the police may have signposted his charity ...)
"We are awaiting the views of the O'Malley-Kumars.
"I am uncomfortable at the suggestion, notwithstanding the support he may offer ...
"What are your views?"
And we see the police views below:
"My personal feelings is it does not appear appropriate for him to attend this meeting with CPS/KC and counsel in the first instance (regardless of the

support ...)
"I have asked Fiona to confirm that the [O'Malley-Kumars] would be content ... for [the] ... joint family meeting ... and ... if allowed, for Mr Hendy to be present ..."
So he's checking at least whether he can be present, but either way, both expressing initial response there to your presence.
A. This is three weeks after I've been in touch with the Chief Constable.
Q. Then if we go to CPSE0002330, page 3 please. This is an email from Mr Murphy:
"Kessie has found this link. Is this the person we're talking about? I would not be happy about somebody not in the family whose intention (however well founded) is to make a documentary about the case to be present at a meeting between the police/CPS/counsel and the families."
So no doubt having seen your documentary experience that assumption is made there.
And then we see Leigh Sanders saying:
"I personally have no problems in as much as they provide a support capacity for Emma."
Then we see, if we go, please, HMCP0000311, page 1. We see, writing to the FLOs, CPS say:

"Please sensitively convey to the Webber family that the only reason we didn't initially agree with the request was because of concerns around privacy and the risk anything discussed outside the meeting could potentially jeopardise the proceedings. However, Mrs Webber's express views and assurances have been considered and, in the circumstances, the Chief Crown Prosecutor has agreed to Mr Hendy's attendance at the meeting."
Now you tell us in your statement that there is resistance when you come along to support, and indeed we have all seen the emails before us.
Why is there, do you think, that response?
A. Well, they seem to have got the wrong end of the stick. They seem to think that I was wanting to make a documentary programme there and then before the tribunal -- before the court case, which is ridiculous. And it wasn't exactly -- as I say, I'd been in touch with the Chief Constable. They knew who I was. I'd stopped making documentary films in 2017. Mrs Webber had given them my contact details so they could enquire if they had concerns for them to speak to me.
So I just thought -- the appearance I had was they wanted to control everything, and I have had quite a bit of experience with diminished responsibility cases, I'm

familiar with the law, and I was concerned -- and I don't know if we're going to come on to it, but --

Q. We're going to go to the CPS meeting.

A. Yeah, I was concerned about that meeting and what was being said at that meeting because I thought it was inaccurate.

Q. Shall we go then to CPSE0010008, page 1, first of all. We see you're invited to introduce yourself.

A. Yeah.

Q. What do you say, if we go to page 1 and 2?

A. So I was -- just --

Q. Page 1 and 2 on the screen together, please. It'll come up, Mr Hendy.

A. So I was on -- this was a Teams call and I said that -- I gave a brief outline of the charity and the families I've supported.

Q. The Inquiry has been through the main discussion, what's set out about diminished responsibility beginning on page 2. If we have page 2 and 3 alongside each other.

A. Yeah, what's missing in Mr Khalil's KC, King's Counsel's account of diminished responsibility is that he misses out the fact that diminished responsibility applies when there is a recognised mental disorder which substantially impairs an offender's ability to do three things: self-control, recognise the nature of their

conduct, and et cetera. And the question is that that's a curious omission because the heart of this case seemed to be: was VC substantially impaired on the 13 June?

Because I think there's lots of evidence, and we saw -- you know, we didn't know from Sergeant Beddoe's report, there was lots of evidence that he was not substantially impaired and that's not to say he wasn't -- you know, he didn't have schizophrenia, but there's a debate to be had about which -- I think the CPS elided in this explanation to the family about was VC substantially impaired? And "substantial" was, I think, was in the -- was -- what's been decided by -- in the Birch case, I believe -- I can't remember -- no Golds, in the Golds case. It has to be, you know, quite considerably impaired.

And VC's actions on the day, able to plan, go on to London or, you know, the dates before -- go to London and come back -- go on the tram without any apparent difficulty. You know, not raised any concerns for a Mental Health Act assessment in police custody. Able to plan -- which shows an extraordinary amount of self-control which meant that it was arguable that he was not substantially impaired on the day, and that debate wasn't happened, and I raised this subsequently with the HMCPSI and didn't get a response. There were

lots of concerns because --

Q. When did you raise that with the HMCPSI?

A. After we had the meeting with -- we had the initial meeting with HMCPSI with Anthony Rogers and their team, and I said we had concerns, and I said I'd send them -- which I'm happy to make available to the Inquiry -- of my concerns which basically said, you know, was VC substantially impaired? And the other thing -- and we can then come onto it: is diminished responsibility is diminished, it's not extinguished, and that there is residual, you know, there is residual accountability, residual responsibility, retained responsibility, which a hospital order doesn't deal with.

I don't know if we're going to come on to hospital orders, but --

Q. We will.

A. We will?

Q. We will.

A. Yeah, yeah.

Q. So in terms of this meeting, we've been through this with the bereaved families and also the CPS, and we see comments, Mr Webber "I'm disgusted".

We've got Mrs Webber commenting on various matters and the whole meeting. You were there, what was the impact on the families of what was being

-- *(overspeaking)* --

A. They didn't accept it was diminished responsibility. And that we -- you know, and we had this farce about your -- essentially, the feeling I had was that "we've decided, you know, and we're telling you, but it's a *fait accompli*, and no matter what you think, we are not going to change this".

Q. That was your impression at that meeting?

A. Yeah, and that information was given that was completely incorrect, you know, about was toxicology done? You know, or we know -- we know that VC's illness had been -- was the result of Covid? You know, I haven't seen that anywhere in the -- but that's what Mr Khalil King's Counsel was saying in this report, and I thought: well, that's not right, from what -- the evidence that I'd heard.

Q. You asked questions, if we go to page 12 and 13, you asked whether the families could get copies of the psychiatric reports?

A. Yes.

Q. Can you take us through your questions and answers at the bottom of 12 and 13, please.

A. Because it's important -- so the problem with when the CPS accept diminished responsibility cases, to my mind, is that decisions are taken behind closed doors based on

evidence that nobody sees, you know, and that the claim is patient confidential. So it is important for the family's understanding and to help to start to, you know, cope and recover is to see well, what are these psychiatric reports and are they credible and are they of sufficient quality? And that would help.

And I can't see how -- and I'm not aware of any legal impediment that says that these cannot be shared with families, you know, possibly with a confidentiality agreement prior to proceedings and completing, or at least after the proceedings, when we could -- why the families can't know.

And it's entirely inappropriate, because I know afterwards they went -- the families were invited to Avon and Wiltshire Police to have the reports read to them. You know, families are deeply grieving, trying to take in a lot of information. It's totally inappropriate for a complicated information, a lengthy report, to be read to them. You know, you can't take it in.

Q. Can we have a look, please, at page 5. The top of page 5. You say:

"Have there been toxicology reports done regarding whether he took substances before? Can we rule out this is drug related paranoid schizophrenia?"

The answer comes:

"Shortly, the answers are yes and yes. ... no suggestion of a drug induced psychosis. Thank you for mentioning it."

A. That wasn't true though, was it?

Q. Why did you ask that question?

A. Because I know it was of concern to the families.

Q. So when the answer came "yes" and "yes", what did you think the "yes and yes" referred to?

A. Well, I thought that there had been toxicology reports and that drug-related paranoid schizophrenia had been definitively ruled out.

Q. So you took that as an affirmative there had been toxicology and nothing --

A. Yeah.

Q. -- and that meant testing for what, for you?

A. For cannabis use or, you know, and as I understood from talking to Dr Kumar is that even if he doesn't give consent, then there can be non-invasive samples taken to show if there's a history and, as I understand it -- and there was press reporting of drug use at some of the accommodation addresses he was staying at.

And given the fact that so many of mental health-related homicides are -- have some co-existing substance abuse problems, it would be normal for there

to have been substance abuse associated with serious mental illness. So that would be normal. And you would expect the police to want to rule that out because that would be a part -- potentially part of the defence, or it might go to the murder point, and the police did not do that.

Q. Can we have your statement back on the screen, page 28 and 29 please. So witness WITN0258001, pages 28 and 29. You say at paragraph 147:

"I have known cases where the CPS has refused to share information with bereaved families that has been delivered in open court and is a matter of public record."

So do you mean the full report, if the report has been discussed in the hearing?

A. No, I've asked for -- so the families can get sentencing remarks. That's allowed. But it's often helpful for families to get copies of the prosecution opening, which is basically read in open court so it's a matter of public record, and --

Q. In advance, or at the time?

A. Around the time. I mean, you know, I think it's difficult for families in court to hear everything. Sometimes the court is difficult to hear everything --

THE CHAIR: I'm just going to remind you about the Terms of

Reference.

MS LANGDALE: Sorry, Mr Hendy, let's --

A. So sometimes it's a pressurised environment in court, it's difficult to understand everything, so having a copy in black and white of the prosecution opening statement can be helpful to families to understand to make sure that they've understood what's happened and that sometimes they might need to tell other people in the family what has been said in court.

Q. In terms of disposals, you referred to hospital orders, hybrid orders. In your experience generally, we heard some evidence about it this morning, but what are the concerns about bereaved families in terms of that?

A. Well, a hospital order is not a punishment. I think Mustill says that in the Birch case. And so that a hospital order essentially treats everybody as being insane and having no responsibility. So a hospital order does not deal with the residual responsibility of a mental ill offender which is why, you know, a lot of families say, "Well look, yes, I understand he's mentally ill, he needs treatment in hospital." But there does need to be a penal element to address the residual responsibility which is why a lot of families would want to see a hybrid order in place, or for there to be a trial for murder and if somebody is, you know,

to get a life sentence and then be transferred from prison to hospital under Section 47 and 49 of the Mental Health Act which allows that transfer.

Q. That can come down, please. Mr Hendy, is there any other matter or fact or correction on the dates or updates that I have neglected to ask you, that you want to say? We're going to have a break in a moment anyway for a short period, so if there's something --

A. There are probably quite a few, but I can't think of anything. I mean I think one of the things we've heard about the difficulty of clinicians accessing risk information, and one of the things I've been advocating for a long time is that on patients' records there should be a cover sheet with all risk information, basic history of diagnosis or different diagnosis, and all risk information, all medication, who the next of kin are, so that it's immediately apparent to a busy doctor or clinician what are the issues in this case.

Q. On a page?

A. On one page.

Q. Just on one page?

A. A cribsheet, a formulation of what have been the problems. I think one of the things I say about risk is risk management is, it's not rocket science. It's what has happened when a person has been unwell in the past

and what are we going to do if they become unwell again in the future? That should be quite clear.

And I did have some additional thoughts about recommendations for the Inquiry, because -- and I don't know if that's appropriate to do now.

Q. It is, yes. Let's take a break now. Is that the right time, Chair? We've been going for an hour-and-a-half, and then we can come back and deal with it.

THE WITNESS: Okay, thank you.

THE CHAIR: We'll come back at 3.20, thank you.

(2.59 pm)

(A short break)

(3.18 pm)

MS LANGDALE: Mr Hendy, the subject of potential recommendations, reminding you that this Inquiry, of course, isn't dealing with the law of homicide, that is a matter for the Law Reform Commission, but other areas of recommendation that you think this Inquiry should consider?

A. I think there should be training for the CPS around expert witnesses, because I am concerned that expert witnesses, particularly in this case and quite a lot of other ones, have spoke outside of their area of expertise. So particularly they spoke about culpability, which is not a medical term, for which they

have no training, and which wasn't explained to the court properly, so the court and the CPS --

Q. Let's not talk about this case specifically, but generally.

THE CHAIR: The point is, Mr Hendy, really the law is for me in this case and we're just asking you about your general experience of any recommendations that you would wish to make, not specific to this case.

A. Okay.

MS LANGDALE: But psychiatrists, sticking to their area of expertise?

A. So I think it would be helpful to have judicial training around some of this, but some of this, needs of victims, around mental health-related homicides. I think I've seen an awful lot of investigations, Inquiry reports, which make a lot of recommendations, and there's no national oversight, there's no system of making sure that actually when recommendations have been made that they're enforced.

Q. That they're implemented and enforced,

-- *(overspeaking)* --

A. Yes, because we've seen from the Ritchie report, we've made the same Inquiry -- we've made the same recommendations for over 35 years now, you know, and -- 32 years. But it seems to be the same recommendations

keep coming up time and time again and nothing is learnt. I see no evidence that there's actually any practical learning from these, and there needs to be some independent mechanism to take all these investigations and Inquiry reports to make sure.

And one of the other things I've been asked --

Q. When you say an independent mechanism, an oversight body, or what?

A. The judge, the inquests, talk about a national oversight, about a national oversight monitoring board, you know, which is independent and looks at all these different investigations, domestic homicide reviews, mental health investigations, coroners prevention of future deaths reports, public inquiries like this. You know, a lot of good time and effort has been taken to try and work out what actually went on and how things can be improved. But we've seen a lot of policies without much practical improvement. So I would like to see that as --

Q. Resources, do you think it's an area mental health services generally are impacted by resources?

A. I think, yeah, resources are important but I think it's also a cultural issue. You know, there's been a tendency for a long time for people, for almost violence and mental illness to be a taboo subject.

I know when I made my film for the BBC, the Re-think charity tried to injunct the film, when the Time to Change organisation wrote to all the TV reviewers to try and influence the way they reviewed my film, there were lots of very negative comments on social media about it.

So I think there needs to be some mechanism for psychiatrists to take the needs of the victims a lot more -- a lot more seriously, you know. And we need to -- and I think psychiatrists need to show their working out. You know, these reports need to be documented and needs to be interrogated and I was concerned that the CPS seemed to basically say, "Well, we're not expert forensic psychiatrists" and leave it like that, where previously -- and the famous case is Peter Sutcliffe -- you know, the CPS decided that four --

THE CHAIR: Well, I think that's -- *(overspeaking)* -- matter.

A. I'm sorry. I'm sorry.

THE CHAIR: I know you have a lot of experience and knowledge, but obviously we're dealing with looking forward.

A. Apologies. Apologies.

The other area that I think needs to be looked at is that the recommendations should be UK-wide. We're

looking at a case in England, but I think there will be areas -- you know, I know that this applies in Scotland and Northern Ireland and Wales as well and in some situations -- some of the countries of the United Kingdom, the situation is worse than it is in England.

MS LANGDALE: Thank you. Was there any detailed correction on your statement when you had to time to think about it in the break? I think you've updated the numbers as you wanted to?

A. No, I think we've done that. I mean, all I'd say is that when I've talked about CTOs and the number of cases where people have killed their families, I think, one on reflection, has killed other people, so that will be the correct to that.

MS LANGDALE: Thank you. There will be other questions, Mr Hendy.

THE CHAIR: Thank you.

Mr Moloney.

Questioned by MR MOLONEY

MR MOLONEY: Just very briefly, if I may, Mr Hendy, just one question. Could you expand upon what you meant by training of expert witnesses? What sort of things would be useful in that regard?

A. I think they should be -- they should not speak about culpability.

Q. Leave that aside.

A. Okay.

Q. Is that the only thing you meant?

A. No, I mean -- I'm not sure what I'm allowed to say because I don't want to stray into areas of legal difficulties.

So there is evidence in from Europe that sometimes medical evidence is not well understood by people in the criminal justice system and that they would benefit from training on that.

Q. Training in terms of being able to explain things to --

A. Or question it. To understand it and question it.

MR MOLONEY: Okay, thank you very much.

THE CHAIR: Thank you. Yes, Ms Cartwright.

Questioned by MS CARTWRIGHT

MS CARTWRIGHT: Good afternoon, Mr Hendy. I ask questions on behalf of the survivors. Can I start by saying I'm very sorry for your great loss.

A. Thank you.

Q. Can we please just go to your witness statement again to your paragraph 75, WITN0258001, at page 16. Thank you. These are the paragraphs that lead to the recommendation that Ms Langdale KC took you through.

You obviously, at this time of this statement in December of last year, was before the provisions of the

Mental Health Act 2025 had been enacted and you say this:

"I am concerned that current proposals for reform of the [Mental Health Act] will make it more difficult for seriously unwell people to obtain effective care in hospital, as I understand there will be a requirement on clinicians to predict that the patient will commit serious harm, and when that serious harm will occur."

It's right, isn't it, that although enacted not yet in law, the Mental Health Act 2025 is doing exactly that? It's essentially highering the threshold in Section 2 and in Section 3 of the statutory criteria for detention; would you agree?

A. That's my understanding, yeah.

Q. Whereas where one of the statutory criteria used to be that the patient ought to be detained in the interests of their own health or safety or with a view to the protection of other persons. Essentially Section 2 and Section 3 -- I know the wording is slightly different as to whether it's for the assessment and treatment -- now requires:

"Serious harm may be caused to the health or safety of the patient or of another person unless the patient is so detained ..."

Then also:

"Given the nature, degree and likelihood of the harm, the patient ought to be so detained."

So would you agree with that being the higher threshold, it's even more important that the recommend that you suggested to the learned Chair ensures fluidity of information as to previous incidents of violence carried out by mental health patients, or those having contact with Trusts or the police or any other agency, to ensure that those assessing patients do so on the fullest and most complete information as to risk?

A. No, I agree, it should be about prevention rather than prediction.

Q. Thank you. I think if we then just look again at your paragraph 77, which was the recommendation you were taken through. You make a recommendation about the guidance but also "reminding staff of the need to safeguard and be cognisant of the needs of ... families and for public protection generally", and I think you've already shared with the Inquiry the fact that the background to the murder of your father had a serious background of violence; would you agree?

A. Yes.

Q. That the statistics that the Inquiry have dealt with today from their research have identified as one of the predictors or background factors is: previous contact

with police in 86%; previous physical violence in 80% of cases; and previous convictions in 48% of cases.

And so would you agree that there really has to be looking at these incidents, where it involves a mental health patient, committing an offence, that it follows that process of being seen as offending?

A. Yes, absolutely. And the lower figures may be because people are diverted from criminal justice agencies, but there needs to be a lot --

Q. And would you agree also that where you then have a patient that's unfit, the safeguards in any event and the process of trial of facts, which also give an opportunity for patients to be on hospital orders for offences?

A. Yes, absolutely. Generally they get hospital orders until such time as they are well enough to come back to court.

Q. Thank you. Then just finally please, obviously from the perspective of the survivors, and obviously victims of violence rather than homicide, can we briefly look at your paragraphs 54 and 55 on page 12.

And again with previous violence being a predictor as a background to homicide offences, obviously you've already been asked and drawn out that there have been even some cases where homicides have been carried out

where there's not been investigation reports conducted. We obviously know the background to the offending history of VC, but would you agree that equally, the significance, not just of homicides, but of incidents of violence by mental health patients that don't result in death but result in serious incidents -- injuries, absolutely have to be the focus for police and Trusts to properly investigate each incident where serious injuries are caused?

A. It's about protection to the public, so absolutely.

MS CARTWRIGHT: Thank you much, Mr Hendy, and thank you for all your work.

THE CHAIR: Yes, Mr Straw.

Mr Hendy, if you turn that way we can't hear you, so can you just make sure you're speaking to the microphone. Thank you.

THE WITNESS: Right okay.

Questioned by MR STRAW

MR STRAW: Good afternoon, I represent VC's family. You talked earlier about the importance of publishing the independent investigations, after killings by recent NHS mental health patients, in full.

Now when those investigations make recommendations, sometimes, is it right, action is taken by health Trusts?

A. There's no evidence that action is necessarily taken. There is usually an action plan made, sometimes the problem about the action plan is that they will say they'll review their risk assessment policy so they can review it, but it doesn't actually involve any fundamental change in mental health treatment.

So a recommendation might result in an action from an action plan but there's no -- it doesn't automatically follow there's an audit and that leads to action to prevent future incidents.

Q. In your view, is there sufficient publication of the action plans and the action that is taken in response to recommendations?

A. I don't think there's enough scrutiny of them and I don't think there's enough publication, but I think you need -- to understand the action plan, you need to see the full report, because they might say, "We need to improve our risk assessment policy." Well, why, in what context and in what area does that need to happen?

Q. But is this right: you consider there should be full public scrutiny of the action that is taken -- *(overspeaking)* --

A. Yes.

Q. -- *(overspeaking)* -- in response to those reports?

A. Yes and there should be follow-up, because I sit on

a number of NHS committees and they seem to be very concerned to close actions, and I'm concerned about that because how do you know that, you know, they might stop for this week, but how do you know it's not a continuing problem three months down the line or a year down the line?

Q. Thank you. The next topic is about CTOs and depot. You discussed those earlier. In your witness statement, you described CTOs as extremely helpful. I'm interested on the evidence you've seen to show that CTOs can be extremely helpful. You already explained the case of Broadmoor, the evidence from Broadmoor. Can you explain in more detail the evidence on which you base that, for example, does it include the various investigation reports that you've reviewed?

A. It does do, and I've seen from various investigation reports that the -- when people come off of the CTO, then that's when serious incidents can happen. And so they're out of treatment or fall out of treatment and that's when problems can occur.

Q. You mentioned earlier the Penrose argument.

A. Yes.

Q. Is the Penrose argument that there is an inverse relationship between the number of psychiatric hospital beds and the prison population?

A. Yeah, yeah.

Q. Again, evidence, is there evidence of a causal relationship between the two?

A. I don't think there's a cause -- I mean, it would seem to be -- I don't think it's definitively proven, but it would seem to be at least curious, the decline of hospital -- you know, and the difficulties in the decline in psychiatric beds means that there does seem to be an increase in the prison population of people with serious mental illnesses, you know, suffering from serious psychiatric morbidities.

Q. It may be completely obvious, but why is it problematic that people with serious mental illnesses are in prison rather than secure psychiatric hospital?

A. Sometimes they can't get access to proper care and treatment.

Q. You discuss in your witness statement problems with risk assessment that you've seen in the reports that you've looked at.

A. Yeah.

Q. You describe a number of problems and they include too much weight being put on a patient's self-report without corroboration?

A. Yeah.

Q. And also not -- the longitudinal view isn't taken. Do

you have any ideas on how to address those problems? Is there -- are there steps that can be taken or recommendations that you would have as to how those problems might be addressed?

A. Like I said, a cribsheet or a cover sheet for the patient records would certainly assist in knowing what the key risk problems are, and I think there is this artificial distinction between historic and current risk. So historic risk can be anything over two weeks, you know, and sometimes -- and I've seen in lots of cases where people have just assessed the person as they present briefly in front of them, you know, and ask, "Are you a danger to yourself or other people?" And people will say, "yes", and that will be taken without any corroboration from the family or from other people or other sources and that will often be accepted.

Q. For the cases you've seen, does this seem to be a problem due to training, due to contents of policy, are there other systemic --

A. I think it's culture. I think it's a cultural problem that people don't like to -- they worry about that if you talk about violence, that you will stigmatise people with serious mental illness and my view is that unless you treat the violence, you won't treat the stigma. You know, it's cases where serious things have gone wrong,

that increases the stigma, but people seem to say, "Well, we can't talk about it because of the stigma". But actually, if you address the violence, you address the stigma.

MR STRAW: Thank you very much.

THE CHAIR: Thank you. Ms Carey?

MS CAREY: *(Inaudible - off microphone)*

THE CHAIR: Ms Carey, I just have a small query arising from something Mr Hendy said that relates to CPSE0010008 at page 2, if we can get that up.

MS CAREY: These are the minutes of the meeting with the family on --

THE CHAIR: Yes, exactly.

MS CAREY: -- 24 November.

THE CHAIR: Yes, it's just a point that Mr Hendy rose, and I just wanted to give the CPS the opportunity of clarifying it.

If you look at the second paragraph from the bottom --

MS CAREY: Yes.

THE CHAIR: Where it says, "sub-impaired" --

MS CAREY: Yes.

THE CHAIR: -- I'm just wondering whether, if one looked back at the original notes, it may say.

MS CAREY: We're going to do that. These are précis of what

was said in quite a long meeting with the families and, as I understand it, that was shorthand for "substantially impaired", but I will clarify that with those who instruct me and --

THE CHAIR: Yes, well if you can come back to the Inquiry with that so that it's clear what was said.

MS CAREY: I will of course, Chair, thank you very much.

Questioned by THE CHAIR

THE CHAIR: Thank you.

Mr Hendy, I just wanted to ask a couple of questions about your experience and you've obviously sat on a number of committees in the NHS over the years and you've been doing a great public service in gathering together this information and assisting families.

Just in relation to that, the recommendations that you have suggested, you were obviously asked to attend that meeting with the families, because --

A. The CPS meeting?

THE CHAIR: The CPS meeting.

A. Yes.

THE CHAIR: Because a lot of families, I think, as you've said, just are unable to or don't know the system or need some assistance?

A. Yes -- *(overspeaking)* --

THE CHAIR: You're obviously someone who is well versed in

this and has spent your time looking at it, but do you think it would help in general to have someone who could be independent to go along and assist families -- *(overspeaking)* --

A. Yes, absolutely, an advocate in effect.

THE CHAIR: -- and to act as a guide, if you like?

A. Yes, and I think it was previously mentioned in the Inquiry that there should be some written documentation about the law and what should happen and that would be helpful, and I know you've addressed that previously.

THE CHAIR: So you think that a combination of someone to assist you plus --

A. Yes.

THE CHAIR: -- at least an outline as to what the -- what's likely to happen.

A. Our families -- I'd never knew anyone who'd been murdered before, you know, and suddenly you're forced into this completely alien environment where you don't really know what your rights are, what you're allowed to do and what you can't do. And I think to have somebody -- I think that's why the families that I support say they appreciate the fact that I've had this lived experience because I know what it's like, and they appreciate that, and rather than somebody who hasn't had that experience. So I think having an

advocate or support for them during all these processes would be helpful, and I think --

THE CHAIR: And somebody who is not themselves going through the trauma of what's just happened --

A. No, somebody else. And, I mean, I think there are Police Family Liaison Officers and they're generally helpful, but they are detectives and part of the investigation team, so they are reporting on the family back to the investigation.

So like I said, nobody told me how to talk to my children after it happened. You know, there was no moral support. I very much appreciated the Family Liaison Officer, he was a decent chap and did his best, but his role was limited to the criminal investigation.

THE CHAIR: Yes, thank you. Finally, I just wanted to thank you for encouraging your group, the Hundred Families, to assist us with the questionnaires. It's been extremely helpful and --

A. Thank you.

THE CHAIR: -- and for you own work on this --

A. Thank you.

THE CHAIR: Right, well, I think we'll finish there for today. Thank you.

THE WITNESS: Thank you.

THE CHAIR: So we'll start again tomorrow at 10.00. Yes.

(3.40 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X

	Page
JULIAN HENDY (affirmed)	1
Questioned by MS LANGDALE	1
Questioned by MR MOLONEY	70
Questioned by MS CARTWRIGHT	71
Questioned by MR STRAW	75
Questioned by THE CHAIR	81

MR MOLONEY: [2] 70/20 71/13
MR STRAW: [2] 75/19 80/5
MS CAREY: [7] 80/7 80/11 80/14 80/20 80/22 80/25 81/7
MS CARTWRIGHT: [2] 71/16 75/11
MS LANGDALE: [7] 1/4 1/7 64/2 66/14 67/10 70/6 70/15
THE CHAIR: [28] 1/3 63/25 66/10 67/5 69/17 69/20 70/17 71/14 75/13 80/6 80/8 80/13 80/15 80/21 80/23 81/5 81/9 81/19 81/21 81/25 82/6 82/11 82/14 83/3 83/15 83/20 83/22 83/25
THE WITNESS: [3] 66/9 75/17 83/24

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-- it [1] 20/17
-- you [1] 60/3

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1,032 [1] 12/9
1,084 [1] 12/9
1.30 [1] 1/2
10 [1] 37/11
10.00 [2] 83/25 84/2
100 [1] 24/5
101 [1] 46/14
118 [1] 40/13
12 [3] 60/17 60/22 74/21
120 [3] 24/5 27/11 27/12
121 [1] 47/25
13 [2] 60/17 60/22
13 June [1] 58/3
130 [1] 48/8
135 [2] 12/19 12/23
14 [2] 38/22 38/22
140 [2] 44/9 44/12
141 [1] 49/21
144 [1] 52/4
145 [2] 53/7 53/9
147 [1] 63/9
150,000 [1] 44/3
16 [1] 71/21
18,000 [1] 44/4
19 [2] 9/24 13/24
1954 [1] 44/3
1986 [1] 1/21
1993 [1] 12/7
1994 [1] 9/24

2

2 November [1] 33/14
2 November 2025 [1] 1/8
2,396 [1] 12/3
2,463 [1] 12/5
2,468 [4] 12/1 12/3 12/6 12/7
2.59 [1] 66/11
20 [3] 24/10 41/4 46/8
20-23 [1] 24/7
2001 [1] 27/9
2007 [3] 3/3 3/5 9/5
2008 [1] 7/2
2009 [1] 9/6
2013 [1] 27/11
2014 [2] 27/8 27/14
2017 [3] 1/21 20/5 56/20
2020 [2] 21/3 25/20
2023 [3] 31/19 34/4 35/8
2024 [2] 34/5 46/20
2025 [4] 1/8 34/6 72/1 72/10
2026 [3] 1/1 24/4 37/4
21 [1] 11/3
21 November [1] 53/22
22 [1] 10/12
23 [3] 24/7 24/10 47/23
24 November [1] 80/14
25 [2] 48/21 48/21
25 years' [1] 2/10
26 [5] 12/2 33/12 33/12 48/21 49/21
27 [4] 31/17 31/19 33/12 50/22
27 October 2023 [1] 31/19
28 [5] 1/1 31/20 31/21 63/7 63/8
29 [3] 13/23 63/8 63/8

3

3.18 [1] 66/13
3.20 [1] 66/10
3.40 [1] 84/1
30 [1] 41/4
300 [2] 14/4 19/6
32 years [1] 67/25
35 years [1] 67/24

4

41 [1] 23/23
42 [1] 47/9
47 [1] 65/2
48 [1] 74/2
49 [1] 65/2

5

50 years [1] 8/6
50,000 [2] 44/19 45/2
500 [2] 19/5 24/9
54 [2] 29/8 74/21
55 [1] 74/21

6

6 July 2023 [1] 34/4
60 [1] 19/6
63 [1] 35/7
66 [1] 38/23
69 [1] 37/24

7

7 February 2024 [1] 34/5
70 [1] 39/25
73 [1] 25/10
75 [4] 12/21 12/23 41/15 71/21
77 [2] 42/1 73/14

8

80 [2] 50/1 74/1
83 [1] 22/17
86 [1] 74/1

9

93 [1] 44/1
99 [1] 46/9

A

aback [1] 35/2
ability [3] 43/19 49/22 57/24
able [6] 6/16 6/20 13/12 58/16 58/20 71/11
about [97]
absolutely [11] 8/16 19/25 39/16 41/8 42/10 42/22 74/7 74/15 75/7 75/10 82/5
abuse [3] 3/12 62/25 63/1
academic [2] 22/6 22/21
accept [4] 45/22 54/9 60/2 60/24
acceptable [1] 53/1
accepted [1] 79/16
access [3] 6/4 30/9 78/15
accessing [1] 65/11
accommodation [1] 62/22
accompli [1] 60/6
accordance [1] 40/15
account [1] 57/21
accountability [8] 14/17 15/10 15/11 23/19 34/15 34/18 37/20 59/11
accountable [1] 35/17
accurate [1] 1/10
act [20] 9/5 17/3 17/9 17/25 28/3 37/16 40/1 40/13 40/14 40/18 41/12 42/5 52/10 52/17 58/20 65/3 72/1 72/4 72/10 82/6
acted [1] 42/15
acting [2] 19/2 20/15
action [11] 75/24 76/1 76/2 76/3 76/7 76/8 76/10 76/12 76/12 76/16 76/21
actions [3] 38/10 58/16 77/2
acts [1] 36/19
actually [20] 3/15 4/17 5/16 9/2 15/24 16/14 18/14 22/4 22/7 22/9 23/10 31/5 32/19 32/23 36/2 67/18 68/2 68/16 76/5 80/3
add [1] 14/11
added [1] 40/17
additional [1] 66/3
address [4] 64/22 79/1 80/3 80/3
addressed [4] 32/6 47/22 79/4 82/10
addresses [1] 62/22
adhere [1] 25/11
adjourned [1] 84/2
adopt [1] 40/8
advance [2] 36/21 63/21
advice [3] 37/4 39/2 39/7
advised [1] 35/11
advisory [1] 16/25
advocate [2] 82/5 83/1
advocating [1] 65/12
affected [4] 2/9 2/19 14/7 21/22
affirmative [1] 62/13
affirmed [2] 1/5 85/3
afraid [1] 54/9
after [29] 2/11 2/16 4/6 4/6 4/14 8/23 8/24 9/4 9/6 9/19 10/19 14/24 23/11 23/13 24/13 27/9 28/3 30/4 35/4 36/6 39/3 39/8 46/16 48/18 55/9 59/3 61/11 75/21 83/11
aftermath [1] 7/11
afternoon [2] 71/16 75/19
afterwards [4] 9/7 14/22 30/5 61/14
again [15] 16/14 23/1 24/4 33/21 37/24 39/1 48/5 53/4 66/1 68/1 71/20 73/13 74/22 78/2 83/25
against [1] 36/6
agencies [5] 9/15 23/14 29/24 30/3 74/8
agency [2] 23/18 73/8
ago [5] 17/7 17/13 25/7 40/21 49/17
agree [8] 56/2 72/13 73/3 73/11 73/21 74/3 74/10 75/3
agreed [1] 56/8
agreement [1] 61/10
airline [1] 24/14
alcohol [2] 7/15 14/2
alerted [1] 6/8
alien [1] 82/18
all [46] 2/9 2/12 5/17 7/12 7/16 7/16 7/18 7/19 10/10 10/21 10/22 10/25 12/11 13/6 13/19 14/1 14/13 16/18 23/14 24/2 24/24 25/23 26/7 27/7 29/9 29/16 34/16 35/20 35/21 36/6 38/14 38/16 43/4 46/25 53/25 56/12 57/7 65/14 65/15 65/16 68/4 68/11 69/3 70/10 75/12 83/1
allotment [1] 8/8
allowed [5] 18/8 55/4 63/17 71/4 82/19
allowing [2] 33/8 33/25
allows [2] 33/1 65/3
alluded [1] 4/3
almost [2] 48/25 68/24
almost revolving [1] 48/25
along [3] 18/20 56/11 82/3
alongside [4] 31/20 33/12 48/22 57/19
already [5] 14/9 30/10 73/19 74/24 77/11
also [17] 7/10 9/18 14/7 22/21 26/6 27/25 32/19 44/16 45/20 49/15 59/21 68/23 72/25 73/16 74/10 74/12 78/25
although [4] 3/15 3/16 14/3 72/9
always [6] 12/24 29/25 38/4 43/24 45/19 53/15
am [4] 54/19 66/21 72/3 84/2
America [1] 2/5
AMHP [1] 52/11
amount [3] 24/19 47/15 58/21
amphetamines [1]

A

amphetamines... [1] 3/17
another [2] 13/9 72/23
answer [4] 23/7 33/13 62/1 62/8
answers [2] 60/21 62/2
Anthony [1] 59/4
any [31] 1/14 2/12 9/2 11/8 11/11 11/11 13/5 15/18 15/22 20/16 20/18 25/4 32/6 37/1 40/22 43/16 43/18 46/3 49/3 58/18 58/19 61/7 65/4 67/7 68/2 70/6 73/8 74/11 76/5 79/1 79/15
anyone [1] 82/16
anything [6] 11/6 11/10 14/11 56/4 65/10 79/9
anyway [1] 65/7
anywhere [1] 60/13
Apologies [2] 69/23 69/23
apologised [1] 5/3
apology [1] 23/19
appalling [1] 9/19
apparent [2] 58/18 65/17
apparently [3] 3/24 39/7 52/25
appeal [1] 18/13
appear [2] 26/2 54/23
appearance [1] 56/23
appeared [2] 39/10 45/22
applied [1] 6/22
applies [2] 57/22 70/2
apply [2] 36/20 40/19
appreciate [2] 82/22 82/24
appreciated [1] 83/12
approach [4] 43/8 43/9 43/12 45/15
Approaches [1] 34/4
appropriate [4] 54/6 54/10 54/24 66/5
appropriately [1] 19/10
April [1] 3/5
April 2007 [1] 3/5
are [120]
area [10] 11/22 13/19 20/20 44/14 53/17 66/23 67/10 68/20 69/24 76/19
areas [6] 10/13 13/21 47/12 66/17 70/2 71/5
aren't [2] 26/18 48/14
arguable [1] 58/22
argument [3] 44/23 77/21 77/23
arising [1] 80/8
around [17] 7/16 7/18 14/4 19/6 23/4 24/5 29/14 37/6 38/1 43/20 44/3 47/16 56/3 63/22 66/20 67/13 67/14
arrest [2] 28/3 38/15
arrested [1] 28/2
article [3] 37/10 37/11 39/8
Article 8 [1] 37/10
artificial [1] 79/8
as [65] 1/10 1/11 1/11 1/17 2/10 2/14 3/5 3/7 3/16 6/6 12/8 13/13 14/2 15/24 16/2 20/22 22/15 23/9 25/14 25/15 26/25 28/11 29/19 30/14 30/14 30/22 31/21 32/3 34/12 35/24 38/4 40/17 41/18 45/11 45/11 46/9 47/23 49/7 50/1 54/11 55/22 55/22 56/18 62/13 62/17 62/20 64/16 68/19 70/3 70/8 72/6 72/19 73/6 73/10 73/24 74/6 74/16 74/23 77/9 79/3 79/11 81/2 81/21 82/6 82/14
aside [1] 71/1
ask [8] 19/17 33/5 50/10 62/6 65/6 71/16 79/12 81/10
asked [16] 20/10 25/8 25/8 25/12 37/13 46/17 49/17 51/17 52/11 55/2 60/17 60/18 63/16 68/6 74/24 81/16
asking [2] 50/8 67/6
assaulted [1] 4/14
assertive [7] 8/2 43/7 43/8 43/9 46/10 47/12 47/16
assertively [4] 40/5 40/7 43/15 49/19
assessed [2] 48/1 79/11
assessing [1] 73/9
assessment [9] 10/23 47/24 52/10 52/17 58/20 72/20 76/4 76/18 78/18
assessments [1] 43/18
assist [5] 9/6 79/6 82/3 82/12 83/17
assistance [1] 81/23
assisted [2] 14/4 14/13
assisting [1] 81/14
associated [1] 63/1
assume [2] 23/8 23/9
assumed [1] 43/24
assumption [1] 55/20
assumptions [1] 23/15
assurances [1] 56/6
assured [2] 19/20 33/15
at [95]
attacked [1] 3/10
attend [4] 17/11 43/1 54/24 81/16
attendance [1] 56/8
attended [2] 17/9 40/21
attention [1] 26/8
attitude [2] 15/20 15/21
audit [1] 76/9
automatic [1] 18/11
automatically [1] 76/9
availability [1] 27/10
available [5] 9/23 10/6 10/16 12/8 59/6
Avon [2] 10/13 61/15
awaiting [1] 54/18
awake [1] 2/7
Awards [1] 2/14
aware [4] 13/17 31/25 48/20 61/7
away [1] 3/1
awful [4] 2/21 14/24 15/4 67/15
Aylesbury [1] 7/18

B

back [15] 3/7 23/18 31/23 35/6 45/13 48/24 54/3 58/18 63/7 66/8 66/10 74/16 80/24 81/5 83/9
background [6] 1/17 73/20 73/21 73/25 74/23 75/2
backlog [1] 26/3
balance [2] 37/10 37/12
balancing [1] 37/16
ban [1] 20/16
base [1] 77/13
based [4] 30/2 39/7 42/18 60/25
basic [2] 23/21 65/14
basically [6] 9/5 18/4 37/2 59/7 63/19 69/12
basis [4] 18/12 27/8 47/11 52/17
BBC [1] 69/1
be [139]
because [66] 5/10 11/10 12/24 13/16 15/2 16/19 19/3 19/15 20/13 23/8 24/7 24/18 26/2 26/5 26/14 29/21 29/21 30/17 31/5 32/9 32/16 32/17 34/21 35/3 35/13 35/18 35/20 36/16 36/18 36/23 36/25 37/21 38/7 38/11 39/12 40/18 42/25 43/12 44/15 45/16 46/2 48/6 52/2 52/22 53/15 56/3 57/5 58/2 58/4 59/1 60/23 61/13 62/7 63/3 66/4 66/21 67/22 71/5 74/7 76/17 76/25 77/3 80/2 81/17 81/21 82/23
become [2] 21/17 66/1
becoming [1] 48/24
Beddoe's [1] 58/5
beds [10] 44/2 44/7 44/9 44/12 44/13 44/17 44/18 45/2 77/25 78/8
been [89]
before [20] 3/6 3/14 3/14 5/20 9/11 15/3 30/5 30/12 32/22 40/18 47/18 49/7 51/6 56/12 56/16 56/17 58/17 61/24 71/25 82/17
beforehand [1] 26/19
beginning [4] 1/16 20/25 33/19 57/18
behalf [1] 71/17
behaviour [2] 2/8 53/1
behind [1] 60/25
being [20] 19/9 19/21 20/9 20/22 26/7 33/14 33/23 41/10 43/18 44/13 44/14 51/19 57/5 59/25 64/16 71/11 73/3 74/6 74/22 78/22
believe [3] 2/21 43/17 58/13
believed [1] 3/21
below [1] 54/22
benefit [1] 71/9
bereaved [7] 14/12 15/7 15/15 29/1 59/21 63/11 64/13
best [7] 8/13 22/22 28/11 39/14 39/15 45/18 83/13
better [4] 9/17 9/17 10/4 11/24
between [12] 4/18 25/14 30/19 30/25 31/3 37/9 37/10 51/5 55/17 77/24 78/3 79/8
big [4] 9/8 26/4 41/4 47/15
bill [1] 3/4
Birch [2] 58/13 64/15
bit [2] 9/10 56/24
bizarre [1] 6/17
black [1] 64/5
blame [1] 15/19
blamed [1] 16/20
bland [1] 39/21
blanket [1] 20/16
bloodbath [1] 51/11
board [2] 34/25 68/10
boards [2] 46/17 50/6
bode [1] 16/3
bodies [1] 37/1
body [1] 68/8
book [1] 22/24
Bosnia [1] 1/23
both [4] 1/17 21/1 21/7 55/7
bottom [5] 33/4 34/8 54/14 60/22 80/19
break [5] 1/13 65/7 66/6 66/12 70/8
breakdown [1] 12/16
brief [2] 32/21 57/15
briefly [3] 70/20 74/20 79/12
Bristol [5] 4/2 5/8 7/18 10/9 11/22
British [1] 25/19
Brixton [1] 2/4
broad [1] 45/14
Broadmoor [4] 49/17 49/18 77/12 77/12
brought [2] 17/16 26/7
bullet [1] 17/2
bulletins [1] 38/7
burdensome [1] 16/2
Bush [1] 3/22
busy [1] 65/17
but [81] 4/3 5/3 7/10 7/23 8/2 8/11 9/18 11/22 15/13 15/23 17/10 17/13 17/16 17/18 17/19 17/22 18/6 18/14 18/21 20/6 21/17 21/24 22/3 25/4 25/17 26/16 27/9 29/3 30/4 31/4 32/15 33/7 35/4 37/6 41/14 43/4 44/23 45/14 46/4 49/6 49/15 50/15 53/12 53/16 55/7 57/2 58/8 59/15 60/5 60/13 63/17 64/12 64/21 65/9 66/17 67/3 67/10 67/13 67/25 68/17 68/22 69/21 70/1 73/16 74/8 75/3 75/4 75/6 76/5 76/8 76/15 76/20 77/4 78/5 78/12 80/1 80/3 81/3 82/1 83/7 83/14

C

call [4] 1/4 25/7 44/23 57/14
called [1] 8/24
came [3] 11/1 27/16 62/8
can [72] 1/8 1/12 1/19 10/17 12/14 12/18 13/11 14/23 14/23 15/6 16/23 17/5 17/12 18/20 18/20 18/21 18/23 19/20 22/1 28/10 28/11 30/14 31/2 31/2 31/5 31/17 31/21 32/25 33/5 35/6 36/10 37/2 37/18 39/24 40/9 45/4 46/8 46/14 46/22 47/23 49/25 50/22 51/1 53/11 53/19 53/25 54/1 55/6 59/9 60/21 61/21 61/24 62/19 63/7 63/16 64/6 65/4 66/8 68/17 71/17 71/20 74/20 75/15 76/4 77/10 77/12 77/18 77/20 79/2 79/9 80/10 81/5
can't [20] 5/16 6/13 14/15 17/13 18/13 18/21 18/25 19/1 20/5 41/1 47/13 58/13 61/7 61/12 61/19 65/9 75/14 78/15 80/2 82/20
Candour [4] 25/8 25/10 25/11 25/13
cannabis [1] 62/17
cannot [1] 61/8
capacity [4] 43/18 43/23 43/24 55/23
capture [1] 26/13
captures [1] 26/11
car [1] 52/19
care [21] 3/2 4/2 7/9 7/14 7/20 8/2 10/23 11/4 37/15 41/18 42/17 43/6 45/3 45/17 45/18 46/17 49/9 50/8 50/11 72/5 78/15
career [2] 1/17 1/21
Carey [2] 80/6 80/8
carried [3] 34/3 73/7 74/25
Cartwright [3] 71/14 71/15 85/6
case [36] 8/9 13/13 13/16 13/22 18/14 20/3 26/24 26/25 27/9 28/9 30/23 31/14 35/21 36/2 36/13 36/17 38/15 38/24 45/19 51/9 52/5 53/20 55/16 56/17 58/2 58/13 58/14 64/15 65/18 66/22 67/3 67/6 67/8 69/14 70/1 77/11
cases [47] 2/17 2/18 7/5 7/7 7/17 7/22 11/20 12/1 12/19 12/21 13/4 13/11 14/1 14/13 26/3 26/7 27/11 27/23 27/24 27/25 29/9 31/6 31/7 36/21 37/13 40/4 43/16 43/23 45/21 49/1 49/3 50/1 50/3 50/18 51/3 51/8 51/13 56/25 60/24 63/10 70/11 74/2 74/2 74/25 79/11 79/17 79/25
catastrophic [1] 24/18
causal [1] 78/2
cause [3] 8/1 49/10 78/4
caused [2] 72/22 75/9
ceased [1] 9/5
certainly [4] 21/21 26/4 53/16 79/6
cetera [1] 58/1
chain [1] 54/15
Chair [8] 1/4 10/17 32/21 66/7 73/5 81/7 81/8 85/8
chairman [1] 8/7
challenge [2] 45/23 46/3
Chamber [1] 20/14
change [4] 9/16 60/7 69/3 76/6
changed [1] 27/14
changes [1] 3/23
chap [1] 83/13
chapter [1] 22/22
charities [1] 9/11
charity [6] 8/21 8/22 14/6 54/17 57/15 69/2
checking [1] 55/6
Chief [8] 31/18 31/23 32/24 33/11 34/14 55/10 56/7 56/19
children [8] 3/23 8/6 8/18 18/19 52/6 52/8 52/19 83/11
Christopher [1] 8/25
Chuck [1] 45/13
circumstances [3] 14/10 50/21 56/7
citing [2] 35/9 39/2
claim [3] 18/6 23/25 61/1
clarify [1] 81/3
clarifying [1] 80/17
clarity [1] 37/6
clear [6] 13/12 16/7 16/10 47/11 66/2 81/6
clearer [1] 42/5
Clinical [1] 44/10
clinician [1] 65/18
clinicians [5] 25/9 40/5 41/19 65/11 72/7
clone [1] 3/23
close [4] 20/9 20/20 44/14 77/2
closed [5] 6/3 6/4 18/7 18/15 60/25
closure [4] 8/11 15/1 15/2 15/2
Clunis [1] 8/25
co [1] 62/24
co-existing [1] 62/24
Code [7] 21/16 42/11 42/12 48/15 48/17 53/12 53/15
cognisance [1] 42/13
cognisant [2] 42/7 73/17
collated [1] 29/17
collected [1] 27/17
College [1] 21/1
combination [1] 82/11
come [25] 6/25 8/2 13/11 14/22 18/13 24/8 28/4 35/6 39/24 45/11 50/14 51/1 52/15 56/11 57/2 57/12 58/18 59/9 59/14 65/4 66/8 66/10 74/16 77/17 81/5
comes [2] 16/8 62/1
coming [4] 23/14 26/3 54/3 68/1
comment [2] 39/24 47/5
commenting [1] 59/23
comments [2] 59/22 69/5
Commission [1] 66/17
commissioned [4] 7/2 34/3 34/4 34/5
Commissioning [1] 44/10
commit [2] 41/20 72/7
committed [3] 18/19 19/23 29/10
committee [2] 32/20 32/20
committees [3] 16/25 77/1 81/12
committing [1] 74/5
common [2] 7/16 23/9
communicate [1] 4/24
communication [2] 31/3 31/12
communities [1] 8/10
community [7] 6/20 25/2 40/10 43/21 45/18 49/2 49/4
competing [1] 37/9
complain [1] 9/13
complaints [1] 39/3
complete [4] 3/9 4/18 19/15 73/10
completely [6] 6/18 36/21 37/14 60/9 78/12 82/18
completing [1] 61/10
compliance [1] 7/13
complicated [2] 31/6 61/18
component [1] 28/12
Conceivably [1] 13/8
concentrate [1] 16/12
concern [8] 8/1 29/4 38/5 39/23 41/7 47/4 47/13 62/7
concerned [14] 1/11 4/19 23/23 40/1 41/16 42/22 50/16 57/1 57/4 66/21 69/12 72/3 77/2 77/2
concerns [18] 3/13 17/17 17/20 24/3 26/11 37/22 39/3 40/3 49/23 50/4 50/20 56/3 56/22 58/19 59/1 59/5 59/7 64/13
concluded [1] 30/23
conclusion [1] 30/12
condition [1] 42/25
conduct [2] 9/25 58/1
conducted [2] 34/2 75/1
conducting [1] 30/12
Conference [4] 21/2 21/3 21/7 21/11
conferences [1] 21/5
confidence [3] 53/2 53/5 53/6
confidential [6] 16/17 22/18 26/9 27/1 46/25 61/2
confidentiality [6] 35/10 35/14 36/12 37/23 39/2 61/9
confirm [2] 1/8 55/2
consent [4] 6/14 6/24 43/20 62/19
consequence [1] 15/18
consequences [1] 15/17
consider [5] 17/25 21/11 42/2 66/19 76/20
considerably [1] 58/15
considered [5] 14/2 18/10 41/24 42/15 56/7
considering [4] 22/8 22/9 25/16 40/20
considering it [1] 22/8
considers [1] 17/23
conspiracy [1] 3/21
Constable [5] 31/19 31/23 32/24 55/10 56/19
Constable's [1] 33/11
consultants [1] 34/16
consultation [1] 40/22
contact [12] 3/11 30/25 30/25 31/15 32/5 32/15 33/8 33/24 46/11 56/21 73/8 73/25
contacted [3] 9/1 28/18 32/12
contacting [1] 31/22
content [1] 55/3
contents [1] 79/18
context [3] 26/6 28/21 76/19
continue [1] 33/2
continued [2] 4/21 6/5
continuing [1] 77/4
contributed [1] 22/21
contribution [1] 25/22
control [4] 6/16 56/24 57/25 58/22
conversations [1] 46/5
convey [1] 56/1
convicted [2] 7/1 26/18
conviction [1] 48/18
convictions [3] 26/16 26/23 74/2
Coordinators [1] 32/19
cope [2] 14/18 61/4
copies [3] 11/5 60/18 63/18
copy [4] 20/2 20/10 34/13 64/5
coroners [1] 68/13
Coroners' [1] 27/21
correct [3] 12/22 37/5 70/14
correction [2] 65/5 70/6
corroboration [4] 30/2 45/24 78/23 79/15
could [15] 4/10 28/25 32/17 32/17 37/25 39/11 42/2 45/5 50/10 56/4 56/21 60/18 61/11 70/21 82/2
couldn't [6] 2/21 2/23 11/5 28/23 29/5 51/17
counsel [5] 54/4 54/13 54/25 55/17

C

counsel... [1] 60/14
Counsel's [1] 57/20
count [3] 26/16 27/4 27/6
counted [2] 5/18 27/15
countries [1] 70/4
country [2] 7/19 47/12
counts [1] 26/10
couple [2] 25/7 81/10
course [4] 34/2 42/20 66/16 81/7
court [20] 3/1 18/17 20/4 20/22 26/3 27/9 36/3 36/14 38/15 54/5 56/17 63/12 63/19 63/23 63/24 64/3 64/9 67/2 67/2 74/17
cover [2] 65/14 79/5
coverage [1] 39/4
Covid [1] 60/12
CPS [20] 30/21 53/17 53/23 54/4 54/13 54/24 55/17 55/25 57/3 58/9 59/21 60/24 63/10 66/20 67/2 69/12 69/15 80/16 81/18 81/19
CPS/KC [1] 54/24
CPSE0002105 [1] 54/1
CPSE0002330 [4] 53/20 54/12 54/14 55/11
CPSE0010008 [2] 57/7 80/9
crash [1] 24/14
crashes [2] 24/12 24/20
credible [1] 61/5
cribsheet [2] 65/22 79/5
crimes [1] 19/23
criminal [13] 9/15 15/14 19/14 22/3 23/24 30/19 33/7 35/15 36/19 50/24 71/9 74/8 83/14
criminals [1] 2/1
crisis [2] 44/9 44/12
criteria [2] 72/12 72/15
Crown [1] 56/7
cruel [2] 4/22 4/23
CTO [1] 77/17
CTOs [4] 70/11 77/7 77/9 77/10
culpability [2] 66/25 70/25
cultural [2] 68/23 79/20
culture [3] 15/19 24/25 79/20
curious [2] 58/2 78/6
current [6] 36/22 38/6 41/16 42/17 72/3 79/8
currently [1] 43/3
custody [4] 52/12 52/13 52/15 58/20
cuts [1] 44/19

D

dad [12] 2/11 2/13 3/4 3/21 4/14 5/6 5/6 6/15 8/23 23/11 23/14 35/1
danger [1] 79/13
dangerous [7] 3/19 7/21 22/20 36/4 42/3 43/15 51/25
data [2] 3/20 26/10
database [4] 11/15 27/17 27/24 28/18
dated [1] 1/8
dates [2] 58/17 65/5
day [8] 1/13 3/19 4/14 43/13 51/22 58/16 58/23 84/2
days [5] 3/8 3/14 14/22 39/8 43/13
de [1] 44/20
de-institutionalising [1] 44/20
deal [4] 40/5 59/13 64/18 66/8
dealing [3] 24/2 66/16 69/21
dealt [1] 73/23
death [4] 7/1 14/10 14/10 75/6
deaths [2] 27/21 68/14
debate [2] 58/9 58/24
December [2] 33/19 71/25
decency [1] 23/5
decent [2] 5/7 83/13
decide [3] 6/20 12/25 37/3
decided [9] 3/18 11/15 18/12 20/13 38/25 52/18 58/12 60/5 69/15
deciding [1] 34/25
decision [3] 20/3 20/10 20/12
decisions [5] 19/21 37/21 41/10 43/20 60/25
decline [4] 43/6 44/17 78/6 78/8
declined [1] 34/17
declining [1] 25/21
dedicated [1] 43/11
deeply [1] 61/16
defence [1] 63/4
defined [1] 41/22
definitely [1] 34/20
definitively [2] 62/12 78/5
degree [1] 73/1
delay [1] 26/2
delivered [1] 63/12
delivering [1] 42/17
demonstrate [1] 11/6
Department [2] 9/24 25/6
depot [5] 43/20 49/2 49/4 49/13 77/7
Deputy [1] 20/14
Deputy Chamber [1] 20/14
describe [1] 78/21
described [3] 3/16 26/20 77/9
describing [1] 52/4
detail [4] 39/23 39/23 53/20 77/13
detailed [1] 70/6
details [1] 56/21
detain [1] 3/18
detainable [1] 52/18
detained [7] 2/3 2/4 17/24 52/9 72/16 72/24 73/2
detectives [1] 83/7
detention [4] 18/4 18/18 41/12 72/13
deterioration [1] 3/14
devices [1] 45/13
diagnosis [2] 65/15 65/15
did [30] 2/16 2/21 4/4 4/24 5/2 5/20 5/24 9/10 10/6 17/11 17/20 25/7 31/14 40/22 41/1 41/2 43/16 44/8 44/9 46/21 46/21 47/8 49/20 52/23 59/2 62/6 62/8 63/5 66/3 83/13
didn't [28] 4/2 9/12 10/15 11/5 31/15 33/19 33/22 35/20 35/21 35/22 39/6 41/13 43/17 44/11 51/16 51/19 52/11 52/16 52/24 52/24 53/2 53/5 53/6 56/2 58/5 58/8 58/25 60/2
died [3] 3/7 8/14 26/19
different [8] 15/3 29/23 29/24 30/20 38/19 65/15 68/12 72/19
difficult [8] 2/12 8/17 15/24 41/17 63/23 63/24 64/4 72/4
difficulties [2] 71/6 78/7
difficulty [2] 58/19 65/11
digging [1] 10/11
diminished [11] 27/10 28/13 31/8 56/25 57/18 57/21 57/22 59/9 59/10 60/2 60/24
dinner [1] 14/23
direct [1] 9/3
directly [1] 53/19
Director [1] 4/17
Directors [1] 50/6
discharged [1] 19/6
disclosed [1] 36/10
disclosure [1] 36/8
discourse [1] 47/2
discover [1] 4/1
discovered [2] 4/5 6/2
discuss [2] 35/22 78/17
discussed [3] 56/4 63/15 77/8
discussion [2] 21/12 57/17
discussions [1] 17/16
disease [1] 2/21
disengage [2] 43/7 46/4
disgusted [1] 59/22
disinfectant [2] 39/14 39/15
dismissive [1] 7/10
disorder [1] 57/23
disordered [1] 3/25
disorders [1] 25/22
disparity [2] 25/14 29/23
disposals [1] 64/10
disposed [1] 27/25
disregarded [1] 50/9
Dissayanaka [1] 43/10
distance [1] 8/12
distinction [1] 79/8
diversion [1] 2/25
diverted [1] 74/8
do [56] 1/14 6/11 10/19 12/23 12/24 13/15 16/5 21/18 21/19 21/20 21/21 22/5 23/13 24/24 25/9 25/11 25/18 27/8 27/18 27/18 29/16 30/11 30/24 35/3 35/22 42/21 43/11 44/6 45/12 46/1 46/10 47/11 48/5 48/19 48/25 51/18 52/10 52/23 53/9 56/13 57/10 57/24 63/6 63/14 66/1 66/5 68/20 73/9 77/3 77/4 77/16 78/25 80/25 82/1 82/20 82/20
doctor [1] 65/17
doctors [3] 31/9 52/9 53/1
document [2] 13/12 42/15
documentary [8] 1/18 1/22 7/3 7/8 55/16 55/19 56/16 56/20
documentation [2] 10/24 82/8
documented [3] 12/1 12/3 69/11
documents [1] 12/13
does [8] 54/23 64/18 64/22 76/19 77/14 77/16 78/8 79/17
does it [1] 77/14
doesn't [14] 16/2 18/25 24/15 24/20 29/16 33/1 36/25 38/11 44/22 44/23 59/13 62/18 76/5 76/8
doing [3] 7/14 72/10 81/13
domain [2] 30/10 38/17
domestic [2] 12/11 68/12
don't [50] 5/2 5/4 5/10 12/24 13/18 15/12 15/13 17/15 17/18 17/22 18/6 18/11 19/2 21/20 23/7 25/4 25/18 26/13 27/5 29/22 30/7 30/8 30/9 38/8 38/18 41/1 41/1 42/21 42/25 43/4 47/12 48/14 48/15 48/18 48/19 53/10 53/12 53/14 57/2 59/14 66/4 71/5 75/5 76/14 76/15 78/4 78/5 79/21 81/22 82/18
done [8] 18/22 25/15 37/16 37/16 37/18 60/10 61/23 70/10
door [2] 48/22 48/25
doors [1] 60/25
doubt [1] 55/19
down [14] 5/9 6/18 13/11 16/10 24/8 26/25 27/16 35/6 39/24 44/3 51/1 65/4 77/5 77/5
dozen [1] 52/21
Dr [2] 43/10 62/18
Dr Dissayanaka [1] 43/10
Dr Kumar [1] 62/18
drawn [1] 74/24
drive [1] 5/9
dropped [1] 13/5
drove [1] 52/19
drug [9] 3/12 6/9 7/15 10/24 14/1 61/25 62/3 62/11 62/21
drug-related [1] 62/11

D

due [4] 5/12 46/19 79/18 79/18
during [4] 1/23 1/23 17/16 83/1
duties [2] 22/12 22/12
duty [14] 21/13 21/14 21/14 21/15 21/16 21/19 22/6 25/8 25/9 25/11 25/13 44/11 48/13 52/16

E

each [11] 3/9 19/6 24/6 27/12 31/12 31/20 33/12 34/11 48/22 57/19 75/8
earlier [7] 4/3 6/6 34/18 53/8 75/20 77/8 77/21
early [1] 23/6
ears [1] 18/23
East [2] 12/19 12/20
East Midlands [2] 12/19 12/20
easy [1] 6/3
eat [2] 14/23 14/24
educated [1] 5/25
effect [3] 5/5 25/9 82/5
effective [3] 35/11 41/18 72/5
effectively [1] 48/9
efficacy [1] 19/8
effort [1] 68/15
either [3] 13/5 49/10 55/7
elaborate [1] 49/25
elderly [1] 28/7
element [2] 28/1 64/22
elements [2] 16/16 23/22
elided [1] 58/9
eloquently [1] 14/9
else [1] 83/5
email [5] 53/21 54/3 54/13 54/14 55/12
emails [2] 53/19 56/12
eminently [1] 52/22
Emma [3] 53/21 54/8 55/23
Emma Webber [1] 54/8
emotional [1] 5/16
emotionally [1] 5/15
emphasis [2] 24/24 43/2
enacted [2] 72/1 72/9
encounter [1] 32/21
encourage [1] 30/14
encouraging [1] 83/16
end [2] 47/7 56/14
enforced [2] 67/19 67/20
engage [2] 23/6 29/22
engaged [1] 9/14
engaging [2] 22/22 23/1
England [16] 13/24 24/9 32/11 32/14 32/18 33/16 33/23 34/6 35/8 38/24 43/3 46/16 46/22 51/14 70/1 70/5
enlarge [1] 12/18
enough [4] 44/7 74/16 76/14 76/15
enquire [1] 56/21
ensure [2] 19/18 73/9
ensures [1] 73/5
entered [1] 27/17
entirely [1] 61/13
entitled [1] 54/10
environment [2] 64/3 82/18
equally [1] 75/3
error [1] 4/25
escalate [1] 49/23
essentially [8] 11/12 18/3 18/6 36/24 60/4 64/16 72/11 72/18
Essex [1] 52/20
Establish [1] 45/7
et [1] 58/1
et cetera [1] 58/1
ethical [1] 22/5
Europe [1] 71/7
even [13] 10/15 11/5 18/8 24/11 24/12 29/5 30/4 30/7 37/9 38/8 62/18 73/4 74/25
event [2] 5/20 74/11
events [2] 24/18 35/16
eventually [2] 33/17 52/9
ever [1] 6/5
every [4] 13/13 13/16 24/6 24/14
everybody [2] 38/19 64/16
everything [5] 38/18 56/24 63/23 63/24 64/4
evidence [25] 11/11 18/12 18/14 25/3 25/4 25/7 31/10 41/23 43/10 43/16 43/18 58/4 58/6 60/15 61/1 64/12 68/2 71/7 71/8 76/1 77/10 77/12 77/13 78/2 78/2
exactly [6] 11/1 20/6 52/23 56/18 72/10 80/13
examined [1] 43/17
examining [1] 53/20
example [3] 25/5 25/6 77/14
exceptions [1] 21/24
exchange [1] 51/4
executive [2] 38/25 39/22
exemptions [2] 35/21 35/23
existing [1] 62/24
expand [1] 70/21
expect [1] 63/3
expense [1] 44/15
experience [14] 2/10 9/3 10/4 14/12 14/12 30/11 55/19 56/25 64/11 67/7 69/20 81/11 82/23 82/25
experiences [1] 2/18
expert [4] 66/21 66/21 69/13 70/22
expertise [2] 66/24 67/11
explain [3] 54/5 71/11 77/12
explained [2] 67/1 77/11
explanation [1] 58/10
express [2] 42/11 56/6
expressing [1] 55/7
extent [4] 5/2 6/1 23/12 46/4
extinguished [1] 59/10
extraordinary [1] 58/21
extremely [4] 47/1 77/9 77/11 83/17
eyes [1] 18/23

F

facilitate [1] 30/25
facilitating [1] 33/24
fact [6] 11/11 57/22 62/23 65/5 73/19 82/22
factors [1] 73/25
facts [1] 74/12
fade [1] 30/17
failings [3] 7/7 15/17 15/17
failure [1] 16/21
fait [1] 60/6
fall [1] 77/19
familiar [1] 57/1
families [88]
families' [1] 14/12
family [27] 3/13 3/22 4/15 4/19 6/8 6/19 14/22 15/7 18/17 32/19 34/12 42/14 50/7 50/16 50/19 50/21 55/4 55/15 56/1 58/10 64/9 75/19 79/15 80/12 83/6 83/8 83/12
family's [1] 61/3
famous [1] 69/14
far [3] 1/11 16/9 48/12
farce [1] 60/3
fate [1] 34/25
father [8] 2/17 3/3 5/21 6/7 7/1 8/5 11/2 73/20
father's [1] 14/10
February [3] 24/4 34/5 37/4
February 2026 [2] 24/4 37/4
feedback [1] 34/14
feel [3] 5/18 5/20 5/24
feeling [1] 60/4
feelings [1] 54/23
felt [6] 4/22 4/25 5/22 23/17 35/4 54/6
few [5] 1/9 17/7 37/13 49/17 65/9
figure [1] 26/21
figures [3] 24/8 26/14 74/7
film [10] 1/18 2/16 2/17 2/25 7/5 9/21 14/20 69/1 69/2 69/4
films [6] 1/22 1/25 2/2 2/9 2/18 56/20
finally [3] 4/24 74/18 83/15
find [9] 10/6 10/8 10/16 11/21 11/22 28/23 28/25 43/16 44/10
finding [1] 28/21
fine [1] 52/14
finish [1] 83/22
Fiona [1] 55/2
first [5] 4/11 16/8 24/2 54/25 57/7
five [1] 51/1
fixed [1] 42/9
FLACSS [1] 32/20
FLOs [1] 55/25
flow [2] 45/10 45/16
fluid [1] 52/2
fluidity [1] 73/5
focus [6] 42/9 45/10 45/15 48/6 48/8 75/7
focused [1] 22/11
FOI [1] 46/21
follow [3] 43/14 76/9 76/25
follow-up [1] 76/25
followed [1] 1/25
following [3] 6/25 51/24 84/2
follows [1] 74/5
forced [1] 82/17
forensic [10] 21/2 21/11 21/13 21/17 21/24 22/2 22/5 22/10 28/17 69/13
form [2] 15/12 18/7
format [1] 17/21
formulation [1] 65/22
forthcoming [1] 27/25
forties [1] 28/7
forward [3] 33/6 33/9 69/22
found [12] 2/11 3/9 4/13 4/13 6/11 9/21 10/8 10/11 11/4 20/14 21/24 55/13
founded [1] 55/16
four [6] 3/14 7/16 10/14 10/22 11/11 69/15
free [1] 3/19
Freedom [3] 13/20 29/13 46/21
friends [2] 22/16 50/2
frightening [1] 29/4
front [1] 79/12
frustrated [1] 35/13
full [11] 34/12 35/9 35/20 39/6 39/11 52/11 52/16 63/14 75/22 76/17 76/20
fullest [1] 73/10
fundamental [1] 76/6
funded [1] 29/1
funding [2] 47/16 47/20
funny [3] 5/6 15/20 15/21
future [5] 27/21 33/10 66/2 68/14 76/10

G

gap [2] 9/8 40/18
gathering [1] 81/13
gave [2] 18/14 57/15
GDPR [1] 35/22
general [7] 25/21 29/9 42/14 45/14 46/7 67/7 82/2
generally [14] 5/24 18/5 21/21 21/24 38/14 42/8 45/15 53/13 64/11 67/4 68/21 73/18 74/15 83/6
generate [1] 47/1
generational [1] 8/15
genocide [1] 1/24
George [1] 3/22
Germany [1] 2/16
get [23] 2/12 4/17 6/9 6/16 6/21 6/22 7/25 9/16 14/14 15/8 20/12 20/18 27/21 30/17 31/5 58/25 60/18 63/16 63/18 65/1 74/15 78/15 80/10

G

getting [5] 26/1 30/5 45/11 45/16 49/9
give [8] 3/23 36/25 37/3 40/22 45/12 62/18 74/12 80/16
given [8] 6/24 9/20 18/2 44/13 56/21 60/9 62/23 73/1
gives [1] 15/14
giving [1] 53/18
global [1] 26/21
GMC [2] 52/25 52/25
go [25] 1/10 17/22 18/20 20/11 20/18 26/25 38/21 46/14 47/10 53/25 54/8 54/12 54/15 55/11 55/24 57/3 57/7 57/10 58/16 58/17 58/18 60/17 63/5 71/20 82/3
goes [5] 15/1 24/19 44/18 47/17 47/18
going [24] 1/9 4/11 6/11 6/21 17/22 31/16 33/15 35/6 37/19 42/23 43/4 43/5 52/7 52/8 57/2 57/3 59/14 60/7 63/25 65/7 66/1 66/7 80/25 83/3
Golds [2] 58/13 58/14
gone [5] 5/17 5/19 36/14 50/20 79/25
good [9] 9/21 16/12 16/13 21/24 21/25 38/9 68/15 71/16 75/19
gosh [1] 5/10
got [7] 6/21 10/4 22/7 27/24 28/4 56/14 59/23
grandchildren [1] 8/7
grandmother [1] 28/8
graphs [1] 26/15
grave [1] 4/25
gravely [1] 6/19
gravity [1] 5/4
great [3] 44/15 71/18 81/13
greater [2] 19/19 37/25
greatly [2] 2/9 2/20
grief [2] 8/11 8/12
grieving [1] 61/16
grounds [1] 41/12
group [7] 17/3 17/6 17/8 32/10 35/19 40/22 83/16
Groups [1] 44/11
guarantees [1] 33/7
guidance [7] 32/5 35/19 36/21 36/22 36/25 42/5 73/16
guide [1] 82/6
guilty [1] 31/7

H

had [81] 1/21 2/3 2/4 2/6 2/9 3/10 3/10 3/11 3/13 3/16 4/1 4/6 4/14 4/15 5/3 5/18 6/8 8/6 8/6 8/18 8/24 8/25 9/3 9/11 9/13 10/9 10/13 10/16 10/19 10/22 11/10 11/12 13/5 14/21 16/18 20/11 20/15 25/13 29/5 32/1 32/7 32/14 32/15 32/21 33/22 35/16 37/13 37/13 39/21 44/11 45/1 45/5 46/20 50/1 50/2 50/5 50/15 50/15 50/18 51/8 52/5 52/15 56/21 56/22 56/23 56/24 58/9 59/3 59/3 59/5 60/3 60/4 60/11 62/10 62/11 62/13 70/7 72/1 73/20 82/22 82/25
hadn't [3] 10/19 10/21 39/17
Hale [1] 36/2
half [3] 20/7 49/20 66/7
hand [1] 3/8
happen [14] 18/18 18/25 22/16 23/15 23/21 24/15 29/16 33/16 33/25 50/1 76/19 77/18 82/9 82/15
happened [28] 2/13 3/3 4/1 5/7 5/21 8/18 9/13 10/9 11/21 14/17 15/6 16/14 16/19 30/22 32/8 35/17 35/17 38/8 38/9 38/11 39/18 39/19 46/20 58/24 64/7 65/25 83/4 83/11
happening [2] 10/10 48/9
happens [1] 15/24
happy [2] 55/14 59/6
hard [3] 14/14 14/14 15/8
harm [7] 41/20 41/21 41/22 72/8 72/8 72/22 73/2
has [39] 4/21 6/19 6/24 13/4 14/17 15/18 16/14 18/22 25/21 25/23 28/2 34/12 35/8 35/15 35/25 36/2 36/4 36/5 36/13 36/14 36/23 38/8 38/9 38/19 41/23 55/13 56/8 57/17 58/14 63/10 63/11 63/14 64/9 65/25 65/25 68/15 70/13 74/3 82/1
hasn't [2] 12/9 82/25
hate [2] 15/1 22/7
have [128]
haven't [3] 12/16 16/15 60/12
having [8] 5/9 29/24 43/19 55/19 64/4 64/17 73/7 82/25
he [41] 3/5 3/7 3/11 3/16 3/18 3/20 3/21 3/24 5/6 5/8 8/6 8/6 8/7 20/6 20/8 27/2 28/23 28/25 36/16 39/13 51/18 51/21 52/7 52/8 52/12 52/18 52/18 52/23 52/23 54/20 55/6 57/21 58/6 58/7 58/8 58/22 61/24 62/18 62/22 64/21 83/13
he'd [3] 3/6 52/7 52/13
he's [7] 6/15 6/15 51/18 52/14 54/16 55/6 64/20
Head [1] 16/1
headline [1] 26/14
health [74] 3/11 3/15 4/8 4/8 4/15 6/7 6/8 6/22 9/15 9/24 10/12 11/4 11/20 12/7 13/18 14/3 17/3 17/9 17/25 22/15 23/24 24/6 24/21 25/7 25/15 25/24 27/12 28/1 28/3 28/9 28/12 28/16 29/10 31/1 31/4 31/5 38/20 40/1 40/13 40/14 40/18 40/24 42/5 42/17 45/18 45/21 46/11 48/11 50/6 50/12 50/15 50/24 51/5 51/12 51/15 52/10 52/17 58/20 62/24 65/3 67/14 68/13 68/20 72/1 72/4 72/10 72/17 72/22 73/7 74/5 75/5 75/22 75/24 76/6
health-related [8] 10/12 11/20 12/7 22/15 24/6 25/24 62/24 67/14
Healthcare [1] 32/2
hear [7] 5/11 5/12 16/13 23/10 63/23 63/24 75/14
heard [7] 22/15 41/23 43/10 43/22 60/16 64/11 65/10
hearing [2] 63/15 84/2
hearings [3] 18/21 19/4 38/16
heart [1] 58/2
held [1] 37/10
help [8] 14/16 14/18 35/16 50/12 50/18 61/3 61/6 82/2
helpful [10] 35/5 63/17 64/6 67/12 77/9 77/11 82/10 83/2 83/7 83/18
Hendy [24] 1/4 1/5 1/7 1/13 16/24 17/2 20/2 31/18 31/22 55/5 57/13 64/2 65/4 66/14 67/5 70/16 70/20 71/16 75/11 75/14 80/9 80/15 81/10 85/3
Hendy's [1] 56/8
her [2] 32/21 54/3
here [3] 10/1 16/24 39/20
hierarchy [2] 16/7 16/10
high [1] 44/24
higher [1] 73/3
highering [1] 72/11
highlighted [1] 7/8
him [7] 3/6 3/7 3/10 3/16 3/18 51/22 54/24
hinders [1] 35/11
his [22] 3/4 3/8 3/13 3/14 3/17 3/23 4/1 6/8 6/8 6/14 28/7 28/24 29/6 36/19 51/14 51/17 51/18 51/20 52/19 54/17 83/13 83/14
historic [2] 79/8 79/9
history [8] 3/10 3/12 42/4 52/5 52/7 62/20 65/15 75/3
hit [1] 5/15
HMCP0000311 [1] 55/24
HMCPSI [3] 58/25 59/2 59/4
holding [1] 3/8
holes [1] 35/20
home [1] 44/15
homicide [20] 4/7 5/5 11/20 12/11 12/25 14/3 21/22 24/8 25/21 25/23 26/9 26/16 27/3 29/10 30/4 51/3 66/16 68/12 74/20 74/23
homicides [15] 10/13 13/19 13/23 22/15 24/6 24/9 24/11 25/24 26/22 27/3 50/25 62/24 67/14 74/25 75/4
honest [1] 46/5
hope [1] 40/9
hoped [1] 33/13
horrible [2] 50/21 50/21
Horseferry [1] 3/1
hospital [22] 3/2 17/24 18/2 19/7 41/18 44/21 45/17 48/24 59/13 59/14 64/10 64/14 64/16 64/17 64/21 65/2 72/6 74/13 74/15 77/24 78/7 78/14
hospitals [1] 44/16
hostels [1] 45/4
hour [1] 66/7
how [38] 2/21 4/10 4/16 4/25 6/16 6/20 8/13 8/14 8/17 9/11 9/24 10/5 10/8 12/8 14/23 14/23 15/5 21/5 26/10 27/17 31/22 36/1 36/5 37/2 37/15 37/18 37/21 41/10 42/11 42/15 53/9 61/7 68/16 77/3 77/4 79/1 79/3 83/10
however [2] 55/15 56/5
hub [1] 43/1
hubs [2] 42/23 43/4
huge [2] 22/9 25/14
Hull [1] 7/19
Hundred [2] 8/21 83/16
hybrid [2] 64/11 64/24

I

I agree [1] 73/11
I am [1] 66/21
I ask [1] 71/16
I be [1] 4/10
I call [1] 1/4
I can [1] 1/12
I can't [2] 17/13 61/7
I contacted [1] 9/1
I couldn't [1] 2/21
I did [7] 2/16 5/24 9/10 41/1 41/2 46/21 66/3
I didn't [3] 9/12 33/19 33/22
I don't [23] 5/2 5/4 5/10 15/12 15/13 17/18 17/22 21/20 25/4 38/18 41/1 41/1 43/4 48/14 48/15 57/2 59/14 66/4 71/5 76/14 76/15 78/4 78/5
I encourage [1] 30/14
I felt [1] 35/4
I found [6] 2/11 4/13 4/13 6/11 10/8 21/24
I gave [2] 18/14 57/15
I get [3] 6/16 6/21 27/21
I had [5] 1/21 2/9 45/1 56/23 60/4

I

I have [4] 41/14 50/22 56/24 65/6
I haven't [1] 60/12
I just [4] 56/23 80/8 80/16 83/15
I kept [1] 47/7
I knew [1] 32/10
I know [20] 13/18 13/21 22/4 22/4 26/4 34/23 43/2 43/9 47/10 49/5 49/16 51/24 61/13 62/7 69/1 69/20 70/2 72/19 82/10 82/23
I let [2] 33/16 33/16
I live [1] 5/8
I loved [1] 5/6
I made [1] 69/1
I may [1] 70/20
I mean [13] 7/22 8/16 14/20 21/15 24/5 32/1 47/17 49/5 63/22 65/10 71/4 78/4 83/5
I must [1] 21/20
I needed [2] 23/17 23/17
I often [1] 25/15
I only [1] 17/9
I personally [1] 55/22
I raised [1] 58/24
I rang [1] 4/8
I relied [1] 5/25
I remember [4] 5/9 5/9 34/20 41/4
I said [8] 6/12 32/18 49/7 57/14 59/5 59/5 79/5 83/10
I sat [2] 32/19 35/18
I saw [2] 7/17 35/19
I say [3] 24/12 27/2 65/23
I see [4] 40/4 45/21 46/22 68/2
I should [2] 7/22 35/3
I sit [1] 76/25
I soon [2] 4/5 6/2
I speak [1] 21/7
I spoke [1] 32/9
I start [1] 71/17
I started [1] 10/11
I support [1] 82/22
I talk [1] 21/23
I think [69] 5/3 8/12 9/4 10/14 11/25 12/10 13/22 15/4 15/16 20/8 21/8 21/15 22/17 23/11 24/3 24/9 26/13 26/13 31/24 33/17 33/18 36/2 36/24 39/12 39/13 39/15 40/12 41/23 43/22 45/18 46/5 46/20 47/9 47/17 49/4 50/13 53/14 58/4 58/9 58/11 63/22 64/14 65/10 65/23 66/20 67/12 67/14 68/22 68/22 69/6 69/9 69/17 69/24 70/8 70/10 70/12 70/24 73/13 73/18 79/7 79/20 79/20 82/7 82/20 82/21 82/25 83/2 83/5 83/22
I thought [11] 5/10 6/15 9/8 9/20 32/23 36/9 47/3 47/6 57/5 60/14 62/10
I took [1] 7/17
I tried [1] 30/24
I try [5] 27/20 27/20 27/23 28/10 30/24
I understand [4] 36/22 41/19 64/20 72/6
I understood [2] 35/24 62/17
I very [1] 83/12
I want [2] 11/10 54/11
I wanted [6] 9/13 10/8 11/9 11/21 11/22 23/13
I was [21] 1/20 1/23 3/7 4/9 15/3 17/17 21/11 23/11 29/3 31/25 32/9 33/15 34/21 35/2 35/13 56/19 57/1 57/4 57/11 57/14 69/11
I was -- you [1] 5/7
I was sat [1] 34/22
I wasn't [1] 35/2
I will [2] 81/3 81/7
I would [3] 42/13 55/14 68/18
I wrote [3] 32/11 33/3 46/21
I'd [14] 1/25 1/25 6/13 9/21 10/11 31/24 31/25 32/21 56/18 56/19 59/5 60/16 70/10 82/16
I'm [22] 5/24 8/2 13/17 15/2 21/8 25/3 42/22 54/9 54/9 56/25 59/6 59/22 61/7 63/25 69/19 69/19 71/4 71/4 71/17 77/2 77/9 80/23
I've [28] 6/21 15/23 27/24 28/4 37/12 37/13 47/9 47/10 50/1 50/2 50/15 50/15 50/18 51/8 51/13 51/23 51/24 53/16 55/9 57/16 63/16 65/12 67/14 68/6 70/11 77/16 79/10 82/22
ICBs [1] 47/9
ideas [1] 79/1
identification [1] 38/12
identified [1] 73/24
identify [1] 47/14
ie [1] 48/2
if [75] 1/13 7/24 11/10 13/22 14/1 15/16 17/12 17/22 18/17 18/23 19/1 19/1 24/12 24/12 24/13 26/24 28/2 28/6 28/6 28/13 28/14 30/4 30/18 32/6 32/23 32/25 33/5 34/7 38/19 38/21 39/17 40/6 42/11 42/25 44/17 45/1 45/5 46/3 46/14 47/23 48/21 49/2 49/6 49/21 50/9 52/12 54/8 54/12 54/15 55/4 55/11 55/24 56/22 57/2 57/10 57/19 59/14 60/17 62/18 62/20 63/14 64/25 65/8 66/1 66/5 70/20 73/13 75/14 79/21 80/3 80/10 80/18 80/23 81/5 82/6
Ifti [1] 33/18
ignored [1] 36/22
ignores [1] 36/23
ill [7] 19/22 20/7 35/11 42/19 42/21 64/19 64/21
ill-advised [1] 35/11
illegitimate [1] 18/4
illness [13] 2/2 2/19 3/12 7/23 9/18 22/20 43/6 46/19 47/20 60/11 63/2 68/25 79/23
illnesses [2] 78/10 78/13
imagined [1] 25/14
imbalance [2] 4/18 4/21
immediately [1] 65/17
impact [6] 8/4 8/5 8/15 14/9 22/1 59/25
impacted [1] 68/21
impacting [1] 53/19
impaired [8] 58/3 58/7 58/11 58/15 58/23 59/8 80/21 81/3
impairs [1] 57/24
impediment [1] 61/8
implement [1] 16/21
implemented [1] 67/20
importance [2] 15/10 75/20
important [10] 14/16 14/18 25/25 25/25 34/19 54/10 60/23 61/2 68/22 73/4
impression [2] 23/25 60/8
improve [1] 76/18
improved [1] 68/17
improvement [2] 35/12 68/18
inaccurate [1] 57/6
inappropriate [2] 61/13 61/18
inappropriately [1] 2/5
Inaudible [1] 80/7
incident [7] 3/14 8/8 28/12 38/9 51/6 52/22 75/8
incidents [9] 11/14 24/22 38/4 73/6 74/4 75/4 75/6 76/10 77/18
include [2] 77/14 78/21
included [1] 26/10
incorrect [1] 60/10
increase [2] 26/5 78/9
increased [1] 25/23
increases [1] 80/1
incredibly [1] 2/12
indeed [3] 38/3 54/16 56/11
independent [13] 9/25 13/2 13/6 19/11 32/10 35/9 36/15 39/1 68/4 68/7 68/11 75/21 82/3
indicating [1] 44/19
induced [1] 62/3
industrial [1] 3/17
influence [2] 9/16 69/4
information [47] 2/12 6/10 6/16 6/20 9/23 10/6 13/20 14/16 15/8 19/3 20/16 20/18 26/22 29/13 29/17 29/19 29/21 29/24 30/4 30/5 36/9 36/10 36/18 37/2 46/22 47/1 48/18 51/5 51/9 51/12 51/16 51/23 52/2 52/11 52/16 52/24 53/18 60/9 61/17 61/18 63/11 65/12 65/14 65/16 73/6 73/10 81/14
informed [2] 5/13 48/17
initial [2] 55/7 59/3
initially [3] 11/21 38/24 56/2
injunct [1] 69/2
injuries [2] 75/6 75/9
injuring [1] 52/20
inquests [1] 68/9
inquiries [2] 12/8 68/14
Inquiry [30] 1/8 10/14 10/17 11/1 11/12 12/10 12/12 16/17 19/17 22/18 26/9 27/1 28/24 37/25 38/1 41/23 42/2 51/24 57/17 59/6 66/4 66/15 66/18 67/15 67/23 68/5 73/19 73/23 81/5 82/8
insane [1] 64/17
insight [1] 42/24
inspire [3] 53/2 53/5 53/6
instance [1] 54/25
institutionalising [2] 44/20 44/21
instruct [1] 81/4
insurance [1] 2/5
Integrated [1] 46/17
Intensive [1] 45/3
intention [1] 55/15
interest [3] 35/23 35/25 38/5
interested [3] 18/10 36/18 77/9
interests [2] 36/7 72/16
internal [6] 6/11 6/12 13/1 13/3 29/11 30/1
International [2] 21/2 21/7
interrogated [1] 69/11
intervention [2] 39/5 39/9
interviewed [1] 14/21
into [14] 3/1 10/11 11/2 11/20 12/21 12/24 24/20 26/9 28/24 40/17 42/24 47/18 71/5 82/18
introduce [1] 57/8
introduced [1] 9/25
invasive [1] 62/19
inverse [1] 77/23
investigate [1] 75/8
investigation [29] 4/7 4/10 4/12 6/12 6/12 6/23 12/24 13/1 13/2 13/7 16/20 29/11 30/7 30/13 30/22 31/2 32/3 32/7 33/2 33/7 34/2 36/15 39/1 75/1 77/14 77/16 83/8 83/9 83/14
investigations [17] 10/1 10/22 13/3 16/2 16/21 22/24 30/1 30/20 31/15 32/10 35/9 67/15 68/5 68/12 68/13 75/21 75/23
investigative [4] 1/18 1/20 1/22 2/10
investigator [1] 10/1
invited [3] 21/1 57/8 61/14

I

involve [1] 76/5
involved [8] 3/21 4/10 34/17 49/1 51/3 54/5 54/6 54/13
involvement [2] 17/5 22/2
involves [1] 74/4
Ireland [1] 70/3
IRG [1] 33/24
is [164]
is all [1] 38/16
isn't [7] 13/15 29/19 30/6 34/19 66/16 72/9 78/25
issue [3] 43/23 51/17 68/23
issues [2] 35/10 65/18
it [153]
It'll [1] 57/12
it's [58] 1/10 1/13 5/16 8/1 12/2 14/14 14/14 15/6 15/24 16/12 24/9 24/17 28/14 31/11 34/18 37/4 38/11 38/22 43/5 43/24 44/22 46/25 47/11 47/17 49/7 53/12 53/14 53/15 53/16 59/10 60/5 60/23 61/13 61/17 63/17 63/19 63/22 64/3 64/4 65/17 65/24 65/24 68/20 68/22 72/9 72/11 72/20 73/4 75/10 77/4 78/5 79/20 79/20 79/25 80/15 81/6 82/23 83/17
itself [1] 41/12

J

January [2] 34/6 47/8
January 2025 [1] 34/6
Jayne [1] 9/1
jeopardise [1] 56/5
joint [1] 55/4
Jonathan [1] 8/25
Jonathan's [1] 9/1
journal [2] 22/7 25/19
journalist [3] 1/18 1/20 2/10
journey [1] 21/9
judge [4] 20/13 36/17 36/20 68/9
judgement [1] 19/13
judges [1] 18/9
judicial [5] 18/7 20/12 20/14 20/18 67/12
JULIAN [3] 1/5 54/11 85/3
July [1] 34/4
June [1] 58/3
just [38] 6/15 6/16 6/25 8/8 8/11 9/12 12/12 20/17 24/2 34/1 40/19 45/2 45/22 46/9 51/1 51/19 56/23 57/11 63/25 65/21 67/6 70/20 70/20 71/20 73/13 74/18 75/4 75/15 79/11 80/8 80/15 80/16 80/23 81/10 81/15 81/22 83/4 83/15
justice [13] 9/15 15/12 15/14 15/15 18/22 19/14 19/24 22/3 23/24 30/19 50/24 71/9 74/8

K

Kate [3] 31/23 32/20 33/3
Kate Meynell [3] 31/23 32/20 33/3
KC [3] 54/24 57/20 71/23
keep [11] 5/18 6/1 8/11 11/5 22/13 29/5 46/6 46/12 49/5 49/5 68/1
keeping [3] 7/14 49/12 49/12
keeps [2] 49/14 52/2
kept [6] 10/19 10/21 44/14 47/7 50/7 52/8
Kessie [1] 55/13
key [6] 21/5 23/1 23/3 23/4 30/6 79/7
Khalil [1] 60/13
Khalil's [1] 57/20
kill [3] 50/20 51/14 52/8
killed [24] 2/11 2/13 3/20 4/6 5/8 6/15 8/23 8/25 14/21 20/5 20/6 20/19 23/11 23/14 26/24 27/2 29/5 35/1 35/15 35/25 36/1 51/22 70/12 70/13
killing [1] 52/20
killings [3] 12/7 23/25 75/21
kills [1] 28/7
kin [1] 65/16
kind [2] 5/6 5/20
King's [2] 57/20 60/14
Kingdom [2] 44/3 70/5
knew [6] 32/2 32/10 51/15 51/21 56/19 82/16
know [160]
knowing [3] 36/1 41/9 79/6
knowledge [3] 14/13 36/13 69/21
known [10] 6/7 12/19 28/15 28/15 32/1 38/19 51/8 51/10 51/13 63/10
knows [1] 43/8
Kumar [1] 62/18
Kumars [3] 31/25 54/18 55/3
Kyle [1] 20/5
Kyle Maher [1] 20/5
Kylie [1] 3/24

L

lack [8] 15/18 16/20 19/15 29/4 37/20 44/13 44/16 48/6
Lady [1] 36/2
Langdale [4] 1/3 1/6 71/23 85/4
large [1] 47/11
largely [1] 42/18
last [4] 6/22 21/8 24/9 71/25
late [2] 3/5 52/12
later [5] 3/8 4/13 20/8 22/2 52/18
law [8] 35/21 54/5 57/1 66/16 66/17 67/5 72/10 82/9
lawful [1] 19/21
lawfully [1] 19/2
lawyers [2] 37/3 54/4
lax [1] 29/7
lead [3] 38/12 46/4 71/22
leads [1] 76/9
learn [2] 30/6 35/16
learned [3] 6/6 11/10 73/5
learning [12] 11/6 11/7 11/11 11/13 15/19 15/20 16/3 16/20 23/20 35/11 38/6 68/3
learning's [1] 16/19
learnt [2] 16/15 68/2
least [13] 10/12 31/2 40/2 40/2 40/8 40/14 40/19 40/22 41/23 55/6 61/11 78/6 82/14
leave [2] 69/13 71/1
leaving [1] 52/19
Leeds [1] 5/8
left [1] 8/18
legal [7] 21/14 21/16 35/19 39/2 39/7 61/8 71/5
legitimate [1] 37/1
Leigh [1] 55/21
lengthy [1] 61/18
less [1] 44/4
lessons [2] 11/8 30/6
let [3] 21/9 33/16 33/16
let's [4] 32/24 64/2 66/6 67/3
letter [2] 31/18 33/2
level [2] 17/1 34/2
level 2 [1] 34/2
Liaison [3] 32/19 83/6 83/13
life [2] 23/12 65/1
Light [1] 39/14
like [23] 3/24 6/13 14/11 16/13 18/24 20/3 21/9 29/19 39/14 41/13 43/12 43/20 44/19 45/9 53/22 68/14 68/18 69/14 79/5 79/21 82/6 82/23 83/10
likelihood [1] 73/1
likely [5] 28/1 28/4 28/8 47/1 82/15
limited [4] 22/11 31/10 41/6 83/14
line [2] 77/5 77/6
link [1] 55/13
list [1] 16/24
listen [1] 23/7
listened [1] 17/18
listening [2] 7/13 10/24
little [2] 10/8 47/20
live [1] 5/8
lived [4] 8/14 20/10 20/20 82/23
lives [1] 8/4
load [1] 52/19
lobotomies [1] 2/6
local [4] 3/11 4/7 4/8 8/7
location [1] 20/9
London [3] 26/4 58/17 58/17
long [9] 3/10 15/1 33/20 33/22 52/5 52/7 65/13 68/24 81/1
longitudinal [1] 78/25
look [11] 3/24 18/17 31/17 35/4 49/21 53/19 61/21 64/20 73/13 74/20 80/18
looked [6] 20/12 36/5 43/16 69/24 78/19 80/23
looking [8] 11/7 17/8 18/4 18/5 69/21 70/1 74/4 82/1
looks [3] 18/17 28/1 68/11
losing [1] 5/5
loss [1] 71/18
lost [2] 30/17 36/16
lot [28] 6/2 8/19 15/4 16/11 19/12 21/17 25/3 31/6 31/6 39/23 43/2 45/3 47/17 47/18 52/1 61/17 64/19 64/23 66/22 67/15 67/16 68/15 68/17 69/7 69/8 69/20 74/9 81/21
lots [7] 15/23 50/15 58/4 58/6 59/1 69/5 79/10
loved [4] 5/6 8/13 20/19 50/17
lower [1] 74/7

M

made [15] 1/25 2/25 7/5 19/21 29/13 41/10 46/17 46/17 52/7 55/20 67/18 67/23 67/23 69/1 76/2
magic [1] 45/1
Magistrates' [1] 3/1
Maher [4] 18/14 19/13 20/5 20/8
Maher's [1] 20/2
mail [1] 22/7
main [4] 34/14 40/1 41/7 57/17
maintain [2] 27/24 46/2
Majid [1] 33/18
make [19] 1/9 3/23 7/3 9/14 9/17 19/17 37/25 41/17 55/16 56/15 59/6 64/7 67/8 67/16 68/5 72/4 73/15 75/15 75/23
maker [1] 1/18
making [6] 1/21 2/18 23/14 42/3 56/20 67/17
man [12] 2/13 3/6 3/10 3/25 5/7 5/11 20/7 28/6 28/7 34/25 51/14 52/5
managed [3] 6/19 9/11 40/9
management [1] 65/24
managing [2] 7/12 11/24
manslaughter [1] 31/7
many [4] 12/8 23/23 45/21 62/23
March [1] 21/3
married [1] 8/5
Martha's [2] 50/10 50/13
massive [2] 8/4 8/5
matter [8] 39/13 47/4 60/6 63/12 63/19 65/5 66/17 69/18
matters [2] 38/4 59/23
may [15] 1/1 1/4 13/4 18/13 28/1 38/9 43/12 50/14 54/17 54/20 70/20 72/22 74/7 78/12 80/24
maybe [2] 16/9 26/7

M

me [20] 2/9 4/11 4/16 8/17 9/3 10/18 11/13 13/22 16/7 17/20 23/16 28/23 32/14 33/24 34/23 47/19 56/22 67/5 81/4 83/10
mean [17] 7/22 8/16 10/19 14/20 21/15 24/5 26/2 32/1 47/17 49/5 63/14 63/22 65/10 70/10 71/4 78/4 83/5
means [2] 44/13 78/8
meant [4] 58/22 62/16 70/21 71/3
mechanism [3] 68/4 68/7 69/6
media [1] 69/5
medical [8] 4/17 25/9 30/2 34/14 49/9 50/6 66/25 71/8
medicated [1] 49/9
medication [6] 7/13 49/4 49/13 49/14 49/19 65/16
meet [3] 34/13 42/23 43/5
meeting [29] 4/17 34/11 34/21 35/2 41/4 41/13 41/14 53/23 53/23 54/4 54/7 54/24 55/4 55/17 56/4 56/9 57/3 57/4 57/5 59/3 59/4 59/20 59/24 60/8 80/11 81/1 81/17 81/18 81/19
meetings [3] 15/22 17/10 54/10
member [3] 17/1 32/9 50/7
members [2] 50/16 50/20
memories [1] 30/17
memory [2] 13/22 21/12
mental [83] 2/2 2/19 3/11 3/12 3/15 4/8 4/8 4/15 6/7 6/22 7/23 9/18 10/12 11/4 11/20 12/7 13/18 14/2 17/3 17/9 17/25 22/15 22/20 23/24 24/6 24/21 25/15 25/22 25/24 27/12 28/1 28/3 28/9 28/12 28/16 29/9 31/1 31/3 31/5 38/20 39/25 40/13 40/14 40/18 40/24 42/5 42/17 43/6 45/18 45/21 46/11 46/19 47/20 48/11 50/11 50/14 50/24 51/5 51/12 51/15 52/10 52/17 57/23 58/20 62/23 63/2 64/19 65/2 67/14 68/13 68/20 68/25 72/1 72/4 72/10 73/7 74/4 75/5 75/22 76/6 78/10 78/13 79/23
mentally [6] 19/22 20/7 27/13 28/6 51/10 64/21
mention [2] 15/10 20/1
mentioned [6] 31/14 35/1 47/18 53/7 77/21 82/7
mentioning [1] 62/4
messages [2] 21/5 23/4
met [4] 3/6 4/3 25/13 40/24
methodology [1] 27/14
Meynell [3] 31/23 32/20 33/3
Michael [3] 36/16 36/16 36/17
microphone [2] 75/16 80/7
middle [1] 35/1
Midlands [2] 12/19 12/20
might [13] 13/8 13/21 37/22 38/12 46/4 47/5 47/14 63/5 64/8 76/7 76/17 77/3 79/4
mind [4] 28/4 35/20 38/7 60/24
Minogue [1] 3/24
minute [1] 52/17
minutes [2] 33/23 80/11
miraculously [1] 27/15
miss [2] 26/17 26/18
missed [2] 39/22 53/3
misses [1] 57/21
missing [2] 29/18 57/20
Moloney [3] 70/18 70/19 85/5
moment [1] 65/7
money [3] 2/5 47/17 47/18
monitor [3] 27/20 27/20 28/11
monitored [1] 40/10
monitoring [3] 7/13 49/6 68/10
month [3] 4/16 33/17 52/18
months [1] 77/5
moral [4] 21/14 21/15 21/19 83/12
morbidities [1] 78/11
morbidity [1] 44/25
more [21] 1/19 4/19 8/2 19/12 25/25 25/25 35/14 40/7 41/17 43/7 45/5 46/10 48/12 49/19 52/1 52/21 69/8 69/8 72/4 73/4 77/13
morning [4] 3/5 22/16 43/22 64/12
most [9] 7/22 7/23 8/1 8/16 10/5 22/15 22/18 22/19 73/10
move [3] 14/15 30/17 33/8
moving [1] 2/24
Mr [34] 1/4 1/7 1/13 16/24 17/2 20/2 31/18 31/22 54/13 55/5 55/12 56/8 57/13 57/20 59/22 60/13 64/2 65/4 66/14 67/5 70/16 70/18 70/19 70/20 71/16 75/11 75/13 75/14 75/18 80/9 80/15 81/10 85/5 85/7
Mr Hendy [22] 1/4 1/7 1/13 16/24 17/2 20/2 31/18 31/22 55/5 57/13 64/2 65/4 66/14 67/5 70/16 70/20 71/16 75/11 75/14 80/9 80/15 81/10
Mr Hendy's [1] 56/8
Mr Khalil [1] 60/13
Mr Khalil's [1] 57/20
Mr Moloney [3] 70/18 70/19 85/5
Mr Murphy [1] 55/12
Mr Murphy's [1] 54/13
Mr Straw [3] 75/13 75/18 85/7
Mr Webber [1] 59/22
Mrs [5] 20/2 20/8 56/6 56/20 59/23
Mrs Maher's [1] 20/2
Mrs Webber [2] 56/20 59/23
Mrs Webber's [1] 56/6
Ms [9] 1/3 1/6 71/14 71/15 71/23 80/6 80/8 85/4 85/6
Ms Carey [2] 80/6 80/8
Ms Cartwright [3] 71/14 71/15 85/6
Ms Langdale [4] 1/3 1/6 71/23 85/4
much [11] 6/16 6/20 19/18 55/22 68/18 71/13 75/11 78/22 80/5 81/7 83/12
multiple [1] 28/8
murder [4] 26/20 63/5 64/25 73/20
murder-suicides [1] 26/20
murdered [1] 82/17
Murphy [1] 55/12
Murphy's [1] 54/13
must [1] 21/20
Mustill [1] 64/15
my [43] 2/11 2/13 2/17 3/4 3/20 3/21 4/14 4/21 5/6 5/6 6/15 6/19 8/5 8/17 8/23 11/2 11/25 13/17 23/3 23/11 23/12 23/13 25/17 28/25 30/24 35/1 35/3 35/20 36/13 38/7 40/12 45/1 47/22 49/14 54/23 56/21 59/7 60/24 69/1 69/4 72/14 79/23 83/10

N

name [2] 18/21 38/18
named [1] 51/20
names [2] 18/9 34/16
national [8] 16/17 22/17 26/9 26/25 39/4 67/17 68/9 68/10
nationally [1] 11/23
nature [2] 57/25 73/1
necessarily [1] 76/1
necessary [1] 38/17
neck [1] 3/7
need [30] 8/2 21/10 23/10 24/18 32/6 40/8 42/6 42/14 43/7 43/10 43/11 45/2 46/5 46/10 47/14 47/15 48/11 48/13 48/20 64/8 64/22 69/8 69/9 69/10 73/16 76/16 76/16 76/17 76/19 81/23
needed [2] 23/17 23/17
needs [22] 9/9 19/11 19/12 19/23 32/23 42/7 42/9 42/23 43/5 47/21 48/9 51/25 52/1 64/21 67/13 68/3 69/6 69/7 69/11 69/24 73/17 74/9
negative [1] 69/5
neglected [1] 65/6
neighbour [2] 51/15 51/20
neighbourhood [2] 42/23 43/3
neighbours [1] 22/17
never [2] 3/6 82/16
new [4] 36/24 40/12 40/13 40/17
news [2] 5/11 16/13
next [5] 34/22 47/24 51/22 65/16 77/7
NHFT0019340 [2] 31/17 33/11
NHS [27] 13/17 13/24 15/18 16/1 30/19 30/22 32/4 32/9 32/11 32/14 32/18 32/23 33/8 33/16 33/23 34/6 35/8 36/21 36/25 38/24 43/3 46/16 46/22 48/14 75/21 77/1 81/12
NHSE [2] 34/15 34/17
night [1] 52/13
no [47] 5/22 8/11 9/6 10/21 13/2 15/1 15/2 15/19 17/7 18/15 18/19 19/10 21/20 24/18 25/1 25/3 26/21 27/7 37/8 37/19 39/19 39/21 41/1 42/22 42/24 43/22 46/25 51/18 52/14 55/19 55/22 58/13 60/6 62/2 63/16 64/17 67/1 67/16 67/17 68/2 70/10 71/4 73/11 76/1 76/8 83/5 83/11
nobody [4] 8/17 43/8 61/1 83/10
non [1] 62/19
non-invasive [1] 62/19
normal [2] 62/25 63/2
Northern [1] 70/3
not [91]
not to [1] 32/16
notable [1] 21/23
notes [2] 30/2 80/24
nothing [3] 46/20 62/14 68/1
notion [1] 41/25
Nottingham [1] 38/24
Nottinghamshire [1] 32/2
notwithstanding [1] 54/20
November [4] 1/8 33/14 53/22 80/14
now [12] 6/15 11/25 12/3 12/9 15/3 45/4 56/10 66/5 66/6 67/24 72/20 75/23
number [19] 1/25 2/1 7/5 7/24 8/1 13/13 13/21 15/22 19/4 24/10 26/3 26/17 42/20 50/2 70/11 77/1 77/24 78/21 81/12
numbers [6] 16/25 24/3 24/5 24/8 27/16 70/8

O

O'Malley [3] 31/25 54/18 55/3
O'Malley-Kumars [3] 31/25 54/18 55/3
observe [1] 18/20

O

obtain [3] 41/18 49/22 72/5
obvious [1] 78/12
obviously [9] 69/21 71/24 74/18 74/19 74/23 75/2 81/11 81/16 81/25
occupation [1] 10/2
occupational [1] 45/9
occur [3] 41/21 72/8 77/20
occurrence [1] 24/11
October [3] 7/2 31/19 31/23
October 2008 [1] 7/2
off [6] 2/23 6/4 10/10 44/19 77/17 80/7
offence [3] 18/19 27/14 74/5
offences [2] 74/14 74/23
offender [7] 4/14 6/6 6/19 6/24 7/1 7/10 64/19
offender's [3] 4/15 37/15 57/24
offenders [2] 19/22 49/18
offending [2] 74/6 75/2
offer [2] 26/14 54/20
offering [1] 54/16
Officer [2] 34/14 83/13
officers [2] 30/21 83/6
official [2] 12/13 12/21
often [9] 23/24 24/15 25/15 31/9 40/4 40/10 44/15 63/17 79/16
oh [2] 5/10 34/23
okay [7] 45/13 52/12 66/9 67/9 71/2 71/13 75/17
omission [1] 58/2
on [118]
one [41] 2/16 2/17 7/17 7/17 7/18 7/19 8/8 8/9 8/16 10/10 10/17 15/3 16/16 17/9 20/19 25/5 25/6 26/25 27/3 27/5 28/23 34/7 35/23 36/13 41/24 43/13 43/22 44/7 50/17 52/20 65/10 65/12 65/20 65/21 65/23 68/6 70/12 70/20 72/15 73/24 80/23
ones [4] 7/25 8/13 28/10 66/23
only [23] 7/9 9/2 13/24 17/9 18/7 19/3 25/12 26/16 27/4 27/15 28/25 30/18 33/6 36/13 36/17 38/25 39/3 43/13 48/1 49/15 52/15 56/2 71/3
ONS [1] 24/8
onto [2] 17/22 59/9
open [4] 19/24 46/5 63/12 63/19
opening [2] 63/18 64/5
openness [2] 19/19 37/25
opinion [2] 49/22 50/11
opportunities [2] 40/7 41/5
opportunity [2] 74/13 80/16
optimistic [1] 40/11
or [72] 7/24 9/9 9/15 10/10 11/24 13/5 13/9 14/12 16/25 17/9 17/24 18/18 19/5 21/8 21/14 26/18 27/6 27/22 27/22 28/6 28/13 29/18 29/22 30/3 30/8 30/21 37/1 40/23 41/4 41/12 42/4 43/13 43/17 43/20 45/23 46/21 49/1 49/5 49/11 49/12 58/17 60/11 61/10 62/17 63/4 63/21 64/24 65/5 65/5 65/5 65/15 65/18 68/8 71/12 72/17 72/17 72/22 72/23 73/7 73/8 73/8 73/25 77/5 77/19 79/2 79/5 79/13 79/15 79/16 81/22 81/22 83/1
order [6] 33/9 59/13 64/14 64/16 64/18 64/24
orders [10] 17/24 18/2 43/21 49/2 49/4 59/15 64/10 64/11 74/13 74/15
organisation [4] 8/23 9/6 16/3 69/3
organising [1] 23/12
original [1] 80/24
Osman [1] 51/17
other [34] 2/17 3/9 3/22 11/18 12/13 13/8 21/10 30/3 30/3 31/13 31/20 33/12 36/21 48/22 49/11 49/16 50/20 51/13 57/19 59/8 64/8 65/5 66/17 66/23 68/6 69/24 70/13 70/15 72/18 73/8 79/13 79/15 79/16 79/19
others [4] 8/4 11/24 48/3 51/11
ought [2] 72/16 73/2
our [8] 5/14 6/19 8/11 8/13 23/18 50/9 76/18 82/16
out [41] 1/16 3/4 3/5 3/15 4/13 6/11 8/9 10/8 11/2 11/21 11/22 12/14 12/15 13/5 14/9 23/13 23/18 26/17 26/18 29/8 34/3 34/24 36/6 37/21 39/10 39/22 44/14 45/11 45/13 57/18 57/22 61/24 62/12 63/3 68/16 69/10 73/7 74/24 74/25 77/19 77/19
outlier [3] 19/14 20/23 20/24
outline [2] 57/15 82/14
Outreach [5] 43/7 43/8 43/9 47/12 47/16
outside [4] 27/6 49/8 56/4 66/23
over [9] 4/16 7/7 8/5 30/21 33/17 52/8 67/24 79/9 81/12
over-zealous [1] 30/21
overriding [1] 35/25
oversight [4] 67/17 68/7 68/10 68/10
overspeaking [14] 11/8 12/5 24/17 27/19 30/3 41/9 53/10 60/1 67/21 69/17 76/22 76/24 81/24 82/4
overturned [1] 39/3
owe [1] 22/5
own [6] 3/3 8/19 16/5 45/13 72/17 83/20

P

page [43] 12/15 12/18 16/23 31/17 31/19 31/21 33/12 34/7 34/8 34/9 38/22 38/22 46/8 47/23 48/21 49/21 50/22 53/21 54/1 54/1 54/2 54/8 54/12 54/14 54/15 55/11 55/24 57/7 57/10 57/12 57/19 57/19 60/17 61/21 61/22 63/7 65/19 65/20 65/21 71/21 74/21 80/10 85/2
page 1 [7] 12/15 54/12 54/14 55/24 57/7 57/10 57/12
page 12 [2] 60/17 74/21
page 14 [2] 38/22 38/22
page 16 [1] 71/21
page 2 [6] 12/18 54/8 54/15 57/19 57/19 80/10
page 20 [1] 46/8
Page 23 [1] 47/23
page 26 [2] 33/12 49/21
page 27 [3] 31/17 31/19 50/22
page 28 [2] 31/21 63/7
page 3 [3] 54/1 54/2 55/11
page 4 [2] 53/21 54/1
page 5 [2] 61/21 61/22
page 6 [2] 34/7 34/8
page 7 [1] 16/23
pages [1] 63/8
pages 28 [1] 63/8
pandemic [1] 26/5
panel [1] 34/23
paper [3] 3/4 22/5 34/13
paragraph [26] 1/17 9/24 11/3 12/2 19/16 23/23 29/8 33/4 35/7 37/24 38/23 39/25 41/15 42/1 44/1 46/9 46/14 48/8 49/21 52/4 53/7 53/9 63/9 71/21 73/14 80/18
paragraph 101 [1] 46/14
paragraph 130 [1] 48/8
paragraph 141 [1] 49/21
Paragraph 144 [1] 52/4
Paragraph 145 [2] 53/7 53/9
paragraph 147 [1] 63/9
paragraph 19 [1] 9/24
paragraph 190 of [1] 19/16
paragraph 21 [1] 11/3
paragraph 26 [1] 12/2
paragraph 4 [1] 1/17
paragraph 41 [1] 23/23
paragraph 63 [1] 35/7
paragraph 66 [1] 38/23
paragraph 69 [1] 37/24
paragraph 70 [1] 39/25
paragraph 75 [2] 41/15 71/21
paragraph 77 [2] 42/1 73/14
paragraph 93 [1] 44/1
paragraph 99 [1] 46/9
paragraphs [2] 71/22 74/21
paragraphs 54 [1] 74/21
paranoid [2] 61/25 62/11
Parole [1] 34/25
part [6] 20/1 21/11 32/4 63/4 63/4 83/7
particularly [5] 20/20 28/7 53/17 66/22 66/24
parties [1] 18/10
party [1] 54/6
pass [3] 51/16 51/19 52/24
passed [1] 51/12
passing [1] 51/23
past [3] 9/12 29/5 65/25
patently [1] 16/19
patient [48] 4/6 4/6 4/19 12/25 13/23 15/21 15/22 15/23 16/1 16/8 22/24 28/24 28/24 29/6 29/11 32/1 32/3 32/7 35/9 35/15 35/15 35/24 36/1 36/3 36/7 36/12 36/14 36/18 39/2 40/15 41/20 42/9 42/18 43/19 45/22 48/2 48/6 48/9 49/15 61/2 72/7 72/16 72/23 72/23 73/2 74/5 74/11 79/6
patient's [2] 37/23 78/22
patients [24] 13/19 14/3 18/1 18/2 19/5 22/11 22/13 24/23 25/12 25/13 27/12 27/15 29/9 42/4 42/21 43/17 46/10 48/24 52/3 73/7 73/9 74/13 75/5 75/22
patients' [2] 42/7 65/13
pay [1] 3/4
penal [1] 64/22
Penrose [3] 44/23 77/21 77/23
people [84] 2/1 2/2 2/3 2/4 2/6 2/22 3/22 7/21 7/23 8/1 8/20 9/2 9/18 14/1 14/18 14/25 15/12 15/16 17/23 17/24 18/1 18/21 19/9 21/10 22/18 22/19 26/17 26/19 26/24

P

people... [55] 27/2 27/4 27/6 27/15 31/21 32/10 40/5 40/6 40/19 41/5 41/18 42/24 43/5 43/12 44/9 44/13 44/21 45/5 45/11 45/16 46/18 47/5 47/14 47/20 49/5 49/5 49/7 49/11 49/12 49/13 49/14 49/16 50/4 50/5 50/10 50/16 50/19 51/25 64/8 68/24 70/12 70/13 71/8 72/5 74/8 77/17 78/9 78/13 79/11 79/13 79/14 79/15 79/21 79/22 80/1
perfectly [1] 53/1
perhaps [3] 12/18 29/19 31/20
period [3] 13/23 27/6 65/8
perpetrator [2] 16/9 38/13
perpetrators [1] 26/23
person [12] 5/25 15/3 20/19 36/5 38/18 40/9 51/10 51/21 55/13 65/25 72/23 79/11
personal [1] 54/23
personally [2] 14/7 55/22
persons [1] 72/18
perspective [1] 74/19
Peter [1] 69/15
phoning [2] 52/6 52/9
physical [1] 74/1
picture [2] 11/23 26/12
place [4] 9/21 28/25 45/5 64/24
placements [1] 44/14
places [1] 45/5
plan [6] 58/16 58/21 76/2 76/3 76/8 76/16
plane [3] 24/12 24/14 24/20
planning [1] 10/23
plans [2] 7/14 76/12
played [1] 49/2
plea [2] 28/13 31/7
please [34] 1/4 1/14 1/19 10/17 12/14 13/11 16/23 17/20 31/17 33/5 33/12 34/7 34/8 38/22 38/23 39/24 46/9 46/23 47/24 49/25 50/22 53/9 53/25 54/12 55/11 55/24 56/1 57/12 60/22 61/21 63/8 65/4 71/20 74/18
pleased [1] 29/3
plenty [1] 36/10
plot [1] 44/17
plus [1] 82/12
pm [4] 1/2 66/11 66/13 84/1
point [7] 1/14 17/2 34/18 46/15 63/5 67/5 80/15
police [24] 27/23 31/1 31/3 31/14 31/15 32/16 32/24 33/1 51/5 51/8 51/16 52/6 53/24 54/17 54/22 55/17 58/20 61/15 63/3 63/5 73/8 74/1 75/7 83/6
police/CPS/counsel [1] 55/17
policies [1] 68/17
policy [5] 9/16 35/13 76/4 76/18 79/18
poor [2] 38/10 45/17
population [4] 25/21 44/18 77/25 78/9
pose [1] 48/2
position [1] 38/6
possession [1] 3/18
possibly [3] 13/10 30/14 61/9
potential [1] 66/14
potentially [8] 26/6 32/17 38/9 42/3 43/15 51/21 56/5 63/4
practical [2] 68/3 68/18
practice [7] 16/12 21/16 22/22 23/9 35/10 48/15 48/17
pragmatic [1] 33/6
pragmatically [1] 32/25
pre [1] 27/10
pre-trial [1] 27/10
predict [2] 41/20 72/7
prediction [1] 73/12
predictor [1] 74/22
predictors [1] 73/25
prejudice [4] 31/11 32/18 33/1 37/22
prejudiced [1] 31/4
prepared [2] 1/7 54/9
presence [1] 55/8
present [5] 54/2 55/5 55/6 55/17 79/12
President [1] 20/14
press [5] 10/11 11/16 27/20 39/4 62/21
pressurised [1] 64/3
presumably [1] 10/5
pretty [1] 38/7
prevent [3] 24/21 33/9 76/10
preventable [1] 52/22
prevention [4] 24/20 27/21 68/13 73/11
previous [7] 4/2 42/4 73/6 73/25 74/1 74/2 74/22
previously [4] 19/23 69/14 82/7 82/10
principle [3] 40/1 40/2 40/23
principles [1] 39/25
prior [1] 61/10
prison [9] 2/4 3/1 44/18 44/22 44/25 65/2 77/25 78/9 78/13
privacy [2] 37/11 56/3
private [1] 44/15
proactive [1] 9/14
probably [3] 15/13 17/13 65/9
problem [9] 8/19 32/13 36/8 53/14 60/23 76/3 77/5 79/18 79/20
problematic [2] 36/25 78/12
problems [19] 7/12 7/15 7/16 7/20 10/25 10/25 43/4 49/6 49/10 51/4 55/22 62/25 65/23 77/20 78/17 78/21 79/1 79/4 79/7
proceedings [3] 56/5 61/10 61/11
process [7] 18/8 30/19 38/15 40/8 54/5 74/6 74/12
processes [1] 83/1
professional [2] 5/25 50/5
professionals [1] 23/24
programme [1] 56/16
promote [1] 26/15
proper [3] 7/14 7/14 78/15
properly [4] 45/6 53/8 67/2 75/8
proportion [1] 25/23
proportionate [2] 19/21 33/6
proportionately [1] 25/25
proposal [1] 50/14
proposals [3] 41/16 42/22 72/3
prosecution [4] 53/13 54/4 63/18 64/5
Prosecutor [1] 56/8
protect [1] 48/20
protection [8] 16/5 16/11 42/8 47/25 48/12 72/18 73/18 75/10
protects [1] 49/15
proven [1] 78/5
provide [2] 44/12 55/23
providing [1] 44/16
provision [1] 14/15
provisions [1] 71/25
précis [1] 80/25
psychiatric [14] 27/9 27/10 28/14 44/2 44/17 44/17 44/24 45/3 60/19 61/5 77/24 78/8 78/11 78/14
psychiatrist [5] 22/4 28/23 34/22 34/24 41/24
psychiatrists [11] 21/13 21/18 21/25 22/3 22/5 22/10 28/17 67/10 69/7 69/9 69/13
Psychiatrists' [1] 21/2
psychiatry [2] 21/23 25/20
psychological [2] 34/3 45/8
psychosis [1] 62/3
public [38] 6/1 6/2 17/1 18/5 18/15 18/23 19/20 22/13 22/13 25/17 30/10 35/23 35/25 36/4 38/5 38/17 40/15 40/15 40/20 42/8 42/14 46/7 46/13 47/4 47/25 48/7 48/11 48/14 48/20 52/1 52/3 63/12 63/20 68/14 73/18 75/10 76/21 81/13
public's [1] 37/11
publication [4] 37/4 38/1 76/11 76/15
Publications [1] 35/18
publish [3] 38/6 39/6 47/8
published [6] 13/4 22/6 35/18 36/11 39/1 39/12
publishing [2] 35/8 75/20
punishment [1] 64/14
purpose [2] 8/22 54/3
purposes [2] 29/17 30/20
pushed [1] 39/17
pushing [1] 47/7
put [3] 8/12 26/22 78/22
putting [1] 11/15

Q

qualify [1] 13/6
quality [2] 2/15 61/6
quantities [1] 3/17
query [1] 80/8
question [8] 31/12 36/14 44/20 58/1 62/6 70/21 71/12 71/12
Questioned [10] 1/6 70/19 71/15 75/18 81/8 85/4 85/5 85/6 85/7 85/8
questionnaires [1] 83/17
questions [8] 19/8 23/7 32/6 60/17 60/21 70/15 71/16 81/10
quite [14] 6/2 9/10 17/7 35/3 37/13 39/22 41/6 47/3 56/24 58/14 65/9 66/2 66/22 81/1
quote [2] 35/20 35/21

R

racist [1] 19/1
radio [1] 5/10
raise [2] 17/21 59/2
raised [2] 58/19 58/24
raises [1] 19/8
raising [4] 3/13 17/17 50/3 50/20
rang [2] 4/8 4/15
rapidly [1] 27/11
rare [5] 23/25 24/2 24/11 24/12 24/13
rarely [1] 43/24
rate [1] 25/20
rather [10] 4/19 16/13 26/16 35/15 36/11 42/8 73/11 74/20 78/14 82/24
re [2] 44/21 69/1
re-institutionalising [1] 44/21
Re-think [1] 69/1
reached [1] 37/21
read [4] 53/25 61/15 61/19 63/19
readily [2] 10/6 15/8
real [1] 8/19
reality [1] 25/17
really [25] 2/22 2/22 5/4 6/5 9/2 9/22 14/14 14/14 14/16 14/16 14/18 16/3 16/4 23/19 30/6 30/9 35/5 43/8 44/7 47/3 50/18 52/16 67/5 74/3 82/19
reason [3] 31/10 36/17 56/2
reasonably [2] 5/24 33/15
reasons [3] 13/25 36/10 39/11
reassurance [1] 24/16
reassured [1] 24/13
recalled [1] 19/7
receive [1] 48/18

R

received [3] 2/6 2/14 21/6
recent [3] 17/6 29/9 75/21
recently [2] 51/9 52/15
recognise [3] 5/2 42/21 57/25
recognised [2] 4/24 57/23
recognising [1] 42/18
recognition [1] 22/11
recommend [1] 73/4
recommendation [8] 19/18 37/25 42/3 66/18 71/22 73/14 73/15 76/7
recommendations [14] 10/23 16/22 66/4 66/15 67/7 67/16 67/18 67/24 67/25 69/25 75/23 76/13 79/3 81/15
record [4] 16/1 29/6 63/13 63/20
records [6] 7/15 28/24 29/6 30/17 65/13 79/6
recover [3] 14/19 45/6 61/4
redact [1] 38/17
redacted [1] 37/14
refer [7] 25/19 26/6 26/8 42/16 44/1 48/21 49/21
reference [2] 20/21 64/1
referrals [1] 27/22
referred [3] 40/23 62/9 64/10
reflection [1] 70/13
reform [3] 41/17 66/17 72/3
reformed [1] 19/12
refused [2] 20/11 63/10
regard [2] 48/7 70/23
regarding [1] 61/23
regardless [1] 54/25
region [1] 13/9
regional [1] 47/11
regions [1] 12/16
regular [2] 31/3 46/10
related [12] 10/12 11/20 12/7 14/3 22/15 24/6 25/24 50/24 61/25 62/11 62/24 67/14
relates [1] 80/9
relation [4] 6/7 7/5 24/4 81/15
relationship [3] 46/3 77/24 78/3
relative [1] 25/22
relatively [1] 51/9
release [5] 17/23 18/1 19/22 20/19 36/15
released [3] 19/10 20/7 20/9
releasing [1] 46/25
relied [1] 5/25
remarkably [2] 11/4 29/7
remarks [3] 12/11 30/9 63/17
remember [10] 5/9 5/9 8/13 8/13 14/20 17/12 20/6 34/20 41/4 58/13
remind [1] 63/25
reminding [3] 42/6 66/15 73/16
repeated [1] 7/12
replicated [1] 24/21
replied [1] 46/24
report [23] 6/23 10/19 11/1 13/18 18/20 26/21 28/24 34/4 34/5 34/6 34/12 39/6 39/11 46/18 46/19 58/6 60/14 61/19 63/14 63/14 67/22 76/17 78/22
reported [4] 13/15 13/16 13/24 34/6
reporters [1] 18/19
reporting [4] 26/7 27/4 62/21 83/8
reports [36] 10/11 10/14 10/14 10/17 11/8 11/12 11/16 11/18 12/10 12/12 12/21 12/23 16/12 27/9 27/10 27/20 27/21 29/18 30/7 34/1 37/14 38/2 60/19 61/5 61/15 61/23 62/10 67/15 68/5 68/14 69/10 75/1 76/24 77/15 77/17 78/18
represent [1] 75/19
representatives [1] 34/11
represented [1] 53/16
request [3] 20/2 46/22 56/3
requested [3] 34/13 46/15 46/15
requesting [3] 34/16 53/22 54/2
requests [2] 13/20 29/13
required [1] 31/10
requirement [5] 9/25 13/2 32/4 41/19 72/6
requires [1] 72/21
research [8] 9/10 22/18 22/21 25/19 44/8 44/9 49/17 73/24
residual [5] 59/11 59/11 59/12 64/18 64/23
resistance [2] 22/9 56/11
resource [2] 28/19 28/22
resources [3] 68/20 68/21 68/22
respect [4] 23/6 23/20 43/19 51/7
respectfully [2] 19/17 37/24
response [8] 29/2 33/11 40/11 55/7 56/13 58/25 76/12 76/24
responses [3] 46/23 47/8 47/9
responsibility [14] 28/13 31/8 56/25 57/18 57/21 57/22 59/9 59/12 59/12 60/2 60/24 64/17 64/18 64/23
restricted [2] 18/1 19/5
restriction [4] 40/2 40/9 40/14 40/19
restrictions [1] 18/3
restrictive [2] 40/2 40/23
result [7] 15/24 29/11 32/4 60/12 75/5 75/6 76/7
retained [1] 59/12
review [11] 17/3 17/6 17/8 17/8 20/12 20/14 20/18 32/10 35/19 76/4 76/5
reviewed [2] 69/4 77/15
reviewers [1] 69/3
reviews [2] 12/11 68/12
revolving [2] 48/22 48/25
ridiculous [1] 56/17
right [14] 13/23 15/7 18/11 25/24 36/4 37/12 39/16 60/15 66/6 72/9 75/17 75/24 76/20 83/22
rights [6] 37/9 37/11 37/11 48/16 53/7 82/19
ripples [1] 8/9
rise [1] 44/18
risk [24] 7/12 10/23 22/19 29/24 36/12 47/24 48/1 48/2 48/2 51/5 52/1 56/4 65/11 65/14 65/16 65/23 65/24 73/10 76/4 76/18 78/17 79/7 79/9 79/9
risks [1] 48/20
Ritchie [1] 67/22
Road [1] 3/1
rocket [1] 65/24
Rogers [1] 59/4
role [3] 35/3 48/25 83/14
rose [1] 80/15
roughly [1] 17/12
round [2] 6/18 14/22
routinely [1] 13/3
Royal [3] 2/14 3/22 21/1
rule [4] 50/10 50/13 61/24 63/3
ruled [1] 62/12
run [1] 52/8
Rwanda [1] 1/23

S

safe [12] 5/18 5/18 5/20 5/24 6/1 19/21 22/14 46/7 46/12 49/5 49/14 52/3
safeguard [4] 42/6 42/14 46/12 73/17
safeguarding [2] 22/12 48/7
safeguards [1] 74/11
safety [19] 15/21 15/22 15/23 16/1 18/5 22/24 24/25 25/2 25/16 29/11 32/3 32/7 33/7 40/15 40/16 40/20 52/1 72/17 72/22
said [44] 6/6 6/12 6/13 6/23 11/12 11/13 14/22 14/23 19/14 20/4 24/14 25/10 25/13 30/8 32/14 32/18 33/14 34/23 36/2 36/17 36/20 37/15 37/16 39/12 39/13 49/7 49/20 50/1 50/9 51/18 52/14 52/25 57/5 57/14 59/5 59/5 59/7 64/9 79/5 80/9 81/1 81/6 81/22 83/10
same [6] 11/1 11/12 31/16 67/23 67/23 67/25
samples [1] 62/19
Sanders [1] 55/21
sat [4] 32/19 34/22 35/18 81/11
saw [3] 7/17 35/19 58/5
say [63] 1/14 2/18 4/9 4/16 4/22 7/22 10/17 11/3 12/2 12/21 13/11 19/16 20/21 21/20 22/1 24/12 26/20 27/2 28/18 29/18 33/4 33/21 35/7 37/6 38/8 38/11 38/23 40/8 40/23 41/15 42/1 42/12 42/13 44/6 45/20 46/2 46/9 46/22 47/25 50/16 51/2 53/4 53/7 55/25 56/18 57/10 58/7 61/22 63/9 64/20 65/7 65/23 68/7 69/12 70/10 71/4 72/1 76/3 76/17 79/14 80/1 80/24 82/22
say: [1] 32/12
say: the [1] 32/12
saying [7] 16/2 16/17 16/18 54/8 55/21 60/14 71/17
says [5] 37/2 40/14 61/8 64/15 80/21
scarred [1] 5/15
schemes [1] 2/25
schizophrenia [5] 2/3 2/22 58/8 61/25 62/11
school [1] 52/20
science [1] 65/24
Scotland [1] 70/2
screen [10] 12/14 16/23 34/7 38/22 46/8 47/23 48/21 50/23 57/12 63/7
scrutiny [3] 18/15 76/14 76/21
second [3] 49/22 50/10 80/18
secrecy [1] 41/9
Secretary [3] 39/5 39/9 39/12
Section [8] 40/13 44/9 44/12 65/2 72/12 72/12 72/18 72/19
Section 140 [2] 44/9 44/12
Section 2 [2] 72/12 72/18
Section 3 [1] 72/19
Section 47 [1] 65/2
secure [1] 78/14
see [48] 3/16 6/13 7/22 9/11 11/7 11/9 11/9 11/11 12/18 15/25 16/11 16/24 17/2 18/21 25/3 25/4 28/11 31/19 31/21 31/24 31/25 32/5 32/25 33/5 33/11 34/9 37/18 40/4 45/21 46/22 53/11 54/1 54/2 54/8 54/12 54/14 54/22 55/21 55/24 55/25 57/8 59/21 61/4 61/7 64/24 68/2 68/19 76/17
seem [18] 21/18

S

seem... [17] 22/10 24/20 44/22 44/24 45/4 45/10 45/12 48/19 48/19 56/14 56/15 77/1 78/4 78/6 78/8 79/17 80/1
seemed [5] 29/6 35/14 36/6 58/2 69/12
seems [11] 4/20 6/4 6/17 16/7 23/8 40/4 40/10 45/15 47/19 53/17 67/25
seen [18] 13/8 47/17 49/1 49/3 51/24 53/16 55/19 56/12 60/13 67/15 67/22 68/17 74/6 77/10 77/16 78/18 79/10 79/17
sees [1] 61/1
self [3] 57/25 58/22 78/22
self-control [2] 57/25 58/22
self-report [1] 78/22
send [2] 10/18 59/5
senior [1] 30/21
sense [1] 9/2
sensitively [1] 56/1
sent [1] 48/24
sentence [1] 65/1
sentencing [4] 12/11 30/9 38/16 63/16
separately [1] 26/21
September [1] 46/20
Sergeant [4] 52/12 52/14 52/15 58/5
Sergeant Beddoe's [1] 58/5
serious [28] 2/2 2/19 3/12 9/18 19/23 22/19 24/22 41/20 41/21 41/22 41/24 43/6 46/19 47/20 50/3 63/1 72/8 72/8 72/22 73/20 75/6 75/8 77/18 78/10 78/11 78/13 79/23 79/25
seriously [15] 3/19 3/25 7/20 24/19 40/6 41/17 42/20 42/24 45/22 48/12 49/8 50/7 50/19 69/8 72/5
serves [1] 13/22
service [6] 13/5 17/1 18/3 27/7 47/14 81/13
services [30] 3/11 3/15 6/1 6/2 6/8 6/8 9/8 9/15 9/17 13/5 13/8 14/2 24/21 25/16 27/5 28/16 31/1 31/4 31/5 38/20 46/12 46/18 47/19 48/11 50/12 50/15 51/6 51/12 51/15 68/21
set [9] 1/16 8/21 8/24 10/5 12/14 12/15 14/9 29/8 57/18
seven [2] 3/8 51/2
several [4] 14/6 50/15 51/3 51/8
severe [1] 44/2
sex [1] 3/23
Shall [1] 57/7
share [3] 6/13 37/2 63/11
shared [6] 29/21 29/25 30/5 34/12 61/8 73/19
sharing [2] 20/16 52/2
she [13] 14/21 14/23 20/9 20/10 20/11 20/13 20/15 22/7 33/14 34/23 34/24 35/1 53/22
she won [1] 20/13
she's [1] 54/1
sheet [2] 65/14 79/5
Sheffield [1] 51/10
shop [1] 3/6
shops [2] 18/7 18/15
short [2] 65/8 66/12
shortage [1] 44/2
shorthand [1] 81/2
Shortly [1] 62/2
should [27] 4/7 7/22 15/7 15/8 18/18 23/15 29/10 31/11 32/3 35/3 35/22 38/19 42/5 43/25 54/2 65/14 66/2 66/18 66/20 69/25 70/24 70/24 73/11 76/20 76/25 82/8 82/9
shouldn't [2] 6/18 20/17
show [3] 62/20 69/9 77/10
showed [3] 27/11 29/3 29/4
showing [1] 25/20
shows [1] 58/21
shut [1] 2/23
significance [2] 44/6 75/4
significant [3] 17/1 38/4 51/4
significantly [1] 42/20
signposted [1] 54/17
silence [1] 4/5
silly [1] 51/19
similar [4] 7/20 10/22 10/25 33/9
similarities [3] 7/7 7/9 9/20
Simon [2] 17/8 40/24
since [4] 6/5 12/7 35/8 41/14
Sir [2] 17/8 40/24
Sir Simon [1] 40/24
sit [1] 76/25
situation [1] 70/5
situations [2] 9/19 70/4
sixth [1] 17/2
sleeping [1] 52/13
slightly [1] 72/19
small [3] 7/24 8/1 80/8
snapshot [1] 26/14
so [160]
social [1] 69/5
society [2] 2/14 8/8
sole [2] 42/8 48/8
solely [2] 22/10 30/1
solve [1] 43/4
some [44] 2/17 5/2 5/3 6/9 8/12 9/16 10/15 11/4 11/24 13/21 14/14 14/15 14/17 15/12 16/13 18/14 19/3 21/21 21/23 23/12 23/17 23/19 28/17 32/21 43/12 44/8 45/12 50/9 50/14 53/19 54/5 62/21 62/24 64/12 66/3 67/13 67/13 68/4 69/6 70/3 70/4 74/25 81/23 82/8
somebody [12] 9/9 13/4 28/2 29/4 43/14 49/7 55/15 64/25 82/21 82/24 83/3 83/5
someone [3] 81/25 82/2 82/11
something [8] 5/23 9/9 13/9 20/22 33/15 39/14 65/8 80/9
sometimes [24] 12/25 13/16 13/17 13/18 14/1 15/14 29/18 29/21 29/22 29/23 29/25 30/1 30/7 30/21 50/4 53/14 63/24 64/3 64/8 71/7 75/24 76/2 78/15 79/10
son [1] 14/21
soon [5] 4/5 6/2 21/17 30/14 45/11
sorry [7] 4/16 28/6 53/3 64/2 69/19 69/19 71/18
sort [3] 28/10 32/25 70/22
sorted [2] 33/14 33/23
sources [2] 29/16 79/16
south [1] 51/13
speak [4] 21/7 41/5 56/22 70/24
speaker [1] 21/1
speaking [2] 21/8 75/15
specialist [1] 46/11
specific [1] 67/8
specifically [1] 67/3
spent [1] 82/1
spoke [4] 9/2 32/9 66/23 66/24
stab [1] 28/8
stabbed [3] 3/6 3/7 5/11
Stabilise [1] 45/12
Stabilise them [1] 45/12
staff [8] 16/5 16/8 25/9 25/10 30/17 42/6 45/21 73/16
stage [2] 31/24 50/14
Stalinist [1] 47/3
start [7] 9/22 11/15 30/14 31/2 61/3 71/17 83/25
started [2] 10/11 47/10
state [4] 39/5 39/9 39/12 46/18
statement [24] 1/7 1/10 1/16 11/25 16/23 19/16 20/1 20/21 20/25 35/7 38/21 42/16 44/1 46/8 47/24 50/22 56/10 63/7 64/6 70/7 71/20 71/24 77/8 78/17
statistical [1] 26/8
statistics [2] 19/3 73/23
statutory [3] 21/17 72/12 72/15
staying [1] 62/22
stays [1] 14/25
steers [1] 37/1
steps [2] 19/18 79/2
stick [1] 56/14
sticking [1] 67/10
stigma [4] 79/24 80/1 80/2 80/4
stigmatise [1] 79/22
still [4] 2/7 6/21 36/22 37/6
Stone [1] 36/16
Stone's [1] 36/17
stop [2] 30/22 77/3
stopped [5] 9/4 9/5 16/18 35/8 56/20
stops [1] 15/19
strangers [1] 3/9
Straw [3] 75/13 75/18 85/7
stray [1] 71/5
structure [1] 39/25
struggle [3] 15/5 15/7 53/17
stuck [1] 14/15
sub [1] 80/21
sub-impaired [1] 80/21
subject [4] 1/9 28/3 66/14 68/25
subjective [1] 41/24
subsequently [1] 58/24
substance [2] 62/25 63/1
substances [1] 61/24
substantial [2] 47/15 58/11
substantially [7] 57/24 58/3 58/7 58/11 58/23 59/8 81/3
such [3] 14/24 54/11 74/16
suddenly [8] 5/17 5/19 23/13 38/17 39/7 39/9 39/11 82/17
suffering [1] 78/10
sufficient [8] 13/1 24/24 37/6 37/8 43/14 45/23 61/6 76/11
suggest [2] 37/24 42/2
suggested [2] 73/5 81/16
suggestion [2] 54/19 62/3
Suicide [1] 26/9
suicides [2] 26/18 26/20
summarise [1] 20/3
summary [2] 38/25 39/22
Sunday [1] 3/4
Sunderland [1] 7/17
supplied [1] 15/9
support [14] 9/10 27/22 34/21 46/11 53/22 54/10 54/16 54/20 55/1 55/23 56/11 82/22 83/1 83/12
supported [1] 57/16
supportive [1] 9/4
supposed [1] 44/8
Supreme [1] 36/3
sure [8] 8/2 9/14 35/3 64/7 67/17 68/5 71/4 75/15
survivors [2] 71/17 74/19
Sutcliffe [1] 69/15
system [19] 15/14 17/23 18/25 19/1 19/2 19/9 19/11 19/13 19/14 19/19 19/24 20/22 22/3 42/17 45/16 50/24 67/17 71/9 81/22
systemic [1] 79/19
systems [1] 5/17

T

tablets [1] 45/12
taboo [1] 68/25
take [10] 23/17 42/13

T

take... [8] 48/11 49/19 60/21 61/17 61/19 66/6 68/4 69/7
taken [16] 5/3 19/18 33/22 35/2 49/13 60/25 62/19 68/15 73/15 75/24 76/1 76/12 76/21 78/25 79/2 79/14
talk [15] 15/13 15/21 18/13 21/23 22/2 23/5 25/3 29/22 32/24 32/24 67/3 68/9 79/22 80/2 83/10
talked [2] 70/11 75/20
talking [7] 17/11 21/15 23/10 23/15 31/12 55/14 62/18
tarnished [1] 38/10
team [3] 43/7 59/4 83/8
teams [4] 43/11 43/11 47/13 57/14
Television [2] 1/21 2/14
tell [19] 1/19 3/3 8/17 8/21 9/23 17/5 17/20 19/1 19/1 20/25 23/23 28/10 28/17 31/22 37/19 46/14 48/8 56/10 64/8
telling [1] 60/5
tells [1] 45/23
ten [1] 13/23
tendency [2] 40/4 68/24
tenets [1] 23/1
tension [1] 30/18
term [2] 15/2 66/25
terms [7] 6/25 41/12 59/20 63/25 64/10 64/13 71/11
terrible [2] 11/14 35/16
terrorists [1] 2/1
tested [1] 43/25
testing [1] 62/16
than [13] 4/20 10/4 16/13 26/16 35/16 36/11 42/8 44/4 70/5 73/11 74/20 78/14 82/24
thank [29] 1/15 35/6 51/1 62/3 66/9 66/10 70/6 70/15 70/17 71/13 71/14 71/19 71/21 73/13 74/18 75/11 75/11 75/16 77/7 80/5 80/6 81/7 81/9 83/15 83/15 83/19 83/21 83/23 83/24
thanked [1] 33/24
that [425]
that's [41] 6/16 7/2 8/19 12/8 12/22 14/2 15/4 16/19 18/1 23/21 24/7 24/10 24/11 24/16 25/24 26/23 27/3 27/3 28/8 34/20 36/20 37/5 39/16 40/17 43/14 45/14 45/14 45/14 45/19 58/1 58/7 60/13 60/15 63/17 66/5 69/17 72/14 74/11 77/18 77/20 82/21
Theemis [2] 34/5 34/23
their [31] 2/7 4/10 5/12 13/19 16/5 16/8 20/19 22/11 22/13 24/22 26/21 42/24 45/13 46/6 46/13 46/18 49/14 49/15 49/19 50/17 50/19 50/21 57/25 59/4 66/23 67/10 69/9 70/12 72/17 73/24 76/4
them [50] 3/23 3/24 4/25 9/1 10/15 10/19 10/21 15/9 15/23 19/6 21/10 23/5 23/6 23/7 23/10 28/11 28/19 29/23 30/14 31/20 32/11 40/7 44/21 45/12 45/12 45/13 45/23 46/3 46/3 46/4 46/6 46/6 46/12 47/10 48/2 49/6 49/20 50/8 52/8 52/20 53/16 54/16 56/21 56/22 59/5 61/16 61/19 76/14 79/12 83/1
themselves [2] 49/11 83/3
then [24] 4/13 11/22 12/18 16/8 16/8 16/9 28/2 36/4 39/7 44/10 55/11 55/21 55/24 56/16 57/7 59/9 62/19 65/1 66/8 72/25 73/13 74/10 74/18 77/18
theoretical [3] 36/7 36/11 37/22
therapeutic [3] 45/7 45/8 46/2
therapists [1] 45/9
there [130]
there'd [2] 10/12 32/17
there's [51] 8/11 12/12 12/23 13/1 15/1 15/2 15/22 16/5 16/7 16/10 19/10 22/9 24/24 25/3 26/3 26/21 27/4 28/11 28/13 28/14 31/10 36/9 36/24 37/8 37/10 37/20 38/16 43/2 44/7 44/8 44/24 45/15 46/16 47/9 47/19 51/9 58/4 58/8 62/20 65/8 67/16 67/17 68/2 68/23 75/1 76/1 76/8 76/9 76/14 76/15 78/4
therefore [2] 24/1 34/16
these [26] 7/16 9/19 10/21 10/25 11/13 18/15 23/14 23/25 24/18 24/19 31/6 37/21 38/4 43/3 50/1 61/4 61/8 68/3 68/4 68/11 69/10 71/22 74/4 80/11 80/25 83/1
they [190]
they'd [3] 9/3 32/16 49/18
they'll [1] 76/4
they're [9] 5/11 12/12 18/4 29/18 44/14 67/19 67/20 77/19 83/6
they've [5] 28/15 37/21 42/15 50/20 64/7
thing [2] 59/8 71/3
things [16] 8/17 9/17 11/12 17/17 23/21 36/24 45/9 57/25 65/10 65/12 65/23 68/6 68/16 70/22 71/11 79/25
think [120]
third [3] 33/4 44/10 54/6
this [86]
those [22] 2/9 2/19 7/7 7/25 12/21 15/17 17/12 21/5 21/21 27/13 29/14 29/17 42/4 50/16 73/7 73/9 75/23 76/24 77/8 79/1 79/3 81/4
though [1] 62/5
thought [13] 5/10 5/23 6/15 9/8 9/20 32/23 36/9 47/3 47/6 56/23 57/5 60/14 62/10
thoughts [1] 66/3
threat [1] 51/20
threatening [5] 51/11 51/11 51/14 52/6 52/6
three [15] 8/6 8/6 17/13 20/7 23/21 23/21 26/24 27/2 27/3 39/8 40/21 52/17 55/9 57/24 77/5
three days [1] 39/8
three months [1] 77/5
three weeks [1] 55/9
three years [2] 17/13 40/21
threshold [2] 72/11 73/4
through [13] 1/10 8/9 14/6 38/14 38/15 45/16 47/10 57/17 59/20 60/21 71/23 73/15 83/3
throughout [2] 1/22 4/21
thrown [1] 39/10
Thursday [1] 1/1
time [25] 3/2 5/3 6/9 10/7 10/10 10/12 12/2 16/14 16/14 27/13 31/16 41/7 63/21 63/22 65/13 66/7 68/1 68/1 68/15 68/24 69/2 70/7 71/24 74/16 82/1
Times [1] 39/8
today [4] 6/21 44/4 73/24 83/23
together [3] 11/15 57/12 81/14
told [7] 4/11 8/17 28/23 32/14 32/15 32/16 83/10
tomorrow [1] 83/25
too [2] 45/14 78/21
took [9] 4/16 6/9 7/17 33/17 33/20 52/25 61/24 62/13 71/23
Tooting [1] 20/6
top [1] 61/21
topic [2] 34/1 77/7
total [2] 13/13 24/10
totally [1] 61/17
touch [4] 27/5 27/7 55/9 56/18
toxicology [4] 60/10 61/23 62/10 62/14
track [1] 28/4
tragedies [1] 33/9
training [7] 66/20 67/1 67/12 70/22 71/10 71/11 79/18
trainwreck [1] 5/16
tram [1] 58/18
transfer [2] 28/14 65/3
transferred [1] 65/1
transparency [5] 19/15 19/19 37/20 38/1 39/15
trauma [3] 14/24 14/25 83/4
traumatic [1] 5/14
treat [5] 23/5 24/19 40/7 79/24 79/24
treated [5] 7/11 23/20 36/5 42/19 49/19
treating [2] 7/15 10/24
treatment [23] 4/2 7/20 7/25 37/15 43/20 43/21 45/7 45/7 45/8 45/8 45/17 49/2 49/4 49/10 49/12 50/8 50/11 64/21 72/20 76/6 77/19 77/19 78/16
treatments [1] 49/8
treats [1] 64/16
trial [8] 27/10 30/8 30/12 31/4 31/11 32/18 64/25 74/12
trial's [1] 30/23
tribunal [17] 17/23 18/3 18/25 19/1 19/2 19/4 19/9 19/11 19/13 19/19 19/24 20/2 20/8 20/11 20/22 41/9 56/17
tribunals [4] 17/17 19/10 20/15 40/24
tried [4] 4/1 30/24 47/10 69/2
troubled [1] 2/22
true [3] 1/11 15/4 62/5
Trust [17] 4/8 4/9 4/15 6/12 6/23 8/24 10/15 13/1 13/3 29/12 32/3 32/5 32/13 33/17 34/3 38/9 38/10
trustees [1] 14/6
trusts [7] 11/5 11/24 13/18 29/10 73/8 75/7 75/25
try [22] 8/12 8/13 9/9 9/15 9/16 9/16 14/18 20/18 21/9 24/21 27/20 27/20 27/23 28/4 28/10 30/22 30/24 34/21 35/4 46/6 68/16 69/3
trying [2] 32/15 61/16
turn [1] 75/14
turned [2] 34/23 52/10
turning [1] 5/10
turns [1] 34/24
TV [1] 69/3
tweaks [1] 1/9
twenty [2] 51/1 51/2
Twenty-five [1] 51/1
twenty-seven [1] 51/2
two [7] 2/14 10/14 17/9 43/13 52/9 78/3 79/9
two days [1] 43/13
Twofold [1] 44/7
Typically [1] 48/1

U

UK [3] 24/6 27/12 69/25
UK-wide [1] 69/25
unable [2] 7/24 81/22

U

unauthorised [1] 36/8
unavoidable [1] 24/1
unclear [6] 12/5 13/25 15/15 44/22 51/13 51/20
uncomfortable [1] 54/19
under [10] 17/24 21/16 26/7 27/4 32/4 34/9 44/11 48/16 50/13 65/2
under-reporting [2] 26/7 27/4
underestimate [1] 13/12
understand [24] 5/17 14/17 15/5 18/11 21/18 21/19 33/20 33/22 36/22 38/18 40/17 41/19 48/13 48/16 53/12 53/15 62/20 64/4 64/6 64/20 71/12 72/6 76/16 81/2
understanding [4] 21/25 40/12 61/3 72/14
understands [1] 48/15
understood [7] 5/4 35/24 53/8 53/13 62/17 64/7 71/8
undertaken [1] 43/19
unfair [3] 4/22 4/23 6/17
unfit [1] 74/11
unhelpful [1] 47/2
unimportant [1] 24/1
United [2] 44/3 70/4
Units [1] 45/3
university [1] 50/6
unlawfully [1] 20/15
unless [2] 72/23 79/23
unpleasant [1] 45/4
until [3] 30/23 74/16 84/2
untoward [1] 24/22
untreated [3] 22/19 40/6 47/21
untrue [1] 16/19
unusually [1] 35/19
unwell [23] 3/19 7/21 22/20 24/23 27/13 28/6 36/4 40/6 41/18 42/18 42/24 42/25 43/15 45/22 47/21 48/24 49/8 50/7 50/19 51/10 65/25 66/1 72/5
unwilling [1] 7/25
up [11] 1/21 8/21 8/24 24/10 27/8 43/14 52/10 57/13 68/1 76/25 80/10
upcoming [1] 27/23
update [4] 11/25 24/3 36/23 46/16
updated [3] 12/8 37/4 70/8
updates [2] 1/9 65/6
upload [1] 27/18
upon [2] 42/15 70/21
us [19] 1/19 3/3 5/18 6/1 8/21 9/23 10/9 17/5 20/25 23/23 25/19 28/17 31/22 46/14 48/8 56/10 56/12 60/21 83/17
use [3] 6/9 62/17 62/21
used [3] 23/12 27/8 72/15
useful [1] 70/23
usefully [1] 42/2
useless [1] 38/7
usually [2] 30/11 76/2

V

valuable [2] 28/18 28/21
various [4] 13/25 59/23 77/14 77/16
vast [1] 3/16
VC [6] 26/24 32/1 58/3 58/10 59/7 75/3
VC's [3] 58/16 60/11 75/19
versed [1] 81/25
very [37] 1/13 2/11 2/23 4/23 4/23 5/14 5/14 7/10 7/19 7/19 9/3 10/8 10/22 10/25 10/25 15/24 16/3 16/9 17/18 20/9 21/23 24/15 35/2 35/5 35/13 43/24 47/19 50/3 50/4 69/5 70/20 71/13 71/18 77/1 80/5 81/7 83/12
victim [2] 14/12 27/22
victim's [3] 34/8 34/10 34/12
victims [19] 4/20 9/19 16/10 18/10 21/13 22/1 22/1 22/6 22/10 26/23 27/12 34/13 37/9 48/16 53/12 53/14 67/13 69/7 74/19
victims' [5] 21/9 21/16 48/15 48/17 53/7
view [10] 30/24 41/13 45/1 47/22 48/10 49/14 72/17 76/11 78/25 79/23
viewpoint [1] 25/18
views [5] 40/22 54/18 54/21 54/22 56/6
violence [12] 3/13 42/4 68/25 73/6 73/21 74/1 74/20 74/22 75/5 79/22 79/24 80/3
violent [2] 2/7 7/23
voice [1] 19/11
voices [1] 2/23

W

wait [2] 30/11 30/18
waiting [1] 5/12
Wales [2] 50/6 70/3
walking [1] 3/5
wall [1] 4/5
wand [1] 45/1
want [20] 1/13 5/11 9/12 11/10 15/12 15/16 16/12 16/13 23/8 23/19 23/20 23/22 34/15 39/6 46/2 54/11 63/3 64/24 65/6 71/5
wanted [13] 9/13 10/8 11/9 11/9 11/21 11/22 23/13 34/20 56/24 70/9 80/16 81/10 83/15
wanting [3] 6/3 42/19 56/15
war [3] 1/23 2/1 2/16
ward [1] 28/14
warm [1] 1/13
warning [2] 51/17 52/23
was [177]
wasn't [11] 30/4 34/19 35/2 35/5 45/10 51/12 56/18 58/7 58/24 62/5 67/1
way [8] 4/5 6/18 14/7 32/25 33/6 55/7 69/4 75/14
ways [1] 7/10
we [120]
we had [1] 59/5
we'll [5] 6/25 8/2 66/10 83/22 83/25
we're [16] 1/9 17/22 18/8 37/19 53/20 55/14 57/2 57/3 59/14 60/5 65/7 67/6 69/13 69/21 69/25 80/25
we've [21] 12/1 37/13 37/15 37/16 38/14 38/15 43/22 47/17 50/1 50/5 53/25 59/20 59/23 60/4 65/10 66/7 67/22 67/22 67/23 68/17 70/10
Webber [6] 53/21 54/8 56/1 56/20 59/22 59/23
Webber's [1] 56/6
Webbers [1] 31/24
website [4] 10/16 12/15 27/18 28/25
week [4] 6/22 43/13 43/13 77/4
weeks [2] 55/9 79/9
weight [1] 78/22
welfare [1] 25/17
well [42] 2/14 5/24 6/23 12/8 16/3 16/18 17/18 17/20 17/22 24/5 24/14 25/10 25/11 29/3 30/7 32/23 36/9 38/14 40/9 42/13 43/18 46/12 47/23 49/5 53/15 55/15 56/14 60/15 61/4 62/10 64/14 64/20 69/12 69/17 70/3 71/8 74/16 76/18 80/2 81/5 81/25 83/22
wellbeing [2] 47/19 50/17
went [6] 3/4 3/15 51/21 52/19 61/14 68/16
were [55] 2/3 2/6 2/7 2/22 3/9 4/3 4/11 4/16 4/18 5/15 6/3 6/4 6/11 7/2 7/7 7/8 7/9 7/11 7/11 7/12 7/19 7/21 9/2 9/3 10/15 10/21 11/1 11/6 11/7 11/8 11/24 13/24 14/3 16/18 17/16 17/18 21/15 23/14 27/13 28/15 31/22 34/1 41/5 41/10 42/11 43/17 43/18 46/19 47/5 58/25 59/24 61/14 69/4 73/14 81/16
weren't [2] 11/13 43/23
Wessely [1] 40/25
Wessely's [1] 17/8
what [93]
what's [12] 5/17 18/11 30/8 30/10 44/23 48/9 57/17 57/20 58/12 64/7 82/14 83/4
whatsoever [1] 18/16
when [47] 4/4 4/24 5/7 6/11 7/2 11/1 14/20 17/11 21/22 22/20 24/23 25/12 27/11 31/14 33/22 35/24 36/3 38/11 40/10 40/21 40/24 41/21 43/15 43/25 49/13 49/17 50/19 51/25 53/25 56/11 57/22 59/2 60/23 61/11 62/8 65/25 67/18 68/7 69/1 69/2 70/7 70/11 72/8 75/23 77/17 77/18 77/20
where [36] 12/11 13/4 13/22 18/8 18/14 20/9 20/15 20/20 36/14 37/13 38/8 38/8 38/11 43/17 43/23 45/5 50/3 50/10 51/8 51/10 51/14 52/5 53/17 63/10 69/14 70/12 72/15 74/4 74/10 74/25 75/1 75/8 79/11 79/25 80/21 82/18
Whereas [1] 72/15
whether [15] 10/9 10/10 11/23 19/9 21/12 21/12 26/11 28/11 28/12 49/18 55/6 60/18 61/24 72/20 80/23
which [47] 8/24 13/25 15/8 17/18 18/17 20/10 20/12 21/17 22/6 27/25 28/10 29/1 29/25 30/20 32/20 35/19 35/22 36/15 37/14 38/7 39/3 39/22 40/14 45/3 45/4 47/3 50/8 56/17 57/23 58/9 58/21 58/22 59/6 59/7 59/12 63/18 64/19 64/23 65/3 66/25 66/25 67/1 67/16 68/11 73/14 74/12 77/13
while [1] 2/7
whilst [2] 2/6 25/20
white [1] 64/5
who [59] 2/3 2/3 2/4 2/6 2/13 3/10 4/9 4/11 6/19 6/22 7/21 7/24 9/2 17/24 18/2 18/19 19/22 20/7 20/19 21/21 21/21 22/4 22/10 22/20 24/23 26/17 26/19 27/4 27/6 27/6 27/13 29/4 29/10 32/11 34/25 35/15 36/3 36/4 42/24 43/6 43/6 43/14 47/21 49/7 49/8 49/8 50/5 50/16 50/17 51/25 52/5 52/7 56/19 65/16 81/4 81/25 82/2 82/24 83/3
who'd [1] 82/16
whole [3] 26/11 26/13 59/24
whose [3] 14/21 50/7 55/15
why [27] 8/21 12/23 13/15 15/11 16/17 29/16 29/20 30/16 31/10 33/20 33/22 36/10 38/17 38/19 38/19 39/11 42/25 46/1 48/5 56/13 61/11 62/6 64/19 64/23

W

why... [3] 76/18 78/12 82/21
wide [1] 69/25
widow [1] 9/1
wife [2] 51/18 51/18
will [37] 15/13 17/25 18/5 21/17 23/8 23/9 26/15 26/18 26/20 30/21 36/20 38/6 40/8 41/17 41/19 41/20 41/21 43/11 48/1 51/18 59/16 59/17 59/18 70/1 70/13 70/15 72/4 72/6 72/7 72/8 76/3 79/14 79/14 79/16 79/22 81/3 81/7
Wiltshire [2] 10/13 61/15
window [1] 39/10
wish [1] 67/8
wished [1] 49/18
within [6] 22/16 27/5 39/8 43/3 50/2 53/13
without [9] 6/14 23/10 30/2 40/19 45/23 58/18 68/18 78/22 79/14
WITN0258001 [4] 16/24 38/22 63/8 71/21
WITN0258006 [1] 12/15
WITN0390104 [2] 34/7 34/9
witness [6] 1/7 38/21 63/8 71/20 77/8 78/17
witnesses [3] 66/21 66/22 70/22
woman [1] 14/21
won [1] 20/13
won't [1] 79/24
wondering [1] 80/23
wording [1] 72/19
words [1] 4/11
work [13] 2/15 4/21 9/4 13/17 23/18 24/19 25/14 25/15 26/8 47/16 68/16 75/12 83/20
worked [1] 29/3
working [4] 9/5 23/13 43/13 69/10
world [1] 1/22
worried [2] 35/14 47/5
worry [2] 17/15 79/21
worse [2] 26/1 70/5
would [50] 4/9 14/11 14/22 19/17 20/3 26/2 26/25 32/11 39/1 39/18 39/21 39/21 39/22 40/19 42/11 42/12 42/13 43/1 45/1 45/2 47/1 50/12 50/18 53/22 55/3 55/14 61/6 62/25 63/2 63/2 63/4 64/24 67/7 67/12 68/18 70/22 71/9 72/13 73/3 73/21 74/3 74/10 75/3 78/4 78/6 79/3 79/6 82/2 82/9 83/2
wouldn't [5] 13/6 24/13 39/17 39/19 39/20
wounds [1] 28/8
write [2] 10/16 33/18
writing [3] 12/2 42/12 55/25
written [2] 22/21 82/8
wrong [5] 6/18 35/11 47/6 56/14 79/25
wrote [6] 22/4 32/11 33/3 33/18 46/21 69/3

X

X-number [1] 13/21

Y

yeah [37] 7/4 7/6 10/3 11/17 11/19 12/4 12/17 12/22 13/10 13/14 14/5 20/24 21/4 22/23 22/25 35/13 37/10 41/8 41/8 41/11 41/22 45/25 48/4 49/24 57/4 57/9 57/20 59/19 59/19 60/9 62/15 68/22 72/14 78/1 78/1 78/20 78/24
year [12] 13/23 17/11 19/6 21/8 21/8 24/7 24/10 27/5 27/12 47/8 71/25 77/5
years [11] 8/6 8/10 17/7 17/13 20/8 25/7 40/21 49/17 67/24 67/25 81/12
years' [1] 2/10
yes [44] 1/3 11/21 12/10 12/20 14/8 17/4 25/10 28/20 29/15 33/14 44/5 48/23 49/20 60/20 62/2 62/2 62/8 62/8 62/9 62/9 64/20 66/6 67/22 71/14 73/22 74/7 74/15 75/13 76/23 76/25 77/22 79/14 80/13 80/15 80/20 80/22 81/5 81/20 81/24 82/5 82/7 82/13 83/15 83/25
yet [2] 25/3 72/9
Yorkshire [1] 1/20
you [367]
you'd [3] 12/2 29/19 33/13
you'll [1] 16/11
you're [12] 1/11 8/18 10/1 23/23 40/1 41/16 42/25 57/8 75/15 81/25 82/17 82/19
you've [23] 1/7 10/4 13/12 14/4 14/9 14/13 22/21 37/18 43/9 49/3 53/7 70/8 73/18 74/23 77/10 77/15 78/18 78/18 79/17 81/11 81/13 81/21 82/10
young [1] 18/19
your [63] 1/16 1/17 1/17 2/15 3/3 5/21 6/7 7/1 8/19 12/15 14/6 14/9 16/23 17/5 19/16 20/1 20/21 20/25 21/5 23/1 26/10 27/17 28/18 29/2 30/11 34/18 35/6 37/3 38/21 40/3 41/7 42/16 44/1 46/8 47/24 48/10 50/22 53/22 54/21 55/8 55/19 56/10 60/4 60/8 60/21 63/7 64/11 67/6 70/7 71/18 71/20 71/21 73/13 73/20 74/21 75/12 76/11 77/8 78/17 81/11 82/1 82/19 83/16
yourself [2] 57/8 79/13

Z

zealous [1] 30/21
Zito [2] 8/24 8/25