

Friday, 29 May 2026

1
2 (10.00 am)
3 **THE CHAIR:** Yes, Mr Weston.
4 **MR WESTON:** Chair, I call Professor Sir Louis Appleby.
5 **PROFESSOR SIR JAMES LOUIS JOHN APPLEBY (sworn)**
6 **Questioned by MR WESTON**
7 **MR WESTON:** Professor Appleby, you've prepared a witness
8 statement for this Inquiry dated 24 October 2025.
9 **A.** Yes.
10 **Q.** Is that statement true to the best of your knowledge and
11 belief?
12 **A.** Yes.
13 **Q.** Professor Appleby, you are the Director of the National
14 Confidential Inquiry into Suicide and Safety in Mental
15 Health?
16 **A.** Yes.
17 **Q.** The National Confidential Inquiry was established in
18 1996?
19 **A.** Yes.
20 **Q.** And you were involved in it from the outset; is that
21 correct?
22 **A.** Yes, it had existed for a couple of years before that
23 but it moved to Manchester and I became Director in
24 1996.
25 **Q.** I'm grateful for that clarification. Could you please

1

1 the name was the National Confidential Inquiry into
2 Suicide and Homicide by People with Mental Illness; is
3 that correct?
4 **A.** Yes.
5 **Q.** When was the name changed to its current name, so
6 National Confidential Inquiry into Suicide and Safety in
7 Mental Health?
8 **A.** That change was made when our remit changed, which was
9 in 2018, and homicide was removed from our remit so of
10 course it had to come out of our title as well.
11 **Q.** I will come to that in a little detail, if I may,
12 shortly.
13 In terms of the initial establishment of the
14 National Confidential Inquiry, or when it moved to
15 Manchester in 1996, can you just tell me why that
16 happened and how it was funded initially, please?
17 **A.** So the context was public concern over the safety of
18 community care. This was -- there had been a number of
19 incidents causing public and political concern, and
20 the -- there was a tradition in the health service of
21 conducting confidential inquiries, in other words asking
22 confidential questions to clinicians about safety
23 incidents, and so the decision was made, I wasn't part
24 of that at that time, but to initiate a confidential
25 inquiry on suicide and on homicide. So the context was

3

1 briefly summarise your professional qualifications and
2 experience prior to 1996.
3 **A.** Before 1996. Well, I'm a psychiatrist. I graduated in
4 medicine in 1980. I have trained in psychiatry,
5 qualified as a psychiatrist, became a Consultant
6 Psychiatrist in 1991, and became Professor of Psychiatry
7 at the University of Manchester around about the same
8 time I became Director of the Inquiry, 1996.
9 **Q.** And you remain an Honorary Consultant Psychiatrist at
10 Greater Manchester Mental Health Foundation Trust; is
11 that correct?
12 **A.** Yes.
13 **Q.** Between 2000 and 2010, you were the National Director
14 for Mental Health in England as part of secondment to
15 the Department of Health?
16 **A.** Correct.
17 **Q.** From 2010 to 2014 you had another role with the
18 Department of Health as National Director of Offender
19 Health?
20 **A.** Yes.
21 **Q.** From 2013 to 2019 you were a Non-Executive Director of
22 the Care Quality Commission?
23 **A.** Yes.
24 **Q.** Can I take you back to 1996 when the National
25 Confidential Inquiry moved to Manchester. At that time

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1 in fact concerns over community care homicides.
2 **Q.** How was it funded, please?
3 **A.** It was funded by the Department of Health, initially,
4 initially.
5 **Q.** Can I take you to your statement, please,
6 WITN0069001_003. And just on the lower page there, it
7 says:
8 "Its objectives were to enhance monitoring and
9 safety in mental health services, identify patterns and
10 risk factors associated with suicide and homicide, and
11 provide recommendations to improve clinical practice,
12 service delivery, and patient and public safety."
13 So those were the objectives --
14 **A.** Yes.
15 **Q.** -- of the National Confidential Inquiry. Can I take
16 you, please, to the Confidential Inquiry's annual report
17 for 2017, please. WITN0069003_001, please. Can we take
18 you to the first page, I'm grateful.
19 This is the annual report from 2017. You've told
20 us that comprehensive data collection in regards to
21 homicide stopped in 2018, a year later. So I want to
22 understand the data and learning that the National
23 Confidential Inquiry had reached up to that point, if
24 I may.
25 Can I take you to page 44 of this document. There's

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1 a section towards the bottom there headed "PATIENT
2 HOMICIDE" and, just to be clear, if you can just zoom
3 out again, this is a part of the report that's talking
4 about patient homicide in England, so it's not all of
5 the UK, just England in this particular part. You do
6 look at all the different regions and put it together in
7 a different part of the report, don't you.

8 **A.** Yes.

9 **Q.** I'll come onto that a little while later.

10 Can I focus back on 109, please. It refers there
11 to:

12 "... 632 confirmed patient cases plus an additional
13 8 cases for 2015 and 1 for 2014 ..."

14 Then the total it says, is a figure of 641:

15 "This represents an average of 58 homicides per
16 year. There were 674 victims, an average of 61 per
17 year."

18 So you are recording both the number of offenders,
19 patients, if I can put it that way, and the victims in
20 that particular paragraph; is that fair?

21 **A.** Yes.

22 **Q.** Then just over the page to page 46, please. We see --
23 and I'm not going to take you through the table now,
24 because I want to understand the methodology first --
25 but we can see this table at the top. It says the

5

1 because of the high standard of evidence required."

2 So there needs to be for homicides, there needs to
3 be a determination by a court. That could be
4 a conviction for murder or manslaughter, but it could
5 also be a finding of insanity or fitness to plead. Some
6 sort of court determination?

7 **A.** Yes.

8 **Q.** You accept that because of that high standard, there
9 could be an under-representation, but there needs to be
10 a methodology, doesn't there?

11 **A.** Yes, in research definition is everything, and the most
12 valid definition is a legal determination.

13 **Q.** Just so we can be clear what the limitations are, then,
14 if a patient commits a homicide but then takes their own
15 life and it never gets to court determination, then they
16 wouldn't come within this primary methodology, would
17 they?

18 **A.** We would report them separately, so they wouldn't be in
19 this -- in a description of people legally determined
20 because they weren't legally determined, but they would
21 be in our data.

22 **Q.** So in terms of the 641 that we're going to come to look
23 at in a moment, they're not within that primary group?

24 **A.** Correct.

25 **Q.** But you do still collect data in relation to those who

7

1 number is 641, so that's that the same group that has
2 been analysed in some detail here; do you see that?

3 **A.** Yes.

4 **Q.** I'm going to refer to this as the primary patient group,
5 if I may, because there's some complexity about
6 methodologies that I want to go through, but I want to
7 understand the methodology in particular for this
8 particular group.

9 Can I take you, please, to page 7 of the report.

10 This is a section referred to as methodology, and this
11 is where you set out what I'm going to call the primary
12 methodology for that particular group of 641 patients.

13 At point one, you state that you rely upon
14 clinicians, responses from clinicians, and the response
15 rate is very good, 95%, is that correct, in terms
16 collecting your data.

17 **A.** Yes, that's very high.

18 **Q.** I want to come back to the way in which you collect that
19 from the clinicians in a moment because there's
20 a questionnaire, it's quite detailed, and I want to
21 touch upon that in a moment, if I may.

22 At point 2, you say:

23 "Suicide and homicide are defined legally, eg
24 inquest conclusion or determination by a court. This
25 provides consistency of definition but may underestimate

6

1 fit within that characteristic of attack followed by
2 suicide before a determination?

3 **A.** Yes.

4 **Q.** That's analysed separately; is that correct?

5 **A.** Yes.

6 **Q.** Point 3:

7 "Patients are defined by recorded contact with
8 specialist mental health services in the 12 months prior
9 to suicide/homicide - this omits some contacts, eg those
10 seen in A&E but not referred to mental health."

11 So in terms of this primary group of patients that
12 we're looking at, that 641, if they have not been in
13 contact with mental health services, then they don't
14 come within the group.

15 **A.** They didn't come within our remit if they weren't
16 patients, yes.

17 **Q.** Even if they may have expressed mental health concerns
18 to A&E or to a GP, or something like that, they're not
19 within your particular group because it needs to be in
20 contact with mental health services?

21 **A.** They weren't within our definition of patients, no.

22 **Q.** Thank you. It also excludes, in this primary group,
23 contact, those who have had contact more than 12 months
24 before the homicide?

25 **A.** Yes, although we also recorded those cases separately.

8

- 1 Q. So those separate cases, because they can be quite
2 important, can't they, because they're very hard to
3 reach, hard to engage patients; what do you do with the
4 data in relation to that, that particular group?
- 5 A. Well, we reported data on what we thought were the
6 12-month samples, so contact within 12 months, then we
7 also reported -- particularly in the first years of
8 where we were trying define the different groups, we
9 reported the whole group, so that's contact at any time
10 in the past, without the 12-month criterion, we would
11 report data on that group too.
- 12 Q. But in the table we are going to come into, that
13 particular cohort is not included in the 641?
- 14 A. That's right.
- 15 Q. So once you've identified a cohort of patients, you then
16 seek data in relation to them via a detailed
17 questionnaire that you send to treating clinicians. Is
18 that usually sent to the Consultant Psychiatrist?
- 19 A. Yes.
- 20 Q. 95% is the response rate. Do psychiatrists ever have
21 any concerns about giving you the patient data when
22 you're asking for it?
- 23 A. It's a very sensitive subject and they are very
24 concerned about how we will handle their data, so yes,
25 they have concerns, but despite that the level of

9

1 In terms of behavioural features: "History of
2 self-harm" in 50% of cases; "History of violence" in
3 53%; "Any previous convictions" in 77% of cases;
4 "History of alcohol misuse" in 73% of cases; "History of
5 drug misuse" in 78% of cases.

6 It then gives a figure for "Abnormal mental state at
7 the time of the offence" and it's 36%. That jumps out
8 as perhaps a little low, given the sort of cohort we're
9 looking at and the potential links between mental health
10 and the actual homicides. Can you just elaborate on
11 that at all?

- 12 A. Yes, well even the patient group is not a homogeneous
13 group, so although our primary remit was -- and still
14 is, will be again, I should say -- the potential
15 problems of community care, we were -- the patients who
16 we detect through that methodology include people with
17 schizophrenia, who I suppose are the primary group
18 because they're the people who might be subject to
19 community care, but it also includes people with other
20 diagnoses, alcohol, drugs, personality disorder, and
21 those are people whose mental state at the time of the
22 offence may not be different or very different from
23 their usual mental state. And we often knew about that
24 not through the clinicians but through information
25 provided by court reports.

11

- 1 cooperation I have from them, I have to say, is very
2 high for a national study.
- 3 Q. The questionnaire you sent, that's been disclosed to the
4 Inquiry. I'm not going to take you to it now, it's very
5 detailed, isn't it?
- 6 A. Yes.
- 7 Q. It looks at a range of matters including diagnosis,
8 presence of psychosis, medication and treatment, alcohol
9 and drug use, previous violence, discharge, and looks at
10 them in various different time periods and blocks,
11 doesn't it?
- 12 A. Yes.
- 13 Q. It also asks the clinicians about risk assessment and
14 how the homicide might have been avoided in that
15 particular case.
- 16 A. Yes.
- 17 Q. Can I take you back to page 46, please, in the table we
18 touched upon before. I think now we've understood the
19 methodology of how this particular information is
20 obtained, we can see that of your 640 -- this is for the
21 period 2005 to 2015; is that correct?
- 22 A. Yes.
- 23 Q. 85% demographic "Male"; 82% "Unemployed/on long-term
24 sick"; 19% "Black and minority ethnic group"; 7%
25 "Homeless".

10

- 1 Q. Going down the page the "Final Outcome", 51% in the
2 period you looked at in 2005 to 2015 was an outcome of
3 murder, manslaughter by reason of diminished
4 responsibility in 16% of cases, another form of
5 manslaughter in 31%.

6 And then "Sentencing Outcome", prison in 73% of the
7 cases you looked at, and hospital order in 24%.

8 Can I take you to page 47, please. Paragraph 113:

9 "The relationship of victim to offender was
10 acquaintance [in 46% of cases] ...family member ([in]
11 19%); spouse/partner ([in] 18%); and [then] stranger
12 ([in] 16%)."

- 13 A. Yes.

14 Q. Then in 115:

15 "There were 356 homicides by people [...] with a
16 history of schizophrenia ..."

17 This information about people with schizophrenia, is
18 that the same methodology we've looked at, or is
19 a different methodology being applied here?

- 20 A. It's an additional methodology because it identifies
21 people who are not patients.

22 Q. Understood. Can you explain how you do that?

- 23 A. That's through going to the courts where psychiatric
24 reports are -- it's actually quite a variable phenomenon
25 now but historically have been prepared on people facing

12

1 a homicide charge. So those psychiatric reports were an
2 additional source of data. So our primary source was
3 about patients but in addition we collected information
4 on people who had schizophrenia but who were not
5 patients. That's the group that's being referred to
6 here.

7 **Q.** Those psychiatric court reports, is that information
8 you've collected throughout the period 2005 to 2015?

9 **A.** On schizophrenia, yes.

10 **Q.** Further down, at the end often that paragraph it says:

11 "281 (92%) had symptoms of psychosis (delusions
12 and/or hallucinations) at the time of the offence."

13 That's within the cohort of those suffering from
14 schizophrenia; is that correct?

15 **A.** Where are we? Yes. Yes, it is.

16 **Q.** At paragraph 117:

17 "65 (32%) of patients with schizophrenia were
18 non-adherent with drug treatment in the month before the
19 homicide, an average of 6 per year."

20 **A.** Yes.

21 **Q.** Apologies, I may not have read it out but the second
22 sentence of paragraph 115:

23 "[Just] 6% of all those convicted of homicide, an
24 average of 32 per year."

25 Were those with schizophrenia, so 6% of the whole --

13

1 **Q.** The number of convictions has fallen steadily during
2 this period and at 356:

3 "11% of people convicted of homicide were mental
4 health patients. ... This figure varied a little across
5 the UK countries ..."

6 Then, at 357, you repeat that 6% figure for those
7 with schizophrenia.

8 **A.** Yes.

9 **Q.** Can I take you to a later annual report, please, for
10 2018, WITN0075013, page 6. So there is a useful summary
11 here at (xxxi), just over halfway down the page:

12 "Our detailed analysis of patient homicide since
13 1997 has highlighted:

14 "the victim is most likely to be an acquaintance and
15 less likely to be unknown to the perpetrator than in
16 homicides by non-patients

17 "most patients had a history of alcohol or drug
18 misuse; homicide in the absence of co-morbid substance
19 misuse is unusual

20 "around half of patients were not receiving care as
21 intended, either through loss of contact or
22 non-adherence with drug treatment

23 "patients are also at high risk of being victims of
24 homicide."

25 **A.** Yes.

15

1 of all homicides?

2 **A.** Yes.

3 **Q.** Just returning to paragraph 117, final sentence in
4 total:

5 "In total 116 (59%) were either non-adherent or
6 missed their final contact with services. There was
7 a fall overall in this group over the reported period."

8 **A.** Yes.

9 **Q.** You go on to say 118:

10 "192 (88%) of patients with primary diagnosis of
11 schizophrenia had a history of alcohol and/or drug
12 misuse, ie, it was unusual (12%) for patients with
13 schizophrenia to be convicted of homicide unless they
14 also had a history of alcohol and/or drug misuse."

15 **A.** Yes.

16 **Q.** Half of all patients with schizophrenia misused
17 cannabis, that's 50%, 48% misused alcohol whilst 35%
18 misused stimulants.

19 **A.** Yes.

20 **Q.** Can I take you to page 116, please. This is a summary
21 of the UK-wide data in relation to patient homicide.

22 The figure at 355 is that:

23 "During 2005-2015 there were 835 mental health
24 patients convicted of a homicide offence."

25 **A.** Yes.

14

1 **Q.** So that finding about loss of contact or non-adherence
2 with drug treatment being a key learning, is that based
3 upon the primary -- that primary group that we've looked
4 at with the methodology, or the various methodologies
5 that you've touched upon?

6 **A.** Well, it's primarily about the patients because it's
7 about whether they received the care that was intended.
8 You can see signs of it in other groups, but our main
9 remit was to look at the care that current and recent
10 patients were receiving, and it's a striking and
11 consistent finding that they are often not receiving the
12 care that was intended.

13 **Q.** One of your recommendations which we'll come to is as
14 regards Assertive Outreach --

15 **A.** Yes.

16 **Q.** -- and that would be a step that goes directly to this
17 particular point of learning, doesn't it?

18 **A.** Yes.

19 **Q.** You also refer to non-adherence with drug treatment.
20 Again, Assertive Outreach plays a role there, as well,
21 doesn't it --

22 **A.** Yes.

23 **Q.** -- in terms of remedying that problem? As might
24 Community Treatment Orders, which is another one of your
25 recommendations?

16

- 1 A. Yes.
- 2 Q. Can I take you, please, to WITN0069005, page 1. This is
3 an academic paper that you co-authored. This not
4 a National Confidential Inquiry document; is that
5 correct?
- 6 A. It's not a report; it's an academic -- we're an academic
7 unit. It's an academic paper.
- 8 Q. It's not one of the reports or annual reports --
- 9 A. Correct.
- 10 Q. -- it's an academic paper.
- 11 A. Correct.
- 12 Q. Now, in this particular study, you used some of the data
13 from the National Confidential Inquiry, you used data up
14 to 2012, and this is a 2020 paper, but you used data up
15 to 2012; is that correct?
- 16 A. Yes.
- 17 Q. You also used, and this is where it goes beyond,
18 perhaps, what's in the other reports, you also used
19 a control of 542 patients who had schizophrenia but had
20 not been convicted of homicide; is that correct?
- 21 A. Correct.
- 22 Q. To ensure comparison between the datasets or proper
23 comparison between the datasets, you limited your
24 analysis to patients who had a history of inpatient
25 treatment?

17

- 1 comorbidity, and that maintaining satisfactory levels of
2 care and follow-up may be linked with reduced risk of
3 serious violence. Almost all (94%) of those who
4 committed homicide either had a history of alcohol or
5 drug misuse or had not received treatment and care as
6 planned. Among the 160 homicides committed by this
7 patient group during the 15-year observation period,
8 only 9 occurred in the [presence] ... of these clinical
9 features -- fewer than 1 per year."
- 10 A. Correct.
- 11 Q. Can I take you, please, to page 7. You touched there on
12 the "Implications for clinical practice and health
13 services", and it says this:
14 "This study adds to the evidence for the
15 relationship between schizophrenia and serious violence.
16 It has been reported previously that much of the
17 elevated risk among these individuals is explained by
18 comorbid substance misuse rather than their mental
19 illness and our findings appear to support this notion.
20 In this study, features of mental healthcare were also
21 associated with homicide, the findings suggesting that
22 maintaining routine treatment and regular contact and
23 avoiding non-adherence to medication and loss of contact
24 are protective. In this clinical population it was
25 exceptionally rare for patient homicide to occur without

19

- 1 A. Yes, that was -- related to the source of the control
2 group. They were people who had -- were on a database
3 where being an inpatient was the important
4 qualification.
- 5 Q. So to more closely match the control group, you trimmed
6 the data that you had from the National Confidential
7 Inquiry to more closely match what's there?
- 8 A. Yes.
- 9 Q. Can I take you, please, to page 4. Bottom right-hand
10 corner. We have a "Summary of [the] main findings":
11 "In this national ... case-control study of previous
12 admitted male patients diagnosed with schizophrenia,
13 those who were convicted of homicide were more likely to
14 be non-adherent with their treatment plan, to have lost
15 contact with services prior to the offence, to have
16 a history of violent criminality, to have a comorbid
17 personality disorder or drug use disorder, to have been
18 admitted multiple times, or to belong to [the] ... BAME
19 group. Homicide perpetrators were less likely to have
20 had recent routine contact with services and to have
21 been recently discharged from hospital. Some observed
22 differences between cases and controls, including the
23 outcome (homicide), were attributable to differences in
24 treatment. These findings suggest that much of the risk
25 of serious violence in schizophrenia is related to

18

- 1 comorbidity or problems in delivering standard clinical
2 care.
- 3 "Prevention of serious violence and schizophrenia
4 should therefore focus on addressing comorbidities and
5 maintaining treatment and service contact. This
6 requires collaborative working between mental health and
7 substance misuse services and the introduction and
8 evaluation of models of intensive support from community
9 mental health teams."
- 10 Intensive support: one example is Assertive Outreach
11 which we'll come on to in a moment.
- 12 A. Yes.
- 13 Q. Could you take that down, please. Professor Appleby, in
14 2018, the National Confidential Inquiry stopped it's
15 comprehensive data collection in relation to homicides.
- 16 A. Yes.
- 17 Q. Can I take you to your witness statement, please,
18 WITN0069001, page 3. At the bottom, paragraph 10, you
19 say that:
20 "In June 2018, the Independent Advisory Group ...
21 established by our commissioners the Healthcare Quality
22 Improvement Partnership ... made the decision to
23 discontinue comprehensive homicide data collection."
24 The Healthcare Quality Improvement Partnership,
25 that's primarily funded by NHS England; is that correct?

20

1 A. Yes.

2 Q. And your primary funder up to until 2018 was also NHS
3 England?

4 A. Yes.

5 Q. It was the Department of Health --

6 A. Through -- yeah --

7 Q. -- when it started, but NHS England took that over; is
8 that correct?

9 A. Correct, yes.

10 Q. Just going over -- well, just continuing there before:
11 "IAG membership [it says] includes funders from all
12 four UK countries and individuals with subject
13 expertise. This decision was based on their assessment
14 of priorities in the context of a reduction of funding
15 [and] ... Competing priority being the extension of our
16 studies of suicide by mental health patients to groups
17 of concern within the general population. Informal
18 discussions also referenced: the growing maturity of NHS
19 serious incident investigations in cases of patient
20 homicide; concerns that regular publication of our
21 homicide findings may inadvertently perpetuate stigma
22 towards people with mental illness; and ... the core
23 learning from our homicide findings had by now been
24 sufficiently achieved."
25 Quite a lot to unpack, there. So can I just start

21

1 in suicide prevention, not just about patients but in
2 other risk groups?

3 Q. You're 2017 annual report notes that suicide amongst
4 patients was falling. So in terms of the work you we're
5 doing there, this was a downward trend, but this was
6 looking at a different group, effectively?

7 A. Correct. People who weren't patients.

8 Q. You mentioned there informal discussions. Who did you
9 have those informal discussions with, please?

10 A. I think people from HQIP and people who are the
11 commissioners and people from NHS England.

12 Q. Can you remember who specifically you discussed these
13 matters with?

14 A. Mm, that's a difficult question, because it means I'll
15 have to remember individuals who -- who were part of
16 that discussion. That's more difficult to remember.
17 And also I have to admit to a slight discomfort about
18 people who are acting on behalf of an organisation who
19 might then be named publicly in an Inquiry.

20 Q. Was it one discussion? Was it several discussions? Was
21 it one person? Were there several people?

22 A. There were several discussions about this.

23 Q. Okay, well you give a lot of information about these
24 informal discussions, so perhaps we'll go through them
25 and you might be able to recall who said what as we go

23

1 with the reduction of funding. What did you understand
2 about that, please?

3 A. Well, that was an important context. There was going to
4 be less money, and so something would have to be -- come
5 out of our remit.

6 Q. Less money generally, less money for mental health, less
7 money for mental health research? Did you have any
8 insight as to -- or perhaps all of them -- as to where
9 and how that was communicated to you?

10 A. Well, no, this was specifically the funding available to
11 us.

12 Q. You've said there that suicide was going to be
13 prioritised. Why was that, please?

14 A. Well, it was -- at the time there were a number of
15 groups at risk of suicide where people wanted to know
16 more. It was a time when the rate of suicide in young
17 people had been rising. There had been concerns about
18 middle-aged men who are the group at highest risk of
19 suicide, and so people with an interest were looking to
20 us to collect information on those important groups, and
21 so the question is arising: can you extend the kind of
22 data collection you carry out beyond people who are
23 under mental health services to the wider population.
24 So there was, you know, in some ways a reasonable
25 argument: can we help understand these other phenomena

22

1 through it.

2 You say first of all that there was a reference to
3 "the growing maturity of NHS serious incident
4 investigations in cases of patient homicide". Do you
5 recall who told you they thought there was a growing
6 maturity of NHS serious incident investigations in cases
7 of patient homicide?

8 A. I think this particular point came up when we were
9 discussing the reasons for removing funding at the
10 meeting itself, the advisory group meeting. I don't
11 think that was -- it's a number of years ago. I'm not
12 sure I can remember exactly but that would have been
13 part of the broader advisory group discussion.

14 Q. So discussions with the Healthcare Quality Improvement
15 Partnership?

16 A. Well, the advisory group convened by them, yes.

17 Q. So was this the view that you understood to be coming
18 from that advisory group?

19 A. Well, from people within the advisory group, yes.

20 Q. And the advisory group was made up of who, please?

21 A. It's -- it was --

22 Q. If not specifically, where did they come from? Which
23 organisations?

24 A. Well, it's primarily -- it was primarily run by the
25 funders, so NHS England, but also the governments of the

24

1 devolved nations in the UK, and then people who were
2 there because they had an individual expertise to offer.
3 So they weren't there in a representative role.
4 **Q.** Can I take you, please, to your statement, WITN0069001.
5 In fact we're already on it. So can we go to page 6,
6 please. Paragraph 18 at the bottom:

7 "The National Confidential Inquiry previously
8 conducted a thematic analysis of recommendations from
9 NHS serious incident investigations into patient
10 homicides ... published between 2002 and 2009, and
11 presented the findings in a series of reports, with our
12 final report in 2010. We have not assessed these
13 investigations more recently. We have not carried out
14 research into any other form of public inquiry."

15 Then your conclusions are at paragraph 19, that (a):
16 "Recommendations lacked specificity, were vague and
17 difficult for mental health trusts to implement or
18 monitor.

19 "Investigations panels were often small, making it
20 hard to ensure they contained the necessary breadth of
21 expertise.

22 "The inquiry process took too long, even in
23 uncomplicated cases.

24 "Reports often lacked an implementation plan with
25 deadlines to ensure delivery.

25

1 page 4. Just coming back to this:

2 "Informal discussions also referenced: the growing
3 maturity of NHS serious incident investigations in cases
4 of patient homicide ..."

5 Your review from 2010, the information from NHS
6 England, does not suggest that there was a growing
7 maturity, does it?

8 **A.** Well, that wasn't our experience, but I think it's fair
9 to say that I think there were some changes after that,
10 they were -- which probably did give the -- these
11 individual homicide inquiries a greater focus, but we
12 never evaluated them, so it's not something I can
13 comment on because we didn't do any further work on it.
14 But it was my impression that the sense from us and from
15 other people that they weren't doing their job did lead
16 to some changes. So it wasn't a completely unreasonable
17 point to make.

18 I didn't think it was a reasonable reason to end the
19 National Confidential Inquiry's data collection,
20 however.

21 **Q.** So your view that you thought it wasn't unreasonable was
22 not based upon studies or information, but just
23 impressions that you'd been given?

24 **A.** Yes.

25 **Q.** By those at the advisory group?

27

1 "Recommendations were often repeated from one report
2 to another, suggesting the inquiry system was not
3 leading to changes in care."

4 So in 2010, the National Confidential Inquiry
5 certainly had concerns about patient safety
6 investigations into homicides.

7 **A.** Yes.

8 **Q.** Can I take you, please, to WITN0310001, that's the
9 statement of Mr Bywater and page 110, please.

10 Mr Bywater is the Regional Director of NHS England.
11 He has provided the corporate statement on behalf of NHS
12 England to this Inquiry. At paragraph 360, he says:

13 "As set out in the NHS Patient Safety Strategy ...
14 (published in 2019), 'compelling evidence from national
15 reviews, patients, families, carers and staff and an
16 engagement programme in 2018 revealed that organisations
17 struggle to deliver' the expectations in the [Safety
18 Incident Framework]. As a result, the Patient Safety
19 Incident Response Framework ... was developed, tested
20 and launched".

21 So certainly from NHS England's perspective, the
22 current framework was struggling to deliver adequate
23 incident investigations in 2019?

24 **A.** Yes, that's how it looks, yeah.

25 **Q.** Can I take you back, then, to your statement, please,

26

1 **A.** Well, no, because the Serious Incident Framework was
2 relatively recent in relation to our review. So we
3 looked at an early period in the history of individual
4 homicide inquiries. In the early 2000s, the Inquiry
5 reports that were published then, and we were very
6 critical of them. I think there were some changes after
7 that and a Serious Incident Framework was part of that,
8 but clearly that's been superseded by a different
9 approach now.

10 **Q.** So in terms of your impression that there was a growing
11 maturity, that was based upon just conversations you had
12 with the advisory group?

13 **A.** It was based on the intention of the Serious Incident
14 Framework and the way it attempted to address the kind
15 of criticisms that we had made.

16 **Q.** Your statement goes on to say, refer, to a reference to:
17 "... concerns that regular publication of our
18 homicide findings may inadvertently perpetuate stigma
19 towards people with mental illness."

20 Where did that information come from in 2018?

21 **A.** It was a point raised at the advisory group.

22 **Q.** Are those concerns you shared?

23 **A.** No.

24 **Q.** Can you just tell us why?

25 **A.** Well, our -- first of all, it's important to have the

28

1 facts, and we were about -- our aim was to collect the
2 data and make the information publicly known. So that
3 in itself, I think, is enough reason to publish.

4 The issue of how that relates to stigma, and this is
5 a very sensitive issue in mental health. People in
6 mental health do feel that the subject of homicide
7 creates an impression with the public that could rebound
8 on people with mental illness. It could lead to an
9 impression that more people with mental illness are at
10 risk of being violent than is true.

11 So it is certainly a risk that the regular
12 publication, the annual publication, of data, it's
13 reasonable to question whether it could have that risk.

14 I disagree with it, as I say, I disagree with that
15 because from my point of view it is not talking about
16 this issue that carries the risk of adding to stigma,
17 it's not making the figures available, it's not
18 acknowledging the risk and I suppose, by implication,
19 not taking it seriously enough.

20 **Q.** It's through learning and improvement and reducing the
21 number of homicides that that stigma can be reduced?

22 **A.** Well, the worst thing that could happen to stigma is
23 when incidents occur that cause public anxiety. So if
24 we can help improve the safety of services in a way that
25 makes these incidents less frequent, then that's the way
29

1 that combination where patient homicides had occurred,
2 in people with severe mental illness. So from our point
3 of view there was an absolute justification in
4 repeatedly making this, drawing attention to this
5 problem.

6 I think the point that was being made was that that
7 message had been heard. We'd said it a number of times,
8 and that maybe we didn't need to keep saying it.

9 **Q.** Learning doesn't stop?

10 **A.** Well, it depends what you mean by learning. I think
11 there is learning which is that people are aware of
12 something and there is learning when people are doing
13 something about it. So they may have been aware, but
14 I think the evidence from our repeated analysis of the
15 data was that it hadn't improved.

16 **Q.** But without the work from the National Confidential
17 Inquiry in relation to homicides, the learning was
18 stopping and the information dissemination was stopping
19 as well from you?

20 **A.** From us, yes.

21 **Q.** So both the learning and the information side ended?

22 **A.** From us, yes.

23 **Q.** To suggest that there isn't more to be learned, to
24 suggest there isn't more information to put out to
25 politicians or to the public, that's quite complacent,

31

1 to defeat stigma, not by deciding that we'd rather not
2 talk about it.

3 **Q.** It then goes on to say in your statement that there was
4 reference to:

5 "... the core learning from our homicide findings
6 had by now been sufficiently achieved."

7 Where did that come from, please?

8 **A.** That was a point made at the advisory group.

9 **Q.** So the message coming from the advisory group was that
10 all the core learning had been sufficiently achieved,
11 there was limited purpose in ongoing learning, and
12 that's quite a dangerously complacent attitude; do you
13 agree?

14 **A.** Well, I didn't agree with it. In repeated reports and
15 repeated publications we had highlighted the risks in
16 severe mental illness of people not receiving treatment,
17 and people whose illness was complicated by drug or
18 alcohol misuse, which has an important relationship to
19 non-adherence with treatment. So it's part of an
20 overall picture where people who are taking drugs, their
21 mental state's being destabilised by the substances
22 they're taking and the relationship between that and
23 refusing medication is quite a close relationship. So
24 it was all part of an overall picture.

25 And we had repeatedly highlighted the importance of
30

1 isn't it?

2 **A.** I think it's misguided. I think it's fair to say that
3 that's not the only subject that we had information on,
4 as well. So there are -- and part of the new Homicide
5 Inquiry, now that it's been re-established, will be to
6 make clear that this is an evolving concern, and so
7 there are other issues that we want to make -- to
8 highlight as well.

9 But yes, I think the assumption that the NHS had
10 already learnt this, I think, is misguided. My own view
11 is that part of the problem on this issue is that even
12 when services learn, over time, that learning fades
13 away, and so the learning is lost, so you can't just
14 learn once and then that's the end of it. That learning
15 stays with you forever and influences your practice.
16 The learning fades and the unlearning, if you like, of
17 important clinical data is a real danger.

18 **Q.** Indeed, the VC case, and all the concerns explored
19 during this Inquiry, make clear that learning was not
20 sufficiently embedded?

21 **A.** Yes.

22 **Q.** So this misguided decision was not only misguided, it
23 was dangerous as well, wasn't it?

24 **A.** Well, it puts people at risk, so yes.

25 **Q.** So, in 2018, you had an impression that there may have
32

1 been a growing maturity, but it wasn't something you
2 were actively studying. You didn't share the views as
3 regards stigma, and you considered that it was
4 misguided, dangerously misguided, to think that learning
5 and information had come to an actual close or that all
6 lessons had been learned.

7 Did you, therefore, feel properly consulted when
8 this was stopped in 2018?

9 **A.** Well, we were consulted. I suppose consulting obviously
10 does not imply agreement, so we were consulted and we
11 gave our view.

12 **Q.** I can take it from what you are saying, can I, that as
13 an expert in your field that stopping funding for the
14 National Confidential Inquiry to look at comprehensive
15 homicide data in 2018 was, you consider, a mistake?

16 **A.** Yes.

17 **Q.** Did you -- you shared your concerns in the advisory
18 group?

19 **A.** Yes.

20 **Q.** With the advisory group? Did you share it with anyone
21 else?

22 **A.** Hmm, I'm not sure I did. I mean, we shared our concern
23 with members of the advisory group and with our
24 commissioners, but that discussion was properly taking
25 place at the advisory group, and we alerted the advisory

33

1 the country from about 1999, were reduced and we were
2 down to about a one-third coverage at around this same
3 sort of time.

4 Now Assertive Outreach is something you recommend to
5 this Inquiry. Were you concerned in 2018 that this data
6 was no longer being collected, this analysis was no
7 longer being done, and this intensive form of
8 intervention was gradually disbanding? Was that
9 a concern to you, that picture?

10 **A.** Yes. So I should declare an interest here. I was
11 National Director for Mental Health at the time when we
12 introduced Assertive Outreach. I was National Director
13 at the time we introduced the Community Treatment Order.

14 So I felt -- I suppose in some ways I'm not
15 an unbiased observer of what was evolving in clinical
16 services. These were two very important ways in which
17 we could ensure, or at least make more likely, the
18 proper receipt of planned care. And so the gradual
19 erosion of Assertive Outreach, after 2010, was --
20 I think it probably started slightly before then
21 actually, but that gradual erosion was a big sort of
22 regret for me.

23 **Q.** Can I take you to your recommendations, please.
24 WITN0069001, page 8. Can we start -- yes, page 8.
25 Paragraph 22.

35

1 group to the risks here that it was our view that the
2 Homicide Inquiry would have to be recommissioned at some
3 stage.

4 **Q.** You told them that, that at some stage it would have to
5 come back?

6 **A.** Yes. That was the reason we continued to collect
7 minimal data because we didn't want to lose the data
8 collection pathways that we relied on, because setting
9 them up again is much more difficult.

10 **Q.** So things were being stopped but there was no funding
11 for that; is that correct?

12 **A.** No, there was no funding.

13 **Q.** So you took a decision without funding to continue
14 counting the number of homicides so you could try and,
15 if you had to, fill in the gap?

16 **A.** Yes, so to be fair, the advisory group agreed we should
17 do that, but it was our attempt to maintain, even in
18 minimal form, data collection on homicide which we could
19 use as the basis of future studies, short-term studies,
20 and at some point I suppose I rather assumed that the
21 public anxiety would return and we would -- and it would
22 be necessary to re-establish the kind of data collection
23 that we'd previously had.

24 **Q.** We've heard evidence that from about 2010 Assertive
25 Outreach teams, which had been rolled out almost across

34

1 "Based on the findings from my research group above
2 and on what I know about the Nottingham tragedy, the key
3 areas for recommendations should be the maintenance of
4 treatment in the community, the response of services to
5 signs of risk or relapse and oversight of evidence-based
6 safe care.

7 "With respect to maintaining treatment in the
8 community, I believe the Inquiry should offer
9 unequivocal support to:

10 "... Community Treatment Order[s] ... "

11 You say there they're introduced in 2007:

12 "... which the new Mental Health Act supports
13 despite opposition from some mental health leaders and
14 parliamentarians ..."

15 You declare your interest there, that you were
16 "National Director for Mental Health and adviser to the
17 Government in 2007".

18 "The evidence for improved outcomes from CTOs is
19 equivocal but in part this reflects the problem of
20 conducting clinical trials with high-risk patients.
21 Individual case histories are less equivocal, as in
22 Nottingham."

23 You refer there to there being "opposition from
24 some", and indeed we've heard that one of the concerns
25 in the passage of the latest Mental Health Act was that

36

1 CTOs were being overused. Why or for what reason do you
2 think that opposition exists, please?

3 **A.** It's a cultural problem in mental health and it probably
4 has humane origins, a concern about the -- what might be
5 seen as coercive practice by some, but you have to see
6 the cyclical way in which that culture evolves.

7 So in the 1990s there was considerable concern about
8 community care and that was -- that eventually led to
9 the establishment of the Community Treatment Order so
10 that increased focus on the receipt of care as
11 planned -- don't forget we're not really talking about
12 any very unusual care, this was routine care being
13 properly received. So the Community Treatment Order is
14 a way of ensuring that.

15 So that whole movement, that shift in opinion, as a
16 result of what happened in the nineties, affected
17 decisions made about policy and practice in the 2000s.
18 But after that, and this, for me, is the biggest risk,
19 that once that initial public concern begins to die down
20 and once initial decisions are made about policy and
21 practice, the learning begins to erode, and so people
22 began to forget all the reasons why we needed
23 a Community Treatment Order and the -- and from my point
24 of view rather incredibly began to argue that maybe we
25 didn't need one at all.

37

1 given the impression that they don't achieve anything.
2 And that trial became very popular, I have to say,
3 amongst people who were engaged in the debate about
4 CTOs. Research doesn't always have that level of
5 support, but it was a very popular trial to be quoted
6 and I think it did influence a lot of people. But it's
7 very important to know that that trial can't ever be the
8 word on the success of Community Treatment Orders. It
9 had to exclude a number of people, the high-risk people
10 I'm referring to; it's debatable whether it's possible
11 to have the right outcome, because you're trying to
12 prevent a very rare -- well, not very rare, but an
13 unusual outcome, and in the lifetime of a clinical trial
14 that's rather difficult and so you need proxy outcomes.

15 So the trial evidence is equivocal, I think we have
16 to admit that, but that is partly because for
17 methodological reasons, and the overemphasis on one or
18 two trials I thought was misplaced.

19 In the end, Community Treatment Orders are not
20 a treatment; they are a way of delivering treatment.
21 And if you believe that the treatments we have in mental
22 health are effective, then a way of delivering those
23 treatments is bound to carry benefits if it can be
24 successfully implemented.

25 **Q.** You refer to "Individual case histories are less

39

1 That, to me, was astonishing, and a clear example of
2 forgetting the lessons that we had had to learn through
3 previous tragedies.

4 **Q.** You say that:

5 "The evidence from improved outcomes ... is
6 equivocal ... in part this reflects the problem of
7 conducting clinical trials with high risk patients."

8 Can you just explain that, please?

9 **A.** Well, it refers in particular -- there are different
10 trials. It isn't easy to do a trial in this area
11 because, by definition, your subjects, the patients in
12 a trial are people at high risk, otherwise they wouldn't
13 be eligible for a Community Treatment Order. And if
14 your subjects are high risk, that sometimes means they
15 can't take part in a trial because a trial, if it's
16 a randomised control trial, involves people not
17 receiving the intervention.

18 So it would be ethically very dubious to take
19 high-risk people and make a decision that they could
20 enter a trial where they might not receive the,
21 I suppose, guarantee of the Community Treatment Order
22 that their care would be delivered.

23 So there's a well-known trial in -- conducted in
24 this country which has proved very influential in how
25 people have viewed Community Treatment Orders and has

38

1 equivocal". Can you just elaborate on that?

2 **A.** Well, I mean, I suppose everybody in mental health has
3 watched the discussion about the Nottingham tragedy and
4 the clinical care, and the clear message that's come
5 from, as I see it, from the CQC Report, from NHS
6 England's commissioned report and from the evidence
7 that's come to this Inquiry, is about the importance of
8 ensuring delivery of what I would regard as routine
9 care: the delivery of medication, the support for people
10 in the community.

11 So those individual case histories are absolutely
12 compelling in relation to Community Treatment Orders.

13 **Q.** So just so it can be understood what you're
14 recommending, you consider there is a greater role,
15 where appropriate, for use of CTOs, where they can be
16 used under statute following detention under Section 3
17 of the Mental Health Act?

18 **A.** I think we -- I'm saying that this is part of the
19 problem of culture in mental health and I think we need
20 to recognise that we are always trying to achieve the
21 right balance between patient autonomy and
22 self-determination by patients, voluntary care,
23 decision -- respecting decision making, patient autonomy
24 on the one hand, and on the other hand, our
25 responsibility for public and patient safety. And that

40

1 social responsibility is sometimes outweighed by that
2 respect for autonomy, and for me, that is a constantly
3 shifting balance.

4 And the argument over the Mental Health Act, for me,
5 was in danger of allowing that balance to be in the
6 wrong place. And I think culturally in mental health,
7 once we had the Community Treatment Order in place, that
8 balance was allowed to shift away from our social
9 responsibility. We're publicly funded, we work in
10 a public service, we're responsible to the public and
11 public safety should be one of our key concerns. It is
12 one of our key concerns, but it should be explicitly one
13 of our concerns.

14 And so my reason for suggesting that, if that's
15 okay, to this Inquiry, was to try to prevent that
16 unlearning, to prevent that fading away of the public
17 concern, the clinical determination to do better,
18 because over time, that determination fades, and this
19 Inquiry, I would suggest, can do something very valuable
20 by setting out why that loss of -- that fading, that
21 loss of determination over CTOs should not be allowed to
22 happen.

23 **Q.** Any other ways in which that cultural balance can be
24 addressed, in your view?

25 **A.** Well, we've touched briefly on Assertive Outreach teams.

41

1 We see there at section 1 "Principles". "Least
2 restriction" references to:

3 "Minimising restrictions on liberty so far as
4 consistent with patient wellbeing and safety and public
5 safety."

6 Sorry, just to explain, this is setting out a new
7 Section 118 for the Mental Health Act under the new
8 legislation. So in both the existing guidance about the
9 statute about the Code of Practice and the new, there is
10 an emphasis there upon public safety within the statute;
11 do you see that?

12 **A.** Yes.

13 **Q.** Can I take you to the Mental Health Act Code, please,
14 NHSE0000312, page 23. This is the Code which will often
15 be what clinicians actually go to look at when they're
16 trying to understand how to apply the Mental Health Act.

17 Can you see the section:

18 "Least restrictive option and maximising
19 independence"?

20 **A.** Yes.

21 **Q.** It says:

22 "Where it is possible to treat a patient safely and
23 lawfully without detaining them under the Act, the
24 patient should not be detained. Wherever possible
25 a patient's independence should be encouraged and

43

1 **Q.** Yes.

2 **A.** That's one very important part. Those two things, I
3 think, are the key.

4 But whenever we're talking about culture, culture
5 can be an excuse sometimes for something so vague that
6 we don't know what to do about it, but culture in this
7 case is about leadership. And it is the leadership of
8 the service which needs to be clear about -- well,
9 monitoring issues of safety, about ensuring that
10 individual local services are following up on their
11 social responsibility for safety, and that that
12 leadership cascades from a national level through to
13 regional organisations, they're currently known as ICBs,
14 and into individual trusts and clinical services. So
15 that sense throughout the system of providing leadership
16 on the importance of safety.

17 **Q.** Can I take you, please, to INQY0000031, page 158. This
18 is Section 118 of the Mental Health Act 1983. Can
19 I take you down to section (2B)(i). Sorry, over the
20 page, apologies. This is in terms of guidance of what
21 needs to be in the Code of Practice in relation to the
22 Mental Health Act. One of the matters that's addressed
23 there is public safety at (i).

24 Can I take you, please, to the Mental Health Act
25 2025, so that's RLIT0000036, page 1.

42

1 supported with a focus on promoting recovery wherever
2 possible."

3 So the word "patient safety" is there, but no
4 mention of public safety, is there, as per the statutes
5 that we've looked at?

6 **A.** That's correct, yeah.

7 **Q.** Indeed, I won't take you to it, but nowhere within
8 section 1, which is talking about the guiding principles
9 for clinicians, is there any mention of public safety.
10 Indeed, public safety doesn't appear in the Code at all,
11 save in an entirely unrelated context in relation to
12 particular orders.

13 So safety, as drafted there, could be patient
14 safety, it could include public safety, potentially,
15 analogously, but it's not very clear, is it? It's not
16 emphasising patient safety as part of the moral
17 responsibility, the social responsibility, of the
18 clinicians involved; do you agree?

19 **A.** In that paragraph, no.

20 **Q.** Do you consider that public safety is something that
21 should be emphasised to a greater degree within the
22 Code?

23 **A.** Yes.

24 **Q.** I think it follows from what you said before that public
25 safety is something that should be emphasised at all

44

1 levels of mental health treatment so that the focus is
2 not lost in the way you've described?
3 **A.** Yes, the leadership on the issue continues, that it
4 doesn't -- it doesn't become possible for it to become
5 less important over time, as time passes and people
6 forget about some of the tragedies that happen, tragic
7 though it might be to think that these incidents
8 eventually lose their public impact. That is the
9 history, that is what happens and the culture shifts
10 away from that social responsibility.

11 **Q.** I'm going to come back on to another recommendation of
12 yours about oversight bodies in a moment. Can I look at
13 Assertive Outreach, please. Can we go back to your
14 statement, WITN0069001, page 8.

15 So we've looked at the first bullet point about
16 Community Treatment Orders; the second, you refer to:
17 "Outreach teams (also referred to as assertive
18 outreach) whose purpose is to ensure that care is
19 delivered to patients who have a history of
20 disengagement and treatment refusal, often associated
21 with previous drug or alcohol misuse. Outreach teams
22 were national policy in England in the 2000s, were
23 subsequently discontinued in most areas, and are again
24 a commitment in the recent 10 Year ... Plan."

25 Can I take you to the 10-year plan, please,
45

1 Outreach, even if it uses the word "assertive".
2 **Q.** Can I take you to WITN0412001, page 6. This is the
3 witness statement of Dr Nuwan Dissanayaka. He's an
4 Assertive Outreach clinician and he's given evidence to
5 the Inquiry in relation to Assertive Outreach.

6 In his witness statement he discusses a number of
7 the fidelity principles. Those are those specific
8 principles that you were referring to, no doubt, that
9 make Assertive Outreach Team intervention effective.

10 He then goes on to say this at paragraph 14 in the
11 second half:

12 "Standard community teams cannot offer this and
13 hybrid approaches, as well as lacking a positive
14 evidence base, have shown to lose the benefits such as
15 decreased hospitalisation rates. Low fidelity teams
16 [I think he's saying that as opposed to high fidelity
17 teams] drift towards office-based interventions,
18 decreased intensity, less intensive reactive care as
19 well as increased staff burnout due to the risks and
20 complexity of the patient group."

21 Do you agree with Dr Dissanayaka that this hybrid
22 approach doesn't have a positive evidence base?

23 **A.** Yes, I do agree. This is what happened, actually, in
24 the -- in 2010 and around about then, because the
25 essence of Assertive Outreach is a low caseload. So

47

1 NHSE0000524, page 35.

2 On the top right-hand side, there is a bullet point
3 headed:

4 "People with severe and enduring mental illness
5 face being bounced from one service to another ..."

6 Towards the bottom, the last third that paragraph,
7 it says:

8 "We will transform mental health services into 24/7
9 neighbourhood care models."

10 We're going to hear another witness on that
11 particular topic later today.

12 It then goes on:

13 "We will improve Assertive Outreach care and
14 treatment to ensure 100% national coverage in the next
15 decade ..."

16 Now we've heard evidence from NHS England, from
17 Dr Adrian James, that that 100% coverage refers to
18 assertiveness of approach rather than necessarily
19 Assertive Outreach teams. Assertiveness of approach, is
20 that a Model of Care that you recognise?

21 **A.** Well, I recognise the argument. But Assertive Outreach
22 refers to something quite specific. It has a number of
23 components that are fairly clearly set out in clinical
24 descriptions. So the concern here would be that
25 anything other than Assertive Outreach is not Assertive

46

1 experienced clinicians, they can be nurses but they can
2 be social workers, experienced people in the clinical
3 team with a small number of patients to maintain contact
4 with who have a history of complex mental health
5 problems, usually schizophrenia, and who don't easily
6 accept treatment.

7 So you can only provide the right amount of time to
8 those individuals if you don't have a large caseload.
9 And in a standard Community Mental Health Team the
10 caseloads are too large to allow what I would recognise
11 as Assertive Outreach.

12 **Q.** So when you're making a recommendation about Assertive
13 Outreach, it's Assertive Outreach teams?

14 **A.** Yes. Can I just say one thing about that, if it's okay.
15 When we introduced Assertive Outreach in the 2000s, it
16 was very tightly performance managed by the government.
17 These are in the days of targets and central control,
18 central direction, which went out of fashion. And
19 almost every part of the country where we were asking
20 them to set up a team said that they felt they were
21 slightly different from the national model, almost every
22 part. And they may have been correct, maybe there were
23 differences, but those differences weren't great enough
24 to mean that they didn't need Assertive Outreach as it
25 was defined.

48

1 And so a degree of flexibility is possible. For
 2 example, in rural communities, which are more dispersed,
 3 transport links are less reliable, perhaps. So there
 4 may be reasons for being flexible on some of the less
 5 important features, but the core features, a lower
 6 caseload, experienced staff, ability to work not just on
 7 clinical care but on the social supports that accompany
 8 it, these are essential and you can't compromise on
 9 those things.

10 **Q.** So if the 10-year plan is just about assertiveness of
 11 approach, we're not really moving forward from the
 12 position we had from 2010 to 2023, are we?

13 **A.** Well, there's a risk of -- I mean it's a good thing that
 14 Assertive Outreach is now back on as a requirement under
 15 government policy, but it will be going back in to
 16 the -- it risks going back to the same problem if we
 17 allow the interpretation to be sufficiently flexible
 18 that we lose those core features. Assertive Outreach
 19 means certain things and they have to be maintained.

20 **Q.** Can I take you back to your statement and your
 21 recommendations, please. WITN0069001, page 9, please.
 22 Thank you. Paragraph 24:
 23 "The Inquiry should aim to strengthen the rights of
 24 patients' families to request assessment, acknowledging
 25 that they are often in the best position to identify

49

1 collaborative style working with families. This is true
 2 it's not just about homicide, it's about suicide as
 3 well. And do you know, in the data that we collect,
 4 where we ask clinicians -- you referred to it earlier --
 5 we ask clinicians what might have made an incident less
 6 likely, working more closely with families is one of the
 7 things that clinicians themselves say would have made
 8 a difference.

9 **Q.** So in what circumstances would a family be able to
 10 request assessment, do you envisage there?

11 **A.** I do think this needs further working. It's clear when
 12 somebody is under the Mental Health Act, because there
 13 are legal rights to assessment.

14 **Q.** Yes.

15 **A.** So my -- what I'm suggesting here is that we need to be
 16 able to look for an equivalent right for patients who
 17 were informal patients when there is sufficient concern.

18 Now, and I accept that isn't straightforward,
 19 because the legal powers are not there, but we still
 20 need to find a route thorough which families find ease
 21 of access to services when they're worried and don't
 22 find themselves in the position of being unsure of where
 23 to turn, or asking -- and it does happen -- asking for
 24 assessment and finding that their word, their evidence,
 25 is not taken as seriously as they feel it should be.

51

1 deterioration and risk. Services might respond to this
 2 with concern about excessive demand but this has to be
 3 considered beside the high risk of not only violence but
 4 suicide and self-harm in mental health patients, and the
 5 benefit of providing reassurance to worried families,
 6 even when assessment leads to no further action. A
 7 period of piloting would be needed and presumably
 8 a protocol to limit repeat requests. The Inquiry could
 9 consider:

10 "A right for families to assessment for patients
 11 with a history of high risk, as exists for patients
 12 subject to Mental Health Act powers."

13 Then the second bullet point:
 14 "A right to a second opinion, equivalent to Martha's
 15 Rule in acute health care".

16 Can you just elaborate, explain that first bullet
 17 point, please?

18 **A.** Well, families are often the people who know best about
 19 the deterioration, they can spot the times, and they
 20 have valuable information. The way we work with
 21 families is a crucial part of safe care.

22 Now, sometimes, for a variety of reasons, that
 23 doesn't happen and families find it hard to alert
 24 services to their concerns.

25 We have to develop a service that has a more

50

1 So I'm suggesting an equivalent right, but I am
 2 acknowledging that it may need some working through as
 3 to exactly what that right might be outside the scope of
 4 the Mental Health Act.

5 I'm referencing Martha's Rule because it's been such
 6 an important development in acute healthcare and there
 7 the right is to a second opinion, so it's a slightly
 8 different outcome.

9 It seems to have been beneficial in acute healthcare
 10 and I do think it's something that we should be
 11 considering for mental health, but both of these things
 12 are, I suppose, my suggestions as to how we might take
 13 forward this very important discussion about the access
 14 that families can bring about to assessment at times of
 15 impending crisis.

16 **Q.** Just to give an example of what sort of decisions or
 17 aspects of clinical care could that Martha's Rule apply
 18 to? Detention, I suspect? Or discharge?

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

20 **Q.** Whether there needs to be a CTO, medication, all of
 21 these sorts of features could be something where
 22 a family ask for a second opinion?

23 **A.** Yes, yes.

24 **Q.** Paragraph 25, just further down. You say:
 25 "After a devastating incident there is often an

52

1 immediate determination in mental health services to
2 prevent further incidents above other priorities but
3 over time this tends to subside."

4 That's a theme that you've touched upon a few times
5 in your evidence.

6 **A.** Yes.

7 **Q.** "I believe, that in the merged DHSC/NHS England, a new
8 national oversight body is needed to ensure that
9 evidence-based and safety-critical mental health
10 interventions are implemented, maintained and
11 monitored."

12 So you have in mind there a body that reviews the
13 steps taken by the Department of Health and by the NHS
14 to meet recommendations made in inquiries and
15 investigations?

16 **A.** Yes, but also evidence from other sources, I suppose,
17 the re-established National Confidential Inquiry will
18 have regular evidence. It's also about the signal that
19 it sends out about the priorities of mental health care.
20 That if there is renewed oversight and that oversight
21 and leadership follows through from a national level
22 down to clinical care in individual Trusts, then I think
23 we're talking about a better chance, at least, of
24 maintaining the social responsibility that I'm referring
25 to.

53

1 reporting back on experience, just a level of -- an
2 intensity of focus that I think naturally does fade, and
3 we -- it is absolutely extraordinary we're in the
4 position of discussing the same things that we were
5 discussing 30 years ago.

6 So we have to understand why that has happened and
7 understand the cultural pressure to move that balance of
8 autonomy against social responsibility, the way in which
9 that balance naturally shifts, and this is part of my
10 suggestion as to how that might be prevented: a
11 continuing, official, and high-level focus on safety.

12 **Q.** Are there any other recommendations you would like to
13 touch upon? We've covered all the ones in your witness
14 statement -- (*overspeaking*) --

15 **A.** Yes. That's fine.

16 **Q.** Is there anything else?

17 **A.** I do think that -- there is one other thing to mention,
18 perhaps, and that is that I do think we need to
19 consider, take a fresh look at models of risk
20 assessment, and that would be part of what this group,
21 this group might do. I think, having watched the
22 proceedings, we need to recognise that recommendations
23 about strengthening risk assessment have been
24 a permanent feature of this discussion for about
25 30 years, and yet here we are still talking about it.

55

1 **Q.** So to have that oversight, there needs to be
2 independence from the Department of Health and NHS
3 itself?

4 **A.** Well, there would need to be independent input, but
5 sometimes independent bodies, I think you also need
6 -- it needs to be part of the system as well, it needs
7 to be part of the system of care from the Government
8 through to the frontline.

9 **Q.** The aim of this is to try and ensure that the learning
10 that we had from the 1990s onwards with the National
11 Confidential Inquiry, with Assertive Outreach, that
12 these sorts of things aren't just dissipated with time
13 and the lessons are properly embedded and not just moved
14 with cultural changes.

15 **A.** Yes, so it's, I suppose, the opposite of what was
16 suggested about the National Confidential Inquiry; the
17 repetition of lessons becomes unhelpful. In the end the
18 repetition of -- of course it won't always be
19 repetition, but the repetition of some lessons, the
20 reminder to the service about the importance of some
21 aspects of clinical care, that can only be beneficial,
22 maintaining a sort of high, a strong focus from
23 frontline clinicians, from Trusts and others on this
24 issue.

25 So looking at new evidence, monitoring practice,

54

1 We have to take a step back and understand why it is
2 that risk assessment is still problematic, and, if I say
3 so, it won't be enough for this Inquiry to recommend
4 a strengthening of risk assessment practice. I think it
5 has to take a fresh look at what we require of services
6 in the management of risk. And it's not just about
7 assessment, it's about action; it's about this cultural
8 balance that I was referring to. It's a different
9 approach that might be needed, otherwise there's a risk
10 that the learning will be lost, as I've been saying.

11 **MR WESTON:** Yes, thank you. I don't have any further
12 questions, but others might.

13 **THE CHAIR:** Yes, thank you.

14 Mr Moloney.

15 **Questioned by MR MOLONEY**

16 **MR MOLONEY:** Funding has now been restored for the National
17 Comprehensive (*sic*) Inquiry comprehensive data
18 collection relating to homicide. How long is the
19 commitment to fund that comprehensive data collection in
20 relation to homicide?

21 **A.** So it's NHS funding which tends to be confirmed
22 annually, so we're not yet at the end of year one, but
23 funding for year two has been confirmed.

24 **Q.** And so it will be on a rolling basis without you really
25 having any commitment to it being, say, for five years

56

1 or 10 years, or anything like that?

2 **A.** I'm -- certainly we've made the point that this has to
3 be a long-term commitment. There is no sense in setting
4 it up again and then in a few years' time discussing
5 whether it is needed or not. It's a long term
6 commitment, and my impression is that is understood and
7 accepted, but in the nature of funding, it has to be
8 renewed more frequently.

9 **Q.** Yes.

10 GPs, such as Dr Kumar, treat a lot of poor mental
11 health which might not require specialist mental health
12 services, especially depression. In terms of your data
13 collection, would homicide by such patients only come
14 within your study if you received court reports which
15 revealed that they had been subject to treatment by
16 their GP for poor mental health?

17 **A.** Yes, although -- so people with depression, yes. So our
18 core remit, I make clear, our core remit is about
19 patients, people who are in close proximity to services.
20 They're the people where prevention is most possible,
21 and that means -- and it has a focus on people with
22 severe mental illness which equates to more or less to
23 schizophrenia. Most of the people in primary care with
24 schizophrenia are also -- most, but perhaps not all --
25 are also under specialist services, at least in our

57

1 one or two points that you've raised, I think you may be
2 aware that the Inquiry itself has done an analysis of, I
3 think, 580-odd cases, in one sense spanning that gap
4 which has been caused by the finishing of your gathering
5 of information, but not in the same way. And I think
6 you've seen that report, haven't you?

7 **A.** Yes.

8 **THE CHAIR:** There are very few of those cases where CTOs
9 were in operation. Has that been your experience,
10 anecdotally at least, since you've been looking at this
11 area?

12 **A.** Yes. In our database we have found only three people
13 who committed a homicide while on a current CTO.

14 **THE CHAIR:** Yes.

15 **A.** So given the number of cases we're talking about over
16 a long period of time, that's a very small number. So
17 it can happen, because the effectiveness depends on how
18 rigorously it's applied, but it's unusual. And it's
19 possible we are missing cases, but three is a small
20 number in our very large database. We found eight
21 people who had previously been on a CTO, but no longer,
22 who had been convicted of a homicide offence.

23 **THE CHAIR:** And they'd come off the CTO --

24 **A.** They'd come off the --

25 **THE CHAIR:** Before the commission of the offence?

59

1 database. So most primary care patients of that kind
2 would be people we would know about anyway. Otherwise,
3 we would rely on court reports.

4 Court reports are no longer mandatory, and so it's
5 not absolutely reliable that we'd pick up every case in
6 primary care, but if a diagnosis had been made and if
7 the court wanted to use mental health information then
8 we should be able to get the court report, but it's not
9 a hundred per cent reliable, I'm afraid.

10 **Q.** Thank you, Sir Louis, and finally, you've spoken of the
11 importance of families to care and to mental health
12 outcomes. Families themselves are not homogeneous as
13 an entity though, are they; they are very diverse; some
14 are close and supportive; some are fractured and
15 distant.

16 Given the importance of family support to mental
17 health outcomes, would there be any role in Assertive
18 Outreach in encouraging family support to a patient?

19 **A.** Yes, it should be part of the Assertive Outreach
20 approach.

21 **MR MOLONEY:** Thank you very much, Sir Louis.

22 **Questioned by THE CHAIR**

23 **THE CHAIR:** Yes, thank you.

24 Yes, I just wanted to ask -- thank you, Sir Louis,
25 for that very helpful information -- just in relation to

58

1 **A.** Yes.

2 **THE CHAIR:** Yes. As far as the actual CTO is concerned,
3 you've made the point that, in fact, it's a structure,
4 isn't it, rather than a treatment in itself?

5 **A.** Yes. It's a way of delivering good care.

6 **THE CHAIR:** Yes.

7 Just one further point about Martha's Rule. In
8 relation to detention and mental health assessments, you
9 do have to get two opinions, don't you? You have two
10 mental health clinicians who look and make the
11 assessment prior to detention under the Mental Health
12 Act.

13 **A.** Under the Mental Health Act, yes.

14 **THE CHAIR:** Yes. Do you think that that bodes well for an
15 additional second opinion at various stages?

16 **A.** Well, I'm --

17 **THE CHAIR:** Perhaps if they do it separately rather than
18 together, it might help.

19 **A.** I'm admitting that. I think we need to work out what
20 the equivalent would be in mental health, but the
21 principle here of worried families having somewhere to
22 go with their concern when they feel that a response in
23 an urgent situation has not been sufficient. I think we
24 need to allow families a way to -- a place that they can
25 take that concern. And so the suggestion earlier that

60

1 this might apply to a sort of an emergency response to
2 somebody who was in mental health crisis is the near
3 equivalent to what Martha's Rule has been about.

4 **THE CHAIR:** Yes.

5 **A.** The Mental Health Act itself is in one sense covered by
6 current legislation, but for some people, they won't be
7 under the -- they won't have the advantage of the Mental
8 Health Act. So my suggestion is how we go -- what we do
9 for people who don't already have that right.

10 **THE CHAIR:** Do you think there's enough use of the Mental
11 Capacity Act as an alternative in some cases?

12 **A.** I suppose the simple answer to that is probably no, but
13 I'm concerned about the way that the two Acts can
14 sometimes be confused in frontline practice.

15 The Mental Health Act is not based on capacity, it's
16 based on risk and so our social responsibility is about
17 the risk and we don't need to establish capacity in
18 order to take action under the Mental Health Act. So
19 the Mental Health Act should be enough in most
20 situations of acute risk.

21 **THE CHAIR:** Yes, but in terms of the treatment of the
22 patients, sometimes it may be necessary to look at that
23 as an alternative?

24 **A.** Yes, yes, it's not irrelevant, but in an acute
25 situation, I suppose I'm thinking of the powers that

61

1 from the use of Community Treatment Orders, for example.

2 But that risk is still there and it's -- in the end,
3 there is only so much that can be written in the law.
4 In the end, we're talking about clinical practice, we're
5 talking about experienced clinicians assessing patients
6 at times of urgent need and the letter of the law is
7 important in that situation, but so is the understanding
8 of clinical practice, the beliefs of the mental health
9 culture, the kind of assessment that a clinician does.

10 So -- and all of that is about good clinical care.
11 And the law is there to back up good clinical care
12 rather than dictate good clinical care, so we still need
13 clinicians to be thinking about safety, to be thinking
14 about public safety, to be making the safe decisions.
15 And of course the law needs to be observed, but that
16 clinical safety is their primary function.

17 **THE CHAIR:** Because ultimately there's two parts of this
18 equation, aren't there? There's the patient and then
19 there's the community that they are operating in and
20 being treated in, and that's the public, isn't it.

21 **A.** Yes. It's perhaps not all that surprising that
22 clinicians think first about the patient who is in front
23 of them.

24 **THE CHAIR:** Well, I noticed, and I'm sure that you have too,
25 that public safety is the last on that list of

63

1 people -- that clinicians need to respond in a safe way,
2 and those powers are already there within the Mental
3 Health Act.

4 **THE CHAIR:** Just again, you've mentioned, effectively, if
5 you like, the arc since the last public inquiry of this
6 kind, which was the Clunis Inquiry, the Ritchie Inquiry,
7 1994. You've referred to effectively the effects
8 wearing off and people forgetting about this, the
9 reasons for introducing some of the recommendations of
10 that Inquiry and how depressing, from your point of
11 view, it is that we're not talking about the same
12 things.

13 Do you think that the current position, the current
14 balance as represented by the new Mental Health Act is
15 sufficiently enabling of public safety?

16 **A.** Well, I think the first thing to say is I think the
17 Mental Health Act team did a good job in trying to get
18 to the right balance. So I think they recognised the
19 danger. I should say I was on the broader group,
20 I wasn't directly involved with writing the Bill, but
21 I was on the advisory group.

22 **THE CHAIR:** All the better to ask you then, right.

23 **A.** So I think they did a good job in recognising that there
24 was a risk in allowing that balance that I'm referring
25 to to tip too far away from social responsibility, away

62

1 requirements which have been taken into account,
2 I think, in the NHS England orbit.

3 It should be a balance, shouldn't it, and the rights
4 of the community and the importance of keeping people
5 safe in the community, as well as the patient safe, are
6 very important.

7 **A.** Yeah, well it should, it should certainly be a balance
8 and it should be a routine part of what we consider when
9 we're assessing safety. But I just think we need to see
10 that culturally, we should maybe expect that clinicians
11 should see their first responsibility to the patient
12 because that's their daily job, and we have to ensure
13 that this other part of safety, this responsibility of
14 public services to the public, is sufficiently high on
15 there as part of their assessment, and I think that's
16 less natural, and it comes with a certain amount of
17 unease in mental health where culturally, staff worry
18 about the place of coercion, they worry about their
19 relationship with the patients deteriorating because of
20 that, and they worry about the message that goes out
21 about mental health care as being less therapeutic and
22 more about detention.

23 So this is all part of the cultural mixture that we
24 are working in, that clinicians work in. We just need
25 to see that although those are legitimate concerns, they

64

1 don't allow us to lose our -- the responsibility to the
2 public in the way we're talking about.

3 **THE CHAIR:** Yes, just on risk assessment, do you think that
4 there's a real -- there's a resistance to using any of
5 the diagnostic tools, the risk assessment tools, that
6 have been developed over the years, a number of which
7 have been referred to in this inquiry, which I'm sure
8 you're aware of, and research is continuing into ways of
9 looking at it. And obviously it's not going to be like
10 an X-ray where you can look inside somebody's head and
11 provide a clear picture. But do you think that
12 currently, as it were, the perfect is being the enemy of
13 the good?

14 **A.** Well, I think the approach is the wrong approach. And
15 I say that as somebody who has talked in the past about
16 the need for better tools and more rigorous risk
17 assessment, but we have to -- there's a logic to it,
18 there's an appeal to it, and there's bound to be a sense
19 in any Inquiry that if we can just get risk assessment
20 to be better, then that might help the safety of
21 services. But that's what -- that's more or less what
22 we've been saying for 30 years. And so we have to stop
23 and say: why is it that that approach, in different
24 forms, has led us to where we are now?

25 And I think the -- it's -- we have to look at
65

1 a patient's life and our risk management has to reflect
2 that.

3 So action-focused rather than assessment-focused.

4 **THE CHAIR:** If there's no -- I'm going to call it a tool or
5 perhaps a protocol, if I can put it that way -- if
6 there's no protocol then people simply do their own
7 thing, whereas you've just set out there a number of
8 things that you should be doing and taking into account,
9 and that's not always done. So is it not necessary to
10 have some sort of approach which is a common approach,
11 and then a tailored approach?

12 **A.** I think it's vital to have some kind of structure
13 because otherwise it's easy to omit key risks. So that
14 has to happen.

15 I'm suggesting that that can happen as part of
16 a clinical assessment of an individual's risk, without
17 the need to then apply risk tools, which can be
18 complicated for staff to deliver. When we've examined
19 the use of risk assessment tools in suicide prevention,
20 there's a large number of tools that have been developed
21 by services themselves. So they have no validity, but
22 what they do have, they act as a kind of aide-memoire to
23 services to ask the right questions. That's reasonable.
24 That's about structured assessment. And then on top of
25 that, what we need is a way of adapting that risk
67

1 whether that approach is the right approach, and it just
2 so happens that in suicide prevention there's been
3 a shift towards a different style of assessment of risk,
4 which is more about what actions need to be taken, it's
5 about identifying the personal history, the personal
6 risks of an individual rather than you could say the
7 generic risks identified by risk tools.

8 So understanding what is it that puts this
9 particular individual at risk at a particular time, and
10 have we got a plan for their care which accommodates
11 those points of risk?

12 And when we're talking about patient homicide, a lot
13 of the risk comes from violence, previous violence, not
14 receiving care as planned, and drug and alcohol misuse.
15 So if we have care plans that take action on those
16 issues, ensure that they're addressed, then that gives
17 us our best chance of improving public safety.

18 And placing in the process the complexity of
19 a relatively under-developed risk tool I think is the
20 wrong direction. We've got a -- we need a different
21 risk model which is more personalised, more about the
22 dynamic nature of risk, what will happen tomorrow to
23 this patient, what will happen at the weekend, how will
24 they be when they're no longer being looked after by
25 their family, that dynamic sense of what will change in
66

1 assessment to this particular individual. What is it
2 about this individual that might put them at risk?

3 And that doesn't need a -- the complexity of an
4 actuarial assessment of risk, we don't need to know
5 exactly what the risk is in numerical terms, we just
6 need to know that the risks that this particular patient
7 presents are part of our plan of management. So our
8 care is addressing each one of those risks.

9 And as I've said in relation to patient homicide,
10 those key risks are clear. They're about the management
11 of violence, drugs, alcohol, and non-receipt of care.
12 If all of our care plans effectively addressed those
13 things, then risk would reduce.

14 **THE CHAIR:** Yes, and medication, obviously?

15 **A.** As part of care, yes. Indeed.

16 **THE CHAIR:** Yes, thank you very much. We'll take a break
17 now until 11.50.

18 (11.33 pm)

19 (A short break)

20 (11.51 am)

21 **THE CHAIR:** Yes, Mr Blake.

22 **MR BLAKE:** Thank you, Chair. Can I please call Dr Adrian
23 West.

24 **DR ADRIAN GERARD WEST (sworn)**
25 **Questioned by MR BLAKE**
68

1 **THE CHAIR:** Please sit down.
 2 Yes?
 3 **MR BLAKE:** Thank you, Dr West. You produced a witness
 4 statement for this Inquiry, dated 5 December 2025. That
 5 has a unique reference number of WITN0338001; is that
 6 statement true to the best of your knowledge and belief?
 7 **A.** Yes, it is.
 8 **Q.** Thank you. You are a forensic clinical psychologist; is
 9 that correct?
 10 **A.** I am.
 11 **Q.** Your qualifications are set out in your witness
 12 statement. Importantly, for the purposes of today,
 13 you've held several roles relating to matters of serious
 14 violence and crime; is that right?
 15 **A.** Yes.
 16 **Q.** That includes, for example, working in high and medium
 17 secure psychiatric settings; is that right?
 18 **A.** Yes.
 19 **Q.** You've advised the police and you currently advise or
 20 are employed by the National Crime Agency?
 21 **A.** Yes, I am, though I am presenting myself today not as
 22 a representative of the National Crime Agency, but as
 23 a private citizen.
 24 **Q.** Thank you. You also are an advisor in hostage and
 25 crisis negotiation amongst other things?

69

1 If we start on page 6, in the foreword by
 2 Professor Appleby, you've highlighted that first
 3 paragraph where he says:
 4 "Safety is at the centre of all good healthcare.
 5 This is particularly important in mental health but it
 6 is also more sensitive and challenging. Patient
 7 autonomy has to be considered alongside public safety.
 8 A good therapeutic relationship must include both
 9 sympathetic support and objective assessment of risk."
 10 If we turn over, please, to page 8 in the summary,
 11 under "Fundamentals", you've highlighted paragraph 4
 12 which states:
 13 "Risk management must be built on a recognition of
 14 the service user's strengths and should emphasise
 15 recovery."
 16 Then if we please turn to page 24, you've
 17 highlighted the section here that states: "Providing
 18 care proportionate to risk". If we scroll down
 19 slightly, thank you. I'll just read that first
 20 sentence. It says:
 21 "A fundamental principle of mental health care is
 22 that the level of security to which a service user is
 23 subjected should be as non-restrictive as possible and
 24 should be proportionate to the degree of risk that they
 25 actually present at the time."

71

1 **A.** I am.
 2 **Q.** As you say, you're giving evidence in a personal
 3 capacity today having approached the Inquiry yourself;
 4 is that right?
 5 **A.** Yes.
 6 **Q.** You have educated yourself in respect of this case, so
 7 you've read and you've set out in your witness
 8 statement, you've read the Theemis report, you have read
 9 the sentencing remarks in the criminal prosecution; is
 10 that right?
 11 **A.** And the CQC Report.
 12 **Q.** Thank you. I won't be asking you about VC's case
 13 specifically today because you haven't had the benefit
 14 of all of the evidence relating to VC. What I want to
 15 ask you today is about your observations relating to
 16 current policy and practice, and also about some
 17 recommendations that you've proposed in your witness
 18 statement?
 19 **A.** Yes.
 20 **Q.** I'd like to start with the Department of Health policy
 21 Best Practice in Managing Risk. We can find that at
 22 DHSC0000038, and that's the March 2009 policy document.
 23 There are several passages that you've identified in
 24 your witness statement and I'll just take you to a few
 25 now.

70

1 Now, those are just a few examples that you have
 2 highlighted amongst others. Can you assist us with what
 3 your view is as to those statements in that policy
 4 document?
 5 **A.** I had read this guidance closely, but in the context of
 6 the reasons why we are here today, and had noted, as
 7 I have done previously across the years, that I was
 8 concerned that in endorsing and continuing,
 9 understandably, to emphasise the principle of least
 10 restrictive practice and related issues of patient
 11 autonomy and empowerment and positive risk management
 12 and related initiatives or policies that emphasise the
 13 right of the patient, there seemed to me to be the
 14 possibility that the place of the victim, who had been
 15 harmed by patients when we're considering matters of
 16 risk, was overlooked.
 17 **Q.** One of the focuses that you've identified in your
 18 witness statement is positive risk management. If we
 19 please could turn to page 11 of this document. I'll
 20 just read to you that first paragraph under the heading
 21 "Fundamentals". It says there:
 22 "Decisions about risk management involve improving
 23 the service user's quality of life and plans for
 24 recovery, while remaining aware of the safety needs of
 25 the service user, their carer and the public. Positive

72

1 risk management as part of a carefully constructed plan
 2 is a desirable competence for all mental health
 3 practitioners, and will make risk management more
 4 effective. Positive risk management can be developed by
 5 using a collaborative approach. Over-defensive practice
 6 is bad practice. Avoiding all possible risks is not
 7 good for the service user or society in the long term,
 8 and can be counterproductive, creating more problems
 9 than it solves."

10 Do you consider that positive risk management has
 11 changed the focus perhaps away from public protection?

12 **A.** Absolutely. I have to remind myself, you know, that I
 13 work with a number of psychiatrists, psychologists,
 14 nurses, social workers, who try their best to intervene
 15 and help, but that there are policy directives that
 16 sometimes underpin our practice that, in my experience,
 17 I believe, are idealistic, naive, and currently are at
 18 the expense of victims and our understanding
 19 consequently of how we manage risk.

20 I add that when I started my career, I probably had
 21 the same idealism, but for acts -- by accident more than
 22 by design, I ended up working with the police service
 23 some 30 years ago, and in working with the police
 24 service, there is -- what happens is on a very frequent
 25 basis, you encounter the damage that has been done, and

73

1 are hoping that a service user is going to be able to
 2 manage their own risk, they say, in this. And by
 3 managing their own risks ultimately, in one of the
 4 recommendations, become more independent of services.
 5 But, of course, critically, that does depend on the
 6 insight, the mental state, the understanding of the
 7 service user. And that probably is the most important
 8 focus for the other -- amongst the three that are
 9 outlined.

10 **Q.** If we stick with the topic of insight, if we turn over
 11 the page, please, to page 12, there's a passage that
 12 you've highlighted in your statement, it's the second
 13 sentence here on the screen:

14 "Psychopathological symptoms can seriously impact on
 15 a service user's ability to critically assess the
 16 implications of some of their actions, and this can
 17 result in unpredictable and potentially dangerous
 18 behaviour."

19 What's your issue with the words that are used here?

20 **A.** I think I said in my statement would it not be more
 21 straightforward just to say that if the service user has
 22 poor insight then they're likely to be dangerous.

23 **Q.** Is the idea that service users are capable of managing
 24 risks themselves, and that that is inappropriate in
 25 cases where they lack insight?

75

1 when you see the damage that has been done, it acts as
 2 a considerable counterweight to some of the principles
 3 that are set out here.

4 And I've tried to speak about the need for that
 5 counterweight across the decades, hence the reason why
 6 I, in the first place, as a private citizen contacted
 7 the Inquiry.

8 **Q.** We see there in terms of positive risk management
 9 reference both to the service user, their carer, and the
 10 public. Is there, in your view, a distinction to draw
 11 between the risk and risk management when it comes to
 12 the self versus to the public? So in terms of potential
 13 risks to the individual patient and the public?

14 **A.** In my statement, I made reference to a review, a very
 15 comprehensive and detailed review, that had been made by
 16 a clinical psychologist called Daniela Just where she
 17 reviewed almost 5,000 policy-related documents, and her
 18 understanding of it was that the whole kind of notion of
 19 positive risk management is confusing for many of us in
 20 terms of what it means, its contradictions. But
 21 importantly, she also highlighted some of the
 22 differences as risk management might apply to those
 23 differentiated as service user, carer, and public.

24 And, of course, risk management espouses, you know,
 25 strengths-based, hopeful, recovery-oriented, where you

74

1 **A.** I'm sorry, say --

2 **Q.** Is your concern essentially that where somebody lacks
 3 insight, the focus on service users managing risks
 4 themselves is not appropriate?

5 **A.** Again, there's a considerable literature on insight, but
 6 my understanding is that there would be an expectation
 7 that the service user would be, first, able to recognise
 8 that there was a change in the way that they were
 9 perceiving and interpreting their experience so that
 10 they thought: I think I'm relapsing, I think my mental
 11 illness is starting again; and secondly, that they would
 12 then begin to attribute the causes of that to illness
 13 and the need for them to have treatment.

14 If those three aspects of insight are not working as
 15 they should, then that's when I struggle with how it
 16 impacts on their own ability to manage their own risk.

17 **Q.** And the phrase that you develop in your statement is
 18 "cautious practice is good practice". What do you mean
 19 by that?

20 **A.** I can understand -- well, I have a reputation for being
 21 cautious, again, probably informed by my experience of
 22 working with a unit that day in, day out, is involved in
 23 the investigation of serious and violent crime, and
 24 I think to say over-defensive practice is bad practice,
 25 to me makes no sense, I think.

76

1 Q. In your statement you've said that in your
2 understanding, this policy was developed without
3 significant policing input. Is that something you're
4 aware of?

5 A. Well, I counted the number of attendees who'd advised in
6 2009 and I think I'd said amongst the -- understandably,
7 you know, we have service users, experts by experience,
8 bureaucrats, policy advisers, many clinicians, but
9 amongst the 89 that I counted, and I could be wrong,
10 I noted that there was one Police Inspector and one
11 crime analyst and, for me, that just seemed to indicate
12 a bias in the way that Mental Health Services were
13 addressing management of risk.

14 I did say there was no representation from senior
15 investigating officers who had been involved in the
16 situation of homicides committed by mentally disordered
17 offenders or patients. There was no representation, as
18 far as I could see, from emergency department staff, and
19 more broadly, it did not include senior command in
20 policing.

21 Q. Thank you. Could we please bring up on screen
22 paragraph 49 of your statement, that's at page 23.

23 You say there:

24 "My clinical and investigative experience and
25 evidence base have taught me that there are occasions

77

1 experiences are going to then affect how somebody goes
2 on, we know that, those experiences can impact on
3 emotional, physical and mental health for the life
4 course.

5 That's what I understood trauma-informed care to be.

6 Q. And what about risk of harm-informed care? Is that your
7 own idea or is that somebody else's?

8 A. It's mine, but it won't go down well.

9 Q. What do you mean by that?

10 A. Well, as in I think it will be seen as -- it'll be seen
11 as an emotional and pejorative term. I see it as
12 a counterweight whereby it allows consideration of the
13 harm that has been done.

14 Q. Is there not a risk that if you shift too much in that
15 direction, a patient might be less open, might be less
16 accepting of treatment?

17 A. Yeah, there is that risk, yeah. Absolutely, yeah. But
18 some of us work within the context of that risk all the
19 time, and recognise that in trying to have an
20 understanding of how and why somebody has caused harm,
21 there's a requirement for probing, searching questions,
22 but in a way that's still sensitive to the experience of
23 the patient.

24 Q. One of the examples you gave in your witness statement
25 was an HM Inspectorate of Probation report in the case

79

1 when Trauma Informed Care may also need to be practiced
2 in conjunction with Risk of Harm Informed Care. Namely,
3 it is reasonable to be mindful that as a consequence of
4 repeated or chronic trauma, there are people who may
5 experience distressing hallucinations and beliefs that
6 they are going to be harmed, to a degree that they are
7 at risk of perpetrating harm to themselves and [to]
8 other people. It is again fully acknowledged that there
9 are negative stigmatising effects in highlighting the
10 potential link between mental illness and violence.
11 However, it is confusing and misleading to service
12 users, their families, the public and the victims of any
13 related offences to diminish or deny that link."

14 What do you understand by trauma-informed care and
15 how does that sit alongside risk of harm-informed care?

16 A. My understanding of trauma-informed care in brief would
17 begin with the work of Sir John Bowlby, a psychiatrist
18 who has spent his career looking at the effects of
19 separation on children, and he had various maxims, one
20 of the most fundamental being "As we start, we tend to
21 go on", and if a child has experienced neglect,
22 emotional harm, sexual and violent abuse, the harm that
23 we see associated with deprivation, then that would be
24 understood in a more universal category of trauma, and
25 that having given -- having seen that adverse child

78

1 of Anthony Rice, and I'll bring that up onto screen,
2 that's WITN0338011. That's a 2006 report. If we turn
3 over to page 2 we can see the background. It says
4 there:

5 "In October 2005 Anthony Rice was convicted of the
6 murder of Naomi Bryant on 17th August 2005, at a time
7 when he was being supervised on a Life Licence by
8 Hampshire Probation Area. A number of other agencies
9 had been working jointly with the Probation Service on
10 this case through the Hampshire MAPPAs ..."

11 If we turn over to page 5, we see "Principal
12 Findings and ... Recommendations". This is "Principal
13 Finding [number] 3" you've pointed to. If we scroll
14 down, "Principal Finding [number] 3" says as follows:

15 "Based on the reports received about the progress
16 that he had made during his sentence and his proposed
17 resettlement plan, the Parole Board made a final
18 decision in 2004 that Anthony Rice, who was five years
19 past his 'tariff date', was safe to release. We
20 consider that in doing so they gave insufficient weight
21 to the underlying nature of his Risk of Harm to others,
22 and we think this happened for a combination of
23 reasons".

24 And it's the second reason that you point to in your
25 witness statement, that is that:

80

1 "They received cautiously encouraging but ultimately
2 over-optimistic reports of Anthony Rice's progress under
3 treatment."

- 4 Now this is only a single case. Is there, to your
5 knowledge, a body of evidence that suggests there are
6 overly optimistic attitudes in the context of treatment
7 of those pose serious risks?
- 8 **A.** I can't comment on the number of Serious Case Reviews in
9 relation to homicides by men released from prison, but
10 in the review that I tried to make of the cases, say,
11 that are contained in the Hundred Families dataset,
12 there are numerous examples pointed out where clinicians
13 appear to have, as is stated, omitted and minimised the
14 seriousness of past violence, given undue consideration
15 to the possibility of future violence, and have
16 disregarded ominous signs or warning signs that have
17 been made by families, which in some, I think, are
18 understood as then clinicians and others presenting to
19 either Mental Health Review Tribunals or Parole Board
20 what could, with hindsight, then be considered as
21 over-optimistic reports.
- 22 **Q.** Can we now bring on to screen the Royal College of
23 Psychiatrists report, that is at WITN0058002. The
24 Inquiry has already seen this report and heard from
25 Professor Morgan in relation to this report.

81

- 1 services more easily recognise, in protecting the
2 public.
- 3 **Q.** You've pointed to one of the key findings in particular.
4 If we turn over the page, please, at paragraph 5 there,
5 it says:
- 6 "A pre-occupation with risk to others that leads to
7 over-simplistic responses ... can skew professional
8 practice, with unintended consequences. Striving to
9 assess and manage such risks is an essential
10 professional duty. However, rates of homicide by
11 patients have not varied greatly, despite considerable
12 changes in professional practices. A nuanced approach
13 is required, acknowledging that our patients are more
14 [at] risk to themselves or from others, than posing
15 risks to others. This is by a large order of
16 magnitude."
- 17 What is your concern about that approach?
- 18 **A.** That, again, I think you might refer to it as hedging,
19 as in there's an attempt to acknowledge the rate of
20 homicide by patients. But at the same time, it seems to
21 diminish what that risk might be. You will know that
22 the Homicides committed by mentally ill service users,
23 it's a rare event.

24 Nevertheless, there's an average rate of anything
25 that's listed between 50 and 75 per year. I think that

83

1 If we please turn to page 5, we can see the
2 executive summary there. On the right-hand side the
3 third paragraph down, it says as follows, it says:

4 "Tensions remain, and psychiatrists' duty to protect
5 the public needs to be integrated with their primary
6 duty to assess and treat their patients. Thus 'risk to
7 others' gets to the heart of our profession, and our
8 ability to assess and manage risk is a key part of our
9 professional identity".

10 Is this in some way a shift towards the kind of
11 protection that you're talking about, or not?

- 12 **A.** Yes, it's a shift, but I respect my Royal College of
13 Psychiatrist colleagues, but as the paragraph begins,
14 "Tensions remain", and perhaps sometimes ambivalence
15 remains, and my own personal code is that, as
16 a clinician, or a citizen involved in, you know, the
17 role that I have, for me, protection of the public is my
18 primary responsibility.

19 That does not in any way stop me from having the
20 compassion and respect that I need to have towards the
21 service user in assessing or providing intervention.
22 But alongside it, I just think I need to recognise that
23 in some instances there is a risk of harm, and that I
24 need to take account of that. First, meaning I have
25 a primary responsibility, as indeed it seems to be other

82

1 there's a need for the professions and disciplines
2 involved to actually considerably review their practice
3 and attitude towards that figure.

4 Everywhere, when we look in the risk literature, not
5 everywhere, but you'll see in many papers and indeed in
6 conference presentations, there's always the beginning
7 that patients are more at risk to themselves or from
8 others than posing a risk to others. I don't deny that.
9 But there are also those patients who we have to accept
10 can be, when they are not treated, supervised, or
11 otherwise adequately safeguarded, they can be very
12 dangerous. And there seems to be a lack of
13 acknowledgement sometimes to say that publicly.

- 14 **Q.** You mentioned that the 50 to 70 figure, we've heard
15 evidence from Dr Faizal that there are about 50
16 homicides committed each other, but that figure is
17 limited to those who had contact with mental health
18 services in the previous 12 months so perhaps that
19 understates the overall figure.

20 **A.** Indeed.

- 21 **Q.** What is your view about the collection of data in this
22 respect?

23 **A.** Well, up until, I think it was, 2018, the National
24 Confidential Inquiry into Suicide and then as it was
25 named homicide, an Inquiry that was based, and remains

84

- 1 based, at the University of Manchester was exceptional
2 in its diligence in collecting data, but that changed,
3 though I understand that that may have been
4 reinstated.
- 5 **Q.** Should, for example, data be collected in respect of
6 serious harm in addition to homicide, or do you have any
7 other views as to the collection of data?
- 8 **A.** I've said in my statement that I think that the homicide
9 rate is an inaccurate or not a very valid metric of harm
10 done, and what I also highlighted, for example, was in
11 the year ending 2025, I think there were 32,000
12 Section 136s where the police had been involved in
13 taking somebody to a place of safety. Of course those
14 incidents may involve where individuals have been at
15 risk of suicide but also frequently they involve
16 occasions when the police are involved in trying to
17 address a situation where there's violence.
- 18 We also know that there's often violence within the
19 family that gets unreported, there's certainly violence
20 on psychiatric wards that gets unreported. So I don't
21 think the homicide rate is an accurate metric.
- 22 **Q.** I'll move on now to recommendations. The first of
23 several recommendations that you make relates to
24 inter-agency risk reference panels?
- 25 **A.** Yes.

85

- 1 to the attention of law enforcement of having been
2 convicted, where we have had, for example, instances of
3 continuing disruption, social harm, where there have
4 been occasions when significant emergency services have
5 had to respond to a situation but where there has not
6 necessarily been a conviction subsequently, those kind
7 of occasions.
- 8 **Q.** Moving on to another recommendation, you say that there
9 should be greater focus on the victim in mental health
10 services. Can you expand on how you say the police
11 operate as a victims'-focused service?
- 12 **A.** Well, this issue gets to the heart of perhaps some of
13 the reasons why I was motivated to send a note in
14 originally, and again, it goes back to my experience as
15 a clinician, and this is not to castigate, you know, my
16 mental health colleagues; this is about custom and
17 practice over years.
- 18 I'm sorry if it might require a longer answer, but
19 essentially, as I worked through my career as a Forensic
20 Clinical Psychologist, I would have many occasions to
21 attend case conferences and discussions. And it may
22 come as something of a surprise to a lay audience, but
23 this not an exaggeration and will still be ongoing of
24 countless instances of attending case conferences about
25 an offender-patient where the victim of any offence

87

- 1 **Q.** What is it you have in mind there?
- 2 **A.** Well, I was just in my kind of research around MAPPA,
3 and other alternatives. The reason why I made that
4 recommendation was that if there is going to be improved
5 inter-agency co-operation and sharing of information,
6 then perhaps we need to extend the services that are
7 available beyond MAPPA. And whilst MAPPA functions very
8 effectively, there seem to be instances, particularly
9 again where police, social services, health are
10 involved, where an individual has not committed an
11 offence of a kind that brings them to the attention of
12 MAPPA, and perhaps we need to have an extra service that
13 might usefully consider, importantly, sharing of
14 information and shared responsibility in managing
15 somebody's risk. And that Risk Reference Panel, because
16 it involved agencies like Housing, Social Care, Health,
17 and maybe the police, that seemed to offer an option.
- 18 **Q.** So it is something that has been implemented at some
19 point?
- 20 **A.** I think it's implemented in parts of Wales, I think.
- 21 **Q.** Where would you set the threshold, in terms of
22 involvement?
- 23 **A.** Ah ...
- 24 **Q.** Or what factors might you consider?
- 25 **A.** Risk of harm, but not necessarily where someone has come

86

- 1 cannot be named, the nature of the injuries will not be
2 known, and yet we're making decisions about the risk
3 that they present. And that was brought into sharper
4 focus when I was working with the police.
- 5 Again, it sounds rather emotive but, you know, you
6 go to a murder incident room and for all the criticisms
7 that the police may face, when they are operating in
8 that circumstance, I have seen them, they'll have
9 a notebook, the victim will be referred to by their
10 first name, habitually, they will carry oftentimes
11 a photograph of them in their notebook. They'll talk
12 about him or her in terms of the parents are arriving
13 or, you know, and there is this presence of a victim.
- 14 And I've found that, as my involvement with the
15 police continued, to be in absolute marked contrast to
16 what was happening when I was working in hospitals, and
17 I found it hard to reconcile.
- 18 **Q.** How do you translate that into a mental health service?
- 19 **A.** I think, within the policy recommendations. Again, you
20 know, I'm trying to be dispassionate about this, but
21 I think that if we're trying to understand why the
22 patient in front of us has ended up, say, in a forensic
23 setting where there is a criminal history and a history
24 of violence, sexual violence, then where appropriate, we
25 should have in our records the name of that victim, and

88

1 we should have a detail of the injuries and
 2 circumstance, the circumstances in which the injuries
 3 were sustained. We should have more access to the
 4 sentencing remarks from trial. We should have more
 5 access to the collateral sources of information about an
 6 investigation, because otherwise we can rely, sometimes
 7 solely, on the account that's provided by the
 8 offender-patient, and my experience can tell you
 9 frequently that that account can be at a considerable
 10 distance from what has actually happened.
 11 **Q.** In terms of detail about the underlying offence, you've
 12 said in your statement that when it is provided, it is
 13 disregarded. Do you have personal experience of that?
 14 **A.** It's not always -- it's not always disregarded. It's
 15 sometimes disregarded. What I've tried to say is that
 16 we have a situation where we are expected, and indeed
 17 are duty bound to be compassionate and respectful to the
 18 patient in front of us, and that has a trauma-informed
 19 ethos in our approach. And yet, at the same time, we
 20 have to also confront the fact that they have inflicted
 21 harm.
 22 When you have those two elements, they can be very
 23 uncomfortable for people to keep in mind at the same
 24 time. I'm not trying to be clever in terms of
 25 psychological theory, but there's something called

1 separately?
 2 **A.** It can be incorporated into risk assessment. But
 3 that -- what I refer to as an investigative focus has
 4 probably been significantly influenced by my experience
 5 of working on major crime investigations, where I have
 6 necessarily had to read and review forensic pathology,
 7 other forensic-related reports. I've been with
 8 investigators, police officers, and related
 9 multidisciplinary investigative specialists. So you
 10 develop an understanding where you become much more
 11 focused on the detail, granularity, of what has happened
 12 and how that helps you make sense of what this offence
 13 meant to the offender.
 14 Just if an offence happens, if somebody is attacked
 15 from the front, that's a very different offence than if
 16 somebody is attacked from behind. You know, the weapon
 17 that is used, if it's a kitchen knife, it's a very
 18 different from if it's a hammer. You know, I have ended
 19 up going into that kind of detail and I think it's that
 20 kind of detail that we need to inform risk.
 21 **Q.** Does that require a closer relationship between the
 22 police and the mental health services?
 23 **A.** Yes.
 24 **Q.** And presumably an increased role for the police. We
 25 have heard in evidence about Right Care, Right Person,

1 cognitive dissonance. It's not easy to hold two
 2 conflicting sets of information at the same time, and,
 3 therefore, sometimes people are minded to avoid
 4 information or situations that kind of increase that,
 5 you know, what's called dissonance. And that's why it
 6 can be disregarded.
 7 **Q.** I want to explore with you how that can sit alongside
 8 formal risk assessment processes. If we can bring up on
 9 to screen paragraph 93 of your statement, that's at
 10 page 44. Halfway down that paragraph, you say:
 11 "My experience, having applied such tools, is that
 12 they can miss significant (victim, location, weapon,
 13 duration, injury) details of the index offence, the
 14 actions of the perpetrator and the social, cultural and
 15 lifestyle context in which the offending has occurred --
 16 all of which should be the starting point of any
 17 assessment of risk of harm ... However, to achieve this
 18 kind of understanding of risk, forensic clinicians may
 19 need to develop an investigative focus and a readiness
 20 to consider more carefully the nature of the injuries,
 21 the method by which they were inflicted on a victim and
 22 the circumstances in which the patient and the victim
 23 lived and interacted."
 24 How can that be incorporated into a risk assessment
 25 tool or can it, or does it need to be considered

1 which reduces, intentionally reduces, the amount of time
 2 the police spend responding to mental health incidents.
 3 Are you saying that actually what is required is greater
 4 involvement by the police in risk assessment?
 5 **A.** Well, Right Care, Right Person isn't universally
 6 accepted by everyone, but it's probably a separate
 7 notion or domain. I'm talking about perhaps a readiness
 8 to involve the police who are over an original
 9 investigation, to sit down with them, to have a better
 10 understanding of the nature of the offence. Yeah,
 11 I think that should happen.
 12 **Q.** Another recommendation you've made is, or suggested, is
 13 improved access for the police to specialists in mental
 14 health?
 15 **A.** Yes.
 16 **Q.** For what purpose?
 17 **A.** Because there are repeated observations made, especially
 18 in recent years, about how broken mental health services
 19 are, and that the police are left to pick up the pieces,
 20 and we expect the police service to then step in, and
 21 sometimes, despite, you know, their best efforts, there
 22 should be more immediate access, I think, to
 23 specialists, because sometimes you need that specialist
 24 help.
 25 There are initiatives like Street Triage, and there

1 are some clinicians in incident rooms, but I think that
 2 we need to have more involvement.

3 **Q.** Final topic, training. What is your concern about the
 4 current state of training in this regard?

5 **A.** Relating to?

6 **Q.** The matters that you've raised today in your evidence.

7 **A.** Well, I've suggested that, as an absolute basic,
 8 clinicians should have to read some of the Inquiry
 9 reports that go back across these 30 years where
 10 obviously lessons appear not to have been learned.

11 I've asked that, you know, as recently as a couple
 12 of weeks ago, I sit down with a group of psychiatrists
 13 and I say "Who's read the falling shadow about Georgina
 14 Robinson?" Nobody. "Who's read the Clunis Report?"
 15 Nobody."

16 You know, we need to have lessons learned,
 17 instilled, not into policy directives, but into
 18 training, across the board.

19 **Q.** Is your focus there on early stage training, ongoing
 20 training, or something else?

21 **A.** Well, early stage and continuous professional
 22 development training, and then there's this whole other
 23 area of how to increase this what I've referred to as an
 24 investigative focus in trying to supplement better our
 25 understanding of risk.

93

1 conduct.

2 **Q.** Thank you. Then just perhaps building on that, could
 3 I just briefly have displayed paragraph 4 of your
 4 witness statement, WITN0338001 at page 2. Thank you.
 5 Paragraph 4. Just building on where you say in the
 6 middle of the page:

7 "While concerns about stigma and unnecessary
 8 coercion are valid, and the majority of people with
 9 schizophrenia and other mental illnesses are not
 10 violent, public protection goes beyond mere awareness of
 11 'safety needs'. The Inquiry could therefore serve as an
 12 opportunity for the Royal College of Psychiatrists and
 13 other professions to reflect on their responsibilities
 14 in protecting the public, which in my view should be
 15 their priority."

16 So really, are you expecting guidance from the Royal
 17 College of Psychiatrists to make clear what's required
 18 when making assessments of risk?

19 **A.** Yes.

20 **Q.** Can I just be clear, when you're referencing "other
 21 professionals", who are you thinking of, by way of those
 22 other professions?

23 **A.** So within mental health services there would be
 24 representation by nursing, social work, psychology, and
 25 other, you know, ancillary professions.

95

1 **MR BLAKE:** Thank you, Dr West. Those are all the questions
 2 I have to ask. There are some questions from Core
 3 Participants.

4 **THE CHAIR:** Yes, Ms Cartwright.

5 **Questioned by MS CARTWRIGHT**

6 **MS CARTWRIGHT:** Good afternoon, Dr West. I ask questions on
 7 behalf of the survivors.

8 Can I just seek clarification, please, in respect of
 9 some of the evidence you've given to Mr Blake. You told
 10 us there are policy directives that underpin our
 11 practice that are in your experience, idealistic, naive,
 12 and currently at the expense of victims and our
 13 understanding consequently of how we manage risk.

14 Can I just be clear when you say "policy directive",
 15 what you're referring to?

16 **A.** Perhaps policy directives -- I mean, it's right for the
 17 clarification. I think there are Best Guidance
 18 Frameworks and then there are guidance that comes out
 19 from NHS England and others, where there seems to be
 20 an emphasis on, for example, positive risk management,
 21 trauma-informed care.

22 Perhaps they're not coming out as directives, but
 23 they are implicitly, through their recommendations,
 24 giving guidance on how they expect clinicians to behave
 25 and the attitudes that they should have to support that

94

1 **Q.** Thank you. Now obviously noting your experience as
 2 having worked in high and medium secure facilities as
 3 you've detailed in your witness statement, you've
 4 already explained what you mean by trauma-informed care
 5 and I think you've made some reference to Bowlby's
 6 attachment theory. But you said this also in evidence:

7 **"Answer:** ... in trying to have an understanding ...
 8 how and why somebody has caused harm, there's
 9 a requirement for probing, searching questions, but
 10 [that are] ...still sensitive to the experience of the
 11 patient."

12 And really would you agree that there should be
 13 an absolute minimum where there's been a harm event for
 14 those searching, probing questions you've identified to
 15 take place with a patient?

16 **A.** Yes, and the problem is that the reasons why I have
 17 tried to emphasise this emphasis on the nature of the
 18 offence is because, again, in my experience, and this is
 19 recorded by, you know, other colleagues, they will say
 20 that consideration of the index offence is sometimes
 21 a very second thought, which is only given thought when
 22 the patient is about to be discharged.

23 **MS CARTWRIGHT:** Okay. Thank you very much, Dr West.

24 **THE CHAIR:** Thank you.

25 Ms Grey. Ah, Mr Williamson.

96

Questioned by MR WILLIAMSON

MR WILLIAMSON: Dr West, I ask questions on behalf of Nottinghamshire Police.

Just two brief topics, please, expanding on some of the matters in your statement and which Mr Blake dealt with with you, can we have your witness statement at page 21. This is just developing, in paragraph 46, something you were asked about by Ms Cartwright. I just want to draw out the passage that says:

"Perhaps this Inquiry provides an opportunity for Psychiatry and other mental health professionals to consider carefully their responsibility and expertise in protecting the public."

What is the expertise in protecting the public you're referring to there, please?

A. So, psychiatry and related disciplines, I'm a Forensic Clinical Psychologist, have an extensive history of trying to understand the causes of violence, including sexual violence. That involves incorporating a range of disciplines, criminology, investigative psychology, abnormal psychology, psychopathology. There's a whole research, evidence -- a research base, a theoretical evidence base, as well as the experience that those professions have had in attempting to assess and deal with those offenders, and I think that across the years,

97

expect them to be specialists when specialist help is needed.

Q. Ultimately, as a 24/7 service the police may become involved, become responsible, and they may not be the right service to do so?

A. Well, indeed, yeah. One of the things I -- again, in preparation and reflection, the police service are 24-hour, always there, and I think, you know, sometimes they are wired differently to other services, in terms of response to urgent need. I don't think -- "urgent" in mental health doesn't seem to have the same meaning as what "urgent" has to the police.

Q. What that means in practice is that already over-stretched police officers can't always respond appropriately.

A. No, they can't.

Q. And there is only so much that they can do. Do you agree that public services need to work together to prevent the need for a crisis response in the first place?

A. I have experience, although I'm limited in affiliation, but I'm also a Special Constable, so I have some first-hand experience of immediate response in its having to deal with crises. And again, you know, I'm not demeaning the efforts of those other agencies. Many

99

then, they've developed specialist knowledge of how to apply that understanding from the evidence base as well as the clinical experience, to protect the public.

Q. So that applies across the spectrum of different mental health services, not just psychiatry?

A. It's not just psychiatry, no.

Q. And you were asked by Mr Blake about Right Care, Right Person in relation to the police --

A. Yeah.

Q. -- and reducing the involvement of the police. Police officers don't have that same expertise that you've been describing there, do they?

A. No, they do not.

Q. They don't have the expertise required to deal with people with complex or high risk mental health problems.

A. No, and indeed, in my preparation, you know, I highlighted the work that had been done by Zoë Billingham again in trying to address the deficits in other services who then, either through resource constraints or other demand, are left to leave the responsibility for dealing with mental health crises, you know, to the police. And I know that, you know, police training is under review, but I do think that there is a place for increased awareness of mental health -- mental illness presentations, but we can't

98

agencies, partners, will say they're overwhelmed.

I just think that somehow we have to be able to improve the way we work together, and so much of that seems to be limited by the constraints around information sharing. And the readiness of some of those other services to help, instead of saying "There's no evidence of enduring and severe mental illness, the problem's yours," you know, there has to be more evidence to help, collectively.

Q. Before I move to information sharing, professional help with the right expertise needs to be available and provided whenever the patient or potential patient needs it?

A. Yes.

Q. And those needs, like mental health crises, don't just arise during office hours?

A. No, they don't.

Q. Information sharing, please. Can we have on screen page 21 of the statement. Paragraph 47, please. Dr West, looking at the last three lines from the bottom of that paragraph, you say:

"... I question whether there are some mental health services which see themselves as different and separate from other protective services."

Do you see that?

100

- 1 **A.** *(No audible answer).*
- 2 **Q.** Are the police one such protective service who you
3 consider are treated as separate by mental health
4 services?
- 5 **A.** I think I saw it the other way round. I think that the
6 police service sees itself as fundamentally protecting
7 life and limb, and I see that as at the core of what it
8 tries to deliver all the time, and I think sometimes
9 mental health services don't have that same underlying
10 value about where they sit in protecting the public.
- 11 **Q.** I see. Can we now have on screen page 33, paragraph 70,
12 please.
- 13 This has been touched on already but I just want to
14 deal with where you say:
- 15 "In working with the Police, [you] ... began to
16 notice that despite the instruction of the Home Office
17 about what should be included in reports for mental
18 health review tribunals ... explanations as to why the
19 index offence was committed, often included scant
20 reference to how the offence was committed."
- 21 In your view, is there greater scope for mental
22 health services, when managing a patient, to have
23 contact with the police in order to obtain more
24 information, including about how the offence was
25 committed?

101

- 1 expertise?
- 2 **A.** Again, yeah, that's possible, yeah.
- 3 **Q.** The police are unlikely to have the same level of
4 contact with a patient?
- 5 **A.** Well, it depends on whether we're dealing with somebody
6 who is well known to them or not, but again, this is
7 about the more information that we have available to us
8 from the various services involved, whether that means
9 a GP, a health visitor, a teacher, there are times when
10 we need to be able to get over the constraint around
11 confidentiality and recognise that there is a risk of
12 harm, and in the sharing of information, should that
13 require breaching of confidentiality, providing we're
14 doing it for the best interests of the person and the
15 person who may be harmed, then I think we need to find
16 ways of improving our information sharing.
- 17 **Q.** But in terms of patient contact, a person who is an
18 inpatient for, say, a number of weeks, mental health
19 services are likely to have had more contact with them
20 than the police would in perhaps effecting an arrest or
21 something of that nature?
- 22 **A.** Yeah.
- 23 **Q.** Page 45, please, paragraph 95, under the heading "Risk
24 assessment in everyday clinical practice", you describe
25 there handovers, case conferences, meetings and then you

103

- 1 **A.** Yes, there is greater scope. In my own experience,
2 I have been able to contact police officers involved,
3 and had sometimes meetings with them. The information,
4 then, that they've been able to provide in terms of how
5 the offence was committed has considerably enhanced my
6 understanding of the causal pathways of that offence,
7 and then its implications for the treatment of the
8 person, and subsequently how their risk is assessed.
- 9 **Q.** More information about victims, the victim focus that
10 you've talked about.
- 11 **A.** Yeah.
- 12 **Q.** Also to gain more information generally, for example,
13 wider details of police involvement with that
14 individual?
- 15 **A.** Definitely.
- 16 **Q.** Or details of, or reasons for, any particular criminal
17 justice outcome?
- 18 **A.** Including when there has not been a progression to
19 court.
- 20 **Q.** Do you agree that the police may be well placed to
21 provide information if asked, but which they may not
22 offer or volunteer because the potential clinical
23 significance may not be recognised by them?
- 24 **A.** Yeah, that's possible, yeah.
- 25 **Q.** Because the police don't have the relevant clinical

102

- 1 say in the last three lines:
- 2 "These meetings are also more likely to focus on
3 developing a detailed understanding of [a] patient's
4 risk and relapse signatures."
- 5 Do you see that?
- 6 **A.** Yes.
- 7 **Q.** Pausing there, I asked you about mental health services
8 obtaining information from the police. Is there also
9 greater scope, for example when a patient is being
10 discharged into the community, for them to contact the
11 police and provide information in respect of a patient's
12 risk and relapse, which may be relevant to the risk
13 posed to the wider public?
- 14 **A.** Yes, indeed, and perhaps that goes to the heart, again,
15 of some of the implications of what I am trying to
16 address. The constraint is around the restrictions and
17 impositions on confidentiality and the sharing of
18 information, and if that's done in a wrong way, people
19 can, clinicians, can face sanction from their
20 professional bodies.
- 21 **Q.** You go on within that paragraph, you say:
- 22 "At their most effective functioning, they involve
23 members of external agencies, for example, the Prison
24 Service or Probation but very rarely the Police
25 Service."

104

1 Looking forward, do you consider that that very rare
 2 involvement of the police service does need to change?
 3 **A.** It does need to change and, again, that probably
 4 reflected, you know, my experience of a particular unit.
 5 There may be other units where there are -- where
 6 there's more consistent police involvement. I think
 7 that our medium secure units could significantly benefit
 8 from having more organised, consistent, presence from
 9 the police service. Not only to facilitate exchange of
 10 information, but also because, you know, sometimes units
 11 are almost like a semi-permeable membrane in terms of
 12 drugs that are getting in, other things that are
 13 happening. All those things could be addressed if we
 14 had more of a presence rather than what is sometimes
 15 understandably an *ad hoc* presence.
 16 **Q.** Might that also be one way to strengthen risk
 17 assessments?
 18 **A.** Absolutely it would strengthen risk assessment.
 19 **Q.** Finally this, please: in terms of the recommendations
 20 and changes that you have dealt with, are you able to
 21 say from your experience whether the resource of the
 22 police service would require augmentation to enable the
 23 police to assist mental health practitioners in the
 24 regard that you've outlined?
 25 **A.** I think the augmentation needs to come first in
 105

1 training, but also in the hoped-for involvement of other
 2 services, perhaps seconded in to police stations so that
 3 there's more joint working.
 4 **Q.** But in terms of what you envisage, it would a represent
 5 significant additional burden on the police service?
 6 **A.** Oh, it would, yeah. It would, yeah. They won't be glad
 7 that I've made that recommendation.
 8 **MR WILLIAMSON:** Thank you, doctor. Thank you, Chair.
 9 **THE CHAIR:** Thank you. We'll finish there now and start
 10 again at 2.00, thank you.
 11 **(12.59 pm)**
 12 **(The short adjournment)**
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 16
 17
 18
 19
 20
 21
 22
 23
 24
 25

1 **INDEX**

2 Page

3 PROFESSOR SIR JAMES LOUIS JOHN APPLEBY (sworn)1

4 Questioned by MR WESTON 1

5 Questioned by MR MOLONEY 56

6 Questioned by THE CHAIR 58

7

8 DR ADRIAN GERARD WEST (sworn) 68

9 Questioned by MR BLAKE 68

10 Questioned by MS CARTWRIGHT 94

11 Questioned by MR WILLIAMSON 97

12

13

14

15

16

17

18

19

20

21

22

23

24

25

<p>MR BLAKE: [3] 68/22 69/3 94/1</p> <p>MR MOLONEY: [2] 56/16 58/21</p> <p>MR WESTON: [3] 1/4 1/7 56/11</p> <p>MR WILLIAMSON: [2] 97/2 106/8</p> <p>MS CARTWRIGHT: [2] 94/6 96/23</p> <p>THE CHAIR: [27] 1/3 56/13 58/23 59/8 59/14 59/23 59/25 60/2 60/6 60/14 60/17 61/4 61/10 61/21 62/4 62/22 63/17 63/24 65/3 67/4 68/14 68/16 68/21 69/1 94/4 96/24 106/9</p> <hr/> <p>'compelling [1] 26/14</p> <p>'risk [1] 82/6</p> <p>'safety [1] 95/11</p> <p>'tariff [1] 80/19</p> <hr/> <p>-</p> <hr/> <p>-- and [2] 34/21 51/23</p> <p>-- it [1] 54/6</p> <hr/> <p>.</p> <hr/> <p>...family [1] 12/10</p> <p>...still [1] 96/10</p> <hr/> <p>0</p> <p>001 [1] 4/17</p> <p>003 [1] 4/6</p> <hr/> <p>1</p> <p>1 per [1] 19/9</p> <p>10 [2] 20/18 45/24</p> <p>10 years [1] 57/1</p> <p>10-year [2] 45/25 49/10</p> <p>10.00 [1] 1/2</p> <p>100 [2] 46/14 46/17</p> <p>109 [1] 5/10</p> <p>11 [2] 15/3 72/19</p> <p>11.33 [1] 68/18</p> <p>11.50 [1] 68/17</p> <p>11.51 [1] 68/20</p> <p>110 [1] 26/9</p> <p>113 [1] 12/8</p> <p>115 [2] 12/14 13/22</p> <p>116 [2] 14/5 14/20</p> <p>117 [2] 13/16 14/3</p> <p>118 [3] 14/9 42/18 43/7</p> <p>12 [2] 14/12 75/11</p> <p>12 months [4] 8/8 8/23 9/6 84/18</p> <p>12-month [2] 9/6 9/10</p> <p>12.59 [1] 106/11</p> <p>136s [1] 85/12</p>	<p>14 [1] 47/10</p> <p>15-year [1] 19/7</p> <p>158 [1] 42/17</p> <p>16 [2] 12/4 12/12</p> <p>160 homicides [1] 19/6</p> <p>17th August 2005 [1] 80/6</p> <p>18 [2] 12/11 25/6</p> <p>19 [3] 10/24 12/11 25/15</p> <p>192 [1] 14/10</p> <p>1980 [1] 2/4</p> <p>1983 [1] 42/18</p> <p>1990s [2] 37/7 54/10</p> <p>1991 [1] 2/6</p> <p>1994 [1] 62/7</p> <p>1996 [7] 1/18 1/24 2/2 2/3 2/8 2/24 3/15</p> <p>1997 [1] 15/13</p> <p>1999 [1] 35/1</p> <hr/> <p>2</p> <p>2.00 [1] 106/10</p> <p>2000 [1] 2/13</p> <p>2000s [4] 28/4 37/17 45/22 48/15</p> <p>2002 [1] 25/10</p> <p>2004 [1] 80/18</p> <p>2005 [5] 10/21 12/2 13/8 80/5 80/6</p> <p>2005-2015 [1] 14/23</p> <p>2006 [1] 80/2</p> <p>2007 [2] 36/11 36/17</p> <p>2009 [3] 25/10 70/22 77/6</p> <p>2010 [9] 2/13 2/17 25/12 26/4 27/5 34/24 35/19 47/24 49/12</p> <p>2012 [2] 17/14 17/15</p> <p>2013 [1] 2/21</p> <p>2014 [2] 2/17 5/13</p> <p>2015 [5] 5/13 10/21 12/2 13/8 14/23</p> <p>2017 [3] 4/17 4/19 23/3</p> <p>2018 [13] 3/9 4/21 15/10 20/14 20/20 21/2 26/16 28/20 32/25 33/8 33/15 35/5 84/23</p> <p>2019 [3] 2/21 26/14 26/23</p> <p>2020 [1] 17/14</p> <p>2023 [1] 49/12</p> <p>2025 [4] 1/8 42/25 69/4 85/11</p> <p>2026 [1] 1/1</p> <p>21 [2] 97/7 100/19</p> <p>22 [1] 35/25</p> <p>23 [2] 43/14 77/22</p> <p>24 [3] 12/7 49/22 71/16</p> <p>24 October 2025 [1] 1/8</p> <p>24-hour [1] 99/8</p>	<p>24/7 [1] 46/8</p> <p>25 [1] 52/24</p> <p>281 [1] 13/11</p> <p>29 May 2026 [1] 1/1</p> <p>2B [1] 42/19</p> <hr/> <p>3</p> <p>30 years [5] 55/5 55/25 65/22 73/23 93/9</p> <p>31 [1] 12/5</p> <p>32 [2] 13/17 13/24</p> <p>32,000 [1] 85/11</p> <p>33 [1] 101/11</p> <p>35 [2] 14/17 46/1</p> <p>355 [1] 14/22</p> <p>356 [2] 12/15 15/2</p> <p>357 [1] 15/6</p> <p>36 [1] 11/7</p> <p>360 [1] 26/12</p> <hr/> <p>4</p> <p>44 [2] 4/25 90/10</p> <p>45 [1] 103/23</p> <p>46 [4] 5/22 10/17 12/10 97/7</p> <p>47 [2] 12/8 100/19</p> <p>48 [1] 14/17</p> <p>49 [1] 77/22</p> <hr/> <p>5</p> <p>5,000 [1] 74/17</p> <p>50 [5] 11/2 14/17 83/25 84/14 84/15</p> <p>51 [1] 12/1</p> <p>53 [1] 11/3</p> <p>542 [1] 17/19</p> <p>58 [1] 5/15</p> <p>580-odd [1] 59/3</p> <p>59 [1] 14/5</p> <hr/> <p>6</p> <p>61 [1] 5/16</p> <p>632 [1] 5/12</p> <p>640 [1] 10/20</p> <p>641 [6] 5/14 6/1 6/12 7/22 8/12 9/13</p> <p>65 [1] 13/17</p> <p>674 [1] 5/16</p> <hr/> <p>7</p> <p>70 [2] 84/14 101/11</p> <p>73 [2] 11/4 12/6</p> <p>75 [1] 83/25</p> <p>77 [1] 11/3</p> <p>78 [1] 11/5</p> <hr/> <p>8</p> <p>82 [1] 10/23</p> <p>835 [1] 14/23</p> <p>85 [1] 10/23</p> <p>88 [1] 14/10</p> <p>89 [1] 77/9</p> <hr/> <p>9</p> <p>92 [1] 13/11</p>	<p>93 [1] 90/9</p> <p>94 [1] 19/3</p> <p>95 [3] 6/15 9/20 103/23</p> <hr/> <p>A</p> <p>ability [4] 49/6 75/15 76/16 82/8</p> <p>able [11] 23/25 51/9 51/16 58/8 75/1 76/7 100/2 102/2 102/4 103/10 105/20</p> <p>abnormal [2] 11/6 97/21</p> <p>about [131]</p> <p>above [2] 36/1 53/2</p> <p>absence [1] 15/18</p> <p>absolute [4] 31/3 88/15 93/7 96/13</p> <p>absolutely [6] 40/11 55/3 58/5 73/12 79/17 105/18</p> <p>abuse [1] 78/22</p> <p>academic [5] 17/3 17/6 17/6 17/7 17/10</p> <p>accept [4] 7/8 48/6 51/18 84/9</p> <p>accepted [2] 57/7 92/6</p> <p>accepting [1] 79/16</p> <p>access [6] 51/21 52/13 89/3 89/5 92/13 92/22</p> <p>accident [1] 73/21</p> <p>accommodates [1] 66/10</p> <p>accompany [1] 49/7</p> <p>account [5] 64/1 67/8 82/24 89/7 89/9</p> <p>accurate [1] 85/21</p> <p>achieve [3] 39/1 40/20 90/17</p> <p>achieved [3] 21/24 30/6 30/10</p> <p>acknowledge [1] 83/19</p> <p>acknowledged [1] 78/8</p> <p>acknowledgement [1] 84/13</p> <p>acknowledging [4] 29/18 49/24 52/2 83/13</p> <p>acquaintance [2] 12/10 15/14</p> <p>across [8] 15/4 34/25 72/7 74/5 93/9 93/18 97/25 98/4</p> <p>act [26] 36/12 36/25 40/17 41/4 42/18 42/22 42/24 43/7 43/13 43/16 43/23 50/12 51/12 52/4 60/12 60/13 61/5 61/8 61/11 61/15 61/18 61/19 62/3 62/14</p>	<p>62/17 67/22</p> <p>acting [1] 23/18</p> <p>action [5] 50/6 56/7 61/18 66/15 67/3</p> <p>action-focused [1] 67/3</p> <p>actions [3] 66/4 75/16 90/14</p> <p>actively [1] 33/2</p> <p>acts [3] 61/13 73/21 74/1</p> <p>actual [3] 11/10 33/5 60/2</p> <p>actually [8] 12/24 35/21 43/15 47/23 71/25 84/2 89/10 92/3</p> <p>actuarial [1] 68/4</p> <p>acute [5] 50/15 52/6 52/9 61/20 61/24</p> <p>ad [1] 105/15</p> <p>ad hoc [1] 105/15</p> <p>adapting [1] 67/25</p> <p>add [1] 73/20</p> <p>adding [1] 29/16</p> <p>addition [2] 13/3 85/6</p> <p>additional [5] 5/12 12/20 13/2 60/15 106/5</p> <p>address [4] 28/14 85/17 98/18 104/16</p> <p>addressed [5] 41/24 42/22 66/16 68/12 105/13</p> <p>addressing [3] 20/4 68/8 77/13</p> <p>adds [1] 19/14</p> <p>adequate [1] 26/22</p> <p>adequately [1] 84/11</p> <p>adherence [5] 15/22 16/1 16/19 19/23 30/19</p> <p>adherent [3] 13/18 14/5 18/14</p> <p>adjournment [1] 106/12</p> <p>admit [2] 23/17 39/16</p> <p>admitted [2] 18/12 18/18</p> <p>admitting [1] 60/19</p> <p>Adrian [4] 46/17 68/22 68/24 107/8</p> <p>advantage [1] 61/7</p> <p>adverse [1] 78/25</p> <p>advise [1] 69/19</p> <p>advised [2] 69/19 77/5</p> <p>adviser [1] 36/16</p> <p>advisers [1] 77/8</p> <p>advisor [1] 69/24</p> <p>advisory [19] 20/20 24/10 24/13 24/16 24/18 24/19 24/20 27/25 28/12 28/21 30/8 30/9 33/17 33/20 33/23 33/25 33/25 34/16 62/21</p>
---	--	---	--	--

<p>A</p> <p>affect [1] 79/1</p> <p>affected [1] 37/16</p> <p>affiliation [1] 99/21</p> <p>afraid [1] 58/9</p> <p>after [6] 27/9 28/6 35/19 37/18 52/25 66/24</p> <p>afternoon [1] 94/6</p> <p>again [25] 5/3 11/14 16/20 34/9 45/23 57/4 62/4 76/5 76/11 76/21 78/8 83/18 86/9 87/14 88/5 88/19 96/18 98/18 99/6 99/24 103/2 103/6 104/14 105/3 106/10</p> <p>against [1] 55/8</p> <p>aged [1] 22/18</p> <p>agencies [5] 80/8 86/16 99/25 100/1 104/23</p> <p>agency [4] 69/20 69/22 85/24 86/5</p> <p>ago [4] 24/11 55/5 73/23 93/12</p> <p>agree [8] 30/13 30/14 44/18 47/21 47/23 96/12 99/18 102/20</p> <p>agreed [1] 34/16</p> <p>agreement [1] 33/10</p> <p>Ah [2] 86/23 96/25</p> <p>aide [1] 67/22</p> <p>aide-memoire [1] 67/22</p> <p>aim [3] 29/1 49/23 54/9</p> <p>alcohol [12] 10/8 11/4 11/20 14/11 14/14 14/17 15/17 19/4 30/18 45/21 66/14 68/11</p> <p>alcohol misuse [1] 11/4</p> <p>alert [1] 50/23</p> <p>alerted [1] 33/25</p> <p>all [37] 5/4 5/6 11/11 13/23 14/1 14/16 19/3 21/11 22/8 24/2 28/25 30/10 30/24 32/18 33/5 37/22 37/25 44/10 44/25 52/20 55/13 57/24 62/22 63/10 63/21 64/23 68/12 70/14 71/4 73/2 73/6 79/18 88/6 90/16 94/1 101/8 105/13</p> <p>allow [4] 48/10 49/17 60/24 65/1</p> <p>allowed [2] 41/8 41/21</p> <p>allowing [2] 41/5 62/24</p> <p>allows [1] 79/12</p> <p>almost [6] 19/3 34/25</p>	<p>48/19 48/21 74/17 105/11</p> <p>alongside [4] 71/7 78/15 82/22 90/7</p> <p>already [8] 25/5 32/10 61/9 62/2 81/24 96/4 99/13 101/13</p> <p>also [41] 7/5 8/22 8/25 9/7 10/13 11/19 14/14 15/23 16/19 17/17 17/18 19/20 21/2 21/18 23/17 24/25 27/2 45/17 53/16 53/18 54/5 57/24 57/25 69/24 70/16 71/6 74/21 78/1 84/9 85/10 85/15 85/18 89/20 96/6 99/22 102/12 104/2 104/8 105/10 105/16 106/1</p> <p>alternative [2] 61/11 61/23</p> <p>alternatives [1] 86/3</p> <p>although [5] 8/25 11/13 57/17 64/25 99/21</p> <p>always [9] 39/4 40/20 54/18 67/9 84/6 89/14 89/14 99/8 99/14</p> <p>am [8] 1/2 52/1 68/20 69/10 69/21 69/21 70/1 104/15</p> <p>ambivalence [1] 82/14</p> <p>among [2] 19/6 19/17</p> <p>amongst [7] 23/3 39/3 69/25 72/2 75/8 77/6 77/9</p> <p>amount [3] 48/7 64/16 92/1</p> <p>analogously [1] 44/15</p> <p>analysed [2] 6/2 8/4</p> <p>analysis [6] 15/12 17/24 25/8 31/14 35/6 59/2</p> <p>analyst [1] 77/11</p> <p>ancillary [1] 95/25</p> <p>anecdotally [1] 59/10</p> <p>annual [6] 4/16 4/19 15/9 17/8 23/3 29/12</p> <p>annually [1] 56/22</p> <p>another [9] 2/17 12/4 16/24 26/2 45/11 46/5 46/10 87/8 92/12</p> <p>answer [3] 61/12 87/18 101/1</p> <p>Anthony [4] 80/1 80/5 80/18 81/2</p> <p>anxiety [2] 29/23 34/21</p> <p>any [21] 9/9 9/21 11/3 22/7 25/14 27/13 37/12 41/23 44/9 55/12 56/11 56/25</p>	<p>58/17 65/4 65/19 78/12 82/19 85/6 87/25 90/16 102/16</p> <p>anyone [1] 33/20</p> <p>anything [5] 39/1 46/25 55/16 57/1 83/24</p> <p>anyway [1] 58/2</p> <p>apologies [2] 13/21 42/20</p> <p>appeal [1] 65/18</p> <p>appear [4] 19/19 44/10 81/13 93/10</p> <p>Appleby [7] 1/4 1/5 1/7 1/13 20/13 71/2 107/3</p> <p>applied [3] 12/19 59/18 90/11</p> <p>applies [1] 98/4</p> <p>apply [6] 43/16 52/17 61/1 67/17 74/22 98/2</p> <p>approach [19] 28/9 46/18 46/19 47/22 49/11 56/9 58/20 65/14 65/14 65/23 66/1 66/1 67/10 67/10 67/11 73/5 83/12 83/17 89/19</p> <p>approached [1] 70/3</p> <p>approaches [1] 47/13</p> <p>appropriate [3] 40/15 76/4 88/24</p> <p>appropriately [1] 99/15</p> <p>arc [1] 62/5</p> <p>are [151]</p> <p>area [4] 38/10 59/11 80/8 93/23</p> <p>areas [2] 36/3 45/23</p> <p>aren't [2] 54/12 63/18</p> <p>argue [1] 37/24</p> <p>argument [3] 22/25 41/4 46/21</p> <p>arise [1] 100/16</p> <p>arising [1] 22/21</p> <p>around [8] 2/7 15/20 35/2 47/24 86/2 100/4 103/10 104/16</p> <p>arrest [1] 103/20</p> <p>arriving [1] 88/12</p> <p>as [133]</p> <p>ask [10] 51/4 51/5 52/22 58/24 62/22 67/23 70/15 94/2 94/6 97/2</p> <p>asked [5] 93/11 97/8 98/7 102/21 104/7</p> <p>asking [6] 3/21 9/22 48/19 51/23 51/23 70/12</p> <p>asks [1] 10/13</p> <p>aspects [3] 52/17 54/21 76/14</p> <p>assertive [30] 16/14 16/20 20/10 34/24</p>	<p>35/4 35/12 35/19 41/25 45/13 45/17 46/13 46/19 46/21 46/25 46/25 47/1 47/4 47/5 47/9 47/25 48/11 48/12 48/13 48/15 48/24 49/14 49/18 54/11 58/17 58/19</p> <p>assertiveness [3] 46/18 46/19 49/10</p> <p>assess [5] 75/15 82/6 82/8 83/9 97/24</p> <p>assessed [2] 25/12 102/8</p> <p>assessing [3] 63/5 64/9 82/21</p> <p>assessment [36] 10/13 21/13 49/24 50/6 50/10 51/10 51/13 51/24 52/14 55/20 55/23 56/2 56/4 56/7 60/11 63/9 64/15 65/3 65/5 65/17 65/19 66/3 67/3 67/16 67/19 67/24 68/1 68/4 71/9 90/8 90/17 90/24 91/2 92/4 103/24 105/18</p> <p>assessment-focused [1] 67/3</p> <p>assessments [3] 60/8 95/18 105/17</p> <p>assist [2] 72/2 105/23</p> <p>associated [4] 4/10 19/21 45/20 78/23</p> <p>assumed [1] 34/20</p> <p>assumption [1] 32/9</p> <p>astounding [1] 38/1</p> <p>at [111]</p> <p>at page 23 [1] 77/22</p> <p>attachment [1] 96/6</p> <p>attack [1] 8/1</p> <p>attacked [2] 91/14 91/16</p> <p>attempt [2] 34/17 83/19</p> <p>attempted [1] 28/14</p> <p>attempting [1] 97/24</p> <p>attend [1] 87/21</p> <p>attendees [1] 77/5</p> <p>attending [1] 87/24</p> <p>attention [3] 31/4 86/11 87/1</p> <p>attitude [2] 30/12 84/3</p> <p>attitudes [2] 81/6 94/25</p> <p>attributable [1] 18/23</p> <p>attribute [1] 76/12</p> <p>audible [1] 101/1</p> <p>audience [1] 87/22</p> <p>augmentation [2] 105/22 105/25</p> <p>August [1] 80/6</p> <p>authored [1] 17/3</p> <p>autonomy [6] 40/21</p>	<p>40/23 41/2 55/8 71/7 72/11</p> <p>available [5] 22/10 29/17 86/7 100/11 103/7</p> <p>average [5] 5/15 5/16 13/19 13/24 83/24</p> <p>avoid [1] 90/3</p> <p>avoided [1] 10/14</p> <p>avoiding [2] 19/23 73/6</p> <p>aware [6] 31/11 31/13 59/2 65/8 72/24 77/4</p> <p>awareness [2] 95/10 98/24</p> <p>away [7] 32/13 41/8 41/16 45/10 62/25 62/25 73/11</p> <hr/> <p>B</p> <p>back [18] 2/24 5/10 6/18 10/17 26/25 27/11 34/5 45/11 45/13 49/14 49/15 49/16 49/20 55/1 56/1 63/11 87/14 93/9</p> <p>background [1] 80/3</p> <p>bad [2] 73/6 76/24</p> <p>balance [13] 40/21 41/3 41/5 41/8 41/23 55/7 55/9 56/8 62/14 62/18 62/24 64/3 64/7</p> <p>BAME [1] 18/18</p> <p>base [6] 47/14 47/22 77/25 97/22 97/23 98/2</p> <p>based [15] 16/2 21/13 27/22 28/11 28/13 36/1 36/5 47/17 53/9 61/15 61/16 74/25 80/15 84/25 85/1</p> <p>basic [1] 93/7</p> <p>basis [3] 34/19 56/24 73/25</p> <p>be [187]</p> <p>became [5] 1/23 2/5 2/6 2/8 39/2</p> <p>because [42] 5/24 6/5 6/19 7/1 7/8 7/20 8/19 9/1 9/2 11/18 12/20 16/6 23/14 25/2 27/13 28/1 29/15 34/7 34/8 38/11 38/15 39/11 39/16 41/18 47/24 51/12 51/19 52/5 59/17 63/17 64/12 64/19 67/13 70/13 86/15 89/6 92/17 92/23 96/18 102/22 102/25 105/10</p> <p>become [6] 45/4 45/4 75/4 91/10 99/3 99/4</p> <p>becomes [1] 54/17</p> <p>been [71] 3/18 6/2</p>
--	---	--	--	--

<p>B</p> <p>been... [69] 8/12 10/3 10/14 12/25 17/20 18/17 18/21 19/16 21/23 22/17 22/17 24/12 27/23 28/8 30/6 30/10 31/7 31/13 32/5 33/1 33/6 34/25 48/22 52/5 52/9 55/23 56/10 56/16 56/23 57/15 58/6 59/4 59/9 59/10 59/21 59/22 60/23 61/3 64/1 65/6 65/7 65/22 66/2 67/20 72/14 73/25 74/1 74/15 77/15 79/13 80/9 81/17 85/3 85/12 85/14 86/18 87/1 87/4 87/6 91/4 91/7 93/10 96/13 98/11 98/17 101/13 102/2 102/4 102/18</p> <p>before [11] 1/22 2/3 8/2 8/24 10/18 13/18 21/10 35/20 44/24 59/25 100/10</p> <p>began [3] 37/22 37/24 101/15</p> <p>begin [2] 76/12 78/17</p> <p>beginning [1] 84/6</p> <p>begins [3] 37/19 37/21 82/13</p> <p>behalf [4] 23/18 26/11 94/7 97/2</p> <p>behave [1] 94/24</p> <p>behaviour [1] 75/18</p> <p>behavioural [1] 11/1</p> <p>behind [1] 91/16</p> <p>being [27] 12/19 13/5 15/23 16/2 18/3 21/15 29/10 30/21 31/6 34/10 35/6 35/7 36/23 37/1 37/12 46/5 49/4 51/22 56/25 63/20 64/21 65/12 66/24 76/20 78/20 80/7 104/9</p> <p>belief [2] 1/11 69/6</p> <p>beliefs [2] 63/8 78/5</p> <p>believe [4] 36/8 39/21 53/7 73/17</p> <p>belong [1] 18/18</p> <p>beneficial [2] 52/9 54/21</p> <p>benefit [3] 50/5 70/13 105/7</p> <p>benefits [2] 39/23 47/14</p> <p>beside [1] 50/3</p> <p>best [10] 1/10 49/25 50/18 66/17 69/6 70/21 73/14 92/21 94/17 103/14</p> <p>better [7] 41/17 53/23 62/22 65/16</p>	<p>65/20 92/9 93/24</p> <p>between [14] 2/13 11/9 17/22 17/23 18/22 19/15 20/6 25/10 30/22 40/21 74/11 78/10 83/25 91/21</p> <p>beyond [4] 17/17 22/22 86/7 95/10</p> <p>bias [1] 77/12</p> <p>big [1] 35/21</p> <p>biggest [1] 37/18</p> <p>Bill [1] 62/20</p> <p>Billingham [1] 98/18</p> <p>Black [1] 10/24</p> <p>Blake [6] 68/21 68/25 94/9 97/5 98/7 107/9</p> <p>blocks [1] 10/10</p> <p>board [3] 80/17 81/19 93/18</p> <p>bodes [1] 60/14</p> <p>bodies [3] 45/12 54/5 104/20</p> <p>body [3] 53/8 53/12 81/5</p> <p>both [6] 5/18 31/21 43/8 52/11 71/8 74/9</p> <p>bottom [6] 5/1 18/9 20/18 25/6 46/6 100/20</p> <p>bounced [1] 46/5</p> <p>bound [3] 39/23 65/18 89/17</p> <p>Bowlby [1] 78/17</p> <p>Bowlby's [1] 96/5</p> <p>breaching [1] 103/13</p> <p>breadth [1] 25/20</p> <p>break [2] 68/16 68/19</p> <p>brief [2] 78/16 97/4</p> <p>briefly [3] 2/1 41/25 95/3</p> <p>bring [5] 52/14 77/21 80/1 81/22 90/8</p> <p>brings [1] 86/11</p> <p>broader [2] 24/13 62/19</p> <p>broadly [1] 77/19</p> <p>broken [1] 92/18</p> <p>brought [1] 88/3</p> <p>Bryant [1] 80/6</p> <p>building [2] 95/2 95/5</p> <p>built [1] 71/13</p> <p>bullet [4] 45/15 46/2 50/13 50/16</p> <p>burden [1] 106/5</p> <p>bureaucrats [1] 77/8</p> <p>burnout [1] 47/19</p> <p>but [140]</p> <p>Bywater [2] 26/9 26/10</p>	<p>came [1] 24/8</p> <p>can [113]</p> <p>can't [9] 9/2 32/13 38/15 39/7 49/8 81/8 98/25 99/14 99/16</p> <p>cannabis [1] 14/17</p> <p>cannot [2] 47/12 88/1</p> <p>capable [1] 75/23</p> <p>capacity [4] 61/11 61/15 61/17 70/3</p> <p>care [67] 2/22 3/18 4/1 11/15 11/19 15/20 16/7 16/9 16/12 19/2 19/5 20/2 26/3 35/18 36/6 37/8 37/10 37/12 37/12 38/22 40/4 40/9 40/22 45/18 46/9 46/13 46/20 47/18 49/7 50/15 50/21 52/17 53/19 53/22 54/7 54/21 57/23 58/1 58/6 58/11 60/5 63/10 63/11 63/12 64/21 66/10 66/14 66/15 68/8 68/11 68/12 68/15 71/18 71/21 78/1 78/2 78/14 78/15 78/16 79/5 79/6 86/16 91/25 92/5 94/21 96/4 98/7</p> <p>career [3] 73/20 78/18 87/19</p> <p>carefully [3] 73/1 90/20 97/12</p> <p>carer [3] 72/25 74/9 74/23</p> <p>carers [1] 26/15</p> <p>carried [1] 25/13</p> <p>carries [1] 29/16</p> <p>carry [3] 22/22 39/23 88/10</p> <p>Cartwright [4] 94/4 94/5 97/8 107/10</p> <p>cascades [1] 42/12</p> <p>case [17] 10/15 18/11 32/18 36/21 39/25 40/11 42/7 58/5 70/6 70/12 79/25 80/10 81/4 81/8 87/21 87/24 103/25</p> <p>case-control [1] 18/11</p> <p>caseload [3] 47/25 48/8 49/6</p> <p>caseloads [1] 48/10</p> <p>cases [24] 5/12 5/13 8/25 9/1 11/2 11/3 11/4 11/5 12/4 12/7 12/10 18/22 21/19 24/4 24/6 25/23 27/3 59/3 59/8 59/15 59/19 61/11 75/25 81/10</p> <p>castigate [1] 87/15</p> <p>category [1] 78/24</p> <p>causal [1] 102/6</p> <p>cause [1] 29/23</p>	<p>caused [3] 59/4 79/20 96/8</p> <p>causes [2] 76/12 97/18</p> <p>causing [1] 3/19</p> <p>cautious [2] 76/18 76/21</p> <p>cautiously [1] 81/1</p> <p>cent [1] 58/9</p> <p>central [2] 48/17 48/18</p> <p>centre [1] 71/4</p> <p>certain [2] 49/19 64/16</p> <p>certainly [6] 26/5 26/21 29/11 57/2 64/7 85/19</p> <p>Chair [5] 1/4 58/22 68/22 106/8 107/6</p> <p>challenging [1] 71/6</p> <p>chance [2] 53/23 66/17</p> <p>change [5] 3/8 66/25 76/8 105/2 105/3</p> <p>changed [4] 3/5 3/8 73/11 85/2</p> <p>changes [7] 26/3 27/9 27/16 28/6 54/14 83/12 105/20</p> <p>characteristic [1] 8/1</p> <p>charge [1] 13/1</p> <p>child [2] 78/21 78/25</p> <p>children [1] 78/19</p> <p>chronic [1] 78/4</p> <p>circumstance [2] 88/8 89/2</p> <p>circumstances [3] 51/9 89/2 90/22</p> <p>citizen [3] 69/23 74/6 82/16</p> <p>clarification [3] 1/25 94/8 94/17</p> <p>clear [15] 5/2 7/13 32/6 32/19 38/1 40/4 42/8 44/15 51/11 57/18 65/11 68/10 94/14 95/17 95/20</p> <p>clearly [2] 28/8 46/23</p> <p>clever [1] 89/24</p> <p>clinical [35] 4/11 19/8 19/12 19/24 20/1 32/17 35/15 36/20 38/7 39/13 40/4 41/17 42/14 46/23 48/2 49/7 52/17 53/22 54/21 63/4 63/8 63/10 63/11 63/12 63/16 67/16 69/8 74/16 77/24 87/20 97/17 98/3 102/22 102/25 103/24</p> <p>clinician [4] 47/4 63/9 82/16 87/15</p> <p>clinicians [30] 3/22 6/14 6/14 6/19 9/17 10/13 11/24 43/15 44/9 44/18 48/1 51/4</p>	<p>51/5 51/7 54/23 60/10 62/1 63/5 63/13 63/22 64/10 64/24 77/8 81/12 81/18 90/18 93/1 93/8 94/24 104/19</p> <p>close [4] 30/23 33/5 57/19 58/14</p> <p>closely [4] 18/5 18/7 51/6 72/5</p> <p>closer [1] 91/21</p> <p>Clunis [2] 62/6 93/14</p> <p>co [3] 15/18 17/3 86/5</p> <p>co-authored [1] 17/3</p> <p>co-morbid [1] 15/18</p> <p>co-operation [1] 86/5</p> <p>code [7] 42/21 43/9 43/13 43/14 44/10 44/22 82/15</p> <p>coercion [2] 64/18 95/8</p> <p>coercive [1] 37/5</p> <p>cognitive [1] 90/1</p> <p>cohort [4] 9/13 9/15 11/8 13/13</p> <p>collaborative [3] 20/6 51/1 73/5</p> <p>collateral [1] 89/5</p> <p>colleagues [3] 82/13 87/16 96/19</p> <p>collect [6] 6/18 7/25 22/20 29/1 34/6 51/3</p> <p>collected [4] 13/3 13/8 35/6 85/5</p> <p>collecting [2] 6/16 85/2</p> <p>collection [13] 4/20 20/15 20/23 22/22 27/19 34/8 34/18 34/22 56/18 56/19 57/13 84/21 85/7</p> <p>collectively [1] 100/9</p> <p>College [4] 81/22 82/12 95/12 95/17</p> <p>combination [2] 31/1 80/22</p> <p>come [26] 3/10 3/11 5/9 6/18 7/16 7/22 8/14 8/15 9/12 16/13 20/11 22/4 24/22 28/20 30/7 33/5 34/5 40/4 40/7 45/11 57/13 59/23 59/24 86/25 87/22 105/25</p> <p>comes [4] 64/16 66/13 74/11 94/18</p> <p>coming [4] 24/17 27/1 30/9 94/22</p> <p>command [1] 77/19</p> <p>comment [2] 27/13 81/8</p> <p>commission [2] 2/22 59/25</p> <p>commissioned [1] 40/6</p>
(30) been... - commissioned				

<p>C</p> <p>commissioners [3] 20/21 23/11 33/24</p> <p>commitment [5] 45/24 56/19 56/25 57/3 57/6</p> <p>commits [1] 7/14</p> <p>committed [11] 19/4 19/6 59/13 77/16 83/22 84/16 86/10 101/19 101/20 101/25 102/5</p> <p>common [1] 67/10</p> <p>communicated [1] 22/9</p> <p>communities [1] 49/2</p> <p>community [30] 3/18 4/1 11/15 11/19 16/24 20/8 35/13 36/4 36/8 36/10 37/8 37/9 37/13 37/23 38/13 38/21 38/25 39/8 39/19 40/10 40/12 41/7 45/16 47/12 48/9 63/1 63/19 64/4 64/5 104/10</p> <p>comorbid [2] 18/16 19/18</p> <p>comorbidity [2] 19/1 20/1</p> <p>comorbidities [1] 20/4</p> <p>comparison [2] 17/22 17/23</p> <p>compassion [1] 82/20</p> <p>compassionate [1] 89/17</p> <p>compelling [1] 40/12</p> <p>competence [1] 73/2</p> <p>Competing [1] 21/15</p> <p>complacent [2] 30/12 31/25</p> <p>completely [1] 27/16</p> <p>complex [2] 48/4 98/15</p> <p>complexity [4] 6/5 47/20 66/18 68/3</p> <p>complicated [2] 30/17 67/18</p> <p>components [1] 46/23</p> <p>comprehensive [8] 4/20 20/15 20/23 33/14 56/17 56/17 56/19 74/15</p> <p>compromise [1] 49/8</p> <p>concern [18] 3/17 3/19 21/17 32/6 33/22 35/9 37/4 37/7 37/19 41/17 46/24 50/2 51/17 60/22 60/25 76/2 83/17 93/3</p> <p>concerned [5] 9/24 35/5 60/2 61/13 72/8</p>	<p>concerns [18] 4/1 8/17 9/21 9/25 21/20 22/17 26/5 28/17 28/22 32/18 33/17 36/24 41/11 41/12 41/13 50/24 64/25 95/7</p> <p>conclusion [1] 6/24</p> <p>conclusions [1] 25/15</p> <p>conduct [1] 95/1</p> <p>conducted [2] 25/8 38/23</p> <p>conducting [3] 3/21 36/20 38/7</p> <p>conference [1] 84/6</p> <p>conferences [3] 87/21 87/24 103/25</p> <p>confidential [25] 1/14 1/17 2/25 3/1 3/6 3/14 3/21 3/22 3/24 4/15 4/16 4/23 17/4 17/13 18/6 20/14 25/7 26/4 27/19 31/16 33/14 53/17 54/11 54/16 84/24</p> <p>confidentiality [3] 103/11 103/13 104/17</p> <p>confirmed [3] 5/12 56/21 56/23</p> <p>conflicting [1] 90/2</p> <p>confront [1] 89/20</p> <p>confused [1] 61/14</p> <p>confusing [2] 74/19 78/11</p> <p>conjunction [1] 78/2</p> <p>consequence [1] 78/3</p> <p>consequences [1] 83/8</p> <p>consequently [2] 73/19 94/13</p> <p>consider [14] 33/15 40/14 44/20 50/9 55/19 64/8 73/10 80/20 86/13 86/24 90/20 97/12 101/3 105/1</p> <p>considerable [5] 37/7 74/2 76/5 83/11 89/9</p> <p>considerably [2] 84/2 102/5</p> <p>consideration [3] 79/12 81/14 96/20</p> <p>considered [5] 33/3 50/3 71/7 81/20 90/25</p> <p>considering [2] 52/11 72/15</p> <p>consistency [1] 6/25</p> <p>consistent [4] 16/11 43/4 105/6 105/8</p> <p>Constable [1] 99/22</p> <p>constantly [1] 41/2</p> <p>constraint [2] 103/10 104/16</p>	<p>constraints [2] 98/20 100/4</p> <p>constructed [1] 73/1</p> <p>Consultant [3] 2/5 2/9 9/18</p> <p>consulted [3] 33/7 33/9 33/10</p> <p>consulting [1] 33/9</p> <p>contact [23] 8/7 8/13 8/20 8/23 8/23 9/6 9/9 14/6 15/21 16/1 18/15 18/20 19/22 19/23 20/5 48/3 84/17 101/23 102/2 103/4 103/17 103/19 104/10</p> <p>contacted [1] 74/6</p> <p>contacts [1] 8/9</p> <p>contained [2] 25/20 81/11</p> <p>context [9] 3/17 3/25 21/14 22/3 44/11 72/5 79/18 81/6 90/15</p> <p>continue [1] 34/13</p> <p>continued [2] 34/6 88/15</p> <p>continues [1] 45/3</p> <p>continuing [5] 21/10 55/11 65/8 72/8 87/3</p> <p>continuous [1] 93/21</p> <p>contradictions [1] 74/20</p> <p>contrast [1] 88/15</p> <p>control [6] 17/19 18/1 18/5 18/11 38/16 48/17</p> <p>controls [1] 18/22</p> <p>convened [1] 24/16</p> <p>conversations [1] 28/11</p> <p>convicted [9] 13/23 14/13 14/24 15/3 17/20 18/13 59/22 80/5 87/2</p> <p>conviction [2] 7/4 87/6</p> <p>convictions [2] 11/3 15/1</p> <p>cooperation [1] 10/1</p> <p>core [9] 21/22 30/5 30/10 49/5 49/18 57/18 57/18 94/2 101/7</p> <p>corner [1] 18/10</p> <p>corporate [1] 26/11</p> <p>correct [24] 1/21 2/11 2/16 3/3 6/15 7/24 8/4 10/21 13/14 17/5 17/9 17/11 17/15 17/20 17/21 19/10 20/25 21/8 21/9 23/7 34/11 44/6 48/22 69/9</p> <p>could [28] 1/25 7/3 7/4 7/9 20/13 29/7 29/8 29/13 29/22 34/14 34/18 35/17 38/19 44/13 44/14</p>	<p>50/8 52/17 52/21 66/6 72/19 77/9 77/18 77/21 81/20 95/2 95/11 105/7 105/13</p> <p>counted [2] 77/5 77/9</p> <p>counterproductive [1] 73/8</p> <p>counterweight [3] 74/2 74/5 79/12</p> <p>counting [1] 34/14</p> <p>countless [1] 87/24</p> <p>countries [2] 15/5 21/12</p> <p>country [3] 35/1 38/24 48/19</p> <p>couple [2] 1/22 93/11</p> <p>course [7] 3/10 54/18 63/15 74/24 75/5 79/4 85/13</p> <p>court [12] 6/24 7/3 7/6 7/15 11/25 13/7 57/14 58/3 58/4 58/7 58/8 102/19</p> <p>courts [1] 12/23</p> <p>coverage [3] 35/2 46/14 46/17</p> <p>covered [2] 55/13 61/5</p> <p>CQC [2] 40/5 70/11</p> <p>creates [1] 29/7</p> <p>creating [1] 73/8</p> <p>crime [6] 69/14 69/20 69/22 76/23 77/11 91/5</p> <p>criminal [3] 70/9 88/23 102/16</p> <p>criminality [1] 18/16</p> <p>criminology [1] 97/20</p> <p>crises [3] 98/21 99/24 100/15</p> <p>crisis [4] 52/15 61/2 69/25 99/19</p> <p>criterion [1] 9/10</p> <p>critical [2] 28/6 53/9</p> <p>critically [2] 75/5 75/15</p> <p>criticisms [2] 28/15 88/6</p> <p>crucial [1] 50/21</p> <p>CTO [5] 52/20 59/13 59/21 59/23 60/2</p> <p>CTOs [6] 36/18 37/1 39/4 40/15 41/21 59/8</p> <p>cultural [7] 37/3 41/23 54/14 55/7 56/7 64/23 90/14</p> <p>culturally [3] 41/6 64/10 64/17</p> <p>culture [7] 37/6 40/19 42/4 42/4 42/6 45/9 63/9</p> <p>current [9] 3/5 16/9 26/22 59/13 61/6 62/13 62/13 70/16 93/4</p>	<p>currently [5] 42/13 65/12 69/19 73/17 94/12</p> <p>custom [1] 87/16</p> <p>cyclical [1] 37/6</p> <hr/> <p>D</p> <p>daily [1] 64/12</p> <p>damage [2] 73/25 74/1</p> <p>danger [3] 32/17 41/5 62/19</p> <p>dangerous [4] 32/23 75/17 75/22 84/12</p> <p>dangerously [2] 30/12 33/4</p> <p>Daniela [1] 74/16</p> <p>data [39] 4/20 4/22 6/16 7/21 7/25 9/4 9/5 9/11 9/16 9/21 9/24 13/2 14/21 17/12 17/13 17/14 18/6 20/15 20/23 22/22 27/19 29/2 29/12 31/15 32/17 33/15 34/7 34/7 34/18 34/22 35/5 51/3 56/17 56/19 57/12 84/21 85/2 85/5 85/7</p> <p>database [4] 18/2 58/1 59/12 59/20</p> <p>dataset [1] 81/11</p> <p>datasets [2] 17/22 17/23</p> <p>date' [1] 80/19</p> <p>dated [2] 1/8 69/4</p> <p>day [2] 76/22 76/22</p> <p>days [1] 48/17</p> <p>deadlines [1] 25/25</p> <p>deal [4] 97/24 98/14 99/24 101/14</p> <p>dealing [2] 98/21 103/5</p> <p>dealt [2] 97/5 105/20</p> <p>debatable [1] 39/10</p> <p>debate [1] 39/3</p> <p>decade [1] 46/15</p> <p>decades [1] 74/5</p> <p>December [1] 69/4</p> <p>December 2025 [1] 69/4</p> <p>deciding [1] 30/1</p> <p>decision [9] 3/23 20/22 21/13 32/22 34/13 38/19 40/23 40/23 80/18</p> <p>decisions [6] 37/17 37/20 52/16 63/14 72/22 88/2</p> <p>declare [2] 35/10 36/15</p> <p>decreased [2] 47/15 47/18</p> <p>defeat [1] 30/1</p> <p>defensive [2] 73/5 76/24</p>
---	---	--	--	---

<p>D</p> <p>deficits [1] 98/18</p> <p>define [1] 9/8</p> <p>defined [3] 6/23 8/7 48/25</p> <p>Definitely [1] 102/15</p> <p>definition [5] 6/25 7/11 7/12 8/21 38/11</p> <p>degree [4] 44/21 49/1 71/24 78/6</p> <p>deliver [3] 26/22 67/18 101/8</p> <p>deliver' [1] 26/17</p> <p>delivered [2] 38/22 45/19</p> <p>delivering [4] 20/1 39/20 39/22 60/5</p> <p>delivery [4] 4/12 25/25 40/8 40/9</p> <p>delusions [1] 13/11</p> <p>demand [2] 50/2 98/20</p> <p>demeaning [1] 99/25</p> <p>demographic [1] 10/23</p> <p>deny [2] 78/13 84/8</p> <p>department [8] 2/15 2/18 4/3 21/5 53/13 54/2 70/20 77/18</p> <p>depend [1] 75/5</p> <p>depends [3] 31/10 59/17 103/5</p> <p>depressing [1] 62/10</p> <p>depression [2] 57/12 57/17</p> <p>deprivation [1] 78/23</p> <p>describe [1] 103/24</p> <p>described [1] 45/2</p> <p>describing [1] 98/12</p> <p>description [1] 7/19</p> <p>descriptions [1] 46/24</p> <p>design [1] 73/22</p> <p>desirable [1] 73/2</p> <p>despite [5] 9/25 36/13 83/11 92/21 101/16</p> <p>destabilised [1] 30/21</p> <p>detail [7] 3/11 6/2 89/1 89/11 91/11 91/19 91/20</p> <p>detailed [7] 6/20 9/16 10/5 15/12 74/15 96/3 104/3</p> <p>details [3] 90/13 102/13 102/16</p> <p>detained [1] 43/24</p> <p>detaining [1] 43/23</p> <p>detect [1] 11/16</p> <p>detention [5] 40/16 52/18 60/8 60/11 64/22</p> <p>deteriorating [1] 64/19</p>	<p>deterioration [2] 50/1 50/19</p> <p>determination [11] 6/24 7/3 7/6 7/12 7/15 8/2 40/22 41/17 41/18 41/21 53/1</p> <p>determined [2] 7/19 7/20</p> <p>devastating [1] 52/25</p> <p>develop [4] 50/25 76/17 90/19 91/10</p> <p>developed [7] 26/19 65/6 66/19 67/20 73/4 77/2 98/1</p> <p>developing [2] 97/7 104/3</p> <p>development [2] 52/6 93/22</p> <p>devolved [1] 25/1</p> <p>DHSC [1] 53/7</p> <p>DHSC/NHS [1] 53/7</p> <p>DHSC0000038 [1] 70/22</p> <p>diagnosed [1] 18/12</p> <p>diagnoses [1] 11/20</p> <p>diagnosis [3] 10/7 14/10 58/6</p> <p>diagnostic [1] 65/5</p> <p>dictate [1] 63/12</p> <p>did [17] 22/1 22/7 23/8 24/22 27/10 27/15 28/20 30/7 33/7 33/17 33/20 33/22 39/6 62/17 62/23 77/14 77/19</p> <p>didn't [9] 8/15 27/13 27/18 30/14 31/8 33/2 34/7 37/25 48/24</p> <p>die [1] 37/19</p> <p>difference [1] 51/8</p> <p>differences [5] 18/22 18/23 48/23 48/23 74/22</p> <p>different [20] 5/6 5/7 9/8 10/10 11/22 11/22 12/19 23/6 28/8 38/9 48/21 52/8 56/8 65/23 66/3 66/20 91/15 91/18 98/4 100/23</p> <p>differentiated [1] 74/23</p> <p>differently [1] 99/9</p> <p>difficult [5] 23/14 23/16 25/17 34/9 39/14</p> <p>diligence [1] 85/2</p> <p>diminish [2] 78/13 83/21</p> <p>diminished [1] 12/3</p> <p>direction [3] 48/18 66/20 79/15</p> <p>directive [1] 94/14</p> <p>directives [5] 73/15 93/17 94/10 94/16 94/22</p> <p>directly [2] 16/16</p>	<p>62/20</p> <p>Director [10] 1/13 1/23 2/8 2/13 2/18 2/21 26/10 35/11 35/12 36/16</p> <p>disagree [2] 29/14 29/14</p> <p>disbanding [1] 35/8</p> <p>discharge [2] 10/9 52/18</p> <p>discharged [3] 18/21 96/22 104/10</p> <p>disciplines [3] 84/1 97/16 97/20</p> <p>disclosed [1] 10/3</p> <p>discomfort [1] 23/17</p> <p>discontinue [1] 20/23</p> <p>discontinued [1] 45/23</p> <p>discussed [1] 23/12</p> <p>discusses [1] 47/6</p> <p>discussing [4] 24/9 55/4 55/5 57/4</p> <p>discussion [7] 23/16 23/20 24/13 33/24 40/3 52/13 55/24</p> <p>discussions [9] 21/18 23/8 23/9 23/20 23/22 23/24 24/14 27/2 87/21</p> <p>disengagement [1] 45/20</p> <p>disorder [3] 11/20 18/17 18/17</p> <p>disordered [1] 77/16</p> <p>dispassionate [1] 88/20</p> <p>dispersed [1] 49/2</p> <p>displayed [1] 95/3</p> <p>disregarded [5] 81/16 89/13 89/14 89/15 90/6</p> <p>disruption [1] 87/3</p> <p>Dissanayaka [2] 47/3 47/21</p> <p>dissemination [1] 31/18</p> <p>dissipated [1] 54/12</p> <p>dissonance [2] 90/1 90/5</p> <p>distance [1] 89/10</p> <p>distant [1] 58/15</p> <p>distinction [1] 74/10</p> <p>distressing [1] 78/5</p> <p>diverse [1] 58/13</p> <p>do [56] 5/5 6/2 7/25 9/3 9/3 9/20 12/22 24/4 27/13 29/6 30/12 34/17 37/1 38/10 41/17 41/19 42/6 43/11 44/18 44/20 47/21 47/23 51/3 51/10 51/11 52/10 55/17 55/18 55/21 60/9 60/14 60/17 61/8</p>	<p>61/10 62/13 65/3 65/11 67/6 67/22 73/10 76/18 78/14 79/9 85/6 88/18 89/13 98/12 98/13 98/23 99/5 99/17 99/17 100/25 102/20 104/5 105/1</p> <p>do a [1] 38/10</p> <p>doctor [1] 106/8</p> <p>document [5] 4/25 17/4 70/22 72/4 72/19</p> <p>documents [1] 74/17</p> <p>does [13] 27/6 27/7 33/10 51/23 55/2 63/9 75/5 78/15 82/19 90/25 91/21 105/2 105/3</p> <p>does it [2] 27/7 90/25</p> <p>doesn't [13] 7/10 10/11 16/17 16/21 31/9 39/4 44/10 45/4 45/4 47/22 50/23 68/3 99/11</p> <p>doing [6] 23/5 27/15 31/12 67/8 80/20 103/14</p> <p>domain [1] 92/7</p> <p>don't [24] 5/7 8/13 24/10 37/11 39/1 42/6 48/5 48/8 51/21 56/11 60/9 61/9 61/17 65/1 68/4 84/8 85/20 98/11 98/14 99/10 100/15 100/17 101/9 102/25</p> <p>done [10] 35/7 59/2 67/9 72/7 73/25 74/1 79/13 85/10 98/17 104/18</p> <p>doubt [1] 47/8</p> <p>down [17] 12/1 13/10 15/11 20/13 35/2 37/19 42/19 52/24 53/22 69/1 71/18 79/8 80/14 82/3 90/10 92/9 93/12</p> <p>downward [1] 23/5</p> <p>Dr [14] 46/17 47/3 47/21 57/10 68/22 68/24 69/3 84/15 94/1 94/6 96/23 97/2 100/20 107/8</p> <p>Dr Adrian [2] 46/17 68/22</p> <p>Dr Dissanayaka [1] 47/21</p> <p>Dr Faizal [1] 84/15</p> <p>Dr Kumar [1] 57/10</p> <p>Dr Nuwan [1] 47/3</p> <p>Dr West [6] 69/3 94/1 94/6 96/23 97/2 100/20</p> <p>drafted [1] 44/13</p> <p>draw [2] 74/10 97/9</p> <p>drawing [1] 31/4</p> <p>drift [1] 47/17</p>	<p>drug [14] 10/9 11/5 13/18 14/11 14/14 15/17 15/22 16/2 16/19 18/17 19/5 30/17 45/21 66/14</p> <p>drugs [4] 11/20 30/20 68/11 105/12</p> <p>dubious [1] 38/18</p> <p>due [1] 47/19</p> <p>duration [1] 90/13</p> <p>during [6] 14/23 15/1 19/7 32/19 80/16 100/16</p> <p>duty [4] 82/4 82/6 83/10 89/17</p> <p>dynamic [2] 66/22 66/25</p> <hr/> <p>E</p> <p>each [2] 68/8 84/16</p> <p>earlier [2] 51/4 60/25</p> <p>early [4] 28/3 28/4 93/19 93/21</p> <p>ease [1] 51/20</p> <p>easily [2] 48/5 83/1</p> <p>easy [3] 38/10 67/13 90/1</p> <p>educated [1] 70/6</p> <p>effecting [1] 103/20</p> <p>effective [4] 39/22 47/9 73/4 104/22</p> <p>effectively [5] 23/6 62/4 62/7 68/12 86/8</p> <p>effectiveness [1] 59/17</p> <p>effects [3] 62/7 78/9 78/18</p> <p>efforts [2] 92/21 99/25</p> <p>eg [2] 6/23 8/9</p> <p>eight [1] 59/20</p> <p>either [5] 14/5 15/21 19/4 81/19 98/19</p> <p>elaborate [3] 11/10 40/1 50/16</p> <p>elements [1] 89/22</p> <p>elevated [1] 19/17</p> <p>eligible [1] 38/13</p> <p>else [3] 33/21 55/16 93/20</p> <p>else's [1] 79/7</p> <p>embedded [2] 32/20 54/13</p> <p>emergency [3] 61/1 77/18 87/4</p> <p>emotional [3] 78/22 79/3 79/11</p> <p>emotive [1] 88/5</p> <p>emphasis [3] 43/10 94/20 96/17</p> <p>emphasise [4] 71/14 72/9 72/12 96/17</p> <p>emphasised [2] 44/21 44/25</p> <p>emphasising [1] 44/16</p>
---	---	---	--	---

<p>E</p> <p>employed [1] 69/20</p> <p>empowerment [1] 72/11</p> <p>enable [1] 105/22</p> <p>enabling [1] 62/15</p> <p>encounter [1] 73/25</p> <p>encouraged [1] 43/25</p> <p>encouraging [2] 58/18 81/1</p> <p>end [8] 13/10 27/18 32/14 39/19 54/17 56/22 63/2 63/4</p> <p>ended [4] 31/21 73/22 88/22 91/18</p> <p>ending [1] 85/11</p> <p>endorsing [1] 72/8</p> <p>enduring [2] 46/4 100/7</p> <p>enemy [1] 65/12</p> <p>enforcement [1] 87/1</p> <p>engage [1] 9/3</p> <p>engaged [1] 39/3</p> <p>engagement [1] 26/16</p> <p>England [16] 2/14 5/4 5/5 20/25 21/3 21/7 23/11 24/25 26/10 26/12 27/6 45/22 46/16 53/7 64/2 94/19</p> <p>England's [2] 26/21 40/6</p> <p>enhance [1] 4/8</p> <p>enhanced [1] 102/5</p> <p>enough [6] 29/3 29/19 48/23 56/3 61/10 61/19</p> <p>ensure [10] 17/22 25/20 25/25 35/17 45/18 46/14 53/8 54/9 64/12 66/16</p> <p>ensuring [3] 37/14 40/8 42/9</p> <p>enter [1] 38/20</p> <p>entirely [1] 44/11</p> <p>entity [1] 58/13</p> <p>envisage [2] 51/10 106/4</p> <p>equates [1] 57/22</p> <p>equation [1] 63/18</p> <p>equivalent [5] 50/14 51/16 52/1 60/20 61/3</p> <p>equivocal [5] 36/19 36/21 38/6 39/15 40/1</p> <p>erode [1] 37/21</p> <p>erosion [2] 35/19 35/21</p> <p>especially [2] 57/12 92/17</p> <p>espouses [1] 74/24</p> <p>essence [1] 47/25</p> <p>essential [2] 49/8 83/9</p>	<p>essentially [2] 76/2 87/19</p> <p>establish [2] 34/22 61/17</p> <p>established [4] 1/17 20/21 32/5 53/17</p> <p>establishment [2] 3/13 37/9</p> <p>ethically [1] 38/18</p> <p>ethnic [1] 10/24</p> <p>ethos [1] 89/19</p> <p>evaluated [1] 27/12</p> <p>evaluation [1] 20/8</p> <p>even [7] 8/17 11/12 25/22 32/11 34/17 47/1 50/6</p> <p>event [2] 83/23 96/13</p> <p>eventually [2] 37/8 45/8</p> <p>ever [2] 9/20 39/7</p> <p>every [3] 48/19 48/21 58/5</p> <p>everybody [1] 40/2</p> <p>everyday [1] 103/24</p> <p>everyone [1] 92/6</p> <p>everything [1] 7/11</p> <p>everywhere [2] 84/4 84/5</p> <p>evidence [34] 7/1 19/14 26/14 31/14 34/24 36/5 36/18 38/5 39/15 40/6 46/16 47/4 47/14 47/22 51/24 53/5 53/9 53/16 53/18 54/25 70/2 70/14 77/25 81/5 84/15 91/25 93/6 94/9 96/6 97/22 97/23 98/2 100/6 100/8</p> <p>evidence-based [2] 36/5 53/9</p> <p>evolves [1] 37/6</p> <p>evolving [2] 32/6 35/15</p> <p>exactly [3] 24/12 52/3 68/5</p> <p>exaggeration [1] 87/23</p> <p>examined [1] 67/18</p> <p>example [13] 20/10 38/1 49/2 52/16 63/1 69/16 85/5 85/10 87/2 94/20 102/12 104/9 104/23</p> <p>examples [3] 72/1 79/24 81/12</p> <p>exceptional [1] 85/1</p> <p>exceptionally [1] 19/25</p> <p>excessive [1] 50/2</p> <p>exchange [1] 105/9</p> <p>exclude [1] 39/9</p> <p>excludes [1] 8/22</p> <p>excuse [1] 42/5</p> <p>executive [2] 2/21 82/2</p>	<p>existed [1] 1/22</p> <p>existing [1] 43/8</p> <p>exists [2] 37/2 50/11</p> <p>expand [1] 87/10</p> <p>expanding [1] 97/4</p> <p>expect [4] 64/10 92/20 94/24 99/1</p> <p>expectation [1] 76/6</p> <p>expectations [1] 26/17</p> <p>expected [1] 89/16</p> <p>expecting [1] 95/16</p> <p>expense [2] 73/18 94/12</p> <p>experience [27] 2/2 27/8 55/1 59/9 73/16 76/9 76/21 77/7 77/24 78/5 79/22 87/14 89/8 89/13 90/11 91/4 94/11 96/1 96/10 96/18 97/23 98/3 99/21 99/23 102/1 105/4 105/21</p> <p>experienced [5] 48/1 48/2 49/6 63/5 78/21</p> <p>experiences [2] 79/1 79/2</p> <p>expert [1] 33/13</p> <p>expertise [9] 21/13 25/2 25/21 97/12 97/14 98/11 98/14 100/11 103/1</p> <p>experts [1] 77/7</p> <p>explain [4] 12/22 38/8 43/6 50/16</p> <p>explained [2] 19/17 96/4</p> <p>explanations [1] 101/18</p> <p>explicitly [1] 41/12</p> <p>explore [1] 90/7</p> <p>explored [1] 32/18</p> <p>expressed [1] 8/17</p> <p>extend [2] 22/21 86/6</p> <p>extension [1] 21/15</p> <p>extensive [1] 97/17</p> <p>external [1] 104/23</p> <p>extra [1] 86/12</p> <p>extraordinary [1] 55/3</p> <p>F</p> <p>face [3] 46/5 88/7 104/19</p> <p>facilitate [1] 105/9</p> <p>facilities [1] 96/2</p> <p>facing [1] 12/25</p> <p>fact [4] 4/1 25/5 60/3 89/20</p> <p>factors [2] 4/10 86/24</p> <p>facts [1] 29/1</p> <p>fade [1] 55/2</p> <p>fades [3] 32/12 32/16 41/18</p> <p>fading [2] 41/16</p>	<p>41/20</p> <p>fair [4] 5/20 27/8 32/2 34/16</p> <p>fairly [1] 46/23</p> <p>Faizal [1] 84/15</p> <p>fall [1] 14/7</p> <p>fallen [1] 15/1</p> <p>falling [2] 23/4 93/13</p> <p>families [18] 26/15 49/24 50/5 50/10 50/18 50/21 50/23 51/1 51/6 51/20 52/14 58/11 58/12 60/21 60/24 78/12 81/11 81/17</p> <p>family [6] 51/9 52/22 58/16 58/18 66/25 85/19</p> <p>far [4] 43/3 60/2 62/25 77/18</p> <p>fashion [1] 48/18</p> <p>feature [1] 55/24</p> <p>features [7] 11/1 19/9 19/20 49/5 49/5 49/18 52/21</p> <p>feel [4] 29/6 33/7 51/25 60/22</p> <p>felt [2] 35/14 48/20</p> <p>few [5] 53/4 57/4 59/8 70/24 72/1</p> <p>fewer [1] 19/9</p> <p>fidelity [3] 47/7 47/15 47/16</p> <p>field [1] 33/13</p> <p>figure [9] 5/14 11/6 14/22 15/4 15/6 84/3 84/14 84/16 84/19</p> <p>figures [1] 29/17</p> <p>fill [1] 34/15</p> <p>final [6] 12/1 14/3 14/6 25/12 80/17 93/3</p> <p>finally [2] 58/10 105/19</p> <p>find [6] 50/23 51/20 51/20 51/22 70/21 103/15</p> <p>finding [6] 7/5 16/1 16/11 51/24 80/13 80/14</p> <p>findings [12] 18/10 18/24 19/19 19/21 21/21 21/23 25/11 28/18 30/5 36/1 80/12 83/3</p> <p>fine [1] 55/15</p> <p>finish [1] 106/9</p> <p>finishing [1] 59/4</p> <p>first [21] 4/18 5/24 9/7 24/2 28/25 45/15 50/16 62/16 63/22 64/11 71/2 71/19 72/20 74/6 76/7 82/24 85/22 88/10 99/19 99/23 105/25</p> <p>first-hand [1] 99/23</p> <p>fit [1] 8/1</p>	<p>fitness [1] 7/5</p> <p>five [2] 56/25 80/18</p> <p>five years [2] 56/25 80/18</p> <p>flexibility [1] 49/1</p> <p>flexible [2] 49/4 49/17</p> <p>focus [21] 5/10 20/4 27/11 37/10 44/1 45/1 54/22 55/2 55/11 57/21 73/11 75/8 76/3 87/9 88/4 90/19 91/3 93/19 93/24 102/9 104/2</p> <p>focused [4] 67/3 67/3 87/11 91/11</p> <p>focuses [1] 72/17</p> <p>follow [1] 19/2</p> <p>follow-up [1] 19/2</p> <p>followed [1] 8/1</p> <p>following [2] 40/16 42/10</p> <p>follows [4] 44/24 53/21 80/14 82/3</p> <p>forensic [7] 69/8 87/19 88/22 90/18 91/6 91/7 97/16</p> <p>forensic-related [1] 91/7</p> <p>forever [1] 32/15</p> <p>foreword [1] 71/1</p> <p>forget [3] 37/11 37/22 45/6</p> <p>forgetting [2] 38/2 62/8</p> <p>form [4] 12/4 25/14 34/18 35/7</p> <p>formal [1] 90/8</p> <p>forms [1] 65/24</p> <p>forward [3] 49/11 52/13 105/1</p> <p>found [4] 59/12 59/20 88/14 88/17</p> <p>Foundation [1] 2/10</p> <p>four [1] 21/12</p> <p>fractured [1] 58/14</p> <p>framework [6] 26/18 26/19 26/22 28/1 28/7 28/14</p> <p>Frameworks [1] 94/18</p> <p>frequent [2] 29/25 73/24</p> <p>frequently [3] 57/8 85/15 89/9</p> <p>fresh [2] 55/19 56/5</p> <p>Friday [1] 1/1</p> <p>front [4] 63/22 88/22 89/18 91/15</p> <p>frontline [3] 54/8 54/23 61/14</p> <p>fully [1] 78/8</p> <p>function [1] 63/16</p> <p>functioning [1] 104/22</p> <p>functions [1] 86/7</p>
---	--	--	--	---

<p>F</p> <p>fund [1] 56/19</p> <p>fundamental [2] 71/21 78/20</p> <p>fundamentally [1] 101/6</p> <p>Fundamentals [2] 71/11 72/21</p> <p>funded [5] 3/16 4/2 4/3 20/25 41/9</p> <p>funder [1] 21/2</p> <p>funders [2] 21/11 24/25</p> <p>funding [12] 21/14 22/1 22/10 24/9 33/13 34/10 34/12 34/13 56/16 56/21 56/23 57/7</p> <p>further [8] 13/10 27/13 50/6 51/11 52/24 53/2 56/11 60/7</p> <p>future [2] 34/19 81/15</p>	<p>22/12 45/11 46/10 49/15 49/16 65/9 67/4 75/1 78/6 79/1 86/4 91/19</p> <p>good [14] 6/15 49/13 60/5 62/17 62/23 63/10 63/11 63/12 65/13 71/4 71/8 73/7 76/18 94/6</p> <p>got [2] 66/10 66/20</p> <p>government [4] 36/17 48/16 49/15 54/7</p> <p>governments [1] 24/25</p> <p>GP [3] 8/18 57/16 103/9</p> <p>GPs [1] 57/10</p> <p>gradual [2] 35/18 35/21</p> <p>gradually [1] 35/8</p> <p>graduated [1] 2/3</p> <p>granularity [1] 91/11</p> <p>grateful [2] 1/25 4/18</p> <p>great [1] 48/23</p> <p>greater [9] 2/10 27/11 40/14 44/21 87/9 92/3 101/21 102/1 104/9</p> <p>greatly [1] 83/11</p> <p>Grey [1] 96/25</p> <p>group [50] 6/1 6/4 6/8 6/12 7/23 8/11 8/14 8/19 8/22 9/4 9/9 9/11 10/24 11/12 11/13 11/17 13/5 14/7 16/3 18/2 18/5 18/19 19/7 20/20 22/18 23/6 24/10 24/13 24/16 24/18 24/19 24/20 27/25 28/12 28/21 30/8 30/9 33/18 33/20 33/23 33/25 34/1 34/16 36/1 47/20 55/20 55/21 62/19 62/21 93/12</p> <p>groups [6] 9/8 16/8 21/16 22/15 22/20 23/2</p> <p>growing [7] 21/18 24/3 24/5 27/2 27/6 28/10 33/1</p> <p>guarantee [1] 38/21</p> <p>guidance [7] 42/20 43/8 72/5 94/17 94/18 94/24 95/16</p> <p>guiding [1] 44/8</p>	<p>22/17 22/17 25/2 26/5 28/11 28/15 30/6 30/10 30/15 30/25 31/1 31/7 32/3 32/9 32/25 33/5 33/6 34/15 34/23 34/25 38/2 38/2 39/9 41/7 49/12 54/10 57/15 58/6 59/21 59/22 70/13 72/5 72/6 72/14 73/20 74/15 77/15 78/19 80/9 80/16 84/17 85/12 87/2 87/5 91/6 97/24 98/17 102/3 103/19 105/14</p> <p>hadn't [1] 31/15</p> <p>half [3] 14/16 15/20 47/11</p> <p>halfway [2] 15/11 90/10</p> <p>hallucinations [2] 13/12 78/5</p> <p>hammer [1] 91/18</p> <p>Hampshire [2] 80/8 80/10</p> <p>hand [6] 18/9 40/24 40/24 46/2 82/2 99/23</p> <p>handle [1] 9/24</p> <p>handovers [1] 103/25</p> <p>happen [11] 29/22 41/22 45/6 50/23 51/23 59/17 66/22 66/23 67/14 67/15 92/11</p> <p>happened [7] 3/16 37/16 47/23 55/6 80/22 89/10 91/11</p> <p>happening [2] 88/16 105/13</p> <p>happens [4] 45/9 66/2 73/24 91/14</p> <p>hard [5] 9/2 9/3 25/20 50/23 88/17</p> <p>harm [21] 11/2 50/4 78/2 78/7 78/15 78/22 78/22 79/6 79/13 79/20 80/21 82/23 85/6 85/9 86/25 87/3 89/21 90/17 96/8 96/13 103/12</p> <p>harm-informed [2] 78/15 79/6</p> <p>harmed [3] 72/15 78/6 103/15</p> <p>has [56] 6/1 15/1 15/13 19/16 26/11 30/18 37/4 38/24 38/25 40/2 46/22 50/2 50/25 55/6 56/5 56/16 56/23 57/2 57/7 57/21 59/2 59/4 59/9 60/23 61/3 65/15 65/24 67/1 67/14 69/5 71/7 73/10 73/25 74/1 75/21 78/18 78/21 79/13</p>	<p>79/20 81/24 86/10 86/18 86/25 87/5 88/22 89/10 89/18 90/15 91/3 91/11 96/8 99/12 100/8 101/13 102/5 102/18</p> <p>have [148]</p> <p>haven't [2] 59/6 70/13</p> <p>having [12] 55/21 56/25 60/21 70/3 78/25 78/25 82/19 87/1 90/11 96/2 99/24 105/8</p> <p>he [8] 26/11 26/12 47/6 47/10 71/3 78/19 80/7 80/16</p> <p>he's [3] 47/3 47/4 47/16</p> <p>head [1] 65/10</p> <p>headed [2] 5/1 46/3</p> <p>heading [2] 72/20 103/23</p> <p>health [119]</p> <p>healthcare [7] 19/20 20/21 20/24 24/14 52/6 52/9 71/4</p> <p>hear [1] 46/10</p> <p>heard [7] 31/7 34/24 36/24 46/16 81/24 84/14 91/25</p> <p>heart [3] 82/7 87/12 104/14</p> <p>hedging [1] 83/18</p> <p>held [1] 69/13</p> <p>help [10] 22/25 29/24 60/18 65/20 73/15 92/24 99/1 100/6 100/8 100/10</p> <p>helpful [1] 58/25</p> <p>helps [1] 91/12</p> <p>hence [1] 74/5</p> <p>her [2] 74/17 88/12</p> <p>here [15] 6/2 12/19 13/6 15/11 34/1 35/10 46/24 51/15 55/25 60/21 71/17 72/6 74/3 75/13 75/19</p> <p>high [20] 6/17 7/1 7/8 10/2 15/23 36/20 38/7 38/12 38/14 38/19 39/9 47/16 50/3 50/11 54/22 55/11 64/14 69/16 96/2 98/15</p> <p>high-level [1] 55/11</p> <p>high-risk [3] 36/20 38/19 39/9</p> <p>highest [1] 22/18</p> <p>highlight [1] 32/8</p> <p>highlighted [11] 15/13 30/15 30/25 71/2 71/11 71/17 72/2 74/21 75/12 85/10 98/17</p> <p>highlighting [1] 78/9</p> <p>him [1] 88/12</p>	<p>hindsight [1] 81/20</p> <p>his [6] 47/6 78/18 80/16 80/16 80/19 80/21</p> <p>historically [1] 12/25</p> <p>histories [3] 36/21 39/25 40/11</p> <p>history [20] 11/1 11/2 11/4 11/4 12/16 14/11 14/14 15/17 17/24 18/16 19/4 28/3 45/9 45/19 48/4 50/11 66/5 88/23 88/23 97/17</p> <p>HM [1] 79/25</p> <p>Hmm [1] 33/22</p> <p>hoc [1] 105/15</p> <p>hold [1] 90/1</p> <p>Home [1] 101/16</p> <p>Homeless [1] 10/25</p> <p>homicide [59] 3/2 3/9 3/25 4/10 4/21 5/2 5/4 6/23 7/14 8/9 8/24 10/14 13/1 13/19 13/23 14/13 14/21 14/24 15/3 15/12 15/18 15/24 17/20 18/13 18/19 18/23 19/4 19/21 19/25 20/23 21/20 21/21 21/23 24/4 24/7 27/4 27/11 28/4 28/18 29/6 30/5 32/4 33/15 34/2 34/18 51/2 56/18 56/20 57/13 59/13 59/22 66/12 68/9 83/10 83/20 84/25 85/6 85/8 85/21</p> <p>homicides [19] 4/1 5/15 7/2 11/10 12/15 14/1 15/16 19/6 20/15 25/10 26/6 29/21 31/1 31/17 34/14 77/16 81/9 83/22 84/16</p> <p>homogeneous [2] 11/12 58/12</p> <p>Honorary [1] 2/9</p> <p>hoped [1] 106/1</p> <p>hoped-for [1] 106/1</p> <p>hopeful [1] 74/25</p> <p>hoping [1] 75/1</p> <p>hospital [2] 12/7 18/21</p> <p>hospitalisation [1] 47/15</p> <p>hospitals [1] 88/16</p> <p>hostage [1] 69/24</p> <p>hour [1] 99/8</p> <p>hours [1] 100/16</p> <p>Housing [1] 86/16</p> <p>how [38] 3/16 4/2 9/24 10/14 10/19 12/22 22/9 26/24 29/4 38/24 43/16 52/12 55/10 56/18 59/17 61/8 62/10 66/23 73/19 76/15 78/15</p>
(34) fund - how				

<p>H</p> <p>how... [17] 79/1 79/20 87/10 88/18 90/7 90/24 91/12 92/18 93/23 94/13 94/24 96/8 98/1 101/20 101/24 102/4 102/8</p> <p>however [4] 27/20 78/11 83/10 90/17</p> <p>HQIP [1] 23/10</p> <p>humane [1] 37/4</p> <p>hundred [2] 58/9 81/11</p> <p>hybrid [2] 47/13 47/21</p> <hr/> <p>I</p> <p>I accept [1] 51/18</p> <p>I add [1] 73/20</p> <p>I also [1] 85/10</p> <p>I am [6] 52/1 69/10 69/21 69/21 70/1 104/15</p> <p>I ask [1] 94/6</p> <p>I asked [1] 104/7</p> <p>I became [2] 1/23 2/8</p> <p>I believe [1] 36/8</p> <p>I can [6] 5/19 24/12 27/12 33/12 67/5 76/20</p> <p>I can't [1] 81/8</p> <p>I could [2] 77/9 77/18</p> <p>I counted [1] 77/5</p> <p>I did [2] 33/22 77/14</p> <p>I didn't [2] 27/18 30/14</p> <p>I disagree [2] 29/14 29/14</p> <p>I do [5] 47/23 51/11 52/10 55/17 98/23</p> <p>I don't [5] 24/10 56/11 84/8 85/20 99/10</p> <p>I ended [1] 73/22</p> <p>I felt [1] 35/14</p> <p>I focus [1] 5/10</p> <p>I found [1] 88/17</p> <p>I graduated [1] 2/3</p> <p>I had [1] 72/5</p> <p>I have [17] 2/4 10/1 10/1 39/2 72/7 73/12 76/20 82/17 82/24 88/8 91/5 91/18 94/2 96/16 99/21 99/22 102/2</p> <p>I highlighted [1] 98/17</p> <p>I just [12] 21/25 48/14 58/24 64/9 82/22 94/8 94/14 95/3 95/20 97/8 100/2 101/13</p> <p>I know [2] 36/2 98/22</p> <p>I look [1] 45/12</p>	<p>I made [2] 74/14 86/3</p> <p>I make [1] 57/18</p> <p>I may [5] 3/11 4/24 6/5 6/21 13/21</p> <p>I mean [4] 33/22 40/2 49/13 94/16</p> <p>I move [1] 100/10</p> <p>I need [1] 82/22</p> <p>I noted [1] 77/10</p> <p>I noticed [1] 63/24</p> <p>I please [1] 68/22</p> <p>I question [1] 100/22</p> <p>I rather [1] 34/20</p> <p>I recognise [1] 46/21</p> <p>I refer [1] 91/3</p> <p>I respect [1] 82/12</p> <p>I said [1] 75/20</p> <p>I saw [1] 101/5</p> <p>I say [4] 29/14 56/2 65/15 93/13</p> <p>I see [4] 40/5 79/11 101/7 101/11</p> <p>I should [3] 11/14 35/10 62/19</p> <p>I sit [1] 93/12</p> <p>I started [1] 73/20</p> <p>I struggle [1] 76/15</p> <p>I suppose [2] 34/20 38/21</p> <p>I suspect [1] 52/18</p> <p>I take [21] 2/24 4/5 4/15 4/25 6/9 10/17 12/8 14/20 15/9 17/2 18/9 19/11 25/4 26/8 26/25 42/19 42/24 43/13 45/25 47/2 49/20</p> <p>I think [69] 10/18 23/10 24/8 27/8 27/9 28/6 29/3 31/6 31/10 31/14 32/2 32/2 32/9 35/20 39/6 39/15 40/18 40/19 41/6 44/24 47/16 53/22 54/5 55/2 55/21 56/4 59/1 59/5 60/19 60/23 62/16 62/16 62/18 62/23 64/2 64/15 65/14 65/25 66/19 67/12 75/20 76/10 76/10 76/24 76/25 77/6 79/10 83/18 83/25 84/23 85/8 85/11 86/20 86/20 88/19 88/21 91/19 92/11 93/1 94/17 96/5 97/25 99/8 101/5 101/5 101/8 103/15 105/6 105/25</p> <p>I thought [1] 39/18</p> <p>I understand [1] 85/3</p> <p>I understood [1] 79/5</p> <p>I want [7] 4/21 5/24 6/6 6/18 6/20 70/14 90/7</p> <p>I was [8] 35/10 35/12</p>	<p>62/19 62/21 86/2 87/13 88/4 88/16</p> <p>I wasn't [2] 3/23 62/20</p> <p>I will [1] 3/11</p> <p>I worked [1] 87/19</p> <p>I would [4] 40/8 41/19 48/10 87/20</p> <p>I'd [2] 70/20 77/6</p> <p>I'll [7] 5/9 23/14 70/24 71/19 72/19 80/1 85/22</p> <p>I'm [38] 1/25 2/3 4/18 5/23 6/4 6/11 10/4 24/11 33/22 35/14 39/10 40/18 45/11 51/15 52/1 52/5 53/24 57/2 58/9 60/16 60/19 61/13 61/25 62/24 63/24 65/7 67/4 67/15 76/1 76/10 87/18 88/20 89/24 92/7 97/16 99/21 99/22 99/24</p> <p>I've [11] 56/10 68/9 74/4 85/8 88/14 89/15 91/7 93/7 93/11 93/23 106/7</p> <p>I, [1] 74/6</p> <p>I, in [1] 74/6</p> <p>IAG [1] 21/11</p> <p>ICBs [1] 42/13</p> <p>idea [2] 75/23 79/7</p> <p>idealism [1] 73/21</p> <p>idealistic [2] 73/17 94/11</p> <p>identified [5] 9/15 66/7 70/23 72/17 96/14</p> <p>identifies [1] 12/20</p> <p>identify [2] 4/9 49/25</p> <p>identifying [1] 66/5</p> <p>identity [1] 82/9</p> <p>ie [1] 14/12</p> <p>if [65] 3/11 4/23 5/2 5/19 6/5 6/21 7/14 8/12 8/15 8/17 24/22 29/23 32/16 34/15 38/13 38/15 39/21 39/23 41/14 47/1 48/8 48/14 49/10 49/16 53/20 56/2 57/14 58/6 58/6 60/17 62/4 65/19 66/15 67/4 67/5 67/5 68/12 71/1 71/10 71/16 71/18 72/18 75/10 75/10 75/21 76/14 78/21 79/14 80/2 80/11 80/13 82/1 83/4 86/4 87/18 88/21 90/8 91/14 91/14 91/15 91/17 91/18 102/21 104/18 105/13</p> <p>ill [1] 83/22</p> <p>illness [16] 3/2 19/19 21/22 28/19 29/8 29/9</p>	<p>30/16 30/17 31/2 46/4 57/22 76/11 76/12 78/10 98/25 100/7</p> <p>illnesses [1] 95/9</p> <p>immediate [3] 53/1 92/22 99/23</p> <p>impact [3] 45/8 75/14 79/2</p> <p>impacts [1] 76/16</p> <p>impending [1] 52/15</p> <p>implement [1] 25/17</p> <p>implementation [1] 25/24</p> <p>implemented [4] 39/24 53/10 86/18 86/20</p> <p>implication [1] 29/18</p> <p>implications [4] 19/12 75/16 102/7 104/15</p> <p>implicitly [1] 94/23</p> <p>imply [1] 33/10</p> <p>importance [7] 30/25 40/7 42/16 54/20 58/11 58/16 64/4</p> <p>important [18] 9/2 18/3 22/3 22/20 28/25 30/18 32/17 35/16 39/7 42/2 45/5 49/5 52/6 52/13 63/7 64/6 71/5 75/7</p> <p>importantly [3] 69/12 74/21 86/13</p> <p>impositions [1] 104/17</p> <p>impression [7] 27/14 28/10 29/7 29/9 32/25 39/1 57/6</p> <p>impressions [1] 27/23</p> <p>improve [4] 4/11 29/24 46/13 100/2</p> <p>improved [5] 31/15 36/18 38/5 86/4 92/13</p> <p>improvement [4] 20/22 20/24 24/14 29/20</p> <p>improving [3] 66/17 72/22 103/16</p> <p>inaccurate [1] 85/9</p> <p>inadvertently [2] 21/21 28/18</p> <p>inappropriate [1] 75/24</p> <p>incident [15] 21/19 24/3 24/6 25/9 26/18 26/19 26/23 27/3 28/1 28/7 28/13 51/5 52/25 88/6 93/1</p> <p>incidents [8] 3/19 3/23 29/23 29/25 45/7 53/2 85/14 92/2</p> <p>include [3] 11/16 44/14 77/19</p> <p>included [4] 9/13 71/8 101/17 101/19</p>	<p>includes [3] 11/19 21/11 69/16</p> <p>including [5] 10/7 18/22 97/18 101/24 102/18</p> <p>incorporated [2] 90/24 91/2</p> <p>incorporating [1] 97/19</p> <p>increase [2] 90/4 93/23</p> <p>increased [4] 37/10 47/19 91/24 98/24</p> <p>incredibly [1] 37/24</p> <p>indeed [12] 32/18 36/24 44/7 44/10 68/15 82/25 84/5 84/20 89/16 98/16 99/6 104/14</p> <p>independence [3] 43/19 43/25 54/2</p> <p>independent [4] 20/20 54/4 54/5 75/4</p> <p>index [3] 90/13 96/20 101/19</p> <p>indicate [1] 77/11</p> <p>individual [16] 25/2 27/11 28/3 36/21 39/25 40/11 42/10 42/14 53/22 66/6 66/9 68/1 68/2 74/13 86/10 102/14</p> <p>individual's [1] 67/16</p> <p>individuals [5] 19/17 21/12 23/15 48/8 85/14</p> <p>inflicted [2] 89/20 90/21</p> <p>influence [1] 39/6</p> <p>influenced [1] 91/4</p> <p>influences [1] 32/15</p> <p>influential [1] 38/24</p> <p>inform [1] 91/20</p> <p>informal [6] 21/17 23/8 23/9 23/24 27/2 51/17</p> <p>information [40] 10/19 11/24 12/17 13/3 13/7 22/20 23/23 27/5 27/22 28/20 29/2 31/18 31/21 31/24 32/3 33/5 50/20 58/7 58/25 59/5 86/5 86/14 89/5 90/2 90/4 100/4 100/10 100/18 101/24 102/3 102/9 102/12 102/21 103/7 103/12 103/16 104/8 104/11 104/18 105/10</p> <p>informed [11] 76/21 78/1 78/2 78/14 78/15 78/16 79/5 79/6 89/18 94/21 96/4</p> <p>initial [3] 3/13 37/19 37/20</p> <p>initially [3] 3/16 4/3</p>
---	--	--	--	---

I	<p>initially... [1] 4/4</p> <p>initiate [1] 3/24</p> <p>initiatives [2] 72/12 92/25</p> <p>injuries [4] 88/1 89/1 89/2 90/20</p> <p>injury [1] 90/13</p> <p>inpatient [3] 17/24 18/3 103/18</p> <p>input [2] 54/4 77/3</p> <p>inquest [1] 6/24</p> <p>inquiries [4] 3/21 27/11 28/4 53/14</p> <p>inquiry [58] 1/8 1/14 1/17 2/8 2/25 3/1 3/6 3/14 3/25 4/15 4/23 10/4 17/4 17/13 18/7 20/14 23/19 25/7 25/14 25/22 26/2 26/4 26/12 28/4 31/17 32/5 32/19 33/14 34/2 35/5 36/8 40/7 41/15 41/19 47/5 49/23 50/8 53/17 54/11 54/16 56/3 56/17 59/2 62/5 62/6 62/6 62/10 65/7 65/19 69/4 70/3 74/7 81/24 84/24 84/25 93/8 95/11 97/10</p> <p>Inquiry's [2] 4/16 27/19</p> <p>INQY0000031 [1] 42/17</p> <p>insanity [1] 7/5</p> <p>inside [1] 65/10</p> <p>insight [8] 22/8 75/6 75/10 75/22 75/25 76/3 76/5 76/14</p> <p>Inspector [1] 77/10</p> <p>Inspectorate [1] 79/25</p> <p>instances [4] 82/23 86/8 87/2 87/24</p> <p>instead [1] 100/6</p> <p>instilled [1] 93/17</p> <p>instruction [1] 101/16</p> <p>insufficient [1] 80/20</p> <p>integrated [1] 82/5</p> <p>intended [3] 15/21 16/7 16/12</p> <p>intensity [2] 47/18 55/2</p> <p>intensive [4] 20/8 20/10 35/7 47/18</p> <p>intention [1] 28/13</p> <p>intentionally [1] 92/1</p> <p>inter [2] 85/24 86/5</p> <p>inter-agency [2] 85/24 86/5</p> <p>interacted [1] 90/23</p> <p>interest [3] 22/19 35/10 36/15</p> <p>interests [1] 103/14</p> <p>interpretation [1] 49/17</p> <p>interpreting [1] 76/9</p> <p>intervene [1] 73/14</p> <p>intervention [4] 35/8 38/17 47/9 82/21</p> <p>interventions [2] 47/17 53/10</p> <p>into [21] 1/14 3/1 3/6 9/12 25/9 25/14 26/6 42/14 46/8 64/1 65/8 67/8 84/24 88/3 88/18 90/24 91/2 91/19 93/17 93/17 104/10</p> <p>introduced [4] 35/12 35/13 36/11 48/15</p> <p>introducing [1] 62/9</p> <p>introduction [1] 20/7</p> <p>investigating [1] 77/15</p> <p>investigation [3] 76/23 89/6 92/9</p> <p>investigations [11] 21/19 24/4 24/6 25/9 25/13 25/19 26/6 26/23 27/3 53/15 91/5</p> <p>investigative [6] 77/24 90/19 91/3 91/9 93/24 97/20</p> <p>investigators [1] 91/8</p> <p>involve [5] 72/22 85/14 85/15 92/8 104/22</p> <p>involved [14] 1/20 44/18 62/20 76/22 77/15 82/16 84/2 85/12 85/16 86/10 86/16 99/4 102/2 103/8</p> <p>involvement [9] 86/22 88/14 92/4 93/2 98/10 102/13 105/2 105/6 106/1</p> <p>involves [2] 38/16 97/19</p> <p>irrelevant [1] 61/24</p> <p>is [281]</p> <p>is all [1] 64/23</p> <p>is that [1] 31/11</p> <p>isn't [9] 10/5 31/23 31/24 32/1 38/10 51/18 60/4 63/20 92/5</p> <p>issue [8] 29/4 29/5 29/16 32/11 45/3 54/24 75/19 87/12</p> <p>issues [4] 32/7 42/9 66/16 72/10</p> <p>it [222]</p> <p>it together [1] 5/6</p> <p>it'll [1] 79/10</p> <p>it's [88] 5/4 6/20 9/23 10/4 11/7 12/20 12/20 12/24 16/6 16/6 16/10 17/6 17/6 17/7 17/8 17/10 20/14 24/11</p>	<p>24/21 24/24 27/8 27/12 28/25 29/12 29/17 29/17 29/20 30/19 32/2 32/2 32/5 37/3 38/15 39/6 39/10 39/10 44/15 44/15 48/13 48/14 49/13 51/2 51/2 51/11 52/5 52/7 52/10 53/18 54/15 56/6 56/7 56/7 56/8 56/21 57/5 58/4 58/8 59/18 59/18 59/18 60/3 60/5 61/15 61/24 63/2 63/21 65/9 65/25 66/4 67/12 67/13 75/12 79/8 80/24 82/12 83/23 86/20 89/14 89/14 89/14 90/1 91/17 91/17 91/18 91/19 92/6 94/16 98/6</p> <p>its [6] 3/5 4/8 74/20 85/2 99/23 102/7</p> <p>itself [7] 24/10 29/3 54/3 59/2 60/4 61/5 101/6</p>	<p>41/11 41/12 42/3 67/13 68/10 82/8 83/3</p> <p>kind [17] 22/21 28/14 34/22 58/1 62/6 63/9 67/12 67/22 74/18 82/10 86/2 86/11 87/6 90/4 90/18 91/19 91/20</p> <p>kitchen [1] 91/17</p> <p>knew [1] 11/23</p> <p>knife [1] 91/17</p> <p>know [38] 22/15 22/24 36/2 39/7 42/6 50/18 51/3 58/2 68/4 68/6 73/12 74/24 77/7 79/2 82/16 83/21 85/18 87/15 88/5 88/13 88/20 90/5 91/16 91/18 92/21 93/11 93/16 95/25 96/19 98/16 98/22 98/22 98/22 99/8 99/24 100/8 105/4 105/10</p> <p>knowledge [4] 1/10 69/6 81/5 98/1</p> <p>known [5] 29/2 38/23 42/13 88/2 103/6</p> <p>Kumar [1] 57/10</p>	<p>33/4 37/21 54/9 56/10</p> <p>learnt [1] 32/10</p> <p>least [7] 35/17 43/1 43/18 53/23 57/25 59/10 72/9</p> <p>leave [1] 98/20</p> <p>led [2] 37/8 65/24</p> <p>left [2] 92/19 98/20</p> <p>legal [3] 7/12 51/13 51/19</p> <p>legally [3] 6/23 7/19 7/20</p> <p>legislation [2] 43/8 61/6</p> <p>legitimate [1] 64/25</p> <p>less [20] 15/15 18/19 22/4 22/6 22/6 22/6 29/25 36/21 39/25 45/5 47/18 49/3 49/4 51/5 57/22 64/16 64/21 65/21 79/15 79/15</p> <p>lessons [7] 33/6 38/2 54/13 54/17 54/19 93/10 93/16</p> <p>letter [1] 63/6</p> <p>level [8] 9/25 39/4 42/12 53/21 55/1 55/11 71/22 103/3</p> <p>levels [2] 19/1 45/1</p> <p>liberty [1] 43/3</p> <p>Licence [1] 80/7</p> <p>life [6] 7/15 67/1 72/23 79/3 80/7 101/7</p> <p>lifestyle [1] 90/15</p> <p>lifetime [1] 39/13</p> <p>like [11] 8/18 32/16 55/12 57/1 62/5 65/9 70/20 86/16 92/25 100/15 105/11</p> <p>likely [9] 15/14 15/15 18/13 18/19 35/17 51/6 75/22 103/19 104/2</p> <p>limb [1] 101/7</p> <p>limit [1] 50/8</p> <p>limitations [1] 7/13</p> <p>limited [5] 17/23 30/11 84/17 99/21 100/4</p> <p>lines [2] 100/20 104/1</p> <p>link [2] 78/10 78/13</p> <p>linked [1] 19/2</p> <p>links [2] 11/9 49/3</p> <p>list [1] 63/25</p> <p>listed [1] 83/25</p> <p>literature [2] 76/5 84/4</p> <p>little [4] 3/11 5/9 11/8 15/4</p> <p>lived [1] 90/23</p> <p>local [1] 42/10</p> <p>location [1] 90/12</p> <p>logic [1] 65/17</p> <p>long [7] 10/23 25/22</p>
	<p>J</p> <p>JAMES [3] 1/5 46/17 107/3</p> <p>job [4] 27/15 62/17 62/23 64/12</p> <p>JOHN [3] 1/5 78/17 107/3</p> <p>joint [1] 106/3</p> <p>jointly [1] 80/9</p> <p>jumps [1] 11/7</p> <p>June [1] 20/20</p> <p>June 2018 [1] 20/20</p> <p>just [70] 3/15 4/6 5/2 5/2 5/5 5/22 7/13 11/10 13/23 14/3 15/11 21/10 21/10 21/25 23/1 27/1 27/22 28/11 28/24 32/13 38/8 40/1 40/13 43/6 48/14 49/6 49/10 50/16 51/2 52/16 52/24 54/12 54/13 55/1 56/6 58/24 58/25 60/7 62/4 64/9 64/24 65/3 65/19 66/1 67/7 68/5 70/24 71/19 72/1 72/20 74/16 75/21 77/11 82/22 86/2 91/14 94/8 94/14 95/2 95/3 95/5 95/20 97/4 97/7 97/8 98/5 98/6 100/2 100/15 101/13</p> <p>justice [1] 102/17</p> <p>justification [1] 31/3</p>	<p>L</p> <p>lack [2] 75/25 84/12</p> <p>lacked [2] 25/16 25/24</p> <p>lacking [1] 47/13</p> <p>lacks [1] 76/2</p> <p>large [5] 48/8 48/10 59/20 67/20 83/15</p> <p>last [5] 46/6 62/5 63/25 100/20 104/1</p> <p>later [4] 4/21 5/9 15/9 46/11</p> <p>latest [1] 36/25</p> <p>launched [1] 26/20</p> <p>law [5] 63/3 63/6 63/11 63/15 87/1</p> <p>lawfully [1] 43/23</p> <p>lay [1] 87/22</p> <p>lead [2] 27/15 29/8</p> <p>leaders [1] 36/13</p> <p>leadership [6] 42/7 42/7 42/12 42/15 45/3 53/21</p> <p>leading [1] 26/3</p> <p>leads [2] 50/6 83/6</p> <p>learn [3] 32/12 32/14 38/2</p> <p>learned [4] 31/23 33/6 93/10 93/16</p> <p>learning [23] 4/22 16/2 16/17 21/23 29/20 30/5 30/10 30/11 31/9 31/10 31/11 31/12 31/17 31/21 32/12 32/13 32/14 32/16 32/19</p>		

<p>L</p> <p>long... [5] 56/18 57/3 57/5 59/16 73/7</p> <p>long-term [1] 10/23</p> <p>longer [6] 35/6 35/7 58/4 59/21 66/24 87/18</p> <p>look [14] 5/6 7/22 16/9 33/14 43/15 45/12 51/16 55/19 56/5 60/10 61/22 65/10 65/25 84/4</p> <p>looked [8] 12/2 12/7 12/18 16/3 28/3 44/5 45/15 66/24</p> <p>looking [10] 8/12 11/9 22/19 23/6 54/25 59/10 65/9 78/18 100/20 105/1</p> <p>looks [3] 10/7 10/9 26/24</p> <p>lose [5] 34/7 45/8 47/14 49/18 65/1</p> <p>loss [5] 15/21 16/1 19/23 41/20 41/21</p> <p>lost [4] 18/14 32/13 45/2 56/10</p> <p>lot [5] 21/25 23/23 39/6 57/10 66/12</p> <p>Louis [6] 1/4 1/5 58/10 58/21 58/24 107/3</p> <p>low [3] 11/8 47/15 47/25</p> <p>lower [2] 4/6 49/5</p>	<p>making [8] 25/19 29/17 31/4 40/23 48/12 63/14 88/2 95/18</p> <p>male [2] 10/23 18/12</p> <p>manage [6] 73/19 75/2 76/16 82/8 83/9 94/13</p> <p>managed [1] 48/16</p> <p>management [19] 56/6 67/1 68/7 68/10 71/13 72/11 72/18 72/22 73/1 73/3 73/4 73/10 74/8 74/11 74/19 74/22 74/24 77/13 94/20</p> <p>managing [6] 70/21 75/3 75/23 76/3 86/14 101/22</p> <p>Manchester [6] 1/23 2/7 2/10 2/25 3/15 85/1</p> <p>mandatory [1] 58/4</p> <p>manslaughter [3] 7/4 12/3 12/5</p> <p>many [5] 74/19 77/8 84/5 87/20 99/25</p> <p>MAPPA [5] 80/10 86/2 86/7 86/7 86/12</p> <p>March [1] 70/22</p> <p>March 2009 [1] 70/22</p> <p>marked [1] 88/15</p> <p>Martha's [5] 50/14 52/5 52/17 60/7 61/3</p> <p>match [2] 18/5 18/7</p> <p>matters [7] 10/7 23/13 42/22 69/13 72/15 93/6 97/5</p> <p>maturity [7] 21/18 24/3 24/6 27/3 27/7 28/11 33/1</p> <p>maximising [1] 43/18</p> <p>maxims [1] 78/19</p> <p>may [34] 1/1 3/11 4/24 6/5 6/21 6/25 8/17 11/22 13/21 19/2 21/21 28/18 31/13 32/25 48/22 49/4 52/2 59/1 61/22 78/1 78/4 85/3 85/14 87/21 88/7 90/18 99/3 99/4 102/20 102/21 102/23 103/15 104/12 105/5</p> <p>maybe [5] 31/8 37/24 48/22 64/10 86/17</p> <p>me [12] 3/15 35/22 37/18 38/1 41/2 41/4 72/13 76/25 77/11 77/25 82/17 82/19</p> <p>mean [9] 31/10 33/22 40/2 48/24 49/13 76/18 79/9 94/16 96/4</p> <p>meaning [2] 82/24 99/11</p> <p>means [7] 23/14 38/14 49/19 57/21</p>	<p>74/20 99/13 103/8</p> <p>meant [1] 91/13</p> <p>medication [6] 10/8 19/23 30/23 40/9 52/20 68/14</p> <p>medicine [1] 2/4</p> <p>medium [3] 69/16 96/2 105/7</p> <p>meet [1] 53/14</p> <p>meeting [2] 24/10 24/10</p> <p>meetings [3] 102/3 103/25 104/2</p> <p>member [1] 12/10</p> <p>members [2] 33/23 104/23</p> <p>membership [1] 21/11</p> <p>membrane [1] 105/11</p> <p>memoire [1] 67/22</p> <p>men [2] 22/18 81/9</p> <p>mental [127]</p> <p>mentally [2] 77/16 83/22</p> <p>mention [3] 44/4 44/9 55/17</p> <p>mentioned [3] 23/8 62/4 84/14</p> <p>mere [1] 95/10</p> <p>merged [1] 53/7</p> <p>message [4] 30/9 31/7 40/4 64/20</p> <p>method [1] 90/21</p> <p>methodological [1] 39/17</p> <p>methodologies [2] 6/6 16/4</p> <p>methodology [12] 5/24 6/7 6/10 6/12 7/10 7/16 10/19 11/16 12/18 12/19 12/20 16/4</p> <p>metric [2] 85/9 85/21</p> <p>middle [2] 22/18 95/6</p> <p>middle-aged [1] 22/18</p> <p>might [30] 10/14 11/18 16/23 23/19 23/25 37/4 38/20 45/7 50/1 51/5 52/3 52/12 55/10 55/21 56/9 56/12 57/11 60/18 61/1 65/20 68/2 74/22 79/15 79/15 83/18 83/21 86/13 86/24 87/18 105/16</p> <p>mind [3] 53/12 86/1 89/23</p> <p>minded [1] 90/3</p> <p>mindful [1] 78/3</p> <p>mine [1] 79/8</p> <p>minimal [2] 34/7 34/18</p> <p>minimised [1] 81/13</p> <p>Minimising [1] 43/3</p>	<p>minimum [1] 96/13</p> <p>minority [1] 10/24</p> <p>misguided [6] 32/2 32/10 32/22 32/22 33/4 33/4</p> <p>misleading [1] 78/11</p> <p>misplaced [1] 39/18</p> <p>miss [1] 90/12</p> <p>missed [1] 14/6</p> <p>missing [1] 59/19</p> <p>mistake [1] 33/15</p> <p>misuse [12] 11/4 11/5 14/12 14/14 15/18 15/19 19/5 19/18 20/7 30/18 45/21 66/14</p> <p>misused [3] 14/16 14/17 14/18</p> <p>mixture [1] 64/23</p> <p>Mm [1] 23/14</p> <p>model [3] 46/20 48/21 66/21</p> <p>models [3] 20/8 46/9 55/19</p> <p>Moloney [3] 56/14 56/15 107/5</p> <p>moment [5] 6/19 6/21 7/23 20/11 45/12</p> <p>money [4] 22/4 22/6 22/6 22/7</p> <p>monitor [1] 25/18</p> <p>monitored [1] 53/11</p> <p>monitoring [3] 4/8 42/9 54/25</p> <p>month [3] 9/6 9/10 13/18</p> <p>months [4] 8/8 8/23 9/6 84/18</p> <p>moral [1] 44/16</p> <p>morbid [1] 15/18</p> <p>more [51] 8/23 18/5 18/7 18/13 22/16 23/16 25/13 29/9 31/23 31/24 34/9 35/17 49/2 50/25 51/6 57/8 57/22 64/22 65/16 65/21 66/4 66/21 66/21 71/6 73/3 73/8 73/21 75/4 75/20 77/19 78/24 83/1 83/13 84/7 89/3 89/4 90/20 91/10 92/22 93/2 100/8 101/23 102/9 102/12 103/7 103/19 104/2 105/6 105/8 105/14 106/3</p> <p>more problems [1] 73/8</p> <p>Morgan [1] 81/25</p> <p>most [12] 7/11 15/14 15/17 45/23 57/20 57/23 57/24 58/1 61/19 75/7 78/20 104/22</p> <p>motivated [1] 87/13</p> <p>move [3] 55/7 85/22</p>	<p>100/10</p> <p>moved [4] 1/23 2/25 3/14 54/13</p> <p>movement [1] 37/15</p> <p>moving [2] 49/11 87/8</p> <p>Mr [17] 1/3 1/6 26/9 26/10 56/14 56/15 68/21 68/25 94/9 96/25 97/1 97/5 98/7 107/4 107/5 107/9 107/11</p> <p>Mr Blake [6] 68/21 68/25 94/9 97/5 98/7 107/9</p> <p>Mr Bywater [2] 26/9 26/10</p> <p>Mr Moloney [3] 56/14 56/15 107/5</p> <p>Mr Weston [1] 1/3</p> <p>Mr Williamson [1] 96/25</p> <p>Ms [5] 94/4 94/5 96/25 97/8 107/10</p> <p>Ms Cartwright [4] 94/4 94/5 97/8 107/10</p> <p>Ms Grey [1] 96/25</p> <p>much [11] 18/24 19/16 34/9 58/21 63/3 68/16 79/14 91/10 96/23 99/17 100/3</p> <p>multidisciplinary [1] 91/9</p> <p>multiple [1] 18/18</p> <p>murder [4] 7/4 12/3 80/6 88/6</p> <p>must [2] 71/8 71/13</p> <p>my [38] 27/14 29/15 32/10 36/1 37/23 41/14 51/15 52/12 55/9 57/6 61/8 73/16 73/20 74/14 75/20 76/6 76/10 76/21 77/24 78/16 82/12 82/15 82/17 85/8 86/2 87/14 87/15 87/19 88/14 89/8 90/11 91/4 95/14 96/18 98/16 102/1 102/5 105/4</p> <p>myself [2] 69/21 73/12</p>
<p>N</p> <p>naive [2] 73/17 94/11</p> <p>name [5] 3/1 3/5 3/5 88/10 88/25</p> <p>named [3] 23/19 84/25 88/1</p> <p>Namely [1] 78/2</p> <p>Naomi [1] 80/6</p> <p>national [38] 1/13 1/17 2/13 2/18 2/24 3/1 3/6 3/14 4/15 4/22 10/2 17/4 17/13 18/6 18/11 20/14 25/7 26/4 26/14 27/19 31/16</p>				

<p>N</p> <p>national... [17] 33/14 35/11 35/12 36/16 42/12 45/22 46/14 48/21 53/8 53/17 53/21 54/10 54/16 56/16 69/20 69/22 84/23</p> <p>nations [1] 25/1</p> <p>natural [1] 64/16</p> <p>naturally [2] 55/2 55/9</p> <p>nature [8] 57/7 66/22 80/21 88/1 90/20 92/10 96/17 103/21</p> <p>near [1] 61/2</p> <p>necessarily [4] 46/18 86/25 87/6 91/6</p> <p>necessary [4] 25/20 34/22 61/22 67/9</p> <p>need [50] 31/8 37/25 39/14 40/19 48/24 51/15 51/20 52/2 54/4 54/5 55/18 55/22 60/19 60/24 61/17 62/1 63/6 63/12 64/9 64/24 65/16 66/4 66/20 67/17 67/25 68/3 68/4 68/6 74/4 76/13 78/1 82/20 82/22 82/24 84/1 86/6 86/12 90/19 90/25 91/20 92/23 93/2 93/16 99/10 99/18 99/19 103/10 103/15 105/2 105/3</p> <p>needed [6] 37/22 50/7 53/8 56/9 57/5 99/2</p> <p>needs [18] 7/2 7/2 7/9 8/19 42/8 42/21 51/11 52/20 54/1 54/6 54/6 63/15 72/24 82/5 100/11 100/13 100/15 105/25</p> <p>needs it [1] 100/13</p> <p>needs' [1] 95/11</p> <p>negative [1] 78/9</p> <p>neglect [1] 78/21</p> <p>negotiation [1] 69/25</p> <p>neighbourhood [1] 46/9</p> <p>never [2] 7/15 27/12</p> <p>Nevertheless [1] 83/24</p> <p>new [8] 32/4 36/12 43/6 43/7 43/9 53/7 54/25 62/14</p> <p>next [1] 46/14</p> <p>NHS [24] 20/25 21/2 21/7 21/18 23/11 24/3 24/6 24/25 25/9 26/10 26/11 26/13 26/21 27/3 27/5 32/9 40/5 46/16 53/7 53/13 54/2</p>	<p>56/21 64/2 94/19</p> <p>NHS England's [1] 26/21</p> <p>NHSE0000312 [1] 43/14</p> <p>NHSE0000524 [1] 46/1</p> <p>nineties [1] 37/16</p> <p>no [31] 8/21 22/10 28/1 28/23 34/10 34/12 34/12 35/6 35/6 44/3 44/19 47/8 50/6 57/3 58/4 59/21 61/12 66/24 67/4 67/6 67/21 76/25 77/14 77/17 98/6 98/13 98/16 99/16 100/6 100/17 101/1</p> <p>Nobody [2] 93/14 93/15</p> <p>nodded [1] 52/19</p> <p>non [12] 2/21 13/18 14/5 15/16 15/22 16/1 16/19 18/14 19/23 30/19 68/11 71/23</p> <p>non-adherence [5] 15/22 16/1 16/19 19/23 30/19</p> <p>non-adherent [3] 13/18 14/5 18/14</p> <p>non-patients [1] 15/16</p> <p>non-receipt [1] 68/11</p> <p>non-restrictive [1] 71/23</p> <p>not [116]</p> <p>note [1] 87/13</p> <p>notebook [2] 88/9 88/11</p> <p>noted [2] 72/6 77/10</p> <p>notes [1] 23/3</p> <p>notice [1] 101/16</p> <p>noticed [1] 63/24</p> <p>noting [1] 96/1</p> <p>notion [3] 19/19 74/18 92/7</p> <p>Nottingham [3] 36/2 36/22 40/3</p> <p>Nottinghamshire [1] 97/3</p> <p>now [25] 5/23 10/4 10/18 12/25 17/12 21/23 28/9 30/6 32/5 35/4 46/16 49/14 50/22 51/18 56/16 65/24 68/17 70/25 72/1 81/4 81/22 85/22 96/1 101/11 106/9</p> <p>nowhere [1] 44/7</p> <p>nuanced [1] 83/12</p> <p>number [27] 3/18 5/18 6/1 15/1 22/14 24/11 29/21 31/7 34/14 39/9 46/22 47/6 48/3 59/15 59/16 59/20 65/6 67/7 67/20</p>	<p>69/5 73/13 77/5 80/8 80/13 80/14 81/8 103/18</p> <p>numerical [1] 68/5</p> <p>numerous [1] 81/12</p> <p>nurses [2] 48/1 73/14</p> <p>nursing [1] 95/24</p> <p>Nuwan [1] 47/3</p> <p>O</p> <p>objective [1] 71/9</p> <p>objectives [2] 4/8 4/13</p> <p>observation [1] 19/7</p> <p>observations [2] 70/15 92/17</p> <p>observed [2] 18/21 63/15</p> <p>observer [1] 35/15</p> <p>obtain [1] 101/23</p> <p>obtained [1] 10/20</p> <p>obtaining [1] 104/8</p> <p>obviously [5] 33/9 65/9 68/14 93/10 96/1</p> <p>occasions [5] 77/25 85/16 87/4 87/7 87/20</p> <p>occupation [1] 83/6</p> <p>occur [2] 19/25 29/23</p> <p>occurred [3] 19/8 31/1 90/15</p> <p>October [2] 1/8 80/5</p> <p>October 2005 [1] 80/5</p> <p>odd [1] 59/3</p> <p>off [3] 59/23 59/24 62/8</p> <p>offence [22] 11/7 11/22 13/12 14/24 18/15 59/22 59/25 86/11 87/25 89/11 90/13 91/12 91/14 91/15 92/10 96/18 96/20 101/19 101/20 101/24 102/5 102/6</p> <p>offences [1] 78/13</p> <p>offender [5] 2/18 12/9 87/25 89/8 91/13</p> <p>offender-patient [2] 87/25 89/8</p> <p>offenders [3] 5/18 77/17 97/25</p> <p>offending [1] 90/15</p> <p>offer [5] 25/2 36/8 47/12 86/17 102/22 100/16 101/16</p> <p>office [3] 47/17 47/17</p> <p>office-based [1] 47/17</p> <p>officers [5] 77/15 91/8 98/11 99/14 102/2</p> <p>official [1] 55/11</p> <p>often [13] 11/23 13/10 16/11 25/19 25/24 26/1 43/14 45/20 49/25 50/18</p>	<p>52/25 85/18 101/19</p> <p>oftentimes [1] 88/10</p> <p>Oh [1] 106/6</p> <p>okay [4] 23/23 41/15 48/14 96/23</p> <p>ominous [1] 81/16</p> <p>omit [1] 67/13</p> <p>omits [1] 8/9</p> <p>omitted [1] 81/13</p> <p>on [122]</p> <p>once [5] 9/15 32/14 37/19 37/20 41/7</p> <p>one [38] 6/13 16/13 16/24 17/8 20/10 23/20 23/21 26/1 35/2 36/24 37/25 39/17 40/24 41/11 41/12 41/12 42/2 42/22 46/5 48/14 51/6 55/17 56/22 59/1 59/3 60/7 61/5 68/8 72/17 75/3 77/10 77/10 78/19 79/24 83/3 99/6 101/2 105/16</p> <p>ones [1] 55/13</p> <p>ongoing [3] 30/11 87/23 93/19</p> <p>only [13] 19/8 32/3 32/22 48/7 50/3 54/21 57/13 59/12 63/3 81/4 96/21 99/17 105/9</p> <p>onto [2] 5/9 80/1</p> <p>onwards [1] 54/10</p> <p>open [1] 79/15</p> <p>operate [1] 87/11</p> <p>operating [2] 63/19 88/7</p> <p>operation [2] 59/9 86/5</p> <p>opinion [5] 37/15 50/14 52/7 52/22 60/15</p> <p>opinions [1] 60/9</p> <p>opportunity [2] 95/12 97/10</p> <p>opposed [1] 47/16</p> <p>opposite [1] 54/15</p> <p>opposition [3] 36/13 36/23 37/2</p> <p>optimistic [3] 81/2 81/6 81/21</p> <p>option [2] 43/18 86/17</p> <p>or [79] 3/14 6/24 7/4 7/5 8/18 8/18 11/22 12/18 13/12 14/5 14/11 14/14 15/17 15/21 16/1 16/4 17/8 17/22 18/17 18/18 19/4 19/5 20/1 22/8 25/17 27/22 30/17 31/25 33/5 35/17 36/5 37/1 39/17 45/21 51/23 52/16 52/18 57/1 57/1 57/5 57/22 59/1 65/21 67/4 69/19</p>	<p>72/12 73/7 77/17 78/4 78/13 79/7 81/16 81/19 82/11 82/16 82/21 83/14 84/7 84/10 85/6 85/9 86/24 88/12 88/13 90/4 90/25 90/25 92/7 92/12 93/20 98/15 98/20 100/12 102/16 102/16 102/22 103/6 103/20 104/24</p> <p>orbit [1] 64/2</p> <p>order [12] 12/7 35/13 36/10 37/9 37/13 37/23 38/13 38/21 41/7 61/18 83/15 101/23</p> <p>orders [8] 16/24 38/25 39/8 39/19 40/12 44/12 45/16 63/1</p> <p>organisation [1] 23/18</p> <p>organisations [3] 24/23 26/16 42/13</p> <p>organised [1] 105/8</p> <p>oriented [1] 74/25</p> <p>original [1] 92/8</p> <p>originally [1] 87/14</p> <p>origins [1] 37/4</p> <p>other [44] 3/21 11/19 16/8 17/18 22/25 23/2 25/14 27/15 32/7 40/24 41/23 46/25 53/2 53/16 55/12 55/17 64/13 69/25 75/8 78/8 80/8 82/25 84/16 85/7 86/3 91/7 93/22 95/9 95/13 95/20 95/22 95/25 96/19 97/11 98/19 98/20 99/9 99/25 100/5 100/24 101/5 105/5 105/12 106/1</p> <p>others [11] 54/23 56/12 72/2 80/21 81/18 83/6 83/14 83/15 84/8 84/8 94/19</p> <p>others' [1] 82/7</p> <p>otherwise [6] 38/12 56/9 58/2 67/13 84/11 89/6</p> <p>our [60] 3/8 3/9 3/10 7/21 8/15 8/21 11/13 13/2 15/12 16/8 19/19 20/21 21/15 21/20 21/23 22/5 25/11 27/8 28/2 28/17 28/25 29/1 30/5 31/2 31/14 33/11 33/22 33/23 34/1 34/17 40/24 41/8 41/11 41/12 41/13 57/17 57/18 57/25 59/12 59/20 61/16 65/1 66/17 67/1 68/7 68/7 68/12 73/16</p>
--	--	--	---	--

<p>O</p> <p>our... [12] 73/18 82/7 82/7 82/8 83/13 88/25 89/19 93/24 94/10 94/12 103/16 105/7</p> <p>out [27] 3/10 5/3 6/11 11/7 13/21 22/5 22/22 25/13 26/13 31/24 34/25 41/20 43/6 46/23 48/18 53/19 60/19 64/20 67/7 69/11 70/7 74/3 76/22 81/12 94/18 94/22 97/9</p> <p>outcome [8] 12/1 12/2 12/6 18/23 39/11 39/13 52/8 102/17</p> <p>outcomes [5] 36/18 38/5 39/14 58/12 58/17</p> <p>outlined [2] 75/9 105/24</p> <p>outreach [31] 16/14 16/20 20/10 34/25 35/4 35/12 35/19 41/25 45/13 45/17 45/18 45/21 46/13 46/19 46/21 46/25 47/1 47/4 47/5 47/9 47/25 48/11 48/13 48/13 48/15 48/24 49/14 49/18 54/11 58/18 58/19</p> <p>outset [1] 1/20</p> <p>outside [1] 52/3</p> <p>outweighed [1] 41/1</p> <p>over [30] 3/17 4/1 5/22 14/7 15/11 21/7 21/10 32/12 41/4 41/18 41/21 42/19 45/5 53/3 59/15 65/6 71/10 73/5 75/10 76/24 80/3 80/11 81/2 81/21 83/4 83/7 87/17 92/8 99/14 103/10</p> <p>over-defensive [2] 73/5 76/24</p> <p>over-optimistic [2] 81/2 81/21</p> <p>over-simplistic [1] 83/7</p> <p>over-stretched [1] 99/14</p> <p>overall [4] 14/7 30/20 30/24 84/19</p> <p>overemphasis [1] 39/17</p> <p>overlooked [1] 72/16</p> <p>overly [1] 81/6</p> <p>oversight [6] 36/5 45/12 53/8 53/20 53/20 54/1</p> <p>overspeaking [1] 55/14</p> <p>overused [1] 37/1</p>	<p>overwhelmed [1] 100/1</p> <p>own [10] 7/14 32/10 67/6 75/2 75/3 76/16 76/16 79/7 82/15 102/1</p> <hr/> <p>P</p> <p>page [48] 4/6 4/18 4/25 5/22 5/22 6/9 10/17 12/1 12/8 14/20 15/10 15/11 17/2 18/9 19/11 20/18 25/5 26/9 27/1 35/24 35/24 42/17 42/20 42/25 43/14 45/14 46/1 47/2 49/21 71/1 71/10 71/16 72/19 75/11 75/11 77/22 80/3 80/11 82/1 83/4 90/10 95/4 95/6 97/7 100/19 101/11 103/23 107/2</p> <p>page 1 [2] 17/2 42/25</p> <p>page 11 [1] 72/19</p> <p>page 110 [1] 26/9</p> <p>page 116 [1] 14/20</p> <p>page 12 [1] 75/11</p> <p>page 158 [1] 42/17</p> <p>page 2 [2] 80/3 95/4</p> <p>page 21 [2] 97/7 100/19</p> <p>page 23 [1] 43/14</p> <p>page 24 [1] 71/16</p> <p>page 3 [1] 20/18</p> <p>page 33 [1] 101/11</p> <p>page 35 [1] 46/1</p> <p>page 4 [2] 18/9 27/1</p> <p>page 44 [2] 4/25 90/10</p> <p>Page 45 [1] 103/23</p> <p>page 46 [2] 5/22 10/17</p> <p>page 47 [1] 12/8</p> <p>page 5 [2] 80/11 82/1</p> <p>page 6 [4] 15/10 25/5 47/2 71/1</p> <p>page 7 [2] 6/9 19/11</p> <p>page 8 [4] 35/24 35/24 45/14 71/10</p> <p>page 9 [1] 49/21</p> <p>Panel [1] 86/15</p> <p>panels [2] 25/19 85/24</p> <p>paper [4] 17/3 17/7 17/10 17/14</p> <p>papers [1] 84/5</p> <p>paragraph [33] 5/20 12/8 13/10 13/16 13/22 14/3 20/18 25/6 25/15 26/12 35/25 44/19 46/6 47/10 49/22 52/24 71/3 71/11 72/20 77/22 82/3 82/13 83/4 90/9 90/10 95/3 95/5 97/7 100/19 100/21 101/11</p>	<p>103/23 104/21</p> <p>paragraph 10 [1] 20/18</p> <p>Paragraph 113 [1] 12/8</p> <p>paragraph 117 [2] 13/16 14/3</p> <p>paragraph 14 [1] 47/10</p> <p>Paragraph 18 [1] 25/6</p> <p>paragraph 19 [1] 25/15</p> <p>Paragraph 22 [1] 35/25</p> <p>Paragraph 24 [1] 49/22</p> <p>Paragraph 25 [1] 52/24</p> <p>paragraph 360 [1] 26/12</p> <p>paragraph 4 [3] 71/11 95/3 95/5</p> <p>paragraph 46 [1] 97/7</p> <p>Paragraph 47 [1] 100/19</p> <p>paragraph 49 [1] 77/22</p> <p>paragraph 5 [1] 83/4</p> <p>paragraph 70 [1] 101/11</p> <p>paragraph 95 [1] 103/23</p> <p>parents [1] 88/12</p> <p>parliamentarians [1] 36/14</p> <p>Parole [2] 80/17 81/19</p> <p>part [35] 2/14 3/23 5/3 5/5 5/7 23/15 24/13 28/7 30/19 30/24 32/4 32/11 36/19 38/6 38/15 40/18 42/2 44/16 48/19 48/22 50/21 54/6 54/7 55/9 55/20 58/19 64/8 64/13 64/15 64/23 67/15 68/7 68/15 73/1 82/8</p> <p>Participants [1] 94/3</p> <p>particular [23] 5/5 5/20 6/7 6/8 6/12 8/19 9/4 9/13 10/15 10/19 16/17 17/12 24/8 38/9 44/12 46/11 66/9 66/9 68/1 68/6 83/3 102/16 105/4</p> <p>particularly [3] 9/7 71/5 86/8</p> <p>partly [1] 39/16</p> <p>partner [1] 12/11</p> <p>partners [1] 100/1</p> <p>Partnership [3] 20/22 20/24 24/15</p> <p>parts [2] 63/17 86/20</p>	<p>passage [3] 36/25 75/11 97/9</p> <p>passages [1] 70/23</p> <p>passes [1] 45/5</p> <p>past [4] 9/10 65/15 80/19 81/14</p> <p>pathology [1] 91/6</p> <p>pathways [2] 34/8 102/6</p> <p>patient [60] 4/12 5/1 5/4 5/12 6/4 7/14 9/21 11/12 14/21 15/12 19/7 19/25 21/19 24/4 24/7 25/9 26/5 26/13 26/18 27/4 31/1 40/21 40/23 40/25 43/4 43/22 43/24 44/3 44/13 44/16 47/20 58/18 63/18 63/22 64/5 64/11 66/12 66/23 68/6 68/9 71/6 72/10 72/13 74/13 79/15 79/23 87/25 88/22 89/8 89/18 90/22 96/11 96/15 96/22 100/12 100/12 101/22 103/4 103/17 104/9</p> <p>patient's [4] 43/25 67/1 104/3 104/11</p> <p>patients [57] 5/19 6/12 8/7 8/11 8/16 8/21 9/3 9/15 11/15 12/21 13/3 13/5 13/17 14/10 14/12 14/16 14/24 15/4 15/16 15/17 15/20 15/23 16/6 16/10 17/19 17/24 18/12 21/16 23/1 23/4 23/7 26/15 36/20 38/7 38/11 40/22 45/19 48/3 50/4 50/10 50/11 51/16 51/17 57/13 57/19 58/1 61/22 63/5 64/19 72/15 77/17 82/6 83/11 83/13 83/20 84/7 84/9</p> <p>patients' [1] 49/24</p> <p>patterns [1] 4/9</p> <p>Pausing [1] 104/7</p> <p>pejorative [1] 79/11</p> <p>people [73] 3/2 7/19 11/16 11/18 11/19 11/21 12/15 12/17 12/21 12/25 13/4 15/3 18/2 21/22 22/15 22/17 22/19 22/22 23/7 23/10 23/10 23/11 23/18 23/21 24/19 25/1 27/15 28/19 29/5 29/8 29/9 30/16 30/17 30/20 31/2 31/11 31/12 32/24 37/21 38/12 38/16 38/19 38/25</p>	<p>39/3 39/6 39/9 39/9 40/9 45/5 46/4 48/2 50/18 57/17 57/19 57/20 57/21 57/23 58/2 59/12 59/21 61/6 61/9 62/1 62/8 64/4 67/6 78/4 78/8 89/23 90/3 95/8 98/15 104/18</p> <p>per [8] 5/15 5/16 13/19 13/24 19/9 44/4 58/9 83/25</p> <p>perceiving [1] 76/9</p> <p>perfect [1] 65/12</p> <p>performance [1] 48/16</p> <p>perhaps [24] 11/8 17/18 22/8 23/24 49/3 55/18 57/24 60/17 63/21 67/5 73/11 82/14 84/18 86/6 86/12 87/12 92/7 94/16 94/22 95/2 97/10 103/20 104/14 106/2</p> <p>period [9] 10/21 12/2 13/8 14/7 15/2 19/7 28/3 50/7 59/16</p> <p>periods [1] 10/10</p> <p>permanent [1] 55/24</p> <p>permeable [1] 105/11</p> <p>perpetrating [1] 78/7</p> <p>perpetrator [2] 15/15 90/14</p> <p>perpetrators [1] 18/19</p> <p>perpetuate [2] 21/21 28/18</p> <p>person [8] 23/21 91/25 92/5 98/8 102/8 103/14 103/15 103/17</p> <p>personal [5] 66/5 66/5 70/2 82/15 89/13</p> <p>personalised [1] 66/21</p> <p>personality [2] 11/20 18/17</p> <p>perspective [1] 26/21</p> <p>phenomena [1] 22/25</p> <p>phenomenon [1] 12/24</p> <p>photograph [1] 88/11</p> <p>phrase [1] 76/17</p> <p>physical [1] 79/3</p> <p>pick [2] 58/5 92/19</p> <p>picture [4] 30/20 30/24 35/9 65/11</p> <p>pieces [1] 92/19</p> <p>piloting [1] 50/7</p> <p>place [11] 33/25 41/6 41/7 60/24 64/18 72/14 74/6 85/13 96/15 98/24 99/20</p>
--	---	--	--	--

<p>P</p> <p>placed [1] 102/20</p> <p>placing [1] 66/18</p> <p>plan [9] 18/14 25/24 45/24 45/25 49/10 66/10 68/7 73/1 80/17</p> <p>planned [4] 19/6 35/18 37/11 66/14</p> <p>plans [3] 66/15 68/12 72/23</p> <p>plays [1] 16/20</p> <p>plead [1] 7/5</p> <p>please [57] 1/25 3/16 4/2 4/5 4/16 4/17 4/17 5/10 5/22 6/9 10/17 12/8 14/20 15/9 17/2 18/9 19/11 20/13 20/17 22/2 22/13 23/9 24/20 25/4 25/6 26/8 26/9 26/25 30/7 35/23 37/2 38/8 42/17 42/24 43/13 45/13 45/25 49/21 49/21 50/17 68/22 69/1 71/10 71/16 72/19 75/11 77/21 82/1 83/4 94/8 97/4 97/15 100/18 100/19 101/12 103/23 105/19</p> <p>plus [1] 5/12</p> <p>pm [2] 68/18 106/11</p> <p>point [25] 4/23 6/13 6/22 8/6 16/17 24/8 27/17 28/21 29/15 30/8 31/2 31/6 34/20 37/23 45/15 46/2 50/13 50/17 57/2 60/3 60/7 62/10 80/24 86/19 90/16</p> <p>pointed [3] 80/13 81/12 83/3</p> <p>points [2] 59/1 66/11</p> <p>police [51] 69/19 73/22 73/23 77/10 85/12 85/16 86/9 86/17 87/10 88/4 88/7 88/15 91/8 91/22 91/24 92/2 92/4 92/8 92/13 92/19 92/20 97/3 98/8 98/10 98/10 98/22 98/23 99/3 99/7 99/12 99/14 101/2 101/6 101/15 101/23 102/2 102/13 102/20 102/25 103/3 103/20 104/8 104/11 104/24 105/2 105/6 105/9 105/22 105/23 106/2 106/5</p> <p>policies [1] 72/12</p> <p>policing [2] 77/3 77/20</p> <p>policy [17] 37/17 37/20 45/22 49/15 70/16 70/20 70/22</p> <p>72/3 73/15 74/17 77/2 77/8 88/19 93/17 94/10 94/14 94/16</p> <p>policy-related [1] 74/17</p> <p>political [1] 3/19</p> <p>politicians [1] 31/25</p> <p>poor [3] 57/10 57/16 75/22</p> <p>popular [2] 39/2 39/5</p> <p>population [3] 19/24 21/17 22/23</p> <p>pose [1] 81/7</p> <p>posed [1] 104/13</p> <p>posing [2] 83/14 84/8</p> <p>position [5] 49/12 49/25 51/22 55/4 62/13</p> <p>positive [10] 47/13 47/22 72/11 72/18 72/25 73/4 73/10 74/8 74/19 94/20</p> <p>possibility [2] 72/14 81/15</p> <p>possible [12] 39/10 43/22 43/24 44/2 45/4 49/1 57/20 59/19 71/23 73/6 102/24 103/2</p> <p>potential [6] 11/9 11/14 74/12 78/10 100/12 102/22</p> <p>potentially [2] 44/14 75/17</p> <p>powers [4] 50/12 51/19 61/25 62/2</p> <p>practice [29] 4/11 19/12 32/15 37/5 37/17 37/21 42/21 43/9 54/25 56/4 61/14 63/4 63/8 70/16 70/21 72/10 73/5 73/6 73/16 76/18 76/18 76/24 76/24 83/8 84/2 87/17 94/11 99/13 103/24</p> <p>practiced [1] 78/1</p> <p>practices [1] 83/12</p> <p>practitioners [2] 73/3 105/23</p> <p>pre [1] 83/6</p> <p>preparation [2] 98/16 99/7</p> <p>prepared [2] 1/7 12/25</p> <p>presence [6] 10/8 19/8 88/13 105/8 105/14 105/15</p> <p>present [2] 71/25 88/3</p> <p>presentations [2] 84/6 98/25</p> <p>presented [1] 25/11</p> <p>presenting [2] 69/21 81/18</p> <p>presents [1] 68/7</p> <p>pressure [1] 55/7</p>	<p>presumably [2] 50/7 91/24</p> <p>prevent [5] 39/12 41/15 41/16 53/2 99/19</p> <p>prevented [1] 55/10</p> <p>prevention [5] 20/3 23/1 57/20 66/2 67/19</p> <p>previous [7] 10/9 11/3 18/11 38/3 45/21 66/13 84/18</p> <p>previously [5] 19/16 25/7 34/23 59/21 72/7</p> <p>primarily [4] 16/6 20/25 24/24 24/24</p> <p>primary [20] 6/4 6/11 7/16 7/23 8/11 8/22 11/13 11/17 13/2 14/10 16/3 16/3 21/2 57/23 58/1 58/6 63/16 82/5 82/18 82/25</p> <p>Principal [3] 80/11 80/12 80/14</p> <p>principle [3] 60/21 71/21 72/9</p> <p>principles [5] 43/1 44/8 47/7 47/8 74/2</p> <p>prior [4] 2/2 8/8 18/15 60/11</p> <p>priorities [3] 21/14 53/2 53/19</p> <p>prioritised [1] 22/13</p> <p>priority [2] 21/15 95/15</p> <p>prison [3] 12/6 81/9 104/23</p> <p>private [2] 69/23 74/6</p> <p>probably [10] 27/10 35/20 37/3 61/12 73/20 75/7 76/21 91/4 92/6 105/3</p> <p>Probation [4] 79/25 80/8 80/9 104/24</p> <p>probing [3] 79/21 96/9 96/14</p> <p>problem [9] 16/23 31/5 32/11 36/19 37/3 38/6 40/19 49/16 96/16</p> <p>problem's [1] 100/7</p> <p>problematic [1] 56/2</p> <p>problems [5] 11/15 20/1 48/5 73/8 98/15</p> <p>proceedings [1] 55/22</p> <p>process [2] 25/22 66/18</p> <p>processes [1] 90/8</p> <p>produced [1] 69/3</p> <p>profession [1] 82/7</p> <p>professional [8] 2/1 82/9 83/7 83/10 83/12 93/21 100/10 104/20</p> <p>professionals [2] 95/21 97/11</p> <p>professions [5] 84/1</p>	<p>95/13 95/22 95/25 97/24</p> <p>Professor [9] 1/4 1/5 1/7 1/13 2/6 20/13 71/2 81/25 107/3</p> <p>Professor Appleby [4] 1/7 1/13 20/13 71/2</p> <p>Professor Morgan [1] 81/25</p> <p>Professor of [1] 2/6</p> <p>Professor Sir [3] 1/4 1/5 107/3</p> <p>programme [1] 26/16</p> <p>progress [2] 80/15 81/2</p> <p>progression [1] 102/18</p> <p>promoting [1] 44/1</p> <p>proper [2] 17/22 35/18</p> <p>properly [4] 33/7 33/24 37/13 54/13</p> <p>proportionate [2] 71/18 71/24</p> <p>proposed [2] 70/17 80/16</p> <p>prosecution [1] 70/9</p> <p>protect [2] 82/4 98/3</p> <p>protecting [6] 83/1 95/14 97/13 97/14 101/6 101/10</p> <p>protection [4] 73/11 82/11 82/17 95/10</p> <p>protective [3] 19/24 100/24 101/2</p> <p>protocol [3] 50/8 67/5 67/6</p> <p>proved [1] 38/24</p> <p>provide [6] 4/11 48/7 65/11 102/4 102/21 104/11</p> <p>provided [5] 11/25 26/11 89/7 89/12 100/12</p> <p>provides [2] 6/25 97/10</p> <p>providing [5] 42/15 50/5 71/17 82/21 103/13</p> <p>proximity [1] 57/19</p> <p>proxy [1] 39/14</p> <p>psychiatric [5] 12/23 13/1 13/7 69/17 85/20</p> <p>psychiatrist [7] 2/3 2/5 2/6 2/9 9/18 78/17 82/13</p> <p>psychiatrists [6] 9/20 73/13 81/23 93/12 95/12 95/17</p> <p>psychiatrists' [1] 82/4</p> <p>psychiatry [6] 2/4 2/6 97/11 97/16 98/5 98/6</p> <p>psychological [1] 89/25</p>	<p>psychologist [4] 69/8 74/16 87/20 97/17</p> <p>psychologists [1] 73/13</p> <p>psychology [3] 95/24 97/20 97/21</p> <p>Psychopathological [1] 75/14</p> <p>psychopathology [1] 97/21</p> <p>psychosis [2] 10/8 13/11</p> <p>public [52] 3/17 3/19 4/12 25/14 29/7 29/23 31/25 34/21 37/19 40/25 41/10 41/10 41/11 41/16 42/23 43/4 43/10 44/4 44/9 44/10 44/14 44/20 44/24 45/8 62/5 62/15 63/14 63/20 63/25 64/14 64/14 65/2 66/17 71/7 72/25 73/11 74/10 74/12 74/13 74/23 78/12 82/5 82/17 83/2 95/10 95/14 97/13 97/14 98/3 99/18 101/10 104/13</p> <p>publication [4] 21/20 28/17 29/12 29/12</p> <p>publications [1] 30/15</p> <p>publicly [4] 23/19 29/2 41/9 84/13</p> <p>publish [1] 29/3</p> <p>published [3] 25/10 26/14 28/5</p> <p>purpose [3] 30/11 45/18 92/16</p> <p>purposes [1] 69/12</p> <p>put [5] 5/6 5/19 31/24 67/5 68/2</p> <p>puts [2] 32/24 66/8</p>	<p>Q</p> <p>qualification [1] 18/4</p> <p>qualifications [2] 2/1 69/11</p> <p>qualified [1] 2/5</p> <p>quality [5] 2/22 20/21 20/24 24/14 72/23</p> <p>question [4] 22/21 23/14 29/13 100/22</p> <p>Questioned [12] 1/6 56/15 58/22 68/25 94/5 97/1 107/4 107/5 107/6 107/9 107/10 107/11</p> <p>questionnaire [3] 6/20 9/17 10/3</p> <p>questions [10] 3/22 56/12 67/23 79/21 94/1 94/2 94/6 96/9 96/14 97/2</p>
--	---	---	--	--

<p>Q</p> <p>quite [8] 6/20 9/1 12/24 21/25 30/12 30/23 31/25 46/22</p> <p>quoted [1] 39/5</p> <hr/> <p>R</p> <p>raised [3] 28/21 59/1 93/6</p> <p>randomised [1] 38/16</p> <p>range [2] 10/7 97/19</p> <p>rare [5] 19/25 39/12 39/12 83/23 105/1</p> <p>rarely [1] 104/24</p> <p>rate [7] 6/15 9/20 22/16 83/19 83/24 85/9 85/21</p> <p>rates [2] 47/15 83/10</p> <p>rather [13] 19/18 30/1 34/20 37/24 39/14 46/18 60/4 60/17 63/12 66/6 67/3 88/5 105/14</p> <p>ray [1] 65/10</p> <p>re [3] 32/5 34/22 53/17</p> <p>re-establish [1] 34/22</p> <p>re-established [2] 32/5 53/17</p> <p>reach [1] 9/3</p> <p>reached [1] 4/23</p> <p>reactive [1] 47/18</p> <p>read [11] 13/21 70/7 70/8 70/8 71/19 72/5 72/20 91/6 93/8 93/13 93/14</p> <p>readiness [3] 90/19 92/7 100/5</p> <p>real [2] 32/17 65/4</p> <p>really [5] 37/11 49/11 56/24 95/16 96/12</p> <p>reason [9] 12/3 27/18 29/3 34/6 37/1 41/14 74/5 80/24 86/3</p> <p>reasonable [5] 22/24 27/18 29/13 67/23 78/3</p> <p>reasons [11] 24/9 37/22 39/17 49/4 50/22 62/9 72/6 80/23 87/13 96/16 102/16</p> <p>reassurance [1] 50/5</p> <p>rebound [1] 29/7</p> <p>recall [2] 23/25 24/5</p> <p>receipt [3] 35/18 37/10 68/11</p> <p>receive [1] 38/20</p> <p>received [6] 16/7 19/5 37/13 57/14 80/15 81/1</p> <p>receiving [6] 15/20 16/10 16/11 30/16 38/17 66/14</p>	<p>recent [5] 16/9 18/20 28/2 45/24 92/18</p> <p>recently [3] 18/21 25/13 93/11</p> <p>recognise [10] 40/20 46/20 46/21 48/10 55/22 76/7 79/19 82/22 83/1 103/11</p> <p>recognised [2] 62/18 102/23</p> <p>recognising [1] 62/23</p> <p>recognition [1] 71/13</p> <p>recommend [2] 35/4 56/3</p> <p>recommendation [6] 45/11 48/12 86/4 87/8 92/12 106/7</p> <p>recommendations [21] 4/11 16/13 16/25 25/8 25/16 26/1 35/23 36/3 49/21 53/14 55/12 55/22 62/9 70/17 75/4 80/12 85/22 85/23 88/19 94/23 105/19</p> <p>recommending [1] 40/14</p> <p>recommissioned [1] 34/2</p> <p>reconcile [1] 88/17</p> <p>recorded [3] 8/7 8/25 96/19</p> <p>recording [1] 5/18</p> <p>records [1] 88/25</p> <p>recovery [4] 44/1 71/15 72/24 74/25</p> <p>recovery-oriented [1] 74/25</p> <p>reduce [1] 68/13</p> <p>reduced [3] 19/2 29/21 35/1</p> <p>reduces [2] 92/1 92/1</p> <p>reducing [2] 29/20 98/10</p> <p>reduction [2] 21/14 22/1</p> <p>refer [8] 6/4 16/19 28/16 36/23 39/25 45/16 83/18 91/3</p> <p>reference [10] 24/2 28/16 30/4 69/5 74/9 74/14 85/24 86/15 96/5 101/20</p> <p>referenced [1] 27/2</p> <p>referenced: [1] 21/18</p> <p>referenced: the [1] 21/18</p> <p>references [1] 43/2</p> <p>referencing [2] 52/5 95/20</p> <p>referred [9] 6/10 8/10 13/5 45/17 51/4 62/7 65/7 88/9 93/23</p> <p>referring [7] 39/10 47/8 53/24 56/8 62/24</p>	<p>94/15 97/15</p> <p>refers [4] 5/10 38/9 46/17 46/22</p> <p>reflect [2] 67/1 95/13</p> <p>reflected [1] 105/4</p> <p>reflection [1] 99/7</p> <p>reflects [2] 36/19 38/6</p> <p>refusal [1] 45/20</p> <p>refusing [1] 30/23</p> <p>regard [3] 40/8 93/4 105/24</p> <p>regards [3] 4/20 16/14 33/3</p> <p>regional [2] 26/10 42/13</p> <p>regions [1] 5/6</p> <p>regret [1] 35/22</p> <p>regular [5] 19/22 21/20 28/17 29/11 53/18</p> <p>reinstated [1] 85/4</p> <p>relapse [3] 36/5 104/4 104/12</p> <p>relapsing [1] 76/10</p> <p>related [9] 18/1 18/25 72/10 72/12 74/17 78/13 91/7 91/8 97/16</p> <p>relates [2] 29/4 85/23</p> <p>relating [5] 56/18 69/13 70/14 70/15 93/5</p> <p>relation [18] 7/25 9/4 9/16 14/21 20/15 28/2 31/17 40/12 42/21 44/11 47/5 56/20 58/25 60/8 68/9 81/9 81/25 98/8</p> <p>relationship [8] 12/9 19/15 30/18 30/22 30/23 64/19 71/8 91/21</p> <p>relatively [2] 28/2 66/19</p> <p>release [1] 80/19</p> <p>released [1] 81/9</p> <p>relevant [2] 102/25 104/12</p> <p>reliable [3] 49/3 58/5 58/9</p> <p>relied [1] 34/8</p> <p>rely [3] 6/13 58/3 89/6</p> <p>remain [3] 2/9 82/4 82/14</p> <p>remaining [1] 72/24</p> <p>remains [2] 82/15 84/25</p> <p>remarks [2] 70/9 89/4</p> <p>remedying [1] 16/23</p> <p>remember [4] 23/12 23/15 23/16 24/12</p> <p>remind [1] 73/12</p> <p>reminder [1] 54/20</p> <p>remit [8] 3/8 3/9 8/15</p>	<p>11/13 16/9 22/5 57/18 57/18</p> <p>removed [1] 3/9</p> <p>removing [1] 24/9</p> <p>renewed [2] 53/20 57/8</p> <p>repeat [2] 15/6 50/8</p> <p>repeated [6] 26/1 30/14 30/15 31/14 78/4 92/17</p> <p>repeatedly [2] 30/25 31/4</p> <p>repetition [4] 54/17 54/18 54/19 54/19</p> <p>report [24] 4/16 4/19 5/3 5/7 6/9 7/18 9/11 15/9 17/6 23/3 25/12 26/1 40/5 40/6 58/8 59/6 70/8 70/11 79/25 80/2 81/23 81/24 81/25 93/14</p> <p>reported [5] 9/5 9/7 9/9 14/7 19/16</p> <p>reporting [1] 55/1</p> <p>reports [20] 11/25 12/24 13/1 13/7 17/8 17/8 17/18 25/11 25/24 28/5 30/14 57/14 58/3 58/4 80/15 81/2 81/21 91/7 93/9 101/17</p> <p>represent [1] 106/4</p> <p>representation [4] 7/9 77/14 77/17 95/24</p> <p>representative [2] 25/3 69/22</p> <p>represented [1] 62/14</p> <p>represents [1] 5/15</p> <p>reputation [1] 76/20</p> <p>request [2] 49/24 51/10</p> <p>requests [1] 50/8</p> <p>require [6] 56/5 57/11 87/18 91/21 103/13 105/22</p> <p>required [5] 7/1 83/13 92/3 95/17 98/14</p> <p>requirement [3] 49/14 79/21 96/9</p> <p>requirements [1] 64/1</p> <p>requires [1] 20/6</p> <p>research [9] 7/11 22/7 25/14 36/1 39/4 65/8 86/2 97/22 97/22</p> <p>resettlement [1] 80/17</p> <p>resistance [1] 65/4</p> <p>resource [2] 98/19 105/21</p> <p>respect [9] 36/7 41/2 70/6 82/12 82/20 84/22 85/5 94/8 104/11</p>	<p>respectful [1] 89/17</p> <p>respecting [1] 40/23</p> <p>respond [4] 50/1 62/1 87/5 99/14</p> <p>responding [1] 92/2</p> <p>response [9] 6/14 9/20 26/19 36/4 60/22 61/1 99/10 99/19 99/23</p> <p>responses [2] 6/14 83/7</p> <p>responsibilities [1] 95/13</p> <p>responsibility [20] 12/4 40/25 41/1 41/9 42/11 44/17 44/17 45/10 53/24 55/8 61/16 62/25 64/11 64/13 65/1 82/18 82/25 86/14 97/12 98/21</p> <p>responsible [2] 41/10 99/4</p> <p>restored [1] 56/16</p> <p>restriction [1] 43/2</p> <p>restrictions [2] 43/3 104/16</p> <p>restrictive [3] 43/18 71/23 72/10</p> <p>result [3] 26/18 37/16 75/17</p> <p>return [1] 34/21</p> <p>returning [1] 14/3</p> <p>revealed [2] 26/16 57/15</p> <p>review [10] 27/5 28/2 74/14 74/15 81/10 81/19 84/2 91/6 98/23 101/18</p> <p>reviewed [1] 74/17</p> <p>reviews [3] 26/15 53/12 81/8</p> <p>Rice [3] 80/1 80/5 80/18</p> <p>Rice's [1] 81/2</p> <p>right [32] 9/14 18/9 39/11 40/21 46/2 48/7 50/10 50/14 51/16 52/1 52/3 52/7 61/9 62/18 62/22 66/1 67/23 69/14 69/17 70/4 70/10 72/13 82/2 91/25 91/25 92/5 92/5 94/16 98/7 98/7 99/5 100/11</p> <p>right-hand [3] 18/9 46/2 82/2</p> <p>rights [3] 49/23 51/13 64/3</p> <p>rigorous [1] 65/16</p> <p>rigorously [1] 59/18</p> <p>rising [1] 22/17</p> <p>risk [124]</p> <p>risk factors [1] 4/10</p> <p>risks [18] 30/15 34/1 47/19 49/16 66/6 66/7</p>
--	--	---	---	---

<p>R</p> <p>risks... [12] 67/13 68/6 68/8 68/10 73/6 74/13 75/3 75/24 76/3 81/7 83/9 83/15</p> <p>Ritchie [1] 62/6</p> <p>RLIT0000036 [1] 42/25</p> <p>Robinson [1] 93/14</p> <p>role [7] 2/17 16/20 25/3 40/14 58/17 82/17 91/24</p> <p>roles [1] 69/13</p> <p>rolled [1] 34/25</p> <p>rolling [1] 56/24</p> <p>room [1] 88/6</p> <p>rooms [1] 93/1</p> <p>round [1] 101/5</p> <p>route [1] 51/20</p> <p>routine [5] 18/20 19/22 37/12 40/8 64/8</p> <p>Royal [4] 81/22 82/12 95/12 95/16</p> <p>Rule [5] 50/15 52/5 52/17 60/7 61/3</p> <p>run [1] 24/24</p> <p>rural [1] 49/2</p>	<p>saw [1] 101/5</p> <p>say [50] 6/22 10/1 11/14 14/9 20/19 24/2 27/9 28/16 29/14 30/3 32/2 36/11 38/4 39/2 47/10 48/14 51/7 52/24 56/2 56/25 62/16 62/19 65/15 65/23 66/6 70/2 75/2 75/21 76/1 76/24 77/14 77/23 81/10 84/13 87/8 87/10 88/22 89/15 90/10 93/13 94/14 95/5 96/19 100/1 100/21 101/14 103/18 104/1 104/21 105/21</p> <p>saying [8] 31/8 33/12 40/18 47/16 56/10 65/22 92/3 100/6</p> <p>says [18] 4/7 5/14 5/25 13/10 19/13 21/11 26/12 43/21 46/7 71/3 71/20 72/21 80/3 80/14 82/3 82/3 83/5 97/9</p> <p>scant [1] 101/19</p> <p>schizophrenia [21] 11/17 12/16 12/17 13/4 13/9 13/14 13/17 13/25 14/11 14/13 14/16 15/7 17/19 18/12 18/25 19/15 20/3 48/5 57/23 57/24 95/9</p> <p>scope [4] 52/3 101/21 102/1 104/9</p> <p>screen [7] 75/13 77/21 80/1 81/22 90/9 100/18 101/11</p> <p>scroll [2] 71/18 80/13</p> <p>searching [3] 79/21 96/9 96/14</p> <p>second [11] 13/21 45/16 47/11 50/13 50/14 52/7 52/22 60/15 75/12 80/24 96/21</p> <p>seconded [1] 106/2</p> <p>secondly [1] 76/11</p> <p>secondment [1] 2/14</p> <p>section [11] 5/1 6/10 40/16 42/18 42/19 43/1 43/7 43/17 44/8 71/17 85/12</p> <p>section 1 [2] 43/1 44/8</p> <p>Section 118 [2] 42/18 43/7</p> <p>Section 136s [1] 85/12</p> <p>Section 3 [1] 40/16</p> <p>secure [3] 69/17 96/2 105/7</p> <p>security [1] 71/22</p> <p>see [27] 5/22 5/25</p>	<p>6/2 10/20 16/8 37/5 40/5 43/1 43/11 43/17 64/9 64/11 64/25 74/1 74/8 77/18 78/23 79/11 80/3 80/11 82/1 84/5 100/23 100/25 101/7 101/11 104/5</p> <p>seek [2] 9/16 94/8</p> <p>seem [2] 86/8 99/11</p> <p>seemed [3] 72/13 77/11 86/17</p> <p>seems [6] 52/9 82/25 83/20 84/12 94/19 100/3</p> <p>seen [8] 8/10 37/5 59/6 78/25 79/10 79/10 81/24 88/8</p> <p>sees [1] 101/6</p> <p>self [4] 11/2 40/22 50/4 74/12</p> <p>self-determination [1] 40/22</p> <p>self-harm [2] 11/2 50/4</p> <p>semi [1] 105/11</p> <p>send [2] 9/17 87/13</p> <p>sends [1] 53/19</p> <p>senior [2] 77/14 77/19</p> <p>sense [9] 27/14 42/15 57/3 59/3 61/5 65/18 66/25 76/25 91/12</p> <p>sensitive [5] 9/23 29/5 71/6 79/22 96/10</p> <p>sent [2] 9/18 10/3</p> <p>sentence [5] 13/22 14/3 71/20 75/13 80/16</p> <p>sentencing [3] 12/6 70/9 89/4</p> <p>separate [4] 9/1 92/6 100/23 101/3</p> <p>separately [5] 7/18 8/4 8/25 60/17 91/1</p> <p>separation [1] 78/19</p> <p>series [1] 25/11</p> <p>serious [17] 18/25 19/3 19/15 20/3 21/19 24/3 24/6 25/9 27/3 28/1 28/7 28/13 69/13 76/23 81/7 81/8 85/6</p> <p>seriously [3] 29/19 51/25 75/14</p> <p>seriousness [1] 81/14</p> <p>serve [1] 95/11</p> <p>service [44] 3/20 4/12 20/5 41/10 42/8 46/5 50/25 54/20 71/14 71/22 72/23 72/25 73/7 73/22 73/24 74/9 74/23 75/1 75/7 75/15 75/21 75/23 76/3 76/7 77/7 78/11 80/9 82/21</p>	<p>83/22 86/12 87/11 88/18 92/20 99/3 99/5 99/7 101/2 101/6 104/24 104/25 105/2 105/9 105/22 106/5</p> <p>services [54] 4/9 8/8 8/13 8/20 14/6 18/15 18/20 19/13 20/7 22/23 29/24 32/12 35/16 36/4 42/10 42/14 46/8 50/1 50/24 51/21 53/1 56/5 57/12 57/19 57/25 64/14 65/21 67/21 67/23 75/4 77/12 83/1 84/18 86/6 86/9 87/4 87/10 91/22 92/18 95/23 98/5 98/19 99/9 99/18 100/6 100/23 100/24 101/4 101/9 101/22 103/8 103/19 104/7 106/2</p> <p>set [9] 6/11 26/13 46/23 48/20 67/7 69/11 70/7 74/3 86/21</p> <p>sets [1] 90/2</p> <p>setting [5] 34/8 41/20 43/6 57/3 88/23</p> <p>settings [1] 69/17</p> <p>several [6] 23/20 23/21 23/22 69/13 70/23 85/23</p> <p>severe [5] 30/16 31/2 46/4 57/22 100/7</p> <p>sexual [3] 78/22 88/24 97/19</p> <p>shadow [1] 93/13</p> <p>share [2] 33/2 33/20</p> <p>shared [4] 28/22 33/17 33/22 86/14</p> <p>sharing [8] 86/5 86/13 100/5 100/10 100/18 103/12 103/16 104/17</p> <p>sharper [1] 88/3</p> <p>she [2] 74/16 74/21</p> <p>shift [6] 37/15 41/8 66/3 79/14 82/10 82/12</p> <p>shifting [1] 41/3</p> <p>shifts [2] 45/9 55/9</p> <p>short [3] 34/19 68/19 106/12</p> <p>short-term [1] 34/19</p> <p>shortly [1] 3/12</p> <p>should [46] 11/14 20/4 34/16 35/10 36/3 36/8 41/11 41/12 41/21 43/24 43/25 44/21 44/25 49/23 51/25 52/10 58/8 58/19 61/19 62/19 64/3 64/7 64/7 64/8 64/10 64/11 67/8 71/14 71/23 71/24 76/15 85/5 87/9 88/25</p>	<p>89/1 89/3 89/4 90/16 92/11 92/22 93/8 94/25 95/14 96/12 101/17 103/12</p> <p>shouldn't [1] 64/3</p> <p>shown [1] 47/14</p> <p>sic [1] 56/17</p> <p>sick [1] 10/24</p> <p>side [3] 31/21 46/2 82/2</p> <p>signal [1] 53/18</p> <p>signatures [1] 104/4</p> <p>significance [1] 102/23</p> <p>significant [4] 77/3 87/4 90/12 106/5</p> <p>significantly [2] 91/4 105/7</p> <p>signs [4] 16/8 36/5 81/16 81/16</p> <p>simple [1] 61/12</p> <p>simplistic [1] 83/7</p> <p>simply [1] 67/6</p> <p>since [3] 15/12 59/10 62/5</p> <p>single [1] 81/4</p> <p>Sir [7] 1/4 1/5 58/10 58/21 58/24 78/17 107/3</p> <p>Sir John [1] 78/17</p> <p>Sir Louis [2] 58/10 58/24</p> <p>sit [6] 69/1 78/15 90/7 92/9 93/12 101/10</p> <p>situation [7] 60/23 61/25 63/7 77/16 85/17 87/5 89/16</p> <p>situations [2] 61/20 90/4</p> <p>skew [1] 83/7</p> <p>slight [1] 23/17</p> <p>slightly [4] 35/20 48/21 52/7 71/19</p> <p>small [4] 25/19 48/3 59/16 59/19</p> <p>so [155]</p> <p>social [17] 41/1 41/8 42/11 44/17 45/10 48/2 49/7 53/24 55/8 61/16 62/25 73/14 86/9 86/16 87/3 90/14 95/24</p> <p>society [1] 73/7</p> <p>solely [1] 89/7</p> <p>solves [1] 73/9</p> <p>some [50] 6/2 6/5 7/5 8/9 17/12 18/21 22/24 27/9 27/16 28/6 34/2 34/4 34/20 35/14 36/13 36/24 37/5 45/6 49/4 52/2 54/19 54/20 58/13 58/14 61/6 61/11 62/9 67/10 67/12 70/16 73/23 74/2 74/21 75/16</p>
--	---	---	---	---

<p>S</p> <p>some... [16] 79/18 81/17 82/10 82/23 86/18 87/12 93/1 93/8 94/2 94/9 96/5 97/4 99/22 100/5 100/22 104/15</p> <p>somebody [12] 51/12 61/2 65/15 76/2 79/1 79/7 79/20 85/13 91/14 91/16 96/8 103/5</p> <p>somebody's [2] 65/10 86/15</p> <p>somehow [1] 100/2</p> <p>someone [1] 86/25</p> <p>something [21] 8/18 22/4 27/12 31/12 31/13 33/1 35/4 41/19 42/5 44/20 44/25 46/22 52/10 52/21 77/3 86/18 87/22 89/25 93/20 97/8 103/21</p> <p>sometimes [21] 38/14 41/1 42/5 50/22 54/5 61/14 61/22 73/16 82/14 84/13 89/6 89/15 90/3 92/21 92/23 96/20 99/8 101/8 102/3 105/10 105/14</p> <p>somewhere [1] 60/21</p> <p>sorry [4] 42/19 43/6 76/1 87/18</p> <p>sort [8] 7/6 11/8 35/3 35/21 52/16 54/22 61/1 67/10</p> <p>sorts [2] 52/21 54/12</p> <p>sounds [1] 88/5</p> <p>source [3] 13/2 13/2 18/1</p> <p>sources [2] 53/16 89/5</p> <p>spanning [1] 59/3</p> <p>speak [1] 74/4</p> <p>Special [1] 99/22</p> <p>specialist [6] 8/8 57/11 57/25 92/23 98/1 99/1</p> <p>specialists [4] 91/9 92/13 92/23 99/1</p> <p>specific [2] 46/22 47/7</p> <p>specifically [4] 22/10 23/12 24/22 70/13</p> <p>specificity [1] 25/16</p> <p>spectrum [1] 98/4</p> <p>spend [1] 92/2</p> <p>spent [1] 78/18</p> <p>spoken [1] 58/10</p> <p>spot [1] 50/19</p> <p>spouse [1] 12/11</p> <p>spouse/partner [1] 12/11</p>	<p>staff [6] 26/15 47/19 49/6 64/17 67/18 77/18</p> <p>stage [4] 34/3 34/4 93/19 93/21</p> <p>stages [1] 60/15</p> <p>standard [5] 7/1 7/8 20/1 47/12 48/9</p> <p>start [6] 21/25 35/24 70/20 71/1 78/20 106/9</p> <p>started [3] 21/7 35/20 73/20</p> <p>starting [2] 76/11 90/16</p> <p>state [6] 6/13 11/6 11/21 11/23 75/6 93/4</p> <p>state's [1] 30/21</p> <p>stated [1] 81/13</p> <p>statement [38] 1/8 1/10 4/5 20/17 25/4 26/9 26/11 26/25 28/16 30/3 45/14 47/3 47/6 49/20 55/14 69/4 69/6 69/12 70/8 70/18 70/24 72/18 74/14 75/12 75/20 76/17 77/1 77/22 79/24 80/25 85/8 89/12 90/9 95/4 96/3 97/5 97/6 100/19</p> <p>statements [1] 72/3</p> <p>states [2] 71/12 71/17</p> <p>stations [1] 106/2</p> <p>statute [3] 40/16 43/9 43/10</p> <p>statutes [1] 44/4</p> <p>stays [1] 32/15</p> <p>steadily [1] 15/1</p> <p>step [3] 16/16 56/1 92/20</p> <p>steps [1] 53/13</p> <p>stick [1] 75/10</p> <p>stigma [9] 21/21 28/18 29/4 29/16 29/21 29/22 30/1 33/3 95/7</p> <p>stigmatising [1] 78/9</p> <p>still [9] 7/25 11/13 51/19 55/25 56/2 63/2 63/12 79/22 87/23</p> <p>stimulants [1] 14/18</p> <p>stop [3] 31/9 65/22 82/19</p> <p>stopped [4] 4/21 20/14 33/8 34/10</p> <p>stopping [3] 31/18 31/18 33/13</p> <p>straightforward [2] 51/18 75/21</p> <p>stranger [1] 12/11</p> <p>Strategy [1] 26/13</p> <p>Street [1] 92/25</p> <p>strengthen [3] 49/23 105/16 105/18</p>	<p>strengthening [2] 55/23 56/4</p> <p>strengths [2] 71/14 74/25</p> <p>strengths-based [1] 74/25</p> <p>stretched [1] 99/14</p> <p>striking [1] 16/10</p> <p>Striving [1] 83/8</p> <p>strong [1] 54/22</p> <p>structure [2] 60/3 67/12</p> <p>structured [1] 67/24</p> <p>struggle [2] 26/17 76/15</p> <p>struggling [1] 26/22</p> <p>studies [4] 21/16 27/22 34/19 34/19</p> <p>study [6] 10/2 17/12 18/11 19/14 19/20 57/14</p> <p>studying [1] 33/2</p> <p>style [2] 51/1 66/3</p> <p>subject [7] 9/23 11/18 21/12 29/6 32/3 50/12 57/15</p> <p>subjected [1] 71/23</p> <p>subjects [2] 38/11 38/14</p> <p>subsequently [3] 45/23 87/6 102/8</p> <p>subside [1] 53/3</p> <p>substance [3] 15/18 19/18 20/7</p> <p>substances [1] 30/21</p> <p>success [1] 39/8</p> <p>successfully [1] 39/24</p> <p>such [7] 47/14 52/5 57/10 57/13 83/9 90/11 101/2</p> <p>suffering [1] 13/13</p> <p>sufficient [2] 51/17 60/23</p> <p>sufficiently [7] 21/24 30/6 30/10 32/20 49/17 62/15 64/14</p> <p>suggest [5] 18/24 27/6 31/23 31/24 41/19</p> <p>suggested [3] 54/16 92/12 93/7</p> <p>suggesting [6] 19/21 26/2 41/14 51/15 52/1 67/15</p> <p>suggestion [3] 55/10 60/25 61/8</p> <p>suggestions [1] 52/12</p> <p>suggests [1] 81/5</p> <p>suicide [21] 1/14 3/2 3/6 3/25 4/10 6/23 8/2 8/9 21/16 22/12 22/15 22/16 22/19 23/1 23/3 50/4 51/2 66/2 67/19 84/24 85/15</p>	<p>suicide/homicide [1] 8/9</p> <p>summarise [1] 2/1</p> <p>summary [5] 14/20 15/10 18/10 71/10 82/2</p> <p>superseded [1] 28/8</p> <p>supervised [2] 80/7 84/10</p> <p>supplement [1] 93/24</p> <p>support [10] 19/19 20/8 20/10 36/9 39/5 40/9 58/16 58/18 71/9 94/25</p> <p>supported [1] 44/1</p> <p>supportive [1] 58/14</p> <p>supports [2] 36/12 49/7</p> <p>suppose [12] 11/17 29/18 33/9 34/20 35/14 38/21 40/2 52/12 53/16 54/15 61/12 61/25</p> <p>sure [4] 24/12 33/22 63/24 65/7</p> <p>surprise [1] 87/22</p> <p>surprising [1] 63/21</p> <p>survivors [1] 94/7</p> <p>suspect [1] 52/18</p> <p>sustained [1] 89/3</p> <p>sworn [4] 1/5 68/24 107/3 107/8</p> <p>sympathetic [1] 71/9</p> <p>symptoms [2] 13/11 75/14</p> <p>system [4] 26/2 42/15 54/6 54/7</p>	<p>37/11 42/4 44/8 53/23 55/25 59/15 62/11 63/4 63/5 65/2 66/12 82/11 92/7</p> <p>targets [1] 48/17</p> <p>taught [1] 77/25</p> <p>teacher [1] 103/9</p> <p>team [5] 47/9 48/3 48/9 48/20 62/17</p> <p>teams [10] 20/9 34/25 41/25 45/17 45/21 46/19 47/12 47/15 47/17 48/13</p> <p>tell [3] 3/15 28/24 89/8</p> <p>tend [1] 78/20</p> <p>tends [2] 53/3 56/21</p> <p>Tensions [2] 82/4 82/14</p> <p>term [6] 10/23 34/19 57/3 57/5 73/7 79/11</p> <p>terms [25] 3/13 6/15 7/22 8/11 11/1 16/23 23/4 28/10 42/20 57/12 61/21 68/5 74/8 74/12 74/20 86/21 88/12 89/11 89/24 99/9 102/4 103/17 105/11 105/19 106/4</p> <p>tested [1] 26/19</p> <p>than [19] 8/23 15/15 19/9 19/18 29/10 46/18 46/25 60/4 60/17 63/12 66/6 67/3 73/9 73/21 83/14 84/8 91/15 103/20 105/14</p> <p>thank [26] 8/22 49/22 56/11 56/13 58/10 58/21 58/23 58/24 68/16 68/22 69/3 69/8 69/24 70/12 71/19 77/21 94/1 95/2 95/4 96/1 96/23 96/24 106/8 106/8 106/9 106/10</p> <p>that [620]</p> <p>that's [57] 5/3 6/1 6/17 8/4 9/9 9/14 10/3 12/23 13/5 13/5 13/13 14/17 20/25 23/14 23/16 26/8 26/24 28/8 29/25 30/12 31/25 32/3 32/14 39/14 40/4 40/7 41/14 42/2 42/22 42/25 44/6 53/4 55/15 59/16 63/20 64/12 64/15 65/21 65/21 67/9 67/23 67/24 70/22 76/15 77/22 79/5 79/22 80/2 80/2 83/25 89/7 90/5 90/9 91/15 102/24 103/2 104/18</p> <p>Theemis [1] 70/8</p> <p>their [48] 7/14 9/24 11/23 14/6 18/14</p>
---	---	---	---	--

<p>T</p> <p>their... [43] 19/18 21/13 27/15 30/20 38/22 42/10 45/8 50/24 51/24 51/24 57/16 60/22 63/16 64/11 64/12 64/15 64/18 66/10 66/25 67/6 72/25 73/14 74/9 75/2 75/3 75/16 76/9 76/16 76/16 78/12 82/5 82/6 84/2 88/9 88/11 92/21 94/23 95/13 95/15 97/12 102/8 104/19 104/22</p> <p>them [26] 7/18 9/16 10/1 10/10 22/8 23/24 24/16 27/12 28/6 34/4 34/9 43/23 48/20 63/23 68/2 76/13 86/11 88/8 88/11 92/9 99/1 102/3 102/23 103/6 103/19 104/10</p> <p>thematic [1] 25/8</p> <p>theme [1] 53/4</p> <p>themselves [10] 51/7 51/22 58/12 67/21 75/24 76/4 78/7 83/14 84/7 100/23</p> <p>then [60] 5/14 5/22 7/13 7/14 7/15 8/13 9/6 9/15 11/6 12/6 12/11 12/14 15/6 23/19 25/1 25/15 26/25 28/5 29/25 30/3 32/14 35/20 39/22 46/12 47/10 47/24 50/13 53/22 57/4 58/7 62/22 63/18 65/20 66/16 67/6 67/11 67/17 67/24 68/13 71/16 75/22 76/12 76/15 78/23 79/1 81/18 81/20 84/24 86/6 88/24 92/20 93/22 94/18 95/2 98/1 98/19 102/4 102/7 103/15 103/25</p> <p>theoretical [1] 97/22</p> <p>theory [2] 89/25 96/6</p> <p>therapeutic [2] 64/21 71/8</p> <p>there [159]</p> <p>there's [37] 4/25 6/5 6/19 38/23 49/13 56/9 61/10 63/17 63/18 63/19 65/4 65/4 65/17 65/18 65/18 66/2 67/4 67/6 67/20 75/11 76/5 79/21 83/19 83/24 84/1 84/6 85/17 85/18 85/19 89/25 93/22 96/8 96/13 97/21 100/6 105/6 106/3</p> <p>therefore [4] 20/4</p> <p>33/7 90/3 95/11</p> <p>these [18] 18/24 19/8 19/17 22/25 23/12 23/23 25/12 27/10 29/25 35/16 45/7 48/17 49/8 52/11 52/21 54/12 93/9 104/2</p> <p>they [100] 7/15 7/17 7/18 7/20 7/20 8/12 8/13 8/15 8/15 8/17 8/21 9/1 9/2 9/23 9/25 14/13 16/7 16/11 18/2 24/5 24/22 25/2 25/3 25/20 27/10 27/15 31/13 38/12 38/14 38/19 38/20 39/1 39/20 40/15 48/1 48/1 48/20 48/20 48/22 48/24 49/19 49/25 50/19 50/19 51/25 57/15 58/13 58/13 60/17 60/22 60/24 61/6 61/7 62/18 62/23 63/19 64/18 64/20 64/25 66/24 67/21 67/22 67/22 71/24 75/2 75/25 76/8 76/10 76/11 76/15 78/6 78/6 80/20 81/1 84/10 84/11 85/15 88/3 88/7 88/10 89/20 89/22 90/12 90/21 94/23 94/24 94/25 96/19 98/12 98/13 98/14 99/4 99/9 99/16 99/17 100/17 101/10 102/21 104/22 106/6</p> <p>they'd [2] 59/23 59/24</p> <p>they'll [2] 88/8 88/11</p> <p>they're [16] 7/23 8/18 9/2 11/18 30/22 36/11 42/13 43/15 51/21 57/20 66/16 66/24 68/10 75/22 94/22 100/1</p> <p>they've [2] 98/1 102/4</p> <p>thing [6] 29/22 48/14 49/13 55/17 62/16 67/7</p> <p>things [15] 34/10 42/2 49/9 49/19 51/7 52/11 54/12 55/4 62/12 67/8 68/13 69/25 99/6 105/12 105/13</p> <p>think [96] 10/18 23/10 24/8 24/11 27/8 27/9 27/18 28/6 29/3 31/6 31/10 31/14 32/2 32/2 32/9 32/10 33/4 35/20 37/2 39/6 39/15 40/18 40/19 41/6 42/3 44/24 45/7 47/16</p> <p>51/11 52/10 53/22 54/5 55/2 55/17 55/18 55/21 56/4 59/1 59/3 59/5 60/14 60/19 60/23 61/10 62/13 62/16 62/16 62/18 62/23 63/22 64/2 64/9 64/15 65/3 65/11 65/14 65/25 66/19 67/12 75/20 76/10 76/10 76/24 76/25 77/6 79/10 80/22 81/17 82/22 83/18 83/25 84/23 85/8 85/11 85/21 86/20 86/20 88/19 88/21 91/19 92/11 92/22 93/1 94/17 96/5 97/25 98/23 99/8 99/10 100/2 101/5 101/5 101/8 103/15 105/6 105/25</p> <p>thinking [4] 61/25 63/13 63/13 95/21</p> <p>third [3] 35/2 46/6 82/3</p> <p>this [148]</p> <p>this -- in [1] 7/19</p> <p>thorough [1] 51/20</p> <p>those [56] 4/13 7/25 8/9 8/23 8/25 9/1 11/21 13/1 13/7 13/13 13/23 13/25 15/6 18/13 19/3 22/20 23/9 27/25 28/22 39/22 40/11 42/2 47/7 47/7 48/8 48/23 49/9 49/18 59/8 62/2 64/25 66/11 66/15 68/8 68/10 68/12 72/1 72/3 74/22 76/14 79/2 81/7 84/9 84/17 85/13 87/6 89/22 94/1 95/21 96/14 97/23 97/25 99/25 100/5 100/15 105/13</p> <p>though [4] 45/7 58/13 69/21 85/3</p> <p>thought [7] 9/5 24/5 27/21 39/18 76/10 96/21 96/21</p> <p>three [6] 59/12 59/19 75/8 76/14 100/20 104/1</p> <p>threshold [1] 86/21</p> <p>through [20] 5/23 6/6 11/16 11/24 11/24 12/23 15/21 21/6 23/24 24/1 29/20 38/2 42/12 52/2 53/21 54/8 80/10 87/19 94/23 98/19</p> <p>throughout [2] 13/8 42/15</p> <p>Thus [1] 82/6</p> <p>tightly [1] 48/16</p> <p>time [32] 2/8 2/25 3/24 9/9 10/10 11/7 11/21 13/12 22/14 22/16 32/12 35/3 35/11 35/13 41/18 45/5 45/5 48/7 53/3 54/12 57/4 59/16 66/9 71/25 79/19 80/6 83/20 89/19 89/24 90/2 92/1 101/8</p> <p>times [7] 18/18 31/7 50/19 52/14 53/4 63/6 103/9</p> <p>tip [1] 62/25</p> <p>title [1] 3/10</p> <p>today [8] 46/11 69/12 69/21 70/3 70/13 70/15 72/6 93/6</p> <p>together [4] 5/6 60/18 99/18 100/3</p> <p>told [4] 4/19 24/5 34/4 94/9</p> <p>tomorrow [1] 66/22</p> <p>too [6] 9/11 25/22 48/10 62/25 63/24 79/14</p> <p>took [3] 21/7 25/22 34/13</p> <p>tool [3] 66/19 67/4 90/25</p> <p>tools [8] 65/5 65/5 65/16 66/7 67/17 67/19 67/20 90/11</p> <p>top [3] 5/25 46/2 67/24</p> <p>topic [3] 46/11 75/10 93/3</p> <p>topics [1] 97/4</p> <p>total [3] 5/14 14/4 14/5</p> <p>touch [2] 6/21 55/13</p> <p>touched [6] 10/18 16/5 19/11 41/25 53/4 101/13</p> <p>towards [9] 5/1 21/22 28/19 46/6 47/17 66/3 82/10 82/20 84/3</p> <p>tradition [1] 3/20</p> <p>tragedies [2] 38/3 45/6</p> <p>tragedy [2] 36/2 40/3</p> <p>tragic [1] 45/6</p> <p>trained [1] 2/4</p> <p>training [8] 93/3 93/4 93/18 93/19 93/20 93/22 98/23 106/1</p> <p>transform [1] 46/8</p> <p>translate [1] 88/18</p> <p>transport [1] 49/3</p> <p>trauma [9] 78/1 78/4 78/14 78/16 78/24 79/5 89/18 94/21 96/4</p> <p>trauma-informed [5] 78/14 78/16 79/5 94/21 96/4</p> <p>treat [3] 43/22 57/10 82/6</p> <p>treated [3] 63/20 84/10 101/3</p> <p>treating [1] 9/17</p> <p>treatment [44] 10/8 13/18 15/22 16/2 16/19 16/24 17/25 18/14 18/24 19/5 19/22 20/5 30/16 30/19 35/13 36/4 36/7 36/10 37/9 37/13 37/23 38/13 38/21 38/25 39/8 39/19 39/20 39/20 40/12 41/7 45/1 45/16 45/20 46/14 48/6 57/15 60/4 61/21 63/1 76/13 79/16 81/3 81/6 102/7</p> <p>treatments [2] 39/21 39/23</p> <p>trend [1] 23/5</p> <p>Triage [1] 92/25</p> <p>trial [13] 38/10 38/12 38/15 38/15 38/16 38/20 38/23 39/2 39/5 39/7 39/13 39/15 89/4</p> <p>trials [4] 36/20 38/7 38/10 39/18</p> <p>tribunals [2] 81/19 101/18</p> <p>tried [4] 74/4 81/10 89/15 96/17</p> <p>tries [1] 101/8</p> <p>trimmed [1] 18/5</p> <p>true [4] 1/10 29/10 51/1 69/6</p> <p>Trust [1] 2/10</p> <p>trusts [4] 25/17 42/14 53/22 54/23</p> <p>try [4] 34/14 41/15 54/9 73/14</p> <p>trying [15] 9/8 39/11 40/20 43/16 62/17 79/19 85/16 88/20 88/21 89/24 93/24 96/7 97/18 98/18 104/15</p> <p>turn [9] 51/23 71/10 71/16 72/19 75/10 80/2 80/11 82/1 83/4</p> <p>two [12] 35/16 39/18 42/2 56/23 59/1 60/9 60/9 61/13 63/17 89/22 90/1 97/4</p>	<p>U</p> <p>UK [5] 5/5 14/21 15/5 21/12 25/1</p> <p>UK-wide [1] 14/21</p> <p>ultimately [4] 63/17 75/3 81/1 99/3</p> <p>unbiased [1] 35/15</p> <p>uncomfortable [1] 89/23</p> <p>uncomplicated [1] 25/23</p>
--	---

<p>U</p> <p>under [19] 7/9 22/23 40/16 40/16 43/7 43/23 49/14 51/12 57/25 60/11 60/13 61/7 61/18 66/19 71/11 72/20 81/2 98/23 103/23</p> <p>under-developed [1] 66/19</p> <p>under-representation [1] 7/9</p> <p>underestimate [1] 6/25</p> <p>underlying [3] 80/21 89/11 101/9</p> <p>underpin [2] 73/16 94/10</p> <p>understand [14] 4/22 5/24 6/7 22/1 22/25 43/16 55/6 55/7 56/1 76/20 78/14 85/3 88/21 97/18</p> <p>understandably [3] 72/9 77/6 105/15</p> <p>understanding [18] 63/7 66/8 73/18 74/18 75/6 76/6 77/2 78/16 79/20 90/18 91/10 92/10 93/25 94/13 96/7 98/2 102/6 104/3</p> <p>understates [1] 84/19</p> <p>understood [8] 10/18 12/22 24/17 40/13 57/6 78/24 79/5 81/18</p> <p>undue [1] 81/14</p> <p>unease [1] 64/17</p> <p>Unemployed [1] 10/23</p> <p>Unemployed/on [1] 10/23</p> <p>unequivocal [1] 36/9</p> <p>unhelpful [1] 54/17</p> <p>unintended [1] 83/8</p> <p>unique [1] 69/5</p> <p>unit [3] 17/7 76/22 105/4</p> <p>units [3] 105/5 105/7 105/10</p> <p>universal [1] 78/24</p> <p>universally [1] 92/5</p> <p>University [2] 2/7 85/1</p> <p>unknown [1] 15/15</p> <p>unlearning [2] 32/16 41/16</p> <p>unless [1] 14/13</p> <p>unlikely [1] 103/3</p> <p>unnecessary [1] 95/7</p> <p>unpack [1] 21/25</p> <p>unpredictable [1] 75/17</p> <p>unreasonable [2] 27/16 27/21</p>	<p>unrelated [1] 44/11</p> <p>unreported [2] 85/19 85/20</p> <p>unsure [1] 51/22</p> <p>until [3] 21/2 68/17 84/23</p> <p>unusual [5] 14/12 15/19 37/12 39/13 59/18</p> <p>up [21] 4/23 17/13 17/14 19/2 21/2 24/8 24/20 34/9 42/10 48/20 57/4 58/5 63/11 73/22 77/21 80/1 84/23 88/22 90/8 91/19 92/19</p> <p>upon [10] 6/13 6/21 10/18 16/3 16/5 27/22 28/11 43/10 53/4 55/13</p> <p>urgent [5] 60/23 63/6 99/10 99/10 99/12</p> <p>us [17] 4/20 22/11 22/20 27/14 28/24 31/20 31/22 65/1 65/24 66/17 72/2 74/19 79/18 88/22 89/18 94/10 103/7</p> <p>use [8] 10/9 18/17 34/19 40/15 58/7 61/10 63/1 67/19</p> <p>used [8] 17/12 17/13 17/14 17/17 17/18 40/16 75/19 91/17</p> <p>useful [1] 15/10</p> <p>usefully [1] 86/13</p> <p>user [10] 71/22 72/25 73/7 74/9 74/23 75/1 75/7 75/21 76/7 82/21</p> <p>user's [3] 71/14 72/23 75/15</p> <p>users [5] 75/23 76/3 77/7 78/12 83/22</p> <p>uses [1] 47/1</p> <p>using [2] 65/4 73/5</p> <p>usual [1] 11/23</p> <p>usually [2] 9/18 48/5</p> <hr/> <p>V</p> <p>vague [2] 25/16 42/5</p> <p>valid [3] 7/12 85/9 95/8</p> <p>validity [1] 67/21</p> <p>valuable [2] 41/19 50/20</p> <p>value [1] 101/10</p> <p>variable [1] 12/24</p> <p>varied [2] 15/4 83/11</p> <p>variety [1] 50/22</p> <p>various [5] 10/10 16/4 60/15 78/19 103/8</p> <p>VC [2] 32/18 70/14</p> <p>VC's [1] 70/12</p> <p>versus [1] 74/12</p> <p>very [44] 6/15 6/17</p>	<p>9/2 9/23 9/23 10/1 10/4 11/22 28/5 29/5 35/16 37/12 38/18 38/24 39/2 39/5 39/7 39/12 39/12 41/19 42/2 44/15 48/16 52/13 58/13 58/21 58/25 59/8 59/16 59/20 64/6 68/16 73/24 74/14 84/11 85/9 86/7 89/22 91/15 91/17 96/21 96/23 104/24 105/1</p> <p>via [1] 9/16</p> <p>victim [12] 12/9 15/14 72/14 87/9 87/25 88/9 88/13 88/25 90/12 90/21 90/22 102/9</p> <p>victims [7] 5/16 5/19 15/23 73/18 78/12 94/12 102/9</p> <p>victims' [1] 87/11</p> <p>view [15] 24/17 27/21 29/15 31/3 32/10 33/11 34/1 37/24 41/24 62/11 72/3 74/10 84/21 95/14 101/21</p> <p>viewed [1] 38/25</p> <p>views [2] 33/2 85/7</p> <p>violence [21] 10/9 11/2 18/25 19/3 19/15 20/3 50/3 66/13 66/13 68/11 69/14 78/10 81/14 81/15 85/17 85/18 85/19 88/24 88/24 97/18 97/19</p> <p>violent [5] 18/16 29/10 76/23 78/22 95/10</p> <p>visitor [1] 103/9</p> <p>vital [1] 67/12</p> <p>voluntary [1] 40/22</p> <p>volunteer [1] 102/22</p> <hr/> <p>W</p> <p>Wales [1] 86/20</p> <p>want [12] 4/21 5/24 6/6 6/6 6/18 6/20 32/7 34/7 70/14 90/7 97/9 101/13</p> <p>wanted [3] 22/15 58/7 58/24</p> <p>wards [1] 85/20</p> <p>warning [1] 81/16</p> <p>was [146]</p> <p>wasn't [7] 3/23 27/8 27/16 27/21 32/23 33/1 62/20</p> <p>watched [2] 40/3 55/21</p> <p>way [30] 5/19 6/18 28/14 29/24 29/25 37/6 37/14 39/20 39/22 45/2 50/20 55/8</p>	<p>59/5 60/5 60/24 61/13 62/1 65/2 67/5 67/25 76/8 77/12 79/22 82/10 82/19 95/21 100/3 101/5 104/18 105/16</p> <p>ways [6] 22/24 35/14 35/16 41/23 65/8 103/16</p> <p>we [183]</p> <p>we'd [4] 30/1 31/7 34/23 58/5</p> <p>we'll [5] 16/13 20/11 23/24 68/16 106/9</p> <p>we're [27] 7/22 8/12 11/8 17/6 23/4 25/5 37/11 41/9 41/10 42/4 46/10 49/11 53/23 55/3 56/22 59/15 62/11 63/4 63/4 64/9 65/2 66/12 72/15 88/2 88/21 103/5 103/13</p> <p>we've [15] 10/18 12/18 16/3 34/24 36/24 41/25 44/5 45/15 46/16 55/13 57/2 65/22 66/20 67/18 84/14</p> <p>weapon [2] 90/12 91/16</p> <p>wearing [1] 62/8</p> <p>weekend [1] 66/23</p> <p>weeks [2] 93/12 103/18</p> <p>weight [1] 80/20</p> <p>well [63] 2/3 3/10 9/5 11/12 16/6 16/20 21/10 22/3 22/10 22/14 23/23 24/16 24/19 24/24 27/8 28/1 28/25 29/22 30/14 31/10 31/19 32/4 32/8 32/23 32/24 33/9 38/9 38/23 39/12 40/2 41/25 42/8 46/21 47/13 47/19 49/13 50/18 51/3 54/4 54/6 60/14 60/16 62/16 63/24 64/5 64/7 65/14 76/20 77/5 79/8 79/10 84/23 86/2 87/12 92/5 93/7 93/21 97/23 98/2 99/6 102/20 103/5 103/6</p> <p>wellbeing [1] 43/4</p> <p>went [1] 48/18</p> <p>were [70] 1/20 2/13 2/21 4/8 4/13 5/16 9/5 9/8 11/15 12/15 13/1 13/4 13/17 13/25 14/5 14/23 15/3 15/20 16/10 18/2 18/2 18/13 18/13 18/19 18/23 19/20 22/14 22/19 23/15 23/21 23/22 24/8 25/1 25/16 25/19</p>	<p>26/1 27/9 27/10 28/5 28/5 28/6 29/1 33/2 33/9 33/10 34/10 35/1 35/1 35/5 35/16 36/15 37/1 39/3 45/22 45/22 47/8 48/19 48/20 48/22 51/17 55/4 59/9 65/12 76/8 77/12 85/11 89/3 90/21 97/8 98/7</p> <p>weren't [7] 7/20 8/15 8/21 23/7 25/3 27/15 48/23</p> <p>West [9] 68/23 68/24 69/3 94/1 94/6 96/23 97/2 100/20 107/8</p> <p>Weston [3] 1/3 1/6 107/4</p> <p>what [81] 6/11 7/13 9/3 9/5 22/1 23/25 31/10 33/12 35/15 36/2 37/1 37/4 37/16 40/8 40/13 42/6 42/20 43/15 44/24 45/9 47/23 48/10 51/5 51/9 51/15 52/3 52/16 54/15 55/20 56/5 60/19 61/3 61/8 64/8 65/21 65/21 66/4 66/8 66/22 66/23 66/25 67/22 67/25 68/1 68/5 70/14 72/2 73/24 74/20 76/18 78/14 79/5 79/6 79/9 81/20 83/17 83/21 84/21 85/10 86/1 86/24 88/16 89/10 89/15 91/3 91/11 91/12 92/3 92/16 93/3 93/23 94/15 96/4 97/14 99/12 99/13 101/7 101/17 104/15 105/14 106/4</p> <p>what's [5] 17/18 18/7 75/19 90/5 95/17</p> <p>when [50] 2/24 3/5 3/8 3/14 9/21 21/7 22/16 24/8 29/23 31/12 32/12 33/7 35/11 43/15 48/12 48/15 50/6 51/11 51/17 51/21 60/22 64/8 66/12 66/24 67/18 72/15 73/20 74/1 74/11 76/15 78/1 80/7 84/4 84/10 85/16 87/4 88/4 88/7 88/16 89/12 89/22 94/14 95/18 95/20 96/21 99/1 101/22 102/18 103/9 104/9</p> <p>whenever [2] 42/4 100/12</p> <p>where [56] 6/11 9/8 12/23 13/15 17/17 18/3 22/8 22/15 24/22</p>
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<p>W</p> <p>where... [47] 28/20 30/7 30/20 31/1 38/20 40/15 40/15 43/22 48/19 51/4 51/22 52/21 57/20 59/8 64/17 65/10 65/24 71/3 74/16 74/25 75/25 76/2 81/12 85/12 85/14 85/17 86/9 86/10 86/21 86/25 87/2 87/3 87/5 87/25 88/23 88/24 89/16 91/5 91/10 93/9 94/19 95/5 96/13 101/10 101/14 105/5 105/5</p> <p>whereas [1] 67/7 whereby [1] 79/12 wherever [2] 43/24 44/1</p> <p>whether [10] 16/7 29/13 39/10 52/20 57/5 66/1 100/22 103/5 103/8 105/21</p> <p>which [52] 3/8 6/18 16/13 16/24 20/11 24/22 27/10 30/18 31/11 34/18 34/25 35/16 36/12 37/6 38/24 41/23 42/8 43/14 44/8 48/18 49/2 51/20 55/8 56/21 57/11 57/14 57/22 59/4 62/6 64/1 65/6 65/7 66/4 66/10 66/21 67/10 67/17 71/12 71/22 81/17 89/2 90/15 90/16 90/21 90/22 92/1 95/14 96/21 97/5 100/23 102/21 104/12</p> <p>while [4] 5/9 59/13 72/24 95/7</p> <p>whilst [2] 14/17 86/7</p> <p>who [58] 7/25 8/23 11/15 11/17 11/18 12/21 13/4 13/4 17/19 17/24 18/2 18/13 19/3 22/18 22/22 23/7 23/8 23/10 23/12 23/15 23/15 23/18 23/18 23/25 24/5 24/20 25/1 30/20 39/3 45/19 48/4 48/5 50/18 51/16 57/19 59/13 59/21 59/22 60/10 61/2 61/9 63/22 65/15 72/14 73/14 77/15 78/4 78/18 80/18 84/9 84/17 92/8 95/21 98/19 101/2 103/6 103/15 103/17</p> <p>who'd [1] 77/5 Who's [2] 93/13</p>	<p>93/14</p> <p>whole [6] 9/9 13/25 37/15 74/18 93/22 97/21</p> <p>whose [3] 11/21 30/17 45/18</p> <p>why [19] 3/15 22/13 28/24 37/1 37/22 41/20 55/6 56/1 65/23 72/6 74/5 79/20 86/3 87/13 88/21 90/5 96/8 96/16 101/18</p> <p>wide [1] 14/21</p> <p>wider [3] 22/23 102/13 104/13</p> <p>will [24] 3/11 9/24 11/14 32/5 43/14 46/8 46/13 49/15 53/17 56/10 56/24 66/22 66/23 66/23 66/25 73/3 79/10 83/21 87/23 88/1 88/9 88/10 96/19 100/1</p> <p>Williamson [3] 96/25 97/1 107/11</p> <p>wired [1] 99/9</p> <p>within [21] 7/16 7/23 8/1 8/14 8/15 8/19 8/21 9/6 13/13 21/17 24/19 43/10 44/7 44/21 57/14 62/2 79/18 85/18 88/19 95/23 104/21</p> <p>without [8] 9/10 19/25 31/16 34/13 43/23 56/24 67/16 77/2</p> <p>WITN0058002 [1] 81/23</p> <p>WITN0069001 [6] 4/6 20/18 25/4 35/24 45/14 49/21</p> <p>WITN0069003 [1] 4/17</p> <p>WITN0069005 [1] 17/2</p> <p>WITN0075013 [1] 15/10</p> <p>WITN0310001 [1] 26/8</p> <p>WITN0338001 [2] 69/5 95/4</p> <p>WITN0338011 [1] 80/2</p> <p>WITN0412001 [1] 47/2</p> <p>witness [18] 1/7 20/17 46/10 47/3 47/6 52/19 55/13 69/3 69/11 70/7 70/17 70/24 72/18 79/24 80/25 95/4 96/3 97/6 won't [8] 44/7 54/18 56/3 61/6 61/7 70/12 79/8 106/6</p> <p>word [4] 39/8 44/3</p>	<p>47/1 51/24</p> <p>words [2] 3/21 75/19</p> <p>work [15] 23/4 27/13 31/16 41/9 49/6 50/20 60/19 64/24 73/13 78/17 79/18 95/24 98/17 99/18 100/3</p> <p>worked [2] 87/19 96/2</p> <p>workers [2] 48/2 73/14</p> <p>working [17] 20/6 51/1 51/6 51/11 52/2 64/24 69/16 73/22 73/23 76/14 76/22 80/9 88/4 88/16 91/5 101/15 106/3</p> <p>worried [3] 50/5 51/21 60/21</p> <p>worry [3] 64/17 64/18 64/20</p> <p>worst [1] 29/22</p> <p>would [47] 7/16 7/18 7/20 9/10 16/16 22/4 24/12 34/2 34/4 34/21 34/21 34/21 38/18 38/22 40/8 41/19 46/24 48/10 50/7 51/7 51/9 54/4 55/12 55/20 57/13 58/2 58/2 58/3 58/17 60/20 68/13 75/20 76/6 76/7 76/11 78/16 78/23 86/21 87/20 95/23 96/12 103/20 105/18 105/22 106/4 106/6 106/6</p> <p>wouldn't [3] 7/16 7/18 38/12</p> <p>writing [1] 62/20</p> <p>written [1] 63/3</p> <p>wrong [5] 41/6 65/14 66/20 77/9 104/18</p> <hr/> <p>X</p> <p>X-ray [1] 65/10</p> <p>xxxi [1] 15/11</p> <hr/> <p>Y</p> <p>yeah [18] 21/6 26/24 44/6 64/7 79/17 79/17 79/17 92/10 98/9 99/6 102/11 102/24 102/24 103/2 103/2 103/22 106/6 106/6</p> <p>year [14] 4/21 5/16 5/17 13/19 13/24 19/7 19/9 45/24 45/25 49/10 56/22 56/23 83/25 85/11</p> <p>years [16] 1/22 9/7 24/11 55/5 55/25 56/25 57/1 65/6 65/22 72/7 73/23 80/18 87/17 92/18 93/9 97/25</p> <p>years' [1] 57/4</p>	<p>yes [127]</p> <p>yet [4] 55/25 56/22 88/2 89/19</p> <p>you [296]</p> <p>you'd [1] 27/23</p> <p>you'll [1] 84/5</p> <p>you're [12] 9/22 23/3 39/11 40/13 48/12 65/8 70/2 77/3 82/11 94/15 95/20 97/15</p> <p>you've [42] 1/7 4/19 9/15 13/8 16/5 22/12 45/2 53/4 58/10 59/1 59/6 59/10 60/3 62/4 62/7 67/7 69/13 69/19 70/7 70/7 70/8 70/17 70/23 71/2 71/11 71/16 72/17 75/12 77/1 80/13 83/3 89/11 92/12 93/6 94/9 96/3 96/3 96/5 96/14 98/11 102/10 105/24</p> <p>young [1] 22/16</p> <p>your [73] 1/10 2/1 4/5 6/16 8/19 10/20 16/13 16/24 17/23 20/17 21/2 25/4 25/15 26/25 27/5 27/21 28/10 28/16 30/3 32/15 33/13 33/17 35/23 36/15 38/11 38/14 41/24 45/13 49/20 49/20 53/5 55/13 57/12 57/14 59/4 59/9 62/10 69/6 69/11 69/11 70/7 70/15 70/17 70/24 72/3 72/17 74/10 75/12 75/19 76/2 76/17 77/1 77/1 77/22 79/6 79/24 80/24 81/4 83/17 84/21 89/12 90/9 93/3 93/6 93/19 94/11 95/3 96/1 96/3 97/5 97/6 101/21 105/21</p> <p>yours [2] 45/12 100/8</p> <p>yourself [2] 70/3 70/6</p> <hr/> <p>Z</p> <p>zoom [1] 5/2</p> <p>Zoë [1] 98/17</p>	
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