Monday, 11 May 2026

(2.19 pm)

THE CHAIR: Yes, Mr Carr.

MR CARR: Chair, good afternoon. May I call, please, Dr Ajith Gurusinghe?

DR AJITH INDRAN GURUSINGHE (sworn)

Questioned by MR CARR

THE CHAIR: Yes.

MR CARR: Dr Gurusinghe, you have prepared two witness statements for this Inquiry, haven't you?

A. That's correct, yes.

Q. The first dated 7 November 2025.

A. That's correct.

Q. The second dated 9 December 2025.

A. That's right.

Q. Are those statements true to your best knowledge and belief?

A. Yes.

Q. So far as your professional background, you're a Consultant Psychiatrist.

A. That's correct, yes.

Q. You work for the Priory Group.

A. That's correct.

Q. Since 2020 you have been the Medical Director of Priory Arnold.

A. That's correct.

Q. That is a hospital, isn't it, that VC was transferred to from Cygnet, the Cygnet Psychiatric Intensive Care Unit, on 1 October 2021?

A. That's right, yes.

Q. During the admission at the Priory, you were VC's Responsible Clinician.

A. Yes, that's correct.

Q. So that part of the admission that was under Section 3.

A. Yes.

Q. The overview, so far as VC's time at Priory is concerned, is he was transferred on 1 October on a Section 3 detention, the Section 3 detention was rescinded by you two and a half weeks later on 18 October 2021.

A. That is correct, yes.

Q. And a few days later, 22 October 2021, he was discharged back into the community.

A. That's correct.

Q. So a three-week stay in total?

A. Yes.

Q. When discharged back into the community, it was with no CTO and no depot medication in place?

A. That's correct.

Q. The reason why you have prepared two statements is

because one you deal with your interactions with VC from your perspective as a doctor, and the other is looking at things more broadly in your position as Medical Director for the Priory?

A. That's correct.

Q. Now, at the time of VC's admission, the Priory Arnold was on special measures, wasn't it, from the CQC?

A. That's correct.

Q. That is because of concerns that had been raised by the CQC on inspection of your hospital?

A. That's correct.

Q. If we can look at some of those concerns, please, first document CQCM0016484, and if we could go to page 9, please. At the bottom of that page we can see the risks being raised are that staff did not always assess and manage risks to patients well.

A. Yeah, I can see that, yes.

Q. The concern being described in that paragraph is essentially one as to inadequate and an inadequate approach to risk assessment?

A. Yeah, I suppose that implies that, yes.

Q. To be clear, this is following a visit, it was in June 2021, wasn't it? So it was prior to VC's admission?

A. That's correct, yeah.

Q. If we turn to page 10, the next page of this document, we can see about five paragraphs down:

"The service did not have a good track record on safety."

The next paragraph:

"The service did not always manage patient safety incidents well."

A. Yeah, that's what the report states, yes.

Q. So again, concerns that go to the safety of the provision --

A. Yes.

Q. -- at your hospital.

Then the final entry I'm going to go to in this document, next page, page 11. The final paragraph on that page:

"Ward teams did not have access to the information they needed to provide safe and effective care and did not use that information to good effect."

So again, this is another point as to the safety of your hospital, isn't it?

A. That's correct.

Q. The particular point being raised here is in relation to obtaining necessary information, and information sharing; is that right?

A. I cannot make a comment on that. It does say it did not

1 use that information to good effect. Maybe it's in
2 reference to a particular incident?
3 **Q.** Well, it doesn't seem to be referring, does it, to a
4 specific incident. It's talking in general terms:
5 "Ward teams did not have access to the information
6 they needed to provide safe and effective care and did
7 not use that information to good effect."
8 That appears, doesn't it, or it reads as a general
9 comment?
10 **A.** Yes, I agree, yes.
11 **Q.** But in any event, you're the Medical Director, you would
12 have received this report --
13 **A.** Mm-hm.
14 **Q.** -- and it would have been a cause of concern for you?
15 **A.** It was.
16 **Q.** So how did you understand that paragraph?
17 **A.** So it was a comment on following their inspection, so
18 that, you know, was following evidence and observations.
19 So I accepted that was a concern that was highlighted.
20 **Q.** What steps did you take between receiving this feedback
21 from the CQC as to the safety of your hospital and prior
22 to VC's admission? Had any steps been taken prior to 1
23 October 2021 to correct these or address these concerns?
24 **A.** Yeah, I'm sure we had taken steps to address these
25 concerns. Following each report, each recommendation,

1 we are provided to provide an action plan. I'm sure we
2 have provided an action plan following this as well.
3 **Q.** My question was specifically in respect of the periods
4 to 1 October 2021, and what I'm asking you essentially
5 is what we read in this report, does this reflect the
6 position at your unit at the time that VC was admitted
7 or had steps been taken prior to 1 October 2021 to
8 address those concerns?
9 **A.** We -- I can't remember exact steps that we have taken,
10 but surely, following each review, we are required to
11 provide an action plan. So that action plan would have
12 been sent to the CQC.
13 **Q.** Prior to 1 October?
14 **A.** I hope so, but I cannot really confirm. I don't have
15 that information.
16 **Q.** Quite apart from any action plan, these concerns raised
17 by the CQC, they really ought to have been at the
18 forefront of your mind and the mind of all the staff at
19 Priory Arnold --
20 **A.** That's correct, yes.
21 **Q.** -- in October 2021?
22 **A.** Correct.
23 **Q.** If we can look, please, at another document,
24 WITN0187001. What's about to be put on screen, it's
25 page 2, please, what is on screen, Dr Gurusinghe, this

1 a witness statement of Noel Prince, he was one of your
2 employees, wasn't he, at Priory Arnold?
3 **A.** Yes, ex-employees, yes.
4 **Q.** Ex-employee, and he had some interactions with VC. You
5 can see what he says about that under the heading
6 "Interactions with VC" paragraphs 6 to 8, but it is the
7 entry under paragraph 9 that I want you to look at, and
8 halfway down that paragraph, where he comments in
9 respect of the Priory:
10 "The focus of such an environment is simply to make
11 sure that the patient is safe and alive and no real
12 effort is made to get a sense of who each patient is and
13 what their specific needs are in order to help them
14 recover. The training provided is mostly centred around
15 containing physical destructive behaviours with minimal
16 education to help recognise and understand psychological
17 symptoms ..."
18 Do you accept that's a fair representation of
19 treatment in Priory Arnold --
20 **A.** No, I wouldn't.
21 **Q.** -- at October 2021?
22 **A.** No.
23 **Q.** Which bits of it do you take particular issue with?
24 **A.** I mean, this particular person was an occupational
25 therapy assistant activity coordinator. I'm surprised

1 that he has made this observation, because it was part
2 of his job role, actually, to interact with VC if that
3 was the case.
4 **Q.** Can we look, please, at document CQCM0019689. Do you
5 see this is another CQC report. It's an inspection
6 report following a visit or visits, rather, in
7 December 2021. So it post-dates the previous document
8 I took you to and it post-dates VC's admission, doesn't
9 it?
10 **A.** Yes.
11 **Q.** You can see from page 1 that the rating the overall
12 rating for your hospital was "inadequate"; do you see
13 that?
14 **A.** Yes, I can.
15 **Q.** In respect of whether services were safe, again it was
16 "inadequate"?
17 **A.** That's correct.
18 **Q.** And those previous entries I took you to in the last CQC
19 document, they also went to the issue of safety, didn't
20 they?
21 **A.** They have, yes.
22 **Q.** If we look within this report, and go, please, to
23 page 13, I'm not going to read it out in full, but you
24 can see towards the bottom half of the page there's
25 a heading "Assessment of patient risk", that has

1 a paragraph underneath it, and then "Management of
2 patient risk" and again, it's raising similar concerns
3 to the previous report following the June visit, as to
4 the approach of your hospital to risk assessment,
5 Dr Gurusinghe.
6 **A.** Sorry, I was kind of focusing on the --
7 **Q.** Forgive me. Page 15, please, bottom of the page, "Track
8 record on safety":
9 "The service did not have a good track record on
10 safety."
11 Then the final entry on in this document at page 16
12 at the top of the page under the heading: "Reporting
13 incidents and learning from when things go wrong":
14 "The service did not always manage patient safety
15 incidents well."
16 It seems, on reading through this document and
17 comparing it to the previous one, it's the same
18 criticisms, isn't it?
19 **A.** That's right.
20 **Q.** So between those two documents, do they reflect the
21 state of play as at the time that VC was admitted to
22 Priory Arnold?
23 **A.** Well, obviously I mean the CQC did observe certain
24 lapses. If I remember right, this report was completed
25 following the death of a patient as an inpatient. So

1 they were scrutinising many things very closely and they
2 did identify certain lapses.
3 **Q.** As a result of the inadequacies found by the CQC, the
4 special measures that apply to you, or amongst the
5 special measures that apply to your hospital, were that
6 you were required to obtain the consent of the CQC
7 before admitting a patient.
8 **A.** That's correct, yes.
9 **Q.** And it required you to submit certain documents to the
10 CQC in order to do so.
11 **A.** That's correct.
12 **Q.** There is a referral checklist amongst the Priory
13 documents and that's the document you would have sent to
14 the CQC to obtain their consent.
15 **A.** That's correct, yes.
16 **Q.** VC was admitted. He was admitted to a ward in which all
17 the patients were from the Nottinghamshire Healthcare
18 Foundation Trust.
19 **A.** That's correct. We had a contract back then.
20 **Q.** So you were effectively operating a whole ward on behalf
21 of --
22 **A.** That's correct, yes.
23 **Q.** Now in terms of documentation, when you are receiving
24 a patient and the documentation that you have or should
25 have available to you, the Priory had is own policy,

1 didn't it, on admission and discharge. We can put that
2 up. It's PAGR0000033. Do you see this policy:
3 "Admission, Transfer and Discharge"?
4 **A.** Yes.
5 **Q.** If you turn to page 4 of this document, at number 3.8,
6 it states:
7 "A request should be made for medical records for
8 any patient who has had previous inpatient treatment,
9 especially details of potential risks and serious
10 incidents."
11 **A.** That's correct, yeah.
12 **Q.** So as a starting point, when you're receiving a patient,
13 particularly one who previously has been admitted, the
14 expectation and requirement is that you go and obtain
15 their medical records?
16 **A.** That's correct, yes.
17 **Q.** And that's for the purposes of obtaining as full
18 a history as possible.
19 **A.** That's correct, yes.
20 **Q.** And you've explained in your statement, the first
21 witness statement, so the one ending 2001, it's page 5,
22 top of that page, you've explained that in fact the
23 Priory had "read only access to [the Trust's] ...
24 [electric] ... patient records system."
25 **A.** Sorry, if you could repeat that question?

1 **Q.** So if you look on to the screen, you've explained in
2 your statement that you had access to the RiO records --
3 **A.** That's correct, yes.
4 **Q.** -- the medical records --
5 **A.** Yes.
6 **Q.** -- held by the Trust, but that was read only.
7 **A.** That's correct, yes.
8 **Q.** So did that mean that where you had a patient who was
9 going to this ward that you operated on behalf of the
10 Trust, you could log on and you could see
11 -- *(overspeaking)* --
12 **A.** That's correct, yes.
13 **Q.** -- of their RiO records?
14 **A.** That's correct, yes. However, I'm not too sure if
15 I have -- I have recollection of reading RiO notes but
16 this RiO access we had was on and off, because sometimes
17 with password issues, you don't. But we had access to
18 RiO notes whenever we wanted. So that wasn't an issue
19 at all, so we could access --
20 **Q.** Okay, let's deal with that point. The procedure or
21 policy was, or the practice, was that you had access to
22 RiO records -- *(overspeaking)* --
23 **A.** That's correct, yes.
24 **Q.** -- (overspeaking) -- access to RiO records.
25 **A.** Yes.

1 **Q.** And it may be that there were technical difficulties on
2 occasion with passwords.
3 **A.** Yes.
4 **Q.** But it wasn't a case of the Trust withholding access
5 -- *(overspeaking)* --
6 **A.** No, not at all, no.
7 **Q.** -- *(overspeaking)* -- and if you encountered a technical
8 issue with any patient, then presumably you could pick
9 up the phone to the Trust and say --
10 **A.** Oh yes, yes. Absolutely, yes --*(overspeaking)* --
11 **Q.** "Sort this out. We would like to see the records. Our
12 policy requires us to see the records," and you as
13 a clinician would want to see the records.
14 **A.** That's correct.
15 **Q.** And in respect of VC, was there any issue in accessing
16 his RiO records, so far --
17 **A.** No.
18 **Q.** -- as you recall?
19 Did you read VC's RiO records?
20 **A.** I have a brief recollection of reading at some point.
21 Having access to some records that I was provided
22 recently, I had a recollection that I might have read
23 some of this information. They were family.
24 **Q.** Sorry, say the last bit?
25 **A.** They were family, the records that I read recently, that

13

1 was handed over to me recently over the weekend and
2 recently.
3 **Q.** When I refer to VC's RiO records, do you know what I'm
4 talking about?
5 **A.** Yes.
6 **Q.** My question is when VC became your patient, you had
7 access to those RiO records.
8 **A.** Yes.
9 **Q.** Did you read those RiO records when he was your patient?
10 **A.** I read some of it, yes.
11 **Q.** And in terms of the responsibility to read records, is
12 that one that's on you, or you and the rest of the team?
13 **A.** Sorry, when you are referring to reading RiO records,
14 are you asking me whether I have actually logged on and
15 viewed the records?
16 **Q.** How else would you read the records?
17 **A.** Sometimes they do provide RiO records printed, sometimes
18 they share records if we ask. So in this case
19 I remember reading -- I have a recollection of reading
20 through some of the RiO records.
21 **Q.** Yes, well whether printed or reading on screen --
22 **A.** Yes, yes.
23 **Q.** -- I think the point is you have access to the RiO
24 records --
25 **A.** Yes.

14

1 **Q.** -- for patients?
2 **A.** Yes.
3 **Q.** You don't remember difficulty accessing VC's RiO
4 records?
5 **A.** No.
6 **Q.** And your recollection is that you read them?
7 **A.** Yes.
8 **Q.** I'm asking whether the responsibility for reading them,
9 whether that's one that fell only on your shoulders or
10 whether everybody in your team at the Priory would be
11 reading, or should be reading, RiO records?
12 **A.** Well, not everyone had access to RiO. If I remember
13 right, some of the ward admins, the Mental Health Act
14 administrator and some of the medics had access to RiO,
15 not everyone had access to RiO.
16 **Q.** Who didn't have access to RiO?
17 **A.** Sorry?
18 **Q.** Who did not have access to RiO?
19 **A.** Most of the staff did not have access to RiO. Only
20 a handful of staff members had access to RiO. A few
21 medics, few ward admins, and Mental Health Act
22 administrator.
23 **Q.** What was the rationale for that? Do you know?
24 **A.** Because they did not give free access to everyone.
25 They --

15

1 **Q.** The Trust did not --
2 **A.** The Trust did not, no.
3 **Q.** So how did the system work? If you looked at RiO
4 records and there was something in there that you
5 thought it was important for the rest of your team to
6 know, those who didn't have access, how would you go
7 about communicating that with them?
8 **A.** Well, if I -- so we do have meetings on a regular basis.
9 In the morning we discuss patients during handover, and
10 we discuss patients during MDT meetings. So if I have
11 some information that I feel relevant for the rest of
12 the team, I would let them know.
13 **Q.** Was there any relevant information from VC's RiO records
14 that you passed on to the rest of your team?
15 **A.** So we had adequate information already received at the
16 time of the referral. I cannot really remember
17 discussing anything further, other than that.
18 **Q.** So the answer is no?
19 **A.** Yes.
20 **Q.** In respect of the RiO records, and we can put them up,
21 please. It's NHFT0000168, and I'm going to go to a
22 number of entries in this document in order to establish
23 the information that was available to you and whether
24 this accords with your understanding of the patient you
25 had in your care.

16

1 So we're on page 1 of this document, and you can see
2 the very first entry on that page refers to VC kicking
3 the door in to another flat and being arrested and this
4 led to his first Mental Health Act Assessment.
5 **A.** Yes.
6 **Q.** Then if you turn to page 3 of the records, the entry in
7 the -- towards the middle of the page, 24 May, 9.13 pm,
8 we can see reference there to VC -- and this is later on
9 -- "trying to smash the door" of another property, and
10 the fact that the neighbour has jumped from a first
11 floor window and is "currently in the back of an
12 ambulance complaining of lower back pain", on the way to
13 hospital.
14 Now just pausing there, did you understand from
15 these records that on 24 May there'd been a Mental
16 Health Act Assessment, hadn't led to admission, VC had
17 returned home, and then tried to --
18 **A.** That's correct.
19 **Q.** -- access another flat.
20 Did you seek information or were you aware of the
21 injuries that had been suffered by VC's neighbour who
22 had jumped from a window?
23 **A.** Yes.
24 **Q.** You did?
25 **A.** Yes.

1 **Q.** Where did you get the information from?
2 **A.** Because we received it from the referral paperwork
3 itself.
4 **Q.** What was your understanding of the injuries suffered?
5 **A.** Some back injury, serious form of back injury. That's
6 my recollection, yeah.
7 **Q.** Then if we go forward to page 11, this is during VC's
8 first admission, this is a ward review. Presumably the
9 ward reviews would be particularly important documents
10 for you to consider because that's where VC would be
11 being reviewed by another Consultant Psychiatrist?
12 **A.** That's correct.
13 **Q.** We can see under the heading "MDT discussion" reference
14 to VC saying, when asked what he was talking about, he
15 said, "capital punishment".
16 That, for a psychiatrist, that would be a matter of
17 concern, wouldn't it, if you have a psychotic patient
18 who reports that they are having thoughts of capital
19 punishment?
20 **A.** It would be a concern, yes.
21 **Q.** Then page 17 of these records. This is another ward
22 review during VC's first admission in the middle of the
23 page under "Patient comments" it says:
24 "Thinks people have been following him/watching him,
25 probably since last October."

1 A few lines down:
2 "Did not feel fear but became angry about this.
3 "This is why he went to the neighbouring flat to try
4 to get the people he thought were invading his mind."
5 Again, was that an important piece of --
6 **A.** That is important --
7 **Q.** Why is that an important piece of information?
8 **A.** It's evidence that he was paranoid about other people
9 interfering with his mind.
10 **Q.** And acting on that paranoia?
11 **A.** Acting on that as well, yes.
12 **Q.** Trying to get at the people that he thinks
13 -- *(overspeaking)* --
14 **A.** Yes.
15 **Q.** In a deluded sense?
16 **A.** It is deluded, yes.
17 **Q.** At page 21 -- and again still in the first admission --
18 this is an entry by Dr Seedat, the Consultant, one of
19 the consultants on the ward VC was admitted to. And
20 this is a summary by Dr Seedat of text messages and
21 phone communications that had been sent to him by VC's
22 family. Did you see this in the course of the --
23 **A.** I cannot remember everything, but I have, like, while
24 I was reading notes recently, kind of reminded me that
25 oh, I've seen this some time back. So that's kind of

1 recollection I have.
2 **Q.** Do you think you saw the actual text messages? They've
3 been provided to --
4 **A.** No, I don't think, no. I haven't seen this.
5 **Q.** Do you think they should have been provided to you, to
6 The Priory?
7 **A.** Not necessarily. I mean, when -- so they don't provide
8 everything that's on RiO. It's really impossible. It's
9 loads of information, but if they felt some of the
10 information was relevant, they should have. So those
11 text messages, of course, never seen that before.
12 I have no recollection of seeing that.
13 **Q.** But you've reviewed them for the purposes of giving your
14 evidence today?
15 **A.** Yes.
16 **Q.** Having reviewed them, they go further, don't they, than
17 what is in the summary on the page in front of you on
18 the screen?
19 **A.** Yes, I agree. Yes.
20 **Q.** They have entries, for instance, to VC, stating:
21 "I think they are watching. I know that I can break
22 their heads with my hands."
23 A text message from VC "Wanted to hurt permanently".
24 And text from VC:
25 "I was thinking about red rum not 120 minutes ago."

1 **A.** Mm.
2 **Q.** Do you know what that reference to red rum was?
3 **A.** Yes, I do, yes.
4 **Q.** Those are significant entries, aren't they, because they
5 come straight from --
6 **A.** They are significant entries and that's a classic
7 representation of somebody who is suffering with
8 a severe mental illness at the time.
9 **Q.** It indicates potentially, doesn't it, thoughts -- pretty
10 strongly -- thoughts of harm to others?
11 **A.** Yes. I mean, the experiences he was going through,
12 trying to understand the experience. So he was
13 reporting back to people the experience. He was trying
14 to explain his own experience to others and that's quite
15 normal. We see it all the time with patients when they
16 first, for the first time when they go through such
17 experiences. They are quite traumatic and they are
18 quite confused, and they will try to understand what's
19 going on.
20 **Q.** So having seen those text messages for all the purposes
21 of your evidence, do you think that they don't contain
22 any information that you weren't already aware of in
23 respect of VC?
24 **A.** No, so I knew that he suffered from a severe mental
25 illness. There was no doubt in my mind it was paranoid

1 schizophrenia, and he was a classic case of a severe --
2 a person suffering with severe form of paranoid
3 schizophrenia. And that was -- all these symptoms were
4 part and parcel of his clinical features, his symptoms.
5 **Q.** If we go in the records, please, to page 56, you were
6 aware that VC had been admitted again to hospital
7 shortly following his first admission?
8 **A.** That's correct, yes.
9 **Q.** Were you aware of the circumstances, as we see set out
10 on this page, the entry of 14 July, of VC banging on
11 a door, forcing his way in, pushing past the resident,
12 having to be restrained?
13 **A.** Yes.
14 **Q.** Also within that entry, it's the third paragraph, there
15 is a reference, isn't there, to the police finding
16 unused medication, a medication strip?
17 **A.** Yes.
18 **Q.** That would indicate that VC was not concordant?
19 **A.** Yes, it could indicate he was not concordant or -- at
20 some point, or he had additional medication. Possibly
21 he wasn't concordant fully.
22 **Q.** Were you unclear about whether or not it was an --
23 **A.** No, no, it was clear to me that he might have been
24 non-concordant at some points, but I could not conclude
25 that he has not been concordant at all. That's what

1 I'm --
2 **Q.** Well, if you look at page 58, from the Mental Health Act
3 Assessment prior to that second admission, four lines
4 down:
5 "... clear from today assessment ... he ... decided
6 to stop taking his medication 2 weeks after his
7 discharge from hospital."
8 **A.** Mm-hm.
9 **Q.** So pretty clear, wasn't it, that he was non-concordant?
10 **A.** Yes, it seems like that, yes.
11 **Q.** So following a period when he had been readmitted --
12 **A.** Yes.
13 **Q.** -- and released medication, within a fortnight he had
14 stopped taking his medication.
15 **A.** Yes.
16 **Q.** That was an important factor, wasn't it --
17 **A.** Yes.
18 **Q.** -- something you ought to have heeded once you were
19 caring for VC?
20 **A.** Yes.
21 **Q.** Then page 138, and this is an appointment in the
22 community with Dr Burri, so Dr Burri was a doctor who
23 was working under Consultant Tuhina Lloyd in the EIP
24 team. This was an appointment from November 2020, and
25 it's the second paragraph in particular that I want to

1 take you to on this page, second sentence:
2 "He [that's reference to VC] said that just before
3 his discharge from admission at Highbury Hospital back
4 in July, he told ward doctor that he no longer hear
5 voices but he said that is not the case and he only said
6 that because he was tired for being in the hospital."
7 Now that's a significant entry, isn't it?
8 **A.** That is, yes.
9 **Q.** Why is it a significant entry?
10 **A.** Because he could have well been lying or not being
11 truthful about taking medications.
12 **Q.** Well, isn't there significance to it in that VC is
13 admitting here having deceived and misled his treating
14 doctors in order to get released from hospital?
15 **A.** Because -- so he could basically mask his symptoms and
16 pretend that he's not experiencing psychotic features in
17 order to simply leave the hospital and get out of the
18 hospital.
19 **Q.** This is an example of that?
20 **A.** Yes, that's correct, yes.
21 **Q.** That's a significant risk factor to --
22 **A.** That is a significant risk factor, yes.
23 **Q.** -- (overspeaking) --
24 Then the final entry in the RiO records prior to you
25 caring for him, page 167. This is the note in the

1 records by Dr Lomas of the Mental Health Act Assessment
2 in September 2021. It would have been particularly
3 important for you to consider this, wouldn't it --
4 **A.** Yes, indeed, yes.
5 **Q.** -- *(overspeaking)* -- in his assessment leading to the
6 admission that you were concerned with.
7 If you look in the middle of this page under the
8 heading "Seen", can you see how three lines down, end of
9 that line, it references to VC being "polite and calm"?
10 **A.** Yes.
11 **Q.** A few lines down:
12 "... initially invited us in to the property, and we
13 went with him."
14 Next paragraph:
15 "He answered the door and remained polite ...
16 Politely repeated his assertion that he wasn't going
17 anywhere."
18 Then in the next paragraph onwards, the notes
19 describe, don't they, a brutal and violent attack upon
20 a police officer?
21 **A.** Yes, that's correct, yes.
22 **Q.** So is the key take away here that you have a patient who
23 can go from presenting as polite and calm into extreme
24 violence, motivated by his illness or as a result of his
25 illness?

1 **A.** Yes, it indicates he is capable of.
2 **Q.** We can put the records down for now, but do you accept
3 that the picture that emerges of the patient that you
4 had before you was of someone who, when unmedicated,
5 became violent?
6 **A.** That's correct, yes.
7 **Q.** Someone who could present as calm and polite before
8 becoming extremely violent?
9 **A.** Yes.
10 **Q.** Someone who lacked insight and so was at risk of
11 becoming non-concordant?
12 **A.** I would agree, yes.
13 **Q.** Someone who could mask and deceive those treating him in
14 order to get out of hospital?
15 **A.** I agree, yes.
16 **Q.** If we can look now at the documents dealing with VC's
17 condition, immediately before he is or shortly before he
18 is transferred to The Priory, you received some
19 documents from Cygnet, didn't you --
20 **A.** That's correct, yes.
21 **Q.** -- as part of the referral? We'll look at
22 a PAGR0000006, first. This is a Cygnet Patient Review
23 from the 21 September 2021. If we go to page 3 of this
24 document, you can see at the bottom of that page there
25 is a description there of what Claudia -- and that's

1 a reference to Ms Birtles, VC's care coordinator -- who
2 is describing that since the last discharge -- that is
3 the discharge from the second admission -- she didn't
4 think VC had ever recovered, that his contact was
5 superficial, and his compliance with medication
6 questionable, hence depot has been considered.
7 **A.** Mm-hm.
8 **Q.** Now, did you consider this document -- *(overspeaking)* --
9 **A.** I did see this document, yes.
10 **Q.** You did?
11 **A.** Yes.
12 **Q.** So you were aware, were you, that the Community Team
13 were considering or had considered depot medication?
14 **A.** I was aware, yes.
15 **Q.** At page 4 of this document we have the mental state
16 examination at the top, carried out by Dr Shoilekova and
17 her team, and you can see what it says in there about
18 VC. I'm not going to read the whole thing. But it
19 concludes, doesn't it, with a complete lack of insight
20 by VC?
21 **A.** Yes, so it shows lack of insight in certain areas, yes.
22 **Q.** Well, it's "completely lacks insight" is how the
23 paragraph concludes.
24 **A.** Yeah, I would agree that it shows -- I mean, I wouldn't
25 say "complete lack of insight" unless it's described

1 widely, but I would agree that he had -- he did not have
2 adequate insight, or his insight was very poor.
3 **Q.** This is the description of the patient, this is a little
4 over a week, isn't it, before he was admitted to the
5 Priory?
6 **A.** That's correct.
7 **Q.** In addition, you were also sent, from the same date,
8 21 September, a copy of a Cygnet risk assessment and
9 that's PAGR0000003. If we turn to page two of this
10 document we can see "Risk of harm to others" is marked
11 "Moderate", and "Risk of noncompliance with medication"
12 is also marked "Moderate".
13 Did you understand that this risk assessment tool
14 was assessing VC's risk whilst he was on the Psychiatric
15 Intensive Care Unit --
16 **A.** That's correct.
17 **Q.** -- and was limited to an assessment of the risks on that
18 unit?
19 **A.** Yes.
20 **Q.** It wasn't an assessment of risk, was it, of VC, once off
21 the unit, or whilst in the community?
22 **A.** It's current risk, so it's during the admission period.
23 **Q.** Now both of those documents are from 21 September. The
24 Cygnet running records that you obtained on the referral
25 only ran to 23 September. Was it not important to

1 obtain from Cygnet the assessments, running records,
2 patient reviews, for the entirety of VC's admission to
3 the intensive care unit?
4 **A.** The MDT reviews sort of summarised or captured his
5 presentation throughout his admission, and it all
6 indicated that he didn't have any significant incidents
7 during the PICU admission period.
8 So I didn't require, but if I needed additional
9 information, I would have requested for that. At the
10 time I didn't feel that I needed any additional
11 information in terms of running records since the
12 admission to the PICU.
13 **Q.** So just to be clear, was it your understanding that you
14 had the MDT records --
15 **A.** That's correct.
16 **Q.** -- *(overspeaking)* -- the entirety of the --
17 **A.** That summarises the --
18 **Q.** -- *(overspeaking)* -- Cygnet and MDT records?
19 **A.** Yes.
20 **Q.** If we look in the running records that have been
21 provided by the Priory to the Inquiry, it's PAGR0000004.
22 And it's page 11 of this document, and I'm going towards
23 the end of that entry.
24 Again, we can see -- so we see the diagnosis of
25 paranoid schizophrenia. Just above that, we have

1 a reference again to VC completely lacking insight.
2 This was a couple of days before the tribunal hearing,
3 but what is entered by way of a plan of managing VC
4 going forwards, it says:
5 "Section 3 should be considered after that" so after
6 the tribunal hearing.
7 "Depot antipsychotic medication should be considered
8 if detained on section 3."
9 So we can see, can't we, that a plan of the
10 intensive care unit, once the tribunal hearing was dealt
11 with, was to convert the detention from Section 2 to
12 Section 3 with a view, then, of considering depot
13 medication.
14 **A.** Yes.
15 **Q.** And the reference to considering depot medication, after
16 the conversion to Section 3, did you understand that, or
17 would you understand that, as being in the context of if
18 the patient does not consent, then under a Section 3, of
19 course, the patient can be put on a CTO and a depot can
20 be made a condition of that?
21 **A.** Yes.
22 **Q.** If we go forward to the note of the tribunal, it's
23 PAGR0000016. And again the fact that this is within the
24 Priory documents that indicates, doesn't it, that this
25 was document that was provided to the Priory?

1 **A.** Yes. I had access to that.
2 **Q.** If we go to page 3, and on page 3, paragraph 3.
3 Paragraph 3 is summarising the evidence of
4 Dr Shoilekova, so she was the consultant at Cygnet to
5 the tribunal. And what is said here is that:
6 "... she would be very concerned about [VC's] own
7 safety and that of others [if discharged] ..."
8 You see that in the first line?
9 **A.** Yes.
10 **Q.** Now a few lines down it states:
11 "[VC] can be safely transferred to less restrictive
12 ward closer to his home -- hopefully in a matter of
13 days."
14 **A.** Mm-hm.
15 **Q.** And of course he was shortly after this transferred to
16 Priory Arnold which is in or around Nottingham, isn't
17 it?
18 **A.** That's correct, yes.
19 **Q.** But it goes on to say:
20 "She planned to recommend s3 detention, on the basis
21 that he is young ..."
22 And early treatment will give him "better chances."
23 Then the final sentence of this paragraph:
24 "Dr Shoilekova does not think [VC] has recovered his
25 insight ... he has potential to if he complies with the

1 treatment; if his insight does not improve she would
2 recommend a depot."
3 So there are a few different aspects to this plan,
4 aren't there?
5 **A.** That's correct, yeah.
6 **Q.** So on the one hand whilst it's being suggested that VC
7 be stepped down, as it were, from intensive care to an
8 acute unit such as Priory Arnold, the basis of the
9 detention is going to be increased from a Section 2 to a
10 Section 3. So this isn't a step-down which appears to
11 be put in place as a short stopgap prior to release into
12 the community.
13 **A.** Sorry, you mean recommendation for Section 3, is that
14 what you are referring to?
15 **Q.** Yes, because there's a few different aspects of this
16 plan. So on the one hand it's well, step down from
17 intensive care --
18 **A.** Yes.
19 **Q.** -- but put in place a Section 3 --
20 **A.** That's correct, yeah.
21 **Q.** -- with a view to potentially depot medication.
22 **A.** I mean she has mentioned here that if he does not gain
23 adequate insight then she would recommend a depot.
24 **Q.** Yes, and so that's part of the Section 3.
25 **A.** Yes.

1 **Q.** The implementation of a Section 3 is: this is somebody
2 who requires treatment before being released back into
3 the community, for the reasons that are given at the
4 start of that paragraph.
5 **A.** What Section 3 means is at that point, if you consider
6 somebody requires to be detained for a further period,
7 the only option available is Section 3. You can't
8 extend Section 2, you have to put the patient on another
9 section, a different section. That's all that means.
10 What it implies is that patient requires to be detained
11 for a further period.
12 **Q.** Yes, because if he's not ready for release to the
13 community -- *(overspeaking)* --
14 **A.** Absolutely, yes. At that point, sorry.
15 **Q.** You will have seen the entry at paragraph 6 on this
16 page, again from the Community Care Coordinator Claudia
17 Birtles, who you referred to before, who is raising
18 concern that VC's engagement was superficial following
19 his previous discharge:
20 "He attended appointments and was pleasant but she
21 'wouldn't say we ... got to the nitty-gritty' ..."
22 And at the end of that:
23 "... she was not sure that he ... ever accepted ...
24 he suffers from psychosis."
25 And that's an indication there that you had

1 a patient who could be pleasant with those who were
2 treating him but that didn't necessarily amount to full
3 and proper engagement.
4 **A.** In terms of engagement, I mean, to be fair, I think he
5 has been engaging reasonably well during the follow-up
6 period, meeting with the care coordinator on a regular
7 basis. That's my understanding. In terms of accepting
8 whether he ever accepted that he suffers from
9 a psychosis, my impression was that he was actually
10 struggling to accept a diagnosis of psychosis. I mean
11 that's -- we've seen that with many young patients,
12 especially educated, you know, students or professionals
13 trying to deal with a serious diagnosis. But it shows
14 that he was lacking insight, that this is, you know,
15 a serious illness. It could also be that he was in
16 denial that he was suffering with a serious mental
17 illness.
18 **Q.** Can we look, please, at VC's comments and I want to
19 compare what he said to the Mental Health Tribunal with
20 what was said in the Mental Health Act Assessment
21 shortly thereafter. So if we stay in this document but
22 go to page 4 of it. Number 8, where it refers to,
23 starts with a reference to VC, just over halfway down it
24 says:
25 "He felt medication had 'possibly' helped him but

1 the conversations with staff and his family have
2 certainly helped."
3 Well, the reference to medication possibly helping,
4 is that an indication of limited insight?
5 **A.** Partial insight.
6 **Q.** It goes on to say:
7 "[VC] said he would continue to take medication in
8 the community. If discharged he would want to leave
9 hospital straight away but [he] might need to wait a day
10 until the accommodation he has arranged is available."
11 Before we move on to the Mental Health Act
12 Assessment, just finally in this document, it's page 5,
13 and it's the decision of the tribunal. At (v) makes
14 reference to that entry I just read out about the
15 possible improvement, but can you see how this paragraph
16 ends:
17 "... it is essential that medication is maintained
18 and optimised."
19 **A.** Yes.
20 **Q.** So the view of the tribunal, and one of the reasons for
21 refusing the application made by VC, was with a view to
22 the maintenance and optimisation of VC's medication?
23 **A.** That's correct.
24 **Q.** Now, that was a hearing on 23 September. Next day, it's
25 PAGR0000013, we have the Mental Health Act Assessment

1 which took place whilst VC was in Cygnet, so this is
2 what converted his detention from a Section 2 to a
3 Section 3. If we go to page 3 of this document,
4 penultimate paragraph, it reads:
5 "[VC] said he is not experiencing any psychosis. He
6 said his MH [mental health] disorder stopped in early
7 August 2021 and so he stopped his medication."
8 Well, the first sentence, that's a complete lack of
9 insight, isn't it?
10 **A.** It appears to be. So I'm not too sure whether he -- so
11 this was in reference to at the point, or whether he was
12 saying that he never suffered. It's not really clear.
13 But it shows that he's not accepting that he was
14 psychotic.
15 **Q.** Yes, which shows a complete lack of insight, doesn't it?
16 **A.** Yes. I mean, he has followed -- I mean, following on,
17 he said that his mental health disorder stopped in early
18 August 2021. So he's acknowledging that he was
19 experiencing symptoms until that point, and the reason
20 he stopped was because he was no longer experiencing
21 symptoms, and he concluded that his psychosis has
22 stopped.
23 **Q.** If you look at the final sentence:
24 "He does not feel that the beliefs he had could have
25 been due to a paranoid psychotic illness."

1 That indicates, does it not --
2 **A.** Yeah, well, it clearly indicates that he was not willing
3 to accept that he was suffering from a paranoid
4 psychotic illness or severe enduring illness.
5 **Q.** If we look at the next sentence which goes into the next
6 page:
7 "[VC] said he does not have any [mental health]
8 needs, so does not require treatment. He accepts
9 treatment because he has no choice whilst on Section but
10 doesn't see the need for it and perceives no benefit or
11 side effects. He stated if the section ends he would
12 leave hospital and resume his university studies and
13 have no contact with [mental health] services."
14 Now, if the last paragraph did not show a complete
15 lack of insight in your view, this one does, doesn't it?
16 **A.** Yes.
17 **Q.** It's significant, isn't it, particularly for you as
18 a doctor treating VC within a week of this, in that
19 firstly, it shows again masking and deception to the
20 Mental Health Tribunal. You see the entry I took you to
21 in the previous document --
22 **A.** Yes.
23 **Q.** -- where VC said he would take medication. Well, this
24 is saying something completely different, isn't it?
25 **A.** Yes.

1 **Q.** It is also indicating that he is complying with
2 treatment just because he is on the section or because
3 he feels he has no choice whilst on the section. It is
4 not supportive, is it, of good insight or a commitment,
5 a long-term commitment, to taking antipsychotic
6 medication?
7 **A.** Yes, I agree on that, yes.
8 **Q.** Were you conscious of that at the time?
9 **A.** I was conscious, yes. VC -- I mean, it's a normal
10 pattern with patients who suffer from mental illness
11 during the early part of their illness.
12 **Q.** What steps did you take or did you implement to address
13 the concern that whilst at the Priory, VC was only
14 taking medication because he was in hospital and felt he
15 had no choice?
16 **A.** Well, so I made it very clear in my risk assessment
17 documents that he's capable of masking symptoms. So
18 that we need to be really vigilant whether he is
19 suffering with the symptoms of his psychotic illness.
20 But in terms of supporting him with psychoeducation, so
21 we discussed to engage him as much as we can, to engage
22 him in psychological interventions, psychotherapy,
23 psychoeducation, for him to get a better understanding
24 of his mental health condition.
25 **Q.** So one, you say psychoeducation, two psychological

1 therapies, and three, you made reference to masking in
2 his risk assessment?
3 **A.** Yes.
4 **Q.** That's what you put in place --
5 **A.** Yes.
6 **Q.** -- to manage the risks that he was only taking
7 medication because he was in hospital?
8 **A.** I mean, it implies, yes, he was willing to stay in
9 hospital because he was forced to, and he was taking
10 medication because he had to.
11 But if you look at his engagement while he was in
12 the community, that wasn't the case. He was engaging
13 with the care coordinator on a regular basis, he had the
14 option of not engaging, but he did, and there was
15 evidence that he was taking medication and he was
16 reasonably stable for a period of over a year.
17 So what that indicates that he has been taking
18 medications although he was expressing views against
19 medications, or not acknowledging, or in denial of his
20 mental health problem. He still continued medication.
21 If not, he would have relapsed quite severely during
22 that period.
23 **Q.** Say that again he would have relapsed quite seriously?
24 **A.** He could have had relapses within that one-year period
25 or within that 13-month period. So there was no

1 evidence that he was relapsing, but of course he showed
2 signs of some ongoing psychotic features, which he
3 disclosed to the care coordinator.
4 **Q.** Did you read the AMHP report --
5 **A.** Yes.
6 **Q.** -- which led to the detention in September? So the
7 detention that you were caring for VC during --
8 **A.** Yes, yes.
9 **Q.** Did you see in there the reference to a bag of
10 medication dating back to February being found?
11 **A.** Yes, I did.
12 **Q.** That would have concerned you, wouldn't it, because that
13 would have indicated --
14 **A.** Yes, because it was an indication that he was, like,
15 there was plenty of evidence that he was not taking
16 medications as advised. So he may have chosen to take
17 a lower dose of medication or may not have taken
18 medication at times on certain days. So that's what it
19 means.
20 **Q.** In light of the CQC's findings as to information sharing
21 and lack of information, what steps were taken with
22 respect to VC to obtain information from other agencies,
23 from the police or from his university?
24 **A.** Prior to admission?
25 **Q.** Or during the admission.

1 **A.** No, so we -- there was no need for us to contact police,
2 because for any further information at that point,
3 because police did not ask, or any information from our
4 service or visited him during his admission to our
5 service, as far as I know.
6 So we normally don't ask for additional information
7 as such. There's no kind of clear way of receiving
8 information in that manner. I mean if you are to ask
9 for information, they would say it's an ongoing
10 investigation and would not give. So during his
11 admission we did not ask for any additional information
12 from police.
13 **Q.** Is that because -- is that for the reason you just gave
14 towards the end of that answer: because you considered
15 that the police wouldn't give you the information?
16 **A.** Yes. I mean that's a normal pattern. They would not
17 give any information on an ongoing investigation.
18 **Q.** And what about in respect of the incidents from
19 May 2020? Would you not want further insight from the
20 police on those matters?
21 **A.** So my understanding, reading through reports, was that
22 there was no prosecution prior to that, you know,
23 incident that led to the admission to our hospital.
24 **Q.** Well, in your second statement, it's page 8 of your
25 second statement, paragraph 25, you set out the

1 circumstances in which you would seek further
2 information from the police, and you describe them as
3 where there has been an assessment or admission "as a
4 result of or in connection with criminal behaviour, or
5 where the police have been otherwise involved in the
6 circumstances of the patient's admission."
7 Of course, that applies, doesn't it, to all of the
8 assessments undertaken on VC up until that point. Apart
9 from the one in Cygnet, they all had some degree of
10 police involvement.
11 **A.** Yes.
12 **Q.** So why did this paragraph of your statement not apply?
13 **A.** So let me read it so I can ... *(Pause)*
14 Yes, so what that means is that if the patient was
15 apprehended by police due to an incident in the
16 community and brought to the police, to a hospital, or
17 has been remanded in custody, or if he had a custodial
18 sentence, then, you know, I would try to obtain PNC
19 records, Police National Computer records, for
20 information of his past prosecutions.
21 **Q.** But you wouldn't contact the police for further
22 information as to the particular instance of violence or
23 information surrounding it?
24 **A.** You mean to say this particular incident or you mean
25 previous incidents?

1 **Q.** Previous incidents.
2 **A.** No, I mean so the evidence was that there had not been
3 any previous prosecution for those incidents.
4 **Q.** Can we turn, please, to PAGR0000165. Sorry, 164, in
5 fact. This is a care plan. It's one of a number of
6 care plans that were carried out on VC during his
7 admission at the Priory. This one is from
8 1 October 2021. So it's at the start of his admission
9 and it's the Keeping Safe care plan that has been
10 complete by Emelia Parton. And we can see in the middle
11 of that page a description of the background leading to
12 the admission. About four lines town:
13 "[VC] spoke about how he had got into an altercation
14 with 'hospital staff' at his home, he stated he had
15 thoughts that someone was being raped in his neighbours
16 homes ..."
17 Now that isn't a correct description, is it, of the
18 circumstances leading to his third admission?
19 **A.** Yeah, I agree, yes.
20 **Q.** Describing what happened as an "altercation", it was in
21 fact with the police and not hospital staff, that is
22 a significant understatement, isn't it?
23 **A.** That's correct, yes.
24 **Q.** And if we go down in this page, please, we have
25 a reference there in the middle of the page "What do the

1 MDT want me to achieve".
2 Well, there wouldn't have been an MDT meeting at
3 this point, would there? Is that -- is what's in that
4 box --
5 **A.** No. Yeah, so what that means is that the expectation
6 from the treating team from him.
7 **Q.** Then towards the bottom, "What the nursing team will
8 do". I want to look at the very first entry there:
9 "Provide 1:1 nursing session every week". Now that
10 was not implemented, was it?
11 **A.** I have seen one-to-one sessions but I don't think they
12 were every week.
13 **Q.** No. So that was not implemented, was it?
14 **A.** Yes, I agree. Yes.
15 **Q.** We can look at the records. It's PAGR0000025, and if we
16 go to page 5 of this document it's the entry at the top
17 of the page, 13 October 2021, 16:57. You can see there
18 there's a reference to a nursing one-to-one, a key
19 worker session.
20 Now, that comes almost two weeks into VC's stay,
21 doesn't it?
22 **A.** Correct, yes.
23 **Q.** Why was that, if this was supposed to be weekly?
24 **A.** I cannot really comment why. I mean it's noted as
25 a one-to-one session so some nurses do make it a point

1 to highlight that it was a one-to-one session because
2 that's part of their role or, you know, the job role or
3 the expectation. If you're a named nurse, key worker,
4 then you must provide one-to-one session.
5 **Q.** Yes, but this is the first -- in terms of the
6 chronology, this is the first one-to-one session that's
7 in the notes, isn't it, for something that's supposed to
8 occur weekly?
9 **A.** Yes.
10 **Q.** And the only other one-to-one session that we see is
11 page 3 of this document and it's the penultimate entry
12 entitled "1 [to] 1 session". But if you read through
13 that, that appears to be a pretty brief interaction,
14 doesn't it?
15 **A.** That's correct, yes.
16 **Q.** VC does not engage, does he, with that one-to-one
17 session?
18 **A.** Yes.
19 **Q.** And so rather than there being a one-to-one session
20 every week, as was envisaged at the start, there's only
21 two offered and one of them VC doesn't engage with; is
22 that a fair summary of the one-to-one sessions?
23 **A.** Yes.
24 **Q.** If we go now to PAGR0000171, please.
25 We're now looking at another care plan. This is

1 Care Plan Keeping Connected. So previously we looked at
2 a care plan for Keeping Safe, but that care plan didn't
3 change, did it, over the course of VC's stay?
4 **A.** Sorry, I didn't follow that question, sorry. Say that
5 again, if you could.
6 **Q.** So I've moved on to another care plan; this the Keeping
7 Connected Care Plan.
8 **A.** Yes.
9 **Q.** Previously we were looking at the Keeping Safe Care
10 Plan?
11 **A.** That's correct.
12 **Q.** But in substance the keeping safe care plan didn't
13 change from 1 October, did it?
14 **A.** So are you referring to whether the Keeping Safe Care
15 Plan changed from since 1 October; is that what you're
16 referring to?
17 **Q.** Yes.
18 **A.** Until when, sorry?
19 **Q.** At any point in the rest of the admission.
20 **A.** No, it's regularly reviewed at each ward round, so you
21 would see updates. So if you scroll down, you would see
22 updates to each of those care plans.
23 **Q.** There are updates but there's no changes, there's no
24 significant changes -- *(overspeaking)* --
25 **A.** If there's no change, then there's no change, yes.

1 **Q.** So now we're looking at the Keeping Connected Care Plan
2 and we have again towards the middle of the page: "What
3 do the MDT want me to achieve".
4 And the first entry:
5 "... work towards a discharge plan into the
6 community".
7 Was there ever a discharge plan created for VC?
8 **A.** So what that means is that progressing with Section 17
9 leave, getting in touch with the University. So
10 basically returning back, so basically planning to
11 discharge him eventually.
12 **Q.** So it's not referring to a document?
13 **A.** No, no.
14 **Q.** It's referring to a discharge plan document.
15 The next entry is VC attending his weekly ward round
16 and engaging with all members of the MDT and we'll come
17 to the MDT entries in a moment. The one after that:
18 "The MDT would like [VC] to engage with the
19 therapies team so he can attend activities and groups
20 which are of interest to him."
21 Again, that did not happen, did it?
22 **A.** Yes, so they tried to engage him in activities, but he
23 wasn't interested because I think he was quite
24 preoccupied resolving his own issues, which is of
25 interest to him, which was actually returning back to

1 studies at the earliest, resolving his housing issue,
2 and he was focusing on his studies. I mean, he was
3 reading, he was going on his laptop quite a lot. So he
4 was quite a busy person, in terms of his own interests.
5 That's what it means.
6 **Q.** He was in the hospital because he needed treatment?
7 **A.** That's correct, yes.
8 **Q.** Part of the treatment plan was for him to engage in
9 therapies?
10 **A.** That's correct.
11 **Q.** There are benefits to that, aren't there?
12 **A.** Yes, of course --
13 **Q.** Therapeutic benefits.
14 **A.** Yes.
15 **Q.** That part of the treatment plan was not implemented, was
16 it?
17 **A.** No, I think they did try to, you know, implement that by
18 offering sessions or the --
19 **Q.** But VC declined?
20 **A.** Yes, he did decline, and I think he politely declined
21 saying he was busy with some other things, and so some
22 of the activities offered to him may not have been of
23 any interest to him because we do offer it to all
24 patients, and we tried to kind of capture their
25 interests as well, such as like, you know, going to the

1 gym, which would have been an activity of interest to
2 him -- *(overspeaking)* --
3 **Q.** The running records show that on, in his admission,
4 there were three activities that were offered to him, so
5 table tennis on 5 October, a cricket match on the 15th,
6 and a walking group on the 22nd and on each occasion he
7 declined.
8 **A.** Mm.
9 **Q.** So he wasn't engaged, and there was nothing else
10 offered, and he wasn't engaged in any --
11 **A.** Yes, he wasn't engaged in any of those, yes.
12 **Q.** There was no other therapy offered to him, was there?
13 **A.** Not that I know of in terms of different types of
14 therapies.
15 **Q.** Next entry:
16 "The MDT would like [VC] to engage with any external
17 support network during his admission."
18 That did not happen, did it?
19 **A.** As far as I know, no, that didn't happen. No.
20 **Q.** Next one:
21 "... MDT would like [VC] to engage with the
22 psychology team to support a safe discharge plan."
23 That didn't happen, did it?
24 **A.** That didn't happen either.
25 **Q.** So in respect of the aims of the MDT, as set out in this

1 box, which doesn't include the one-to-one nursing plan
2 which we've already established was not implemented
3 according to plan, the only one VC did comply with was
4 turning up at the MDT?
5 **A.** And attending to his medication times. He was complying
6 with medications.
7 **Q.** Well, we can go through the records, but in fact he
8 doesn't always turn up to medication, does he?
9 Sometimes he needs prompting, he doesn't go for
10 medication --
11 **A.** Yeah. As with most patients, sometimes they do not turn
12 up. Staff have to go and remind them.
13 **Q.** So he wasn't fully compliant with that either, was he?
14 **A.** No, I would say he was compliant with medication,
15 otherwise he would have resisted, he would have refused,
16 but on each occasion, as far as I know, when offered he
17 did take his medication and there were occasions when he
18 voluntarily attended the clinic and had his medications.
19 **THE CHAIR:** Mr Carr, it's time for a break, don't you think?
20 **MR CARR:** Yes, that would be an appropriate time.
21 **THE CHAIR:** All right, we'll take a break until quarter to,
22 please. Thank you.
23 **(3.35 pm)**
24 **(A short break)**.
25 **(3.45 pm)**

1 **MR CARR:** Dr Gurusinghe, before the break we identified
2 a number of failure to comply with the plan that had
3 been put in place so far as one-to-one time with the
4 nurse, engaging with therapies offers of therapies.
5 Those are failures of yours, aren't they? You are the
6 responsible consultant and it was your job to make sure
7 that the plan was implemented?
8 **A.** I mean, I have the overall responsibility as part of his
9 detention, but the responsibility is shared among all
10 the different specialties. So it is a shared
11 responsibility.
12 **Q.** We spent some time looking at the care plans. Can we
13 look, please, at Priory document 9. This is a risk
14 assessment, the first risk assessment that you carried
15 out on VC; do you see that?
16 **A.** Yes.
17 **Q.** The risk of violence and aggressive, intimidating
18 behaviour is reduced from high historical to medium
19 current, and is kept at medium for non-adherence to
20 treatment, both current and historical?
21 What was the basis for reducing from high to medium
22 so far as violence was concerned, was it because he was
23 currently an inpatient?
24 **A.** Yes, so it's current risks, so it relates to the risk at
25 the time. So there was no incident to indicate that he

1 was violent or aggressive or intimidating.
2 **Q.** At the bottom of the page under "Other risk factors" you
3 identify, don't you, "May be able to mask symptoms to
4 get discharged"?
5 **A.** That's correct, yes.
6 **Q.** Page 2 of this document sets out information at the top.
7 This is information which pre-dates, doesn't it, there's
8 an update there for August, but the first two paragraphs
9 pre-date his time at the Priory.
10 **A.** Yes, yes.
11 **Q.** What this document doesn't do and what none of your
12 subsequent risk assessments do is consider the risk in
13 the future?
14 **A.** I mean, the past risk patterns gives an indication of
15 potential risk in the future, that's the understanding
16 in any risk assessments. I agree that it doesn't
17 specifically say that in future this might happen, but
18 it's giving a pattern of risk incidents that would give
19 a reasonable understanding of potential risk in the
20 future.
21 **Q.** It does not identify the risk of VC becoming
22 non-compliant when he is in the community. We spent
23 some time before the break going through the history and
24 the records and, following the previous admissions, VC
25 had become non-concordant. Your risk assessments do not

1 address that risk factor, do they?
2 A. In terms of non-concordance? We have --
3 Q. In the community.
4 A. Well, it hasn't -- yeah, so well, this risk assessment
5 has not predicted what might happen in the community at
6 this moment.
7 Q. And this risk assessment was completed at the same time
8 as your first MDT, that was on 7 October, it's
9 PAGR0000159.
10 A. Yes, so this was done on the 4th; the first MDT review
11 took place on the 7th so there was another risk
12 assessment.
13 Q. If we get that first MDT document, this PAGR0000159. Oh
14 yes, it's a few days on. This is 7 October. Now at
15 page 3 of this document there are the patient's views
16 and feedback section. In the middle of the page:
17 "He did not agree he had a relapse, on this
18 occasion -- said he was too stressed and he overreacted
19 when police got involved."
20 That's a significant underplaying, isn't it, of the
21 circumstances leading to his admission?
22 A. I would agree to a certain degree. In his mind he
23 acknowledged that he shouldn't have acted in that
24 manner, but yes, I would agree he has undermined the
25 seriousness of the incident.

1 Q. Did you not challenge him on that?
2 A. No, I believe not on that occasion, I can't say
3 I have -- I have no recollection whether I have.
4 Q. In the next paragraph it refers to him preferring to be
5 back on aripiprazole and to come off haloperidol because
6 of a side effect. He said it was making him salivate
7 a lot. Aripiprazole is the medication that he had
8 previously been prescribed and discontinued, become
9 non-concordant on, isn't it?
10 A. At certain points, yes, yes.
11 Q. And you agree to that request, didn't you?
12 A. I did, yes.
13 Q. Now, why didn't you take steps during this MDT, or did
14 you take steps during this MDT to ensure that VC did
15 engage with therapy, did engage with nursing, and wasn't
16 permitted simply to isolate in his room during his stay
17 at the Priory?
18 A. Are you asking me why I -- sorry, I didn't --
19 Q. Yes.
20 A. -- I didn't really understand the question.
21 Q. Well, this is an MDT on 7 October.
22 A. Yes.
23 Q. And the notes up until that point indicate that VC was
24 basically spending his time in his room --
25 A. Right, okay.

1 Q. -- not engaging.
2 A. Yes.
3 Q. And that is a theme which continues throughout his stay
4 in the Priory, isn't it?
5 A. Mm-hm.
6 Q. I'm saying why didn't you take steps at this MDT, or
7 indeed any MDT, to ensure that he was engaging and he
8 was seeking therapy and he was having one-to-one nursing
9 sessions?
10 A. Right. Well, I mean, in terms of engagement, it is --
11 it's quite common for patients, especially young
12 patients, university students, professionals, they tend
13 to, when they are improving or improving in their mental
14 health, they tend to kind of alienate from the other
15 patients and then tend to kind of remain in their own
16 rooms, and focus on their interests. So it is not
17 unusual for patients to isolate themselves because for
18 me -- for various reasons like they do not want to align
19 with the other patients, feeling that they are too
20 unwell, I need to focus on other things. That's one of
21 the reasons.
22 But in terms of engaging with staff and therapy and
23 activities, yeah, we should have been more proactive.
24 I would agree that we should have been more proactive.
25 Q. You carried out a risk assessment on the same date as

1 this MDT. It's PAGR0000010. And we can see that the
2 risks of non-adherence with treatment and violent and
3 aggressive and intimidating behaviour has reduced from
4 what you previously ranked it at, from medium to low.
5 A. Yes.
6 Q. What was the basis for you reducing it, given that there
7 had been no engagement or very limited engagement by VC
8 on the ward?
9 A. So this is referring to violence, aggression,
10 intimidating behaviour. There was no such -- no
11 evidence to suggest that it was still present.
12 Q. It was simply the absence of incidents --
13 A. That's correct, yes.
14 Q. -- in the last few days.
15 A. Yes.
16 Q. Again, no other material looked at for the purposes of
17 the risk assessment. What were you taking into account?
18 A. So it's -- yeah, well simply the feedback we discussed
19 during morning meetings, so I get a good understanding
20 of -- the whole team gets a good understanding of what's
21 going on with each patient, and, you know, no
22 significant incidents were highlighted at that point.
23 Q. You have another MDT on 14 October. We see that at
24 PAGR0000160. And at this stage he's been allowed --
25 you've implemented his wish, haven't you? You've

1 allowed him to transition to aripiprazole.
2 **A.** I think that transition commenced from the 7th MDT ward
3 round. So by the 14th, the -- what we call swapping of
4 medications had taken place, and gone further forwards.
5 So we were in the process of reducing haloperidol dose
6 and increasing the aripiprazole dose.
7 **Q.** Now at this MDT, you were considering, weren't you,
8 rescinding the Section 3?
9 **A.** That's correct.
10 **Q.** And that's despite, if we look at page 3 in the "Current
11 Mental State ..." Sorry, page 4, just towards the
12 middle of the page:
13 "Section 3 discussed".
14 It says you:
15 "... suggested the section be rescinded, if [VC]
16 agreed to remain informally for a few more weeks."
17 At this stage VC was still, for the most part,
18 isolated on the ward, wasn't he? He wasn't engaging.
19 **A.** He was isolating, yes. He wasn't engaging in the
20 recommended -- some of the recommended therapy
21 activities such as OT and psychology.
22 **Q.** So isolating, no therapies, and -- *(overspeaking)* --
23 unclear, you say, whether he had insight.
24 **A.** He was fully compliant and I think he did demonstrate
25 degree of insight by requesting to trial him back on his

1 previous medications, which was helpful, which
2 attributed to his improvement of symptoms. So that
3 demonstrated adequate insight to me.
4 **Q.** Why does requesting a change of medication in
5 circumstances where you have seen in the Mental Health
6 Act Assessment VC said that he was only taking
7 medication because he was under section? Why does
8 changing the medication demonstrate insight?
9 **A.** We know that although he said that he was taking
10 medication while he was in the community, there was
11 evidence that he was taking medication, if you look at
12 care coordinator's notes, she indicated she wasn't
13 convinced that he was taking regularly, but her records
14 imply that there was a good degree of engagement and
15 concordance.
16 **Q.** This was the third time that VC had been detained in
17 a relatively short period.
18 **A.** That's correct.
19 **Q.** Each time unmedicated and each time leading to violence?
20 **A.** That's correct.
21 **Q.** So it was important and it was key, really, to the
22 period of treatment that you had him for, to ensure that
23 the same thing didn't happen again because a pattern had
24 emerged, hadn't it?
25 **A.** That's correct, yes.

1 **Q.** And in none of your risk assessments do you identify
2 that pattern?
3 **A.** In terms of medication compliance?
4 **Q.** In the community?
5 **A.** Well, I mean, we have identified, I'm not too sure
6 whether I kind of specified, but we have identified
7 there is a potential that eventually, or later on, he
8 may not be fully concordant. That's what it means.
9 **Q.** The MDT of 14 October, PAGR0000160, that's the MDT that
10 his care coordinator attended, wasn't it, Claudia
11 Birtles?
12 **A.** That's correct, yes.
13 **Q.** It also came four days after it being noted in the
14 records that VC had brought a hammer in a rucksack onto
15 the ward. Yes?
16 **A.** Yes.
17 **Q.** You deal with this in your witness statement, it's your
18 second witness statement at page 55, paragraph 206, and
19 you say:
20 "My recollection of his explanation is that he
21 picked this up as he was moving to a new property and
22 needed a hammer to hang items. [It] was detected during
23 a search upon returning from communality leave."
24 What's clear is that he did not have that hammer,
25 did he, when he was first admitted -- *(overspeaking)* --

1 **A.** That's correct, yes, and this took place on the 10th,
2 not after -- on the 10th, that weekend.
3 **Q.** Yes, I said it's noted in the records on the 10th?
4 **A.** Yeah, okay.
5 **Q.** Now, your discussion with VC, it's not noted in the
6 records, is it, this explanation of wanting to hang
7 items up?
8 **A.** No --
9 **Q.** It should have been?
10 **A.** It should have been, yes.
11 **Q.** It's not mentioned in this MDT discussion, is it?
12 **A.** I agree, yes.
13 **Q.** It should have been?
14 **A.** It should have been, yes.
15 **Q.** Did you communicate it to Ms Birtles --
16 **A.** No, I cannot remember -- if I had communicated it would
17 have been recorded.
18 **Q.** The account of having a hammer to hang up items, it was
19 totally implausible, wasn't it?
20 **A.** Well, I mean, it was plausible in his mind, but we were
21 sceptical so I remember having a discussion with the
22 nurse or somebody that we should keep an eye, he could
23 still be paranoid -- *(overspeaking)* --
24 **Q.** At that stage, he is still detained, isn't he, he is
25 still detained subject to section -- *(overspeaking)* --

1 **A.** Yes, he was detained, that was early part of his
2 admission when he was supported to go out into the
3 community in order to bring items that he wanted to get
4 on with his studies which included some books and
5 laptops and charging cables and so on.
6 **Q.** Yes, he didn't need a hammer for that?
7 **A.** No, he didn't.
8 **Q.** The suggestion that he needs it to hang items in a new
9 property, well, he hadn't secured a new or alternative
10 accommodation -- *(overspeaking)* --
11 **A.** That's correct, yes. I mean this was his explanation
12 so --
13 **Q.** His explanation was implausible, wasn't it, because he
14 didn't have a new property he was on section --
15 **A.** Yes, at the time, yes, at the time it wasn't valid. But
16 we didn't go to challenge him on that.
17 **Q.** Why didn't you go to challenge him on it?
18 **A.** Because, I mean, if somebody is insisting that, you
19 know, that's their version of thoughts or plans, then
20 there's no point challenging him at that point. That's
21 not the right point to challenge. That's, you know,
22 my --
23 **Q.** If it didn't need challenging, what it certainly needed
24 was (a) it needs to be reported as an incident,
25 shouldn't it, it should have been investigated?

1 **A.** It should have been reported as an incident, yes.
2 **Q.** That was failure, wasn't it?
3 **A.** I agree, yes.
4 **Q.** Failure on your part?
5 **A.** Failure on the part of, you know, the MDT or the staff
6 member who was responsible for that event.
7 **Q.** It required a risk assessment, didn't it?
8 **A.** Well, it would have required -- I mean, every incident,
9 you know, requires a risk assessment.
10 **Q.** The incident with the hammer is not reflected in your
11 risk assessment, is it?
12 **A.** No.
13 **Q.** This is somebody who has come back with something that
14 can be used as a hammer -- sorry, used as a weapon?
15 **A.** Yes.
16 **Q.** And is given an explanation which, Dr Gurusinghe, it
17 sounds like you thought was nonsense?
18 **A.** Yes.
19 **Q.** So that should have led to a change in the risk
20 assessment? That should have led to a new risk
21 assessment?
22 **A.** In terms of when I knew about it or, sorry?
23 **Q.** Yes, from the point you knew about it, at any point up
24 to discharging him, when you are risking violent,
25 aggressive, intimidating behaviour --

1 **A.** Mm, that should have been, you know, included in the
2 risk assessment at --
3 **Q.** It's not included in any of them, is it?
4 **A.** Sorry?
5 **Q.** It's not included in any of them?
6 **A.** No, it's not. It's been missed. I admit that it's been
7 missed to be included. As an incident, but in terms of
8 any harm occurred or to anyone, there was no harm.
9 That's probably, that's why it may not have been
10 highlighted enough.
11 **Q.** Now, you decide to rescind VC's Section 3 detention with
12 effect from 18 October?
13 **A.** That's correct.
14 **Q.** He's not actually discharged until the 22nd?
15 **A.** That's correct.
16 **Q.** But as at 18 October, what has changed from the point of
17 VC's admission to the point of discharge? In light of
18 what we've seen written in the Mental Health Tribunal
19 documents, Dr Shoilekova's view, Dr Shoilekova's
20 evidence to this Inquiry is that she expected VC to be
21 detained for a period of months, not
22 -- *(overspeaking)* --
23 **A.** Yeah, I mean, that's not my view. I mean, that's, you
24 know, that consultant's view which I don't agree at all.
25 **Q.** What had changed in VC's presentation given he didn't

1 engage, he was isolated, he didn't have any of the
2 therapies that the MDT thought he should have, he didn't
3 have -- didn't undertake any activities, and he had
4 turned up at the ward with a hammer?
5 **A.** Well, I mean I didn't want to kind of link the hammer
6 incident to his general presentation. In my mind, he
7 was detained for a period of nearly eight weeks or so,
8 and at least for the last six weeks there were no
9 incidents of any significance in terms of violence,
10 intimidation, aggression towards staff or any other
11 patients. So he has managed his risk really well.
12 In terms of his medication compliance, he has
13 complied really well throughout the admission period.
14 In case of his engagement, he has engaged reasonably at
15 times -- sorry, at times when he was on the PICU, in
16 some of the psychology therapies initially.
17 So there was no reason for me to justify detaining
18 him any longer, based on, you know, that presentation.
19 Being stable, relatively, as far as we can observe, for
20 a period of six weeks.
21 **Q.** So Dr Gurusinghe, again, we've been through the records,
22 we've seen what the risks are in respect of VC, in
23 particular it's becoming non-concordant in the
24 community. What steps did you take and what plan did
25 you put in place to protect the public following VC's

1 discharge from the Priory given that risk, known risk,
2 of him becoming non-concordant in the community?
3 **A.** Well, so in terms of risk to public, I mean we did
4 assess that throughout our admission period --
5 **Q.** My question wasn't about assessment; it's what steps did
6 you put in place?
7 **A.** In terms of?
8 **Q.** Protecting the public.
9 **A.** Well, the patient was -- so the expectation was the
10 Early Intervention Team to have been involved as they
11 had been in the past. So to carry out regular
12 assessments of his mental state, to ensure that he's not
13 relapsing and to ensure his medication concordance as
14 well.
15 **Q.** We went through some earlier documents and you said that
16 you were aware that the Early Intervention Team had been
17 considering depot. We went through the documents from
18 Cygnet, Dr Shoilekova, and you've seen the
19 recommendation that she was making for depot. Despite
20 that, your witness statement and your evidence is that
21 you do not recall having any discussion with VC about
22 depot.
23 **A.** That's correct.
24 **Q.** There's nothing in the notes to suggest you had
25 a discussion --

1 **A.** No, no.
2 **Q.** -- with VC -- *(overspeaking)* --
3 **A.** But my understanding of the point that he was quite
4 resistive of the depot plan. He --
5 **Q.** Something you should have discussed with him. As his
6 consultant and Responsible Clinician, it's something
7 that you ought to have -- *(overspeaking)* --
8 **A.** On reflecting, I should have, you know, discussed
9 further, but my view was -- I mean we see this all the
10 time, especially with younger people, that they are
11 quite reluctant to be on a depot; they would rather have
12 the tablet form.
13 So it's quite tricky, you know, it takes a while to
14 build that therapeutic relationship in order to convince
15 the patient the benefits of being on a depot, and I was
16 expecting the Community Team, the Early Intervention
17 Team, and the care coordinator, who built up a good
18 therapeutic relationship with him to persuade him to
19 agree to have the medication as a depot.
20 **Q.** But the point of there being a Section 3 detention, or
21 one of the benefits of there being a Section 3 detention
22 is one, you could have started depot during that
23 detention, couldn't you?
24 **A.** Mm-hm.
25 **Q.** And two, you could have ensured that VC's release to the

1 community was subject to a CTO where taking depot was
2 one of the conditions.
3 **A.** I mean --
4 **Q.** Those were two options that were available to you under
5 Section --
6 **A.** Yes, I am fully aware of those -- *(overspeaking)* --
7 **Q.** They were not available, were they, to the community
8 team?
9 **A.** I'm fully aware of those two options but in terms of
10 feasibility of those two options, if you look at the
11 powers of a common treatment order (*sic*), it's not
12 a mandatory condition so you can't really force somebody
13 to go on a depot, and especially in the community if
14 somebody is resistive, there's no way of administering
15 a depot medication against a patient's wish.
16 **MR CARR:** Chair, those are my questions. Thank you.
17 **THE CHAIR:** Yes, thank you.
18 Mr Moloney.
19 **Questioned by MR MOLONEY**
20 **MR MOLONEY:** Dr Gurusinghe, I'd just like to ask you, if
21 I could, please, about the MDT of 7 October 2021, which
22 is PAGR0000159, please. And if I could take you to
23 page 3 of that, Mr Carr has already been through with
24 you a lot of the detail in relation to this, and -- but
25 if I could take you down to the middle of this paragraph

1 where he says that:
2 "He did admit to 3rd person auditory hallucinations,
3 thought intrusions, and abnormal beliefs in the past, he
4 stated that they went away when he was on aripiprazole.
5 He preferred to be back on aripiprazole and come off
6 haloperidol -- he said it was making him salivate
7 a lot."
8 And that was the, as it were, summary of the
9 exchange between you and VC --
10 **A.** That's correct.
11 **Q.** -- in relation to his preferred medication on 7 October
12 2021.
13 Now of course, he has -- he's displaying a certain
14 lack of insight in the sentence before the first one
15 I took you to, where he said:
16 "He did not agree he had a relapse on this
17 occasion -- said he was too stressed and he overreacted
18 when police got involved ..."
19 So perhaps not being entirely open with you at that
20 stage, given what you must have known about the
21 circumstances of that incident with PC Pritchard, and
22 I won't repeat all the details, but there he is talking
23 to you about medication.
24 **A.** Mm.
25 **Q.** And I just ask you this, him having said that he went --

1 the hallucinations went away when he was on aripiprazole
2 and that he'd been having side effects with haloperidol
3 of salivating. Was that -- at that MDT, was that the
4 first you had heard of any -- of VC complaining of
5 salvation or was this something it notes that the nurses
6 had found that this is essentially corroborated?
7 **A.** No, I cannot really recall whether there was any
8 conversation. I might have. I mean, I can't really
9 comment for sure, but I know for a fact that there's
10 a difference between haloperidol and aripiprazole in
11 terms of side effect profile, so I --
12 **Q.** Sorry, of course --
13 **A.** Yes.
14 **Q.** -- different drugs have different side effects. That is
15 a matter of fact which you know for a fact, as any
16 responsible clinician would know for a fact.
17 The question is, whether or not there was anything
18 in VC's notes whilst he was at the Priory to suggest
19 that he was complaining of salivation, that you saw
20 before you did this MDT on 7 October 2021?
21 **A.** I believe there was some notes. I believe there were.
22 But I can't really confirm whether I have actually seen,
23 or my decision was based on -- if you are asking whether
24 my decision was based on collaborative information from
25 other members of staff. No, it was during this

1 discussion when he reported that he is struggling to,
2 you know, use haloperidol because of the side effects.
3 Of course I did listen to him.
4 **Q.** Yeah, of course. Because of course -- and it's very
5 straightforward, but if one simply uses a search engine
6 and looks at side effects of haloperidol, then
7 salivation will be referred to, won't it?
8 **A.** Not necessarily. I mean, you know, you can't, you know,
9 make such, you know, inferences from that, because --
10 **Q.** No, no, no, that's not what I asked you, Dr Gurusinghe
11 and please forgive me for talking over you. I don't
12 want to be rude but there's limited time. If one wants
13 to look in a search engine to look for side effects of
14 haloperidol, that would have salivation, wouldn't it?
15 **A.** I agree, yes.
16 **Q.** Absolutely. That's why people can and know that as a
17 fact by just looking at a search engine.
18 Now, you saw his request as a significant turning
19 point in his recovery, didn't you?
20 **A.** I did, yes.
21 **Q.** Just to get of the full extent of your confidence in
22 that as a significant turning point in VC's recovery,
23 can I take you to paragraph 145 of your statement,
24 please. That's at page 39 of WITN0102002. Just the
25 context to this, please. Page 39, paragraph 145, and

1 this is how you sum up that interaction with VC on 7
2 October:
3 "I consider acknowledging abnormal experiences such
4 as hearing 'multiple voices', being able to be express
5 his concerns about some of the medication side effects
6 and suggesting alternative but effective medications as
7 significant turning points of VC's recovery."
8 Then if we could just go to paragraph 151, just to
9 reinforce had, that is over the page, essentially:
10 "I believe VC understood the importance of
11 medication as he himself suggested change of medication
12 to Aripiprazole, stating it was more effective and
13 tolerant in the past in terms of relieving his
14 symptoms."
15 And that you were reliant on his EIP to continue to
16 build therapeutic relations to ensure his medication
17 concordance.
18 Now, in order to express, in order to feel that this
19 was a significant turning point in VC's recovery, you'd
20 have to have a full appreciation of VC's history in
21 relation to medication, wouldn't you?
22 **A.** Yes.
23 **Q.** Are you aware that VC told the Community Team in
24 November 2020 that during his second admission he'd lied
25 about the effect of aripiprazole?

1 **A.** Mm.
2 **Q.** Are you aware of that?
3 **A.** Yes.
4 **Q.** Then were you also aware that during a recent Mental
5 Health Act Assessment, he'd said he'd only accepted
6 treatment whilst on section to get discharged?
7 **A.** I'm not aware of a recent one, but back then --
8 **Q.** Not long before you saw him in a -- one that was
9 recently before you seeing him that he had said he'd
10 only accepted treatment whilst on section to get
11 discharged.
12 **A.** Yes, I agree, yes.
13 **Q.** Then in the tribunal decision, which presumably you saw,
14 Dr Gurusinghe, that essentially at paragraph 8, and I'll
15 save time and won't bring this up, he said that the
16 voices had not stopped when he was previously discharged
17 and living in the community until August 2021 when
18 they'd stopped with no particular prompt.
19 That was only just a few weeks before you were
20 seeing him here on the ward, on 7 October, he was
21 telling you something that he'd not told others. Did
22 you bother to check back and see whether or not what he
23 was saying to you about the -- essentially his positive
24 experiences with aripiprazole, his willingness to be
25 concordant with aripiprazole, whether or not that might

1 be just in some sort of variance with what he'd said to
2 other practitioners before and whether or not you ought
3 to be sceptical about whether or not this was
4 a significant turning point in VC's recovery.
5 **A.** We were always sceptical about medication compliance.
6 There's no doubt about it.
7 **MR MOLONEY:** Thank you very much, Dr Gurusinghe.
8 **THE CHAIR:** Yes, Ms Cartwright.
9 **Questioned by MS CARTWRIGHT**
10 **MS CARTWRIGHT:** Good afternoon, doctor.
11 **A.** Good afternoon.
12 **Q.** I ask questions on behalf of the survivors. Can we
13 please display PAGR0000014. There may not be enough
14 zeros. Because you've essentially said it was the
15 decision of the MDT, but it's right, isn't it, you, as
16 the Responsible Clinician are the relevant individual
17 who has made the decision and discharged VC from his
18 section, Section 3, and we see there confirmation of
19 that: "As responsible clinician ..." That it's you, on
20 18 October, that makes that decision significantly to
21 change VC from a patient detained for treatment to
22 become an informal patient on --
23 **A.** That's right, yes.
24 **Q.** -- 18 October. So whilst you sought to say well, you're
25 just part of a Multi-Disciplinary Team, when you're

1 making this decision pursuant to section 172 of the
2 Mental Health Act, you have to satisfy yourself in
3 respect of those statutory criteria; would you agree?
4 **A.** Yes.
5 **Q.** So you do have a significant responsibility for that
6 decision; would you agree?
7 **A.** Oh, I agree, yes.
8 **Q.** Would you agree also that you had had provided to you
9 the last Section 3 consideration from 24 September that
10 had made absolutely clear, from the assessment that took
11 place at Cygnet, that VC had told the treating team he
12 would not comply with his medication in the community
13 when discharged?
14 **A.** My understanding is that his views changed and his views
15 are likely to change --
16 **Q.** Well, you say that, but that's not documented anywhere.
17 **A.** Sorry, in terms of?
18 **Q.** You say that, but bearing in mind this was the
19 opportunity, VC is on a Section 3, where he can be
20 discharged on a Community Treatment Order with a power
21 of recall, whilst subject to the Section 3, and there's
22 significant information in the Mental Health Act
23 Assessment that took place at Cygnet that placed him on
24 the Section 3 that from VC saying, "I take medication
25 when I'm in hospital but I won't take it when I'm in the

1 community."
2 **A.** Yes.
3 **Q.** And so let's just look at your entry, please, in the
4 records that you did make when you reduced VC to an
5 informal patient. It's PAGR, however many zeros, 25 at
6 page 3. So PAGR, thank you.
7 So we can see the entry there, your entry. So
8 18 October, "Revocation of section 3".
9 Thank you, just a little higher.
10 "[VC] was reviewed in his room this afternoon.
11 "He was working on his computer.
12 "[He] reported he's found a private accommodation
13 close to his university and that it is available to move
14 on.
15 "Advised that his section 3 will be rescinded from
16 today at 16:00 -- paper work completed."
17 "He was advised to secure the property and discussed
18 possible discharge plans on Thursday."
19 Where is your recording about the statutory
20 criteria? Where do you address mental disorder? Where
21 do you address the nature and degree of that mental
22 disorder? Where do you address the issue of appropriate
23 medical treatment? Where do you address risk to members
24 of the public or risk to VC, to justify your decision to
25 discharge VC from the Section 3?

1 **A.** Yes, I agree, I should have explained my assessment
2 there. The -- I mean this section rescinding decision
3 was based on my MDT review on the 14th. I was prepared
4 to rescind this section on that date, and I carried out
5 the assessment, and then I thought okay, let's trial the
6 weekend as well, let's see how he does with leave, and
7 medication compliance, and then I'll review him back on
8 Monday. And that's when I decide, well things have gone
9 well as expected, as planned, and there was no reason
10 for me to justify continuing the detention any longer.
11 **Q.** But in the -- let's then look at the last risk
12 assessment because you didn't complete a risk assessment
13 on discharge and we'll look at a document in the --
14 **A.** Sorry what does that mean? That's wrong.
15 **Q.** Pardon?
16 **A.** I have completed a risk assessment on the last --
17 **Q.** I'm going to take you to the last, the 21st, the one we
18 do have for 21 October before VC actually left. Please,
19 if we could go back to that: PAGR0000012.
20 You've already been taken to this document, so
21 I just want to focus on the significant aspect, please,
22 on page 2. We've still got recorded on this document
23 "doesn't agree with his diagnosis".
24 "[He] has no support network in Nottingham.
25 ,Unclear whether there's another resident in the

1 flat, [VC] has been reluctant to discuss anything in
2 detail ..."
3 **A.** Sorry, which part are you referring to, sorry?
4 **Q.** I'm on page 2.
5 **A.** That's historical, you know, risk evidence. That's
6 there.
7 **Q.** But again, there's -- this is saying he's been reluctant
8 to discuss anything in detail, and certainly you've not
9 documented in any of the entries that VC now has
10 insight, that he's addressed the issues of risk factor
11 that led to his detention.
12 **A.** So that's actually covered in that ward round so that's
13 what I'm saying. So you're referring to the 21st, which
14 is the discharge --
15 **Q.** So this is the last risk assessment document we have for
16 the 21 October -- *(overspeaking)* --
17 **A.** Yes, so there was a MDT review on that date, so that's
18 when we discuss his presentation.
19 **Q.** So you're saying we need to go to the clinical entries
20 to look for the justification?
21 **A.** In terms of discharge on that date?
22 **Q.** Yes.
23 **A.** Yes, so that's captured in the MDT review.
24 **Q.** Well, I'm going to suggest to you that your risk
25 assessment was woefully inadequate in the circumstances

1 of the consistent risk information that was available.
2 So then can we look at the discharge, because where
3 in fact was VC discharged to? Because the Priory
4 provided two different addresses. So let's just look
5 first of all at NHFT0000066. So this the "Patient
6 transfer and discharge checklist". That was completed
7 on 27 October. Patient address, 278 Queens Road,
8 Beeston.
9 This document then suggests there should be a
10 "Current risk assessment (updated at discharge)", and
11 the person completing this was not able to say yes, no,
12 or not applicable. And if we move down, please, if we
13 just show the page. Thank you, again. So that was the
14 notification that went, that has an address for VC,
15 which is consistent, if we just then look, please -- and
16 perhaps let's just look there before we pull off here,
17 "Follow-up arrangements ... date of planned NHS Team
18 contact ...and/or Priory outpatient and/or Priory Day
19 Care appointment".
20 Absolutely nothing by way of follow-up appointments;
21 would you agree?
22 **A.** Sorry, if you could repeat that.
23 **Q.** This is the transfer that goes, that gives his address
24 and we see at the top a different address to that that
25 we'll look at in your entries of 278 Queens Road,

1 Beeston.
2 **A.** Mm-hm.
3 **Q.** This patient transfer and discharge checklist is also
4 supposed to include the relevant information as to
5 follow-up. If we just go back down, please, the page,
6 and again, absolutely absent on follow-up arrangements,
7 which is what's required for a safe discharge of
8 a patient back into the community.
9 **A.** Yes, so that's -- this is an audit carried out by --
10 **Q.** That isn't the audit document. I'm going to take you to
11 the audit document, this is the patient transfer.
12 **A.** So this is an audit document carried out by an admin
13 staff member to confirm what they have done and what
14 they have not done.
15 **Q.** Well, let's look at the audit document, then, before
16 I take you into the medical records. PAGR0000163.
17 **A.** Yeah.
18 **Q.** This is the audit discharge tool.
19 **A.** Mm-hm.
20 **Q.** We can see from this, the auditing, as in this is the
21 person who is supposed to check that the Priory have
22 done everything that they should have done:
23 "Phone call was made to discharge to Crisis team.
24 "Yes."
25 We'll come on to show that did not take place; would

1 you agree?
2 **A.** Sorry?
3 **Q.** A phone call was not made to the Crisis Team prior to
4 discharge and we'll look at that in a moment in the
5 medical records; would you agree? But notwithstanding
6 that, this audit tool said yes, it had?
7 **A.** My understanding was that a call was made, but I can't
8 confirm because I didn't do that.
9 **Q.** Then, again, if we look further down on this audit
10 document:
11 "Patient was discharged to Home address.
12 "Crisis team 72 hour follow up arrange[d]."
13 Again, we'll look together that, in fact, that is
14 not correct either; would you agree?
15 **A.** I wouldn't agree because my understanding was that
16 Crisis Team was involved -- that Crisis Team was
17 informed.
18 **Q.** That's why I'm going to suggest again that this was not
19 a safe and appropriate discharge. Would you agree that
20 this audit hasn't picked up that there are two discharge
21 addresses that appear in the notes: the Beeston address,
22 but also the address that you'd put in the note, which
23 is the address where VC went on to carry out the fourth
24 incident which was the property which we'll come on to
25 look at in your notes in a moment.

1 Did you pick up on the fact that there are two
2 different addresses for discharge for VC?
3 **A.** I have picked on while scrutinising these documents, I
4 have.
5 **Q.** You have?
6 **A.** Yes.
7 **Q.** So you can see that The Priory has had your address that
8 you've recorded in the notes, but also the different
9 address that's given that was fed to the Community Team?
10 **A.** What was fed to the Community Team? Had the correct --
11 **Q.** -- *(overspeaking)* -- Let's look at that then.
12 **A.** -- address on it.
13 **Q.** Well, who knows because nobody ever -- (overspeaking) --
14 **A.** Nobody knows because that's the address that he gives
15 us, so you mentioned that address as --
16 **Q.** It is, but who knows? Because actually a safe discharge
17 requires what should have happened was Section 17 leave
18 whilst he was on detention overnight, so it could
19 properly assess, he was ready to be discharged back to
20 the community.
21 **A.** Not necessarily. I mean, he had the option of going on
22 overnight leave, but we wouldn't have necessarily gone
23 and checked, you know, where he was going on, where he
24 was staying.
25 **Q.** So let's then look, please, at NHFT0000168, the RiOs,

1 please, at page 193.
2 **THE CHAIR:** Ms Cartwright, you're already over time.
3 **MS CARTWRIGHT:** I'll just do this and then the other address
4 just to support the two.
5 **THE CHAIR:** How long is that going to take?
6 **MS CARTWRIGHT:** Probably two minutes, please.
7 **THE CHAIR:** Right.
8 **MS CARTWRIGHT:** Thank you.
9 So this is, bottom of the page, 22 October. This is
10 the Community Team over the page. Thank you:
11 "... rang Priory ... to ascertain what happened at
12 [VC's] ward round ...
13 "[He] was discharged this morning ..."
14 We see there the new address that has been given,
15 278 Queens Road, Beeston.
16 Then this note continues to show that the Crisis
17 Team had not been contacted, they were not able to
18 essentially take on VC, and so I'm going to suggest that
19 shows there had not been a safe discharge for VC,
20 because the things that the Priory should have done
21 hadn't taken place. And just to pick up, then, that --
22 **A.** No, it doesn't give that inference because the care
23 coordinator was duly informed. She was well aware. She
24 basically contacted the ward and she was made aware that
25 the patient was going to be discharged the next day. So

1 there was a follow-up plan.
2 **Q.** To 278 Queens Road, but --
3 **A.** So that's the address that he has given when he was
4 contacted by the colleague of the care coordinator.
5 **Q.** Well, let's then go to your PAGR0000025, please, at
6 page 2 and it's also the address that's in the further
7 discharge note that the doctor completed. PAGR0000025.
8 Thank you. I think it's one more page, sorry. To
9 page 1, maybe then, please.
10 If we could just go down a little. Thank you. We
11 see -- could it just be expanded.
12 So you've recorded 22 October, VC was discharged to
13 his new flat. We've got the flat 15 Madison Court,
14 Derwent Way, which was also the address which was in the
15 broader discharge note.
16 **A.** Mm, that's the address that he gave us.
17 **Q.** But it's not the address that was placed on the transfer
18 for discharge, so there's two different addresses that
19 -- *(overspeaking)* --
20 **A.** The discharge summary, in the discharge letter, this
21 address was mentioned. That's my understanding.
22 **Q.** It was, but also there's a different address which has
23 been given on the transfer which is the address that the
24 treating team had, the Community Team. They don't get
25 that other note until much later. So essentially where

1 did VC go? Did he go to flat 15 Madison Court or did he
2 go to be Beeston Road?
3 **A.** We wouldn't know. I mean, he had the option of going
4 anywhere he wants when he's discharged, right, but he
5 had a contactable telephone number and he did respond
6 when I contacted him. So he was contactable, and he was
7 willing to engage, and my assessment was that he was
8 engaging.
9 **MS CARTWRIGHT:** Thank you.
10 Thank you for allowing me extra time.
11 **THE CHAIR:** Mr Straw.
12 **Questioned by MR STRAW**
13 **MR STRAW:** Dr Gurusinghe, I represent VC's family.
14 I'd like to ask first about VC's mother, Celeste
15 Calocane. Did VC decline consent to invite Celeste to
16 attend MDT ward rounds?
17 **A.** That's correct, yes.
18 **Q.** So presumably, because of that, you didn't invite her?
19 **A.** We couldn't invite her.
20 **Q.** Did VC also ask you or someone else in the team that
21 you, the Responsible Clinician, don't contact his
22 mother?
23 **A.** That's correct.
24 **Q.** So again presumably you didn't contact his mother
25 because of that?

1 **A.** No, I did contact the mother.
2 **Q.** You did?
3 **A.** Yes.
4 **Q.** When did you do that?
5 **A.** I can't recollect exactly. That I, you know, accept
6 that it was an omission, but if you can -- you can
7 corroborate that with VC's mother whether I have
8 contacted her or not, because I did phone her. I tried
9 twice or thrice, it was difficult, but I managed to
10 speak to her and had a conversation with her and
11 obtained background information.
12 **Q.** But if he'd said he didn't want you to contact his
13 mother --
14 **A.** Yes, I mean --
15 **Q.** -- why, then, did you contact her?
16 **A.** Yes, so patients can decline consent to share
17 information. It doesn't prevent us contacting and
18 obtaining information.
19 **Q.** But you'd agreed with me -- well, you'd said earlier
20 that VC had declined consent for you to contact his
21 mother?
22 **A.** What I implied there was sharing information rather than
23 contacting. But it's still -- I mean even if he
24 declines consent to contact, I can still contact and
25 obtain information.

1 **Q.** And you've accepted just now there's no note of you
2 doing that.
3 **A.** Yes.
4 **Q.** You would have made a note, wouldn't you, if you had
5 contacted --
6 **A.** I would have, because I think it was out of hours,
7 possibly from home, I may have. But as I said, you can
8 always corroborate that with VC's mum whether I have
9 contacted or not.
10 **Q.** She doesn't remember you doing that. Do you think you
11 might be mistaken?
12 **A.** Well, I mean there's nothing for me to prove, but this
13 is my -- I mean I have sworn under oath that I have, you
14 know, it's accurate, so that's all I can say if she
15 can't remember or if she's denying that. Because it was
16 following a request from her to speak to me. So I made
17 it a point to contact her.
18 **Q.** She wasn't consulted prior to discharge, was she?
19 **A.** That is correct, because he didn't want to disclose,
20 share, you know, plans. But during that conversation
21 now you're saying that, you know, she has no
22 recollection or she's, you know, denying that she was
23 contacted. I think during that conversation I remember
24 discussing about him not having a place to go to, and
25 Beacon Lodge, and imminent discharge plans, he's

1 progressing well, and all that. So I'm surprised why
2 she didn't or she cannot remember. Probably I mean
3 she's -- lots happened after that. So that may be the
4 reason. But ... I can only swear on oath that I have
5 done that. So that's all I can say.
6 **Q.** She wasn't consulted prior to the discharge and you said
7 just now the reason she wasn't consulted was because VC
8 declined consent for you to contact her; is that right?
9 **A.** No. VC declined consent to share his management, his
10 care, during that admission period.
11 **Q.** But if you're claiming now that you could contact
12 Celeste --
13 **A.** I could have said, you know, I could have contacted her
14 and said, "Well, he's discharged now", I could have.
15 **Q.** Well, why didn't you?
16 **A.** Well -- I mean I don't have -- like I mean I don't have
17 reason as to why. I mean things happen quite quickly
18 and I can't really say why I didn't or did.
19 **Q.** But this is a really important stage, isn't it? She has
20 a right, as the nearest relative, to be consulted prior
21 to discharge.
22 **A.** She has the right, but if a patient is adamant that not
23 to share any plans in terms of care, or plans with
24 somebody else, then we have to respect that request.
25 Now, in terms of her knowledge about the discharge,

1 I mean I was under the impression, and I think that was
2 pretty accurate as well, that she was in contact with VC
3 on a regular basis, and VC probably would have disclosed
4 to her that he's going to be discharged soon, or would
5 have. I can't confirm that. Because they were in
6 communication on a regular basis and she did phone the
7 ward as well. So she was talking to staff. Staff were
8 assuring that he's doing well and he's going on leave,
9 found a place and so on.
10 **Q.** But it was important, wasn't it, for you to consult her
11 for two reasons: firstly she could have given you
12 important information about his circumstances on
13 discharge; do you accept that?
14 **A.** Circumstances as in?
15 **Q.** Whether he had a safe place to go, whether he would have
16 support on discharge -- *(overspeaking)* --
17 **A.** No, I knew -- like, in terms of support, I knew that
18 mother was quite caring and she was in regular contact
19 with VC on the phone looking after him, his interests.
20 But in terms of other support, I knew that he didn't
21 have much support and that was one of the reasons that
22 I kind of decided I'm going to check on him and see
23 whether he needs any additional support, how he's
24 coping. Because if you note my records you would
25 realise that after discharging him from my care, I did

1 pick up the phone and contacted him and find out how he
2 was doing at that point.
3 **Q.** And the second reason why it was important to consult
4 her was to make her aware and ready that he was being
5 discharged. You'd accept that, wouldn't you?
6 **A.** Sorry, say that again, please?
7 **Q.** So my question is -- my last two questions have
8 been: there were two reasons why it was important for
9 you to contact her. The first was so that she could
10 give you information, and the second was so that you
11 could make her aware and ready for him to be discharged.
12 **A.** Yeah, well, one of the reasons I contact family members,
13 even if the patient don't consent, is to reassure them,
14 you know, they are -- how they are, I mean in terms of
15 like to reassure that they are being cared for.
16 **Q.** Sorry, I still don't understand your evidence here. So
17 you say that you accept you do contact patients --
18 sorry, family members even, when the patient doesn't
19 consent -- and you claim to have done so earlier in the
20 admission; why didn't you, at the point of discharge?
21 **A.** I mean I can't really give a reason as to why. So the
22 MDTs happen in such a way I won't be able to, you know,
23 pick up the phone and contact her, and she was not
24 easily contactable. Anyway, I didn't make an effort so
25 I'm not kind of trying to find excuses. For some reason

1 it didn't happen that way.
2 **Q.** Are you sure you're not trying to find excuses? She
3 was -- you say she wasn't easily contactable. In fact
4 she regularly spoke to the medical team at *(unclear),*
5 didn't she -- *(overspeaking)* --
6 **A.** That was at night, like on a regular basis at night.
7 **MR STRAW:** Okay, thank you very much, Doctor.
8 **THE CHAIR:** Yes, I just wanted to ask you just about
9 a couple of things.
10 **Questioned by THE CHAIR**
11 **THE CHAIR:** The first is that were you aware, because it's
12 in the document which is PAGR0000028 at page 2, that on
13 20 October, when he was really awaiting being
14 discharged, he had an unexplained injury to his face?
15 **A.** Ma'am, I didn't actually notice that, I saw him on the
16 ward round, so I can't really recollect whether there
17 was a plaster or whether there was any visible injury
18 there.
19 **THE CHAIR:** Well, it's there in the note, isn't it?
20 **A.** Yeah -- *(overspeaking)* --
21 **THE CHAIR:** It's MDT feedback at which you were present.
22 **A.** Yes. Yes.
23 **THE CHAIR:** It said, "He reported he'd fallen over" --
24 **A.** Yes.
25 **THE CHAIR:** -- and that he had a cut to the bridge of his

1 nose and that had occurred over the weekend, hadn't it?
2 **A.** No, my understanding is that it occurred the night
3 before so -- *(overspeaking)* --
4 **THE CHAIR:** Somehow the night before then.
5 **A.** Yeah, so my --
6 **THE CHAIR:** Before he was actually discharged?
7 **A.** Yes, so ... yes, so this is dated 20th, so this might
8 have occurred then on the 19th night, isn't it.
9 **THE CHAIR:** Well, who knows, because you didn't ask the
10 questions, did you?
11 **A.** Yeah, I mean, I didn't notice when he attended the
12 discharge meeting. He didn't have any sort of plaster
13 or anything visible, so I didn't really explore on that.
14 **THE CHAIR:** Well, it says here in the MDT feedback that he
15 accepted a plaster, so it looks like that was done --
16 **A.** So it seems like --
17 **THE CHAIR:** Just listen to my question.
18 **A.** Yes.
19 **THE CHAIR:** He accepted a plaster. So that was done, it
20 looks like it is, on the clinic, 20 October, and that
21 looks like you were present at this review, medical, if
22 we look at the previous page, there's a nurse and the
23 medical, you're named on that.
24 So before he's actually discharged, you have this
25 unexplained injury; did you ask about that?

1 **A.** No, I didn't. I mean --
2 **THE CHAIR:** Because I think you told me earlier, or told the
3 Inquiry earlier, that nothing untoward had happened on
4 his leaves prior to being discharged.
5 **A.** So, I mean, when I kind of reading this reports, my
6 understanding was that something had happened overnight
7 when he was at Priory, and he came to the Nursing
8 Station the following morning and asked for a plaster,
9 and that was given. That was my understanding. Not
10 that anything had happened in the community. If that
11 was the case, then that would have been picked up.
12 **THE CHAIR:** When he left, was he allowed access to the
13 hammer that had been put in his locker?
14 **A.** Well, so with the hammer, so if that belongs to him, so
15 whatever he brings to the hospital, if it belongs to
16 him, I mean, other than something like a sharp weapon or
17 completely inappropriate, it would have been returned
18 back to him because it's his personal property. It's in
19 his inventory and would have been given back to him.
20 **THE CHAIR:** But you didn't make -- ask any questions and you
21 didn't -- you seem to have accepted this account of
22 putting up pictures or something on the wall?
23 **A.** Yes, I agree that I haven't really explored further on
24 to that. He's given an explanation. We discussed among
25 our team that we need to remain vigilant whether he

1 would, you know, present as paranoid. So there were no
2 evidence or indications that he went paranoid over the
3 last couple of weeks or --
4 **THE CHAIR:** He'd simply disappeared into his room, hadn't
5 he, largely?
6 **A.** Not necessarily. I mean, he did attend for his meals on
7 a regular basis most times. He did attend to the clinic
8 to receive his medications. So he was visible.
9 **THE CHAIR:** Yes. All right, thank you.
10 **THE WITNESS:** Thank you.
11 **THE CHAIR:** Right, we'll finish there and we'll start again
12 tomorrow morning at 10.00.
13 **(4.44 pm)**
14 **(The hearing adjourned until 10.00 am the following day)**
15
16
17
18
19
20
21
22
23
24
25

1 I N D E X

2 Page
3 DR AJITH INDRAN GURUSINGHE (sworn) 1
4 Questioned by MR CARR 1
5 Questioned by MR CARR 1
6 Questioned by MR MOLONEY 67
7 Questioned by MS CARTWRIGHT 73
8 Questioned by MR STRAW 84
9 Questioned by THE CHAIR 90

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

MR CARR: [5] 1/4 1/9 50/20 51/1 67/16
MR MOLONEY: [2] 67/20 73/7
MR STRAW: [2] 84/13 90/7
MS CARTWRIGHT: [5] 73/10 82/3 82/6 82/8 84/9
THE CHAIR: [28] 1/3 1/8 50/19 50/21 67/17 73/8 82/2 82/5 82/7 84/11 90/8 90/11 90/19 90/21 90/23 90/25 91/4 91/6 91/9 91/14 91/17 91/19 92/2 92/12 92/20 93/4 93/9 93/11
THE WITNESS: [1] 93/10

'

'hospital [1] 43/14
'multiple [1] 71/4
'possibly' [1] 34/25
'wouldn't [1] 33/21

,

,Unclear [1] 76/25

.

...and [1] 78/18
...and/or [1] 78/18

1

1 October [1] 2/12
1 October 2021 [1] 43/8
10 [1] 4/1
10.00 [2] 93/12 93/14
10th [3] 60/1 60/2 60/3
11 [4] 1/1 4/14 18/7 29/22
120 [1] 20/25
13 [1] 8/23
13 October 2021 [1] 44/17
13-month [1] 39/25
138 [1] 23/21
14 [1] 22/10
14 October [2] 56/23 59/9
145 [2] 70/23 70/25
14th [2] 57/3 76/3
15 [3] 9/7 83/13 84/1
151 [1] 71/8
15th [1] 49/5
16 [1] 9/11
164 [1] 43/4
167 [1] 24/25
16:00 [1] 75/16
16:57 [1] 44/17
17 [3] 18/21 47/8 81/17
172 [1] 74/1
18 [1] 73/24
18 October [4] 63/12 63/16 73/20 75/8
18 October 2021 [1] 2/15
193 [1] 82/1
19th [1] 91/8
1:1 [1] 44/9

2

2.19 [1] 1/2
20 October [2] 90/13 91/20
2001 [1] 11/21
2020 [4] 1/24 23/24 41/19 71/24
2021 [20] 2/4 2/15 2/17 3/23 5/23 6/4 6/7 6/21 7/21 8/7 25/2 26/23 36/7 36/18 43/8 44/17 67/21 68/12 69/20 72/17
2025 [2] 1/12 1/14
2026 [1] 1/1
206 [1] 59/18
20th [1] 91/7
21 [2] 19/17 77/16
21 October [1] 76/18
21 September [2] 28/8 28/23
21 September 2021 [1] 26/23
21st [2] 76/17 77/13
22 October [2] 82/9 83/12
22 October 2021 [1] 2/17
22nd [2] 49/6 63/14
23 September [2] 28/25 35/24
24 May [2] 17/7 17/15
24 September [1] 74/9
25 [2] 41/25 75/5
27 October [1] 78/7
278 [4] 78/7 78/25 82/15 83/2

3

3.35 [1] 50/23
3.45 [1] 50/25
3.8 [1] 11/5
39 [2] 70/24 70/25
3rd [1] 68/2

4

4.44 [1] 93/13
4th [1] 53/10

5

55 [1] 59/18
56 [1] 22/5
58 [1] 23/2

7

7 October [3] 53/8 53/14 68/11
7 October 2021 [1] 67/21
72 [1] 80/12
7th [2] 53/11 57/2

9

9.13 [1] 17/7

A

able [5] 52/3 71/4 78/11 82/17 89/22
abnormal [2] 68/3 71/3
about [37] 4/2 6/24 7/5 14/4 16/7 18/14 19/2 19/8 20/25 22/22 24/11 27/17 31/6 35/14 41/18 43/12 43/13 62/22 62/23 65/5 65/21 67/21 68/20 68/23 71/5 71/25 72/23 73/3 73/5 73/6 75/19 84/14 86/24 87/25 88/12 90/8 91/25
above [1] 29/25
absence [1] 56/12
absent [1] 79/6
absolutely [6] 13/10 33/14 70/16 74/10 78/20 79/6
accept [8] 7/18 26/2 34/10 37/3 85/5 88/13 89/5 89/17
accepted [9] 5/19 33/23 34/8 72/5 72/10 86/1 91/15 91/19 92/21
accepting [2] 34/7 36/13
accepts [1] 37/8
access [25] 4/16 5/5 11/23 12/2 12/16 12/17 12/19 12/21 12/24 13/4 13/21 14/7 14/23 15/12 15/14 15/15 15/16 15/18 15/19 15/20 15/24 16/6 17/19 31/1 92/12
accessing [2] 13/15 15/3
accommodation [3] 35/10 61/10 75/12
according [1] 50/3
accords [1] 16/24
account [3] 56/17 60/18 92/21
accurate [2] 86/14 88/2
achieve [2] 44/1 47/3
acknowledged [1] 53/23
acknowledging [3] 36/18 39/19 71/3
Act [13] 15/13 15/21 17/4 17/16 23/2 25/1 34/20 35/11 35/25 58/6 72/5 74/2 74/22
acted [1] 53/23
acting [2] 19/10 19/11
action [5] 6/1 6/2 6/11 6/11 6/16
activities [7] 47/19 47/22 48/22 49/4 55/23 57/21 64/3
activity [2] 7/25 49/1
actual [1] 20/2
actually [12] 8/2 14/14 34/9 47/25 63/14 69/22 76/18 77/12 81/16 90/15 91/6 91/24
acute [1] 32/8
adamant [1] 87/22
addition [1] 28/7
additional [6] 22/20 29/8 29/10 41/6 41/11 88/23
address [32] 5/23 5/24 6/8 38/12 53/1 75/20 75/21 75/22 75/23 78/7 78/14 78/23 78/24 80/11 80/21 80/22 80/23 81/7 81/9 81/12 81/14 81/15 82/3 82/14 83/3 83/6 83/14 83/16 83/17 83/21 83/22 83/23
addressed [1] 77/10
addresses [4] 78/4 80/21 81/2 83/18
adequate [4] 16/15 28/2 32/23 58/3
adherence [2] 51/19 56/2
adjourned [1] 93/14
admin [1] 79/12
administering [1] 67/14
administrator [2] 15/14 15/22
admins [2] 15/13 15/21
admission [44] 2/6 2/9 3/6 3/24 5/22 8/8 11/1 11/3 17/16 18/8 18/22 19/17 22/7 23/3 24/3 25/6 27/3 28/22 29/2 29/5 29/7 29/12 40/24 40/25 41/4 41/11 41/23 42/3 42/6 43/7 43/8 43/12 43/18 46/19 49/3 49/17 53/21 61/2 63/17 64/13 65/4 71/24 87/10 89/20
admissions [1] 52/24
admit [2] 63/6 68/2
admitted [9] 6/6 9/21 10/16 10/16 11/13 19/19 22/6 28/4 59/25
admitting [2] 10/7 24/13
advised [3] 40/16 75/15 75/17
after [11] 23/6 30/5 30/5 30/15 31/15 47/17 59/13 60/2 87/3 88/19 88/25
afternoon [4] 1/4 73/10 73/11 75/10
again [28] 4/9 4/19 8/15 9/2 19/5 19/17 22/6 29/24 30/1 30/23 33/16 37/19 39/23 46/5 47/2 47/21 56/16 58/23 64/21 77/7 78/13 79/6 80/9 80/13 80/18 84/24 89/6 93/11
against [2] 39/18 67/15
agencies [1] 40/22
aggression [2] 56/9 64/10
aggressive [4] 51/17 52/1 56/3 62/25
ago [1] 20/25
agree [35] 5/10 20/19 26/12 26/15 27/24 28/1 38/7 43/19 44/14 52/16 53/17 53/22 53/24 54/11 55/24 60/12 62/3 63/24 66/19 68/16 70/15 72/12 74/3 74/6 74/7 74/8 76/1 76/23 78/21 80/1 80/5 80/14 80/15 80/19 92/23
agreed [2] 57/16 85/19
aims [1] 49/25
Ajith [3] 1/5 1/6 94/3
alienate [1] 55/14
align [1] 55/18
alive [1] 7/11
all [24] 6/18 10/16 12/19 13/6 21/15 21/20 22/3 22/25 29/5 33/9 42/7 42/9 47/16 48/23 50/21 51/9 63/24 66/9 68/22 78/5 86/14 87/1 87/5 93/9
allowed [3] 56/24 57/1 92/12
allowing [1] 84/10
almost [1] 44/20
already [6] 16/15 21/22 50/2 67/23 76/20 82/2
also [16] 8/19 22/14 28/7 28/12 34/15 38/1

A

also... [10] 59/13 72/4 74/8 79/3 80/22 81/8 83/6 83/14 83/22 84/20
altercation [2] 43/13 43/20
alternative [2] 61/9 71/6
although [2] 39/18 58/9
always [6] 3/15 4/6 9/14 50/8 73/5 86/8
am [2] 67/6 93/14
ambulance [1] 17/12
AMHP [1] 40/4
among [2] 51/9 92/24
amongst [2] 10/4 10/12
amount [1] 34/2
angry [1] 19/2
another [14] 4/19 6/23 8/5 17/3 17/9 17/19 18/11 18/21 33/8 45/25 46/6 53/11 56/23 76/25
answer [2] 16/18 41/14
answered [1] 25/15
antipsychotic [2] 30/7 38/5
any [44] 5/11 5/22 6/16 11/8 13/8 13/15 16/13 21/22 29/6 29/10 36/5 37/7 41/2 41/3 41/11 41/17 43/3 46/19 48/23 49/10 49/11 49/16 52/16 55/7 62/23 63/3 63/5 63/8 64/1 64/3 64/9 64/10 64/18 65/21 69/4 69/7 69/15 76/10 77/9 87/23 88/23 90/17 91/12 92/20
anyone [1] 63/8
anything [6] 16/17 69/17 77/1 77/8 91/13 92/10
Anyway [1] 89/24
anywhere [3] 25/17 74/16 84/4
apart [2] 6/16 42/8
appear [1] 80/21
appears [4] 5/8 32/10 36/10 45/13
applicable [1] 78/12
application [1] 35/21
applies [1] 42/7
apply [3] 10/4 10/5 42/12
appointment [3] 23/21 23/24 78/19
appointments [2] 33/20 78/20
appreciation [1] 71/20
apprehended [1] 42/15
approach [2] 3/20 9/4
appropriate [3] 50/20 75/22 80/19
are [45] 1/16 3/15 6/1 6/10 7/13 10/23 14/13 14/14 18/18 20/21 21/4 21/6 21/17 21/17 28/23 32/3 32/14 33/3 41/8 46/14 46/23 47/20 48/11 51/5 51/5 53/15 54/18 55/13 55/19 62/24 64/22 66/10 67/16 69/23 71/23 72/2 73/16 74/15 77/3 80/20 81/1 89/14 89/14 89/15 90/2
areas [1] 27/21
aren't [4] 21/4 32/4 48/11 51/5
aripiprazole [12] 54/5 54/7 57/1 57/6 68/4 68/5 69/1 69/10 71/12 71/25 72/24 72/25
Arnold [8] 1/25 3/6 6/19 7/2 7/19 9/22 31/16 32/8
around [2] 7/14 31/16
arrange [1] 80/12
arranged [1] 35/10
arrangements [2] 78/17 79/6
arrested [1] 17/3
as [93] 1/19 2/11 3/2 3/3 3/19 4/19 5/8 5/21 6/2 9/3 9/21 9/25 10/3 11/12 11/17 11/18 13/12 13/18 19/11 22/9 25/23 25/24 26/7 26/21 30/17 32/7 32/8 32/11 37/17 38/21 38/21 40/16 40/20 41/5 41/5 41/7 42/2 42/3 42/22 43/20 44/24 45/20 48/25 48/25 49/19 49/19 49/25 50/11 50/16 50/16 51/3 51/8 51/22 53/8 55/25 57/21 59/21 61/24 62/1 62/14 62/14 63/7 63/16 64/19 64/19 65/10 65/13 66/5 66/19 68/8 69/15 70/16 70/18 70/22 71/4 71/6 71/11 73/15 73/19 76/6 76/9 76/9 79/4 79/20 81/15 86/7 87/17 87/20 88/2 88/7 88/14 89/21 93/1
ascertain [1] 82/11
ask [14] 14/18 41/3 41/6 41/8 41/11 67/20 68/25 73/12 84/14 84/20 90/8 91/9 91/25 92/20
asked [3] 18/14 70/10 92/8
asking [5] 6/4 14/14 15/8 54/18 69/23
aspect [1] 76/21
aspects [2] 32/3 32/15
assertion [1] 25/16
assess [3] 3/15 65/4 81/19
assessing [1] 28/14
assessment [46] 3/20 8/25 9/4 17/4 17/16 23/3 23/5 25/1 25/5 28/8 28/13 28/17 28/20 34/20 35/12 35/25 38/16 39/2 42/3 51/14 51/14 53/4 53/7 53/12 55/25 56/17 58/6 62/7 62/9 62/11 62/20 62/21 63/2 65/5 72/5 74/10 74/23 76/1 76/5 76/12 76/12 76/16 77/15 77/25 78/10 84/7
assessments [7] 29/1 42/8 52/12 52/16 52/25 59/1 65/12
assistant [1] 7/25
assuring [1] 88/8
at [147]
attack [1] 25/19
attend [4] 47/19 84/16 93/6 93/7
attended [4] 33/20 50/18 59/10 91/11
attending [2] 47/15 50/5
attributed [1] 58/2
audit [9] 79/9 79/10 79/11 79/12 79/15 79/18 80/6 80/9 80/20
auditing [1] 79/20
auditory [1] 68/2
August [4] 36/7 36/18 52/8 72/17
August 2021 [2] 36/18 72/17
available [8] 10/25 16/23 33/7 35/10 67/4 67/7 75/13 78/1
awaiting [1] 90/13
aware [18] 17/20 21/22 22/6 22/9 27/12 27/14 65/16 67/6 67/9 71/23 72/2 72/4 72/7 82/23 82/24 89/4 89/11 90/11
away [4] 25/22 35/9 68/4 69/1

B

back [27] 2/18 2/22 10/19 17/11 17/12 18/5 18/5 19/25 21/13 24/3 33/2 40/10 47/10 47/25 54/5 57/25 62/13 68/5 72/7 72/22 76/7 76/19 79/5 79/8 81/19 92/18 92/19
background [3] 1/19 43/11 85/11
bag [1] 40/9
banging [1] 22/10
based [4] 64/18 69/23 69/24 76/3
basically [5] 24/15 47/10 47/10 54/24 82/24
basis [11] 16/8 31/20 32/8 34/7 39/13 51/21 56/6 88/3 88/6 90/6 93/7
be [63] 3/22 5/3 6/24 11/7 13/1 15/10 15/11 18/9 18/10 18/16 18/20 22/12 29/13 30/5 30/7 30/19 30/20 31/6 31/11 32/7 32/9 32/11 33/6 33/10 34/1 34/4 34/15 36/10 38/18 44/23 45/13 50/20 52/3 54/4 57/15 59/8 60/23 61/24 62/14 63/7 63/20 66/11 68/5 70/7 70/12 71/4 72/24 73/1 73/3 73/13 74/19 75/15 78/9 81/19 82/25 83/11 84/2 86/11 87/3 87/20 88/4 89/11 89/22
Beacon [1] 86/25
bearing [1] 74/18
became [3] 14/6 19/2 26/5
because [65] 3/1 3/9 8/1 12/16 15/24 18/2 18/10 21/4 24/6 24/10 24/15 32/15 33/12 36/20 37/9 38/2 38/2 38/14 39/7 39/9 39/10 40/12 40/14 41/2 41/3 41/13 41/14 45/1 47/23 48/6 48/23 51/22 54/5 55/17 58/7 58/23 61/13 61/18 70/2 70/4 70/9 73/14 76/12 78/2 78/3 80/8 80/15 81/13 81/14 81/16 82/20 82/22 84/18 84/25 85/8 86/6 86/15 86/19 87/7 88/5 88/24 90/11 91/9 92/2 92/18
become [3] 52/25 54/8 73/22
becoming [5] 26/8 26/11 52/21 64/23 65/2
been [68] 1/24 3/9 5/14 5/22 6/7 6/12 6/17 11/13 17/15 17/21 18/24 19/21 20/3 20/5 22/6 22/23 22/25 23/11 24/10 25/2 27/6 29/20 34/5 36/25 39/17 42/3 42/5 42/17 43/2 43/9 44/2 48/22 49/1 51/3 54/8 55/23 55/24 56/7 56/24 58/16 60/9 60/10 60/13 60/14 60/17 61/25 62/1 63/1 63/6 63/6 63/9 64/21 65/10 65/11 65/16 67/23 69/2 76/20 77/1 77/7 82/14 82/17 82/19 83/23 92/11 92/13 92/17 92/19
been: [1] 89/8
been: there [1] 89/8
Beeston [5] 78/8 79/1 80/21 82/15 84/2
before [27] 10/7 20/11 24/2 26/4 26/7 26/17 26/17 28/4 30/2 33/2 33/17 35/11 51/1 52/23 68/14 69/20 72/8 72/9 72/19 73/2 76/18 78/16 79/15 91/3 91/4 91/6 91/24
behalf [3] 10/20 12/9 73/12
behaviour [5] 42/4 51/18 56/3 56/10 62/25
behaviours [1] 7/15
being [25] 3/15 3/18 4/22 17/3 18/11 24/6 24/10 25/9 30/17 32/6 33/2 40/10 43/15 45/19 59/13 64/19 66/15 66/20 66/21 68/19 71/4 89/4 89/15 90/13 92/4
belief [1] 1/17
beliefs [2] 36/24 68/3
believe [4] 54/2 69/21 69/21 71/10
belongs [2] 92/14 92/15
benefit [1] 37/10
benefits [4] 48/11 48/13 66/15 66/21
best [1] 1/16
better [2] 31/22 38/23
between [4] 5/20 9/20 68/9 69/10
Birtles [4] 27/1 33/17 59/11 60/15

B

bit [1] 13/24
bits [1] 7/23
books [1] 61/4
both [2] 28/23 51/20
bother [1] 72/22
bottom [7] 3/14 8/24 9/7 26/24 44/7 52/2 82/9
box [2] 44/4 50/1
break [6] 20/21 50/19 50/21 50/24 51/1 52/23
bridge [1] 90/25
brief [2] 13/20 45/13
bring [2] 61/3 72/15
brings [1] 92/15
broader [1] 83/15
broadly [1] 3/3
brought [2] 42/16 59/14
brutal [1] 25/19
build [2] 66/14 71/16
built [1] 66/17
Burri [2] 23/22 23/22
busy [2] 48/4 48/21
but [100]

C

cables [1] 61/5
call [5] 1/4 57/3 79/23 80/3 80/7
calm [3] 25/9 25/23 26/7
Calocane [1] 84/15
came [2] 59/13 92/7
can [58] 3/12 3/14 3/17 4/2 6/23 7/5 8/4 8/11 8/14 8/24 11/1 16/20 17/1 17/8 18/13 20/21 25/8 25/23 26/2 26/16 26/24 27/17 28/10 29/24 30/9 30/19 30/19 31/11 34/18 35/15 38/21 42/13 43/4 43/10 44/15 44/17 47/19 50/7 51/12 56/1 62/14 64/19 70/16 70/23 73/12 74/19 75/7 78/2 79/20 81/7 85/6 85/6 85/16 85/24 86/7 86/14 87/4 87/5
can't [15] 6/9 30/9 33/7 54/2 67/12 69/8 69/22 70/8 80/7 85/5 86/15 87/18 88/5 89/21 90/16
cannot [8] 4/25 6/14 16/16 19/23 44/24 60/16 69/7 87/2
capable [2] 26/1 38/17
capital [2] 18/15 18/18
capture [1] 48/24
captured [2] 29/4 77/23
care [38] 2/3 4/17 5/6 16/25 27/1 28/15 29/3 30/10 32/7 32/17 33/16 34/6 39/13 40/3 43/5 43/6 43/9 45/25 46/1 46/2 46/2 46/6 46/7 46/9 46/12 46/14 46/22 47/1 51/12 58/12 59/10 66/17 78/19 82/22 83/4 87/10 87/23 88/25
cared [1] 89/15
caring [4] 23/19 24/25 40/7 88/18
Carr [6] 1/3 1/7 50/19 67/23 94/4 94/5
carried [7] 27/16 43/6 51/14 55/25 76/4 79/9 79/12
carry [2] 65/11 80/23
Cartwright [4] 73/8 73/9 82/2 94/7
case [8] 8/3 13/4 14/18 22/1 24/5 39/12 64/14 92/11
cause [1] 5/14
Celeste [3] 84/14 84/15 87/12
centred [1] 7/14
certain [8] 9/23 10/2 10/9 27/21 40/18 53/22 54/10 68/13
certainly [3] 35/2 61/23 77/8
Chair [4] 1/4 67/16 90/10 94/9
challenge [4] 54/1 61/16 61/17 61/21
challenging [2] 61/20 61/23
chances [1] 31/22
change [9] 46/3 46/13 46/25 46/25 58/4 62/19 71/11 73/21 74/15
changed [4] 46/15 63/16 63/25 74/14
changes [2] 46/23 46/24
changing [1] 58/8
charging [1] 61/5
check [3] 72/22 79/21 88/22
checked [1] 81/23
checklist [3] 10/12 78/6 79/3
choice [3] 37/9 38/3 38/15
chosen [1] 40/16
chronology [1] 45/6
circumstances [10] 22/9 42/1 42/6 43/18 53/21 58/5 68/21 77/25 88/12 88/14
claim [1] 89/19
claiming [1] 87/11
classic [2] 21/6 22/1
Claudia [3] 26/25 33/16 59/10
clear [10] 3/22 22/23 23/5 23/9 29/13 36/12 38/16 41/7 59/24 74/10
clearly [1] 37/2
clinic [3] 50/18 91/20 93/7
clinical [2] 22/4 77/19
clinician [7] 2/7 13/13 66/6 69/16 73/16 73/19 84/21
close [1] 75/13
closely [1] 10/1
closer [1] 31/12
collaborative [1] 69/24
colleague [1] 83/4
come [7] 21/5 47/16 54/5 62/13 68/5 79/25 80/24
comes [1] 44/20
commenced [1] 57/2
comment [5] 4/25 5/9 5/17 44/24 69/9
comments [3] 7/8 18/23 34/18
commitment [2] 38/4 38/5
common [2] 55/11 67/11
communality [1] 59/23
communicate [1] 60/15
communicated [1] 60/16
communicating [1] 16/7
communication [1] 88/6
communications [1] 19/21
community [37] 2/18 2/22 23/22 27/12 28/21 32/12 33/3 33/13 33/16 35/8 39/12 42/16 47/6 52/22 53/3 53/5 58/10 59/4 61/3 64/24 65/2 66/16 67/1 67/7 67/13 71/23 72/17 74/12 74/20 75/1 79/8 81/9 81/10 81/20 82/10 83/24 92/10
compare [1] 34/19
comparing [1] 9/17
complaining [3] 17/12 69/4 69/19
complete [7] 27/19 27/25 36/8 36/15 37/14 43/10 76/12
completed [6] 9/24 53/7 75/16 76/16 78/6 83/7
completely [4] 27/22 30/1 37/24 92/17
completing [1] 78/11
compliance [5] 27/5 59/3 64/12 73/5 76/7
compliant [4] 50/13 50/14 52/22 57/24
complied [1] 64/13
complies [1] 31/25
comply [3] 50/3 51/2 74/12
complying [2] 38/1 50/5
computer [2] 42/19 75/11
concern [7] 3/18 5/14 5/19 18/17 18/20 33/18 38/13
concerned [5] 2/12 25/6 31/6 40/12 51/22
concerns [9] 3/9 3/12 4/9 5/23 5/25 6/8 6/16 9/2 71/5
conclude [1] 22/24
concluded [1] 36/21
concludes [2] 27/19 27/23
concordance [4] 53/2 58/15 65/13 71/17
concordant [13] 22/18 22/19 22/21 22/24 22/25 23/9 26/11 52/25 54/9 59/8 64/23 65/2 72/25
condition [4] 26/17 30/20 38/24 67/12
conditions [1] 67/2
confidence [1] 70/21
confirm [5] 6/14 69/22 79/13 80/8 88/5
confirmation [1] 73/18
confused [1] 21/18
Connected [3] 46/1 46/7 47/1
connection [1] 42/4
conscious [2] 38/8 38/9
consent [11] 10/6 10/14 30/18 84/15 85/16 85/20 85/24 87/8 87/9 89/13 89/19
consider [6] 18/10 25/3 27/8 33/5 52/12 71/3
consideration [1] 74/9
considered [5] 27/6 27/13 30/5 30/7 41/14
considering [5] 27/13 30/12 30/15 57/7 65/17
consistent [2] 78/1 78/15
consult [2] 88/10 89/3
consultant [7] 1/20 18/11 19/18 23/23 31/4 51/6 66/6
consultant's [1] 63/24
consultants [1] 19/19
consulted [4] 86/18 87/6 87/7 87/20
contact [22] 27/4 37/13 41/1 42/21 78/18 84/21 84/24 85/1 85/12 85/15 85/20 85/24 85/24 86/17 87/8 87/11 88/2 88/18 89/9 89/12 89/17 89/23
contactable [4] 84/5 84/6 89/24 90/3
contacted [10] 82/17 82/24 83/4 84/6 85/8 86/5 86/9 86/23 87/13 89/1
contacting [2] 85/17 85/23
contain [1] 21/21
containing [1] 7/15
context [2] 30/17 70/25
continue [2] 35/7 71/15
continued [1] 39/20
continues [2] 55/3 82/16
continuing [1] 76/10
contract [1] 10/19
conversation [4] 69/8 85/10 86/20 86/23
conversations [1] 35/1
conversion [1] 30/16
convert [1] 30/11
converted [1] 36/2
convince [1] 66/14
convinced [1] 58/13
coordinator [10] 7/25 27/1 33/16 34/6 39/13 40/3 59/10 66/17 82/23 83/4
coordinator's [1] 58/12
coping [1] 88/24
copy [1] 28/8
correct [71] 1/11 1/13 1/21 1/23 2/1 2/8 2/16 2/19 2/24 3/5 3/8 3/11 3/25 4/21 5/23 6/20 6/22 8/17 10/8 10/11 10/15 10/19

C

correct... [49] 10/22 11/11 11/16 11/19 12/3 12/7 12/12 12/14 12/23 13/14 17/18 18/12 22/8 24/20 25/21 26/6 26/20 28/6 28/16 29/15 31/18 32/5 32/20 35/23 43/17 43/23 44/22 45/15 46/11 48/7 48/10 52/5 56/13 57/9 58/18 58/20 58/25 59/12 60/1 61/11 63/13 63/15 65/23 68/10 80/14 81/10 84/17 84/23 86/19
corroborate [2] 85/7 86/8
corroborated [1] 69/6
could [36] 3/13 11/25 12/10 12/10 12/19 13/8 22/19 22/24 24/10 24/15 26/7 26/13 34/1 34/15 36/24 39/24 46/5 60/22 66/22 66/25 67/21 67/22 67/25 71/8 76/19 78/22 81/18 83/10 83/11 87/11 87/13 87/13 87/14 88/11 89/9 89/11
couldn't [2] 66/23 84/19
couple [3] 30/2 90/9 93/3
course [13] 19/22 20/11 30/19 31/15 40/1 42/7 46/3 48/12 68/13 69/12 70/3 70/4 70/4
Court [2] 83/13 84/1
covered [1] 77/12
CQC [12] 3/7 3/10 5/21 6/12 6/17 8/5 8/18 9/23 10/3 10/6 10/10 10/14
CQC's [1] 40/20
CQCM0016484 [1] 3/13
CQCM0019689 [1] 8/4
created [1] 47/7
cricket [1] 49/5
criminal [1] 42/4
Crisis [6] 79/23 80/3 80/12 80/16 80/16 82/16
criteria [2] 74/3 75/20
criticisms [1] 9/18
CTO [3] 2/23 30/19 67/1
current [6] 28/22 51/19 51/20 51/24 57/10 78/10
currently [2] 17/11 51/23
custodial [1] 42/17
custody [1] 42/17
cut [1] 90/25
Cygnet [14] 2/3 2/3 26/19 26/22 28/8 28/24 29/1 29/18 31/4 36/1 42/9 65/18 74/11 74/23

D

date [7] 28/7 52/9 55/25 76/4 77/17 77/21 78/17
dated [3] 1/12 1/14 91/7
dates [3] 8/7 8/8 52/7
dating [1] 40/10
day [5] 35/9 35/24 78/18 82/25 93/14
days [7] 2/17 30/2 31/13 40/18 53/14 56/14 59/13
deal [4] 3/1 12/20 34/13 59/17
dealing [1] 26/16
dealt [1] 30/10
death [1] 9/25
deceive [1] 26/13
deceived [1] 24/13
December [2] 1/14 8/7
December 2021 [1] 8/7
December 2025 [1] 1/14
deception [1] 37/19
decide [2] 63/11 76/8
decided [2] 23/5 88/22
decision [11] 35/13 69/23 69/24 72/13 73/15 73/17 73/20 74/1 74/6 75/24 76/2
decline [3] 48/20 84/15 85/16
declined [6] 48/19 48/20 49/7 85/20 87/8 87/9
declines [1] 85/24
degree [5] 42/9 53/22 57/25 58/14 75/21
deluded [2] 19/15 19/16
demonstrate [2] 57/24 58/8
demonstrated [1] 58/3
denial [2] 34/16 39/19
denying [2] 86/15 86/22
depot [21] 2/23 27/6 27/13 30/7 30/12 30/15 30/19 32/2 32/21 32/23 65/17 65/19 65/22 66/4 66/11 66/15 66/19 66/22 67/1 67/13 67/15
Derwent [1] 83/14
describe [2] 25/19 42/2
described [2] 3/18 27/25
describing [2] 27/2 43/20
description [4] 26/25 28/3 43/11 43/17
despite [2] 57/10 65/19
destructive [1] 7/15
detail [3] 67/24 77/2 77/8
details [2] 11/9 68/22
detained [10] 30/8 33/6 33/10 58/16 60/24 60/25 61/1 63/21 64/7 73/21
detaining [1] 64/17
detected [1] 59/22
detention [16] 2/13 2/13 30/11 31/20 32/9 36/2 40/6 40/7 51/9 63/11 66/20 66/21 66/23 76/10 77/11 81/18
diagnosis [4] 29/24 34/10 34/13 76/23
did [97]
didn't [57] 8/19 11/1 15/16 16/6 26/19 27/3 29/6 29/8 29/10 34/2 46/2 46/4 46/12 49/19 49/23 49/24 54/11 54/13 54/18 54/20 55/6 58/23 61/6 61/7 61/14 61/16 61/17 61/23 62/7 63/25 64/1 64/2 64/3 64/5 70/19 76/12 80/8 84/18 84/24 85/12 86/19 87/2 87/15 87/18 88/20 89/20 89/24 90/1 90/5 90/15 91/9 91/11 91/12 91/13 92/1 92/20 92/21
difference [1] 69/10
different [14] 32/3 32/15 33/9 37/24 49/13 51/10 69/14 69/14 78/4 78/24 81/2 81/8 83/18 83/22
difficult [1] 85/9
difficulties [1] 13/1
difficulty [1] 15/3
Director [3] 1/24 3/4 5/11
disappeared [1] 93/4
discharge [46] 11/1 11/3 23/7 24/3 27/2 27/3 33/19 47/5 47/7 47/11 47/14 49/22 63/17 65/1 75/18 75/25 76/13 77/14 77/21 78/2 78/6 78/10 79/3 79/7 79/18 79/23 80/4 80/19 80/20 81/2 81/16 82/19 83/7 83/15 83/18 83/20 83/20 86/18 86/25 87/6 87/21 87/25 88/13 88/16 89/20 91/12
discharged [27] 2/17 2/22 31/7 35/8 52/4 63/14 72/6 72/11 72/16 73/17 74/13 74/20 78/3 80/11 81/19 82/13 82/25 83/12 84/4 87/14 88/4 89/5 89/11 90/14 91/6 91/24 92/4
discharging [2] 62/24 88/25
Disciplinary [1] 73/25
disclose [1] 86/19
disclosed [2] 40/3 88/3
discontinued [1] 54/8
discuss [5] 16/9 16/10 77/1 77/8 77/18
discussed [7] 38/21 56/18 57/13 66/5 66/8 75/17 92/24
discussing [2] 16/17 86/24
discussion [7] 18/13 60/5 60/11 60/21 65/21 65/25 70/1
disorder [4] 36/6 36/17 75/20 75/22
display [1] 73/13
displaying [1] 68/13
do [43] 7/18 7/23 8/4 8/12 9/20 10/10 11/2 14/3 14/17 15/23 16/8 20/2 20/5 21/2 21/3 21/21 26/2 43/25 44/8 44/25 47/3 48/23 50/11 51/15 52/11 52/12 52/25 53/1 55/18 59/1 65/21 74/5 75/20 75/21 75/22 75/23 76/18 80/8 82/3 85/4 86/10 88/13 89/17
doctor [7] 3/2 23/22 24/4 37/18 73/10 83/7 90/7
doctors [1] 24/14
document [44] 3/13 4/1 4/14 6/23 8/4 8/7 8/19 9/11 9/16 10/13 11/5 16/22 17/1 26/24 27/8 27/9 27/15 28/10 29/22 30/25 34/21 35/12 36/3 37/21 44/16 45/11 47/12 47/14 51/13 52/6 52/11 53/13 53/15 76/13 76/20 76/22 77/15 78/9 79/10 79/11 79/12 79/15 80/10 90/12
documentation [2] 10/23 10/24
documented [2] 74/16 77/9
documents [13] 9/20 10/9 10/13 18/9 26/16 26/19 28/23 30/24 38/17 63/19 65/15 65/17 81/3
does [20] 4/25 5/3 6/5 30/18 31/24 32/1 32/22 36/24 37/1 37/7 37/8 37/15 45/16 45/16 50/8 52/21 58/4 58/7 76/6 76/14
does it [2] 5/3 37/1
doesn't [24] 5/3 5/8 8/8 21/9 27/19 30/24 36/15 37/10 37/15 42/7 44/21 45/14 45/21 50/1 50/8 50/9 52/7 52/11 52/16 76/23 82/22 85/17 86/10 89/18
doing [4] 86/2 86/10 88/8 89/2
don't [20] 6/14 12/17 15/3 20/4 20/7 20/16 21/21 25/19 41/6 44/11 50/19 52/3 63/24 70/11 83/24 84/21 87/16 87/16 89/13 89/16
done [10] 53/10 79/13 79/14 79/22 79/22 82/20 87/5 89/19 91/15 91/19
door [4] 17/3 17/9 22/11 25/15
dose [3] 40/17 57/5 57/6
doubt [2] 21/25 73/6
down [19] 4/2 7/8 19/1 23/4 25/8 25/11 26/2 31/10 32/7 32/10 32/16 34/23 43/24 46/21 67/25 78/12 79/5 80/9 83/10
Dr [25] 1/5 1/6 1/9 6/25 9/5 19/18 19/20 23/22 23/22 25/1 27/16 31/4 31/24 51/1 62/16 63/19 63/19

D

Dr... [8] 64/21 65/18 67/20 70/10 72/14 73/7 84/13 94/3
Dr Ajith Gurusinghe [1] 1/5
Dr Burri [2] 23/22 23/22
Dr Gurusinghe [11] 1/9 6/25 9/5 51/1 62/16 64/21 67/20 70/10 72/14 73/7 84/13
Dr Lomas [1] 25/1
Dr Seedat [2] 19/18 19/20
Dr Shoilekova [4] 27/16 31/4 31/24 65/18
Dr Shoilekova's [2] 63/19 63/19
drugs [1] 69/14
due [2] 36/25 42/15
duly [1] 82/23
during [28] 2/6 16/9 16/10 18/7 18/22 28/22 29/7 34/5 38/11 39/21 40/7 40/25 41/4 41/10 43/6 49/17 54/13 54/14 54/16 56/19 59/22 66/22 69/25 71/24 72/4 86/20 86/23 87/10

E

each [11] 5/25 5/25 6/10 7/12 46/20 46/22 49/6 50/16 56/21 58/19 58/19
earlier [5] 65/15 85/19 89/19 92/2 92/3
earliest [1] 48/1
early [8] 31/22 36/6 36/17 38/11 61/1 65/10 65/16 66/16
easily [2] 89/24 90/3
educated [1] 34/12
education [1] 7/16
effect [7] 4/18 5/1 5/7 54/6 63/12 69/11 71/25
effective [4] 4/17 5/6 71/6 71/12
effectively [1] 10/20
effects [7] 37/11 69/2 69/14 70/2 70/6 70/13 71/5
effort [2] 7/12 89/24
eight [1] 64/7
eight weeks [1] 64/7
EIP [2] 23/23 71/15
either [3] 49/24 50/13 80/14
electric [1] 11/24
else [4] 14/16 49/9 84/20 87/24
Emelia [1] 43/10
emerged [1] 58/24
emerges [1] 26/3
employee [1] 7/4
employees [2] 7/2 7/3
encountered [1] 13/7
end [4] 25/8 29/23 33/22 41/14
ending [1] 11/21
ends [2] 35/16 37/11
enduring [1] 37/4
engage [13] 38/21 38/21 45/16 45/21 47/18 47/22 48/8 49/16 49/21 54/15 54/15 64/1 84/7
engaged [4] 49/9 49/10 49/11 64/14
engagement [9] 33/18 34/3 34/4 39/11 55/10 56/7 56/7 58/14 64/14
engaging [11] 34/5 39/12 39/14 47/16 51/4 55/1 55/7 55/22 57/18 57/19 84/8
engine [3] 70/5 70/13 70/17
enough [2] 63/10 73/13
ensure [6] 54/14 55/7 58/22 65/12 65/13 71/16
ensured [1] 66/25
entered [1] 30/3
entirely [1] 68/19
entirety [2] 29/2 29/16
entitled [1] 45/12
entries [9] 8/18 16/22 20/20 21/4 21/6 47/17 77/9 77/19 78/25
entry [24] 4/13 7/7 9/11 17/2 17/6 19/18 22/10 22/14 24/7 24/9 24/24 29/23 33/15 35/14 37/20 44/8 44/16 45/11 47/4 47/15 49/15 75/3 75/7 75/7
environment [1] 7/10
envisaged [1] 45/20
especially [5] 11/9 34/12 55/11 66/10 67/13
essential [1] 35/17
essentially [9] 3/19 6/4 69/6 71/9 72/14 72/23 73/14 82/18 83/25
establish [1] 16/22
established [1] 50/2
even [3] 85/23 89/13 89/18
event [2] 5/11 62/6
eventually [2] 47/11 59/7
ever [5] 27/4 33/23 34/8 47/7 81/13
every [4] 44/9 44/12 45/20 62/8
everybody [1] 15/10
everyone [3] 15/12 15/15 15/24
everything [3] 19/23 20/8 79/22
evidence [16] 5/18 19/8 20/14 21/21 31/3 39/15 40/1 40/15 43/2 56/11 58/11 63/20 65/20 77/5 89/16 93/2
ex [2] 7/3 7/4
Ex-employee [1] 7/4
ex-employees [1] 7/3
exact [1] 6/9
exactly [1] 85/5
examination [1] 27/16
example [1] 24/19
exchange [1] 68/9
excuses [2] 89/25 90/2
expanded [1] 83/11
expectation [4] 11/14 44/5 45/3 65/9
expected [2] 63/20 76/9
expecting [1] 66/16
experience [3] 21/12 21/13 21/14
experiences [4] 21/11 21/17 71/3 72/24
experiencing [4] 24/16 36/5 36/19 36/20
explain [1] 21/14
explained [4] 11/20 11/22 12/1 76/1
explanation [6] 59/20 60/6 61/11 61/13 62/16 92/24
explore [1] 91/13
explored [1] 92/23
express [2] 71/4 71/18
expressing [1] 39/18
extend [1] 33/8
extent [1] 70/21
external [1] 49/16
extra [1] 84/10
extreme [1] 25/23
extremely [1] 26/8
eye [1] 60/22

F

face [1] 90/14
fact [15] 11/22 17/10 30/23 43/5 43/21 50/7 69/9 69/15 69/15 69/16 70/17 78/3 80/13 81/1 90/3
factor [5] 23/16 24/21 24/22 53/1 77/10
factors [1] 52/2
failure [4] 51/2 62/2 62/4 62/5
failures [1] 51/5
fair [3] 7/18 34/4 45/22
fallen [1] 90/23
family [7] 13/23 13/25 19/22 35/1 84/13 89/12 89/18
far [9] 1/19 2/11 13/16 41/5 49/19 50/16 51/3 51/22 64/19
fear [1] 19/2
feasibility [1] 67/10
features [3] 22/4 24/16 40/2
February [1] 40/10
fed [2] 81/9 81/10
feedback [5] 5/20 53/16 56/18 90/21 91/14
feel [5] 16/11 19/2 29/10 36/24 71/18
feeling [1] 55/19
feels [1] 38/3
fell [1] 15/9
felt [3] 20/9 34/25 38/14
few [12] 2/17 15/20 15/21 19/1 25/11 31/10 32/3 32/15 53/14 56/14 57/16 72/19
final [6] 4/13 4/14 9/11 24/24 31/23 36/23
finally [1] 35/12
find [3] 89/1 89/25 90/2
finding [1] 22/15
findings [1] 40/20
finish [1] 93/11
first [31] 1/12 3/12 11/20 17/2 17/4 17/10 18/8 18/22 19/17 21/16 21/16 22/7 26/22 31/8 36/8 44/8 45/5 45/6 47/4 51/14 52/8 53/8 53/10 53/13 59/25 68/14 69/4 78/5 84/14 89/9 90/11
firstly [2] 37/19 88/11
five [1] 4/2
five paragraphs [1] 4/2
flat [7] 17/3 17/19 19/3 77/1 83/13 83/13 84/1
floor [1] 17/11
focus [4] 7/10 55/16 55/20 76/21
focusing [2] 9/6 48/2
follow [8] 34/5 46/4 78/17 78/20 79/5 79/6 80/12 83/1
follow-up [5] 34/5 78/17 78/20 79/5 79/6
followed [1] 36/16
following [19] 3/22 5/17 5/18 5/25 6/2 6/10 8/6 9/3 9/25 18/24 22/7 23/11 33/18 36/16 52/24 64/25 86/16 92/8 93/14
force [1] 67/12
forced [1] 39/9
forcing [1] 22/11
forefront [1] 6/18
forgive [2] 9/7 70/11
form [3] 18/5 22/2 66/12
fortnight [1] 23/13
forward [2] 18/7 30/22
forwards [2] 30/4 57/4
found [5] 10/3 40/10 69/6 75/12 88/9
Foundation [1] 10/18
four [3] 23/3 43/12 59/13
fourth [1] 80/23
free [1] 15/24
front [1] 20/17
full [5] 8/23 11/17 34/2 70/21 71/20
fully [6] 22/21 50/13 57/24 59/8 67/6 67/9
further [13] 16/17 20/16 33/6 33/11 41/2 41/19 42/1 42/21 57/4 66/9 80/9 83/6 92/23
future [4] 52/13 52/15 52/17 52/20

G

gain [1] 32/22
gave [2] 41/13 83/16
general [3] 5/4 5/8 64/6
get [16] 7/12 18/1 19/4 19/12 24/14 24/17 26/14 38/23 52/4 53/13 56/19 61/3 70/21 72/6 72/10 83/24
gets [1] 56/20
getting [1] 47/9
give [9] 15/24 31/22 41/10 41/15 41/17 52/18 82/22 89/10 89/21
given [14] 33/3 56/6 62/16 63/25 65/1

G

given... [9] 68/20 81/9 82/14 83/3 83/23 88/11 92/9 92/19 92/24
gives [3] 52/14 78/23 81/14
giving [2] 20/13 52/18
go [39] 3/13 4/9 4/13 8/22 9/13 11/14 16/6 16/21 18/7 20/16 21/16 22/5 25/23 26/23 30/22 31/2 34/22 36/3 43/24 44/16 45/24 50/7 50/9 50/12 61/2 61/16 61/17 67/13 71/8 76/19 77/19 79/5 83/5 83/10 84/1 84/1 84/2 86/24 88/15
goes [4] 31/19 35/6 37/5 78/23
going [28] 4/13 8/23 12/9 16/21 21/11 21/19 25/16 27/18 29/22 30/4 32/9 48/3 48/25 52/23 56/21 76/17 77/24 79/10 80/18 81/21 81/23 82/5 82/18 82/25 84/3 88/4 88/8 88/22
gone [3] 57/4 76/8 81/22
good [13] 1/4 4/3 4/18 5/1 5/7 9/9 38/4 56/19 56/20 58/14 66/17 73/10 73/11
got [6] 33/21 43/13 53/19 68/18 76/22 83/13
gritty' [1] 33/21
group [2] 1/22 49/6
groups [1] 47/19
Gurusinghe [14] 1/5 1/6 1/9 6/25 9/5 51/1 62/16 64/21 67/20 70/10 72/14 73/7 84/13 94/3
gym [1] 49/1

H

had [96]
hadn't [6] 17/16 58/24 61/9 82/21 91/1 93/4
half [2] 2/14 8/24
halfway [2] 7/8 34/23
hallucinations [2] 68/2 69/1
haloperidol [8] 54/5 57/5 68/6 69/2 69/10 70/2 70/6 70/14
hammer [11] 59/14 59/22 59/24 60/18 61/6 62/10 62/14 64/4 64/5 92/13 92/14
hand [2] 32/6 32/16
handed [1] 14/1
handful [1] 15/20
handover [1] 16/9
hands [1] 20/22
hang [4] 59/22 60/6 60/18 61/8
happen [11] 47/21 49/18 49/19 49/23 49/24 52/17 53/5 58/23 87/17 89/22 90/1
happened [7] 43/20 81/17 82/11 87/3 92/3 92/6 92/10
harm [4] 21/10 28/10 63/8 63/8
has [42] 8/1 8/25 11/8 11/13 17/10 22/25 27/6 31/24 31/25 32/22 34/5 35/10 36/16 36/21 37/9 38/3 39/17 42/3 42/17 43/9 53/5 53/24 56/3 62/13 63/16 64/11 64/12 64/14 67/23 68/13 73/17 76/24 77/1 77/9 78/14 81/7 82/14 83/3 83/22 86/21 87/19 87/22
hasn't [2] 53/4 80/20
have [163]
haven't [4] 1/10 20/4 56/25 92/23
having [13] 13/21 18/18 20/16 21/20 22/12 24/13 55/8 60/18 60/21 65/21 68/25 69/2 86/24
he [297]
he'd [10] 69/2 71/24 72/5 72/5 72/9 72/21 73/1 85/12 90/23 93/4
he's [21] 24/16 33/12 36/13 36/18 38/17 56/24 63/14 65/12 68/13 75/12 77/7 77/10 84/4 86/25 87/14 88/4 88/8 88/8 88/23 91/24 92/24
heading [5] 7/5 8/25 9/12 18/13 25/8
heads [1] 20/22
health [23] 15/13 15/21 17/4 17/16 23/2 25/1 34/19 34/20 35/11 35/25 36/6 36/17 37/7 37/13 37/20 38/24 39/20 55/14 58/5 63/18 72/5 74/2 74/22
Healthcare [1] 10/17
hear [1] 24/4
heard [1] 69/4
hearing [6] 30/2 30/6 30/10 35/24 71/4 93/14
heeded [1] 23/18
held [1] 12/6
help [2] 7/13 7/16
helped [2] 34/25 35/2
helpful [1] 58/1
helping [1] 35/3
hence [1] 27/6
her [21] 27/17 58/13 84/18 84/19 85/8 85/8 85/10 85/10 85/15 86/16 86/17 87/8 87/13 87/25 88/4 88/10 89/4 89/4 89/9 89/11 89/23
here [9] 4/22 24/13 25/22 31/5 32/22 72/20 78/16 89/16 91/14
high [2] 51/18 51/21
Highbury [1] 24/3
higher [1] 75/9
highlight [1] 45/1
highlighted [3] 5/19 56/22 63/10
him [60] 18/24 18/24 19/21 24/25 25/13 26/13 31/22 34/2 34/25 38/20 38/21 38/22 38/23 41/4 44/6 47/11 47/20 47/22 47/25 48/8 48/22 48/23 49/2 49/4 49/12 54/1 54/4 54/6 57/1 57/25 58/22 61/16 61/17 61/20 62/24 64/18 65/2 66/5 66/18 66/18 68/6 68/25 70/3 72/8 72/9 72/20 74/23 76/7 84/6 86/24 88/19 88/22 88/25 89/1 89/11 90/15 92/14 92/16 92/18 92/19
him/watching [1] 18/24
himself [1] 71/11
his [127]
historical [3] 51/18 51/20 77/5
history [3] 11/18 52/23 71/20
hm [8] 5/13 23/8 27/7 31/14 55/5 66/24 79/2 79/19
home [5] 17/17 31/12 43/14 80/11 86/7
homes [1] 43/16
hope [1] 6/14
hopefully [1] 31/12
hospital [28] 2/2 3/10 4/12 4/20 5/21 8/12 9/4 10/5 17/13 22/6 23/7 24/3 24/6 24/14 24/17 24/18 26/14 35/9 37/12 38/14 39/7 39/9 41/23 42/16 43/21 48/6 74/25 92/15
hour [1] 80/12
hours [1] 86/6
housing [1] 48/1
how [14] 5/16 14/16 16/3 16/6 25/8 27/22 35/15 43/13 71/1 76/6 82/5 88/23 89/1 89/14
however [2] 12/14 75/5
hurt [1] 20/23

I

I accepted [1] 5/19
I admit [1] 63/6
I agree [14] 5/10 20/19 26/15 38/7 43/19 44/14 52/16 60/12 62/3 70/15 72/12 74/7 76/1 92/23
I ask [1] 73/12
I asked [1] 70/10
I call [1] 1/4
I can [5] 42/13 85/24 86/14 87/4 87/5
I can't [10] 6/9 54/2 69/8 69/22 80/7 85/5 87/18 88/5 89/21 90/16
I cannot [5] 4/25 6/14 16/16 19/23 44/24
I carried [1] 76/4
I consider [1] 71/3
I contact [1] 89/12
I contacted [1] 84/6
I could [6] 22/24 67/21 67/22 67/25 87/13 87/13
I decide [1] 76/8
I did [6] 27/9 70/3 70/20 85/1 85/8 88/25
I didn't [13] 29/8 29/10 46/4 54/18 54/20 64/5 80/8 87/18 89/24 90/15 91/11 91/13 92/1
I do [1] 21/3
I don't [6] 6/14 20/4 44/11 63/24 70/11 87/16
I get [1] 56/19
I had [3] 13/22 31/1 60/16
I have [19] 12/15 12/15 13/20 14/14 14/19 16/10 19/23 20/1 20/12 44/11 54/3 54/3 69/22 76/16 81/3 85/7 86/8 86/13 87/4
I hope [1] 6/14
I implied [1] 85/22
I just [3] 35/14 68/25 76/21
I kind [3] 59/6 88/22 92/5
I knew [4] 21/24 62/22 88/17 88/20
I know [5] 20/21 41/5 49/19 50/16 69/9
I made [2] 38/16 86/16
I managed [1] 85/9
I mean [47] 7/24 9/23 20/7 21/11 27/24 32/22 34/4 34/10 36/16 36/16 38/9 39/8 41/8 41/16 43/2 44/24 48/2 51/8 52/14 55/10 59/5 61/18 62/8 63/23 63/23 64/5 65/3 66/9 69/8 70/8 76/2 81/21 84/3 85/14 85/23 86/12 86/13 87/2 87/16 87/17 89/14 89/21 91/11 92/1 92/5 92/16 93/6
I might [1] 69/8
I need [1] 55/20
I needed [1] 29/8
I read [1] 14/10
I refer [1] 14/3
I remember [5] 9/24 14/19 15/12 60/21 86/23
I represent [1] 84/13
I said [2] 60/3 86/7
I should [2] 66/8 76/1
I still [1] 89/16
I take [3] 70/23 74/24 79/16
I think [12] 14/23 20/21 34/4 47/23 48/17 48/20 57/2 57/24 83/8 86/23 88/1 92/2
I thought [1] 76/5
I took [4] 8/8 8/18 37/20 68/15
I tried [1] 85/8
I want [2] 34/18 44/8
I was [7] 19/24 20/25 27/14 38/9 66/15 76/3 88/1
I won't [2] 68/22 89/22
I would [11] 16/12 26/12 27/24 28/1 29/9 42/18 50/14 53/22 53/24 55/24 86/6
I wouldn't [3] 7/20 27/24 80/15
I'd [2] 67/20 84/14
I'll [3] 72/14 76/7 82/3
I'm [30] 4/13 5/24 6/1 6/4 7/25 8/23 12/14 14/3 15/8 16/21 23/1 27/18 29/22 36/10 55/6 59/5 67/9 72/7 74/25 74/25 76/17

I

I'm... [9] 77/4 77/13 77/24 79/10 80/18 82/18 87/1 88/22 89/25
I've [2] 19/25 46/6
identified [3] 51/1 59/5 59/6
identify [4] 10/2 52/3 52/21 59/1
if [98]
illness [12] 21/8 21/25 25/24 25/25 34/15 34/17 36/25 37/4 37/4 38/10 38/11 38/19
immediately [1] 26/17
imminent [1] 86/25
implausible [2] 60/19 61/13
implement [2] 38/12 48/17
implementation [1] 33/1
implemented [6] 44/10 44/13 48/15 50/2 51/7 56/25
implied [1] 85/22
implies [3] 3/21 33/10 39/8
imply [1] 58/14
importance [1] 71/10
important [14] 16/5 18/9 19/5 19/6 19/7 23/16 25/3 28/25 58/21 87/19 88/10 88/12 89/3 89/8
impossible [1] 20/8
impression [2] 34/9 88/1
improve [1] 32/1
improvement [2] 35/15 58/2
improving [2] 55/13 55/13
inadequacies [1] 10/3
inadequate [5] 3/19 3/19 8/12 8/16 77/25
inappropriate [1] 92/17
incident [15] 5/2 5/4 41/23 42/15 42/24 51/25 53/25 61/24 62/1 62/8 62/10 63/7 64/6 68/21 80/24
incidents [13] 4/7 9/13 9/15 11/10 29/6 41/18 42/25 43/1 43/3 52/18 56/12 56/22 64/9
include [2] 50/1 79/4
included [5] 61/4 63/1 63/3 63/5 63/7
increased [1] 32/9
increasing [1] 57/6
indeed [2] 25/4 55/7
indicate [4] 22/18 22/19 51/25 54/23
indicated [3] 29/6 40/13 58/12
indicates [6] 21/9 26/1 30/24 37/1 37/2 39/17
indicating [1] 38/1
indication [4] 33/25 35/4 40/14 52/14
indications [1] 93/2
individual [1] 73/16
INDRAN [2] 1/6 94/3
inference [1] 82/22
inferences [1] 70/9
informal [2] 73/22 75/5
informally [1] 57/16
information [49] 4/16 4/18 4/23 4/23 5/1 5/5 5/7 6/15 13/23 16/11 16/13 16/15 16/23 17/20 18/1 19/7 20/9 20/10 21/22 29/9 29/11 40/20 40/21 40/22 41/2 41/3 41/6 41/8 41/9 41/11 41/15 41/17 42/2 42/20 42/22 42/23 52/6 52/7 69/24 74/22 78/1 79/4 85/11 85/17 85/18 85/22 85/25 88/12 89/10
informed [2] 80/17 82/23
initially [2] 25/12 64/16
injuries [2] 17/21 18/4
injury [5] 18/5 18/5 90/14 90/17 91/25
inpatient [3] 9/25 11/8 51/23
Inquiry [4] 1/10 29/21 63/20 92/3
insight [25] 26/10 27/19 27/21 27/22 27/25 28/2 28/2 30/1 31/25 32/1 32/23 34/14 35/4 35/5 36/9 36/15 37/15 38/4 41/19 57/23 57/25 58/3 58/8 68/14 77/10
insisting [1] 61/18
inspection [3] 3/10 5/17 8/5
instance [2] 20/20 42/22
intensive [6] 2/3 28/15 29/3 30/10 32/7 32/17
interact [1] 8/2
interaction [2] 45/13 71/1
interactions [3] 3/1 7/4 7/6
interest [4] 47/20 47/25 48/23 49/1
interested [1] 47/23
interests [4] 48/4 48/25 55/16 88/19
interfering [1] 19/9
Intervention [3] 65/10 65/16 66/16
interventions [1] 38/22
intimidating [5] 51/17 52/1 56/3 56/10 62/25
intimidation [1] 64/10
into [14] 2/18 2/22 25/23 32/11 33/2 37/5 43/13 44/20 47/5 56/17 61/2 79/8 79/16 93/4
intrusions [1] 68/3
invading [1] 19/4
inventory [1] 92/19
investigated [1] 61/25
investigation [2] 41/10 41/17
invite [3] 84/15 84/18 84/19
invited [1] 25/12
involved [5] 42/5 53/19 65/10 68/18 80/16
involvement [1] 42/10
is [187]
is: [1] 33/1
is: this [1] 33/1
isn't [24] 2/2 4/20 9/18 22/15 24/7 24/12 28/4 31/16 32/10 36/9 37/17 37/24 43/17 43/22 45/7 53/20 54/9 55/4 60/24 73/15 79/10 87/19 90/19 91/8
isolate [2] 54/16 55/17
isolated [2] 57/18 64/1
isolating [2] 57/19 57/22
issue [7] 7/23 8/19 12/18 13/8 13/15 48/1 75/22
issues [3] 12/17 47/24 77/10
it [226]
it's [77] 5/1 5/4 6/24 8/5 9/2 9/17 11/2 11/21 16/21 19/8 20/8 20/8 22/14 23/25 27/22 27/25 28/22 28/22 29/21 29/22 30/22 32/6 32/16 35/12 35/13 35/24 36/12 37/17 38/9 41/9 41/24 43/5 43/8 43/9 44/15 44/16 44/24 45/11 46/20 47/12 47/14 50/19 51/24 52/18 53/8 53/14 55/11 56/1 56/18 59/17 60/3 60/5 60/11 63/3 63/5 63/6 63/6 63/6 64/23 65/5 66/6 66/13 67/11 70/4 73/15 73/19 75/5 83/6 83/8 83/17 85/23 86/14 90/11 90/19 90/21 92/18 92/18
it's your [1] 59/17
items [5] 59/22 60/7 60/18 61/3 61/8
itself [1] 18/3

J

job [3] 8/2 45/2 51/6
July [2] 22/10 24/4
jumped [2] 17/10 17/22
June [2] 3/23 9/3
June 2021 [1] 3/23
just [38] 17/14 24/2 29/13 29/25 34/23 35/12 35/14 38/2 41/13 57/11 67/20 68/25 70/17 70/21 70/24 71/8 71/8 72/19 73/1 73/25 75/3 75/9 76/21 78/4 78/13 78/15 78/16 79/5 82/3 82/4 82/21 83/10 83/11 86/1 87/7 90/8 90/8 91/17
justification [1] 77/20
justify [3] 64/17 75/24 76/10

K

keep [1] 60/22
keeping [8] 43/9 46/1 46/2 46/6 46/9 46/12 46/14 47/1
kept [1] 51/19
key [4] 25/22 44/18 45/3 58/21
kicking [1] 17/2
kind [12] 9/6 19/24 19/25 41/7 48/24 55/14 55/15 59/6 64/5 88/22 89/25 92/5
knew [6] 21/24 62/22 62/23 88/17 88/17 88/20
know [49] 5/18 14/3 15/23 16/6 16/12 20/21 21/2 34/12 34/14 41/5 41/22 42/18 45/2 48/17 48/25 49/13 49/19 50/16 56/21 58/9 61/19 61/21 62/5 62/9 63/1 63/24 64/18 66/8 66/13 69/9 69/15 69/16 70/2 70/8 70/8 70/9 70/16 77/5 81/23 84/3 85/5 86/14 86/20 86/21 86/22 87/13 89/14 89/22 93/1
knowledge [2] 1/16 87/25
known [2] 65/1 68/20
knows [4] 81/13 81/14 81/16 91/9

L

lack [8] 27/19 27/21 27/25 36/8 36/15 37/15 40/21 68/14
lacked [1] 26/10
lacking [2] 30/1 34/14
lacks [1] 27/22
lapses [2] 9/24 10/2
laptop [1] 48/3
laptops [1] 61/5
largely [1] 93/5
last [14] 8/18 13/24 18/25 27/2 37/14 56/14 64/8 74/9 76/11 76/16 76/17 77/15 89/7 93/3
later [5] 2/14 2/17 17/8 59/7 83/25
leading [5] 25/5 43/11 43/18 53/21 58/19
learning [1] 9/13
least [1] 64/8
leave [9] 24/17 35/8 37/12 47/9 59/23 76/6 81/17 81/22 88/8
leaves [1] 92/4
led [7] 17/4 17/16 40/6 41/23 62/19 62/20 77/11
left [2] 76/18 92/12
less [1] 31/11
let [2] 16/12 42/13
let's [11] 12/20 75/3 76/5 76/6 76/11 78/4 78/16 79/15 81/11 81/25 83/5
letter [1] 83/20
lied [1] 71/24
light [2] 40/20 63/17
like [21] 13/11 19/23 23/10 40/14 47/18 48/25 49/16 49/21 55/18 62/17 67/20 84/14 87/16 88/17 89/15 90/6 91/15 91/16 91/20 91/21

L

like... [1] 92/16
likely [1] 74/15
limited [4] 28/17 35/4 56/7 70/12
line [2] 25/9 31/8
lines [6] 19/1 23/3 25/8 25/11 31/10 43/12
link [1] 64/5
listen [2] 70/3 91/17
little [3] 28/3 75/9 83/10
living [1] 72/17
Lloyd [1] 23/23
loads [1] 20/9
locker [1] 92/13
Lodge [1] 86/25
log [1] 12/10
logged [1] 14/14
Lomas [1] 25/1
long [3] 38/5 72/8 82/5
longer [4] 24/4 36/20 64/18 76/10
look [40] 3/12 6/23 7/7 8/4 8/22 12/1 23/2 25/7 26/16 26/21 29/20 34/18 36/23 37/5 39/11 44/8 44/15 51/13 57/10 58/11 67/10 70/13 70/13 75/3 76/11 76/13 77/20 78/2 78/4 78/15 78/16 78/25 79/15 80/4 80/9 80/13 80/25 81/11 81/25 91/22
looked [3] 16/3 46/1 56/16
looking [7] 3/2 45/25 46/9 47/1 51/12 70/17 88/19
looks [4] 70/6 91/15 91/20 91/21
lot [4] 48/3 54/7 67/24 68/7
lots [1] 87/3
low [1] 56/4
lower [2] 17/12 40/17
lying [1] 24/10

M

Ma'am [1] 90/15
made [15] 7/12 8/1 11/7 30/20 35/21 38/16 39/1 73/17 74/10 79/23 80/3 80/7 82/24 86/4 86/16
Madison [2] 83/13 84/1
Madison Court [2] 83/13 84/1
maintained [1] 35/17
maintenance [1] 35/22
make [10] 4/25 7/10 44/25 51/6 70/9 75/4 89/4 89/11 89/24 92/20
makes [2] 35/13 73/20
making [4] 54/6 65/19 68/6 74/1
manage [4] 3/16 4/6 9/14 39/6
managed [2] 64/11 85/9
management [2] 9/1 87/9
managing [1] 30/3
mandatory [1] 67/12
manner [2] 41/8 53/24
many [3] 10/1 34/11 75/5
marked [2] 28/10 28/12
mask [3] 24/15 26/13 52/3
masking [3] 37/19 38/17 39/1
match [1] 49/5
material [1] 56/16
matter [3] 18/16 31/12 69/15
matters [1] 41/20
may [15] 1/1 1/4 13/1 17/7 17/15 40/16 40/17 41/19 48/22 52/3 59/8 63/9 73/13 86/7 87/3
May 2020 [1] 41/19
maybe [2] 5/1 83/9
MDT [42] 16/10 18/13 29/4 29/14 29/18 44/1 44/2 47/3 47/16 47/17 47/18 49/16 49/21 49/25 50/4 53/8 53/10 53/13 54/13 54/14 54/21 55/6 55/7 56/1 56/23 57/2 57/7 59/9 59/9 60/11 62/5 64/2 67/21 69/3 69/20 73/15 76/3 77/17 77/23 84/16 90/21 91/14
MDTs [1] 89/22
me [19] 9/7 14/1 14/14 19/24 22/23 42/13 44/1 47/3 54/18 55/18 58/3 64/17 70/11 76/10 84/10 85/19 86/12 86/16 92/2
meals [1] 93/6
mean [57] 7/24 9/23 12/8 20/7 21/11 27/24 32/13 32/22 34/4 34/10 36/16 36/16 38/9 39/8 41/8 41/16 42/24 42/24 43/2 44/24 48/2 51/8 52/14 55/10 59/5 60/20 61/11 61/18 62/8 63/23 63/23 64/5 65/3 66/9 67/3 69/8 70/8 76/2 76/14 81/21 84/3 85/14 85/23 86/12 86/13 87/2 87/16 87/16 87/17 88/1 89/14 89/21 91/11 92/1 92/5 92/16 93/6
means [8] 33/5 33/9 40/19 42/14 44/5 47/8 48/5 59/8
measures [3] 3/7 10/4 10/5
medical [12] 1/24 3/3 5/11 11/7 11/15 12/4 75/23 79/16 80/5 90/4 91/21 91/23
medication [57] 2/23 22/16 22/16 22/20 23/6 23/13 23/14 27/5 27/13 28/11 30/7 30/13 30/15 32/21 34/25 35/3 35/7 35/17 35/22 36/7 37/23 38/6 38/14 39/7 39/10 39/15 39/20 40/10 40/17 40/18 50/5 50/8 50/10 50/14 50/17 54/7 58/4 58/7 58/8 58/10 58/11 59/3 64/12 65/13 66/19 67/15 68/11 68/23 71/5 71/11 71/11 71/16 71/21 73/5 74/12 74/24 76/7
medications [10] 24/11 39/18 39/19 40/16 50/6 50/18 57/4 58/1 71/6 93/8
medics [2] 15/14 15/21
medium [4] 51/18 51/19 51/21 56/4
meeting [3] 34/6 44/2 91/12
meetings [3] 16/8 16/10 56/19
member [2] 62/6 79/13
members [6] 15/20 47/16 69/25 75/23 89/12 89/18
mental [32] 15/13 15/21 17/4 17/15 21/8 21/24 23/2 25/1 27/15 34/16 34/19 34/20 35/11 35/25 36/6 36/17 37/7 37/13 37/20 38/10 38/24 39/20 55/13 57/11 58/5 63/18 65/12 72/4 74/2 74/22 75/20 75/21
mentioned [4] 32/22 60/11 81/15 83/21
message [1] 20/23
messages [4] 19/20 20/2 20/11 21/20
MH [1] 36/6
middle [9] 17/7 18/22 25/7 43/10 43/25 47/2 53/16 57/12 67/25
might [9] 13/22 22/23 35/9 52/17 53/5 69/8 72/25 86/11 91/7
mind [9] 6/18 6/18 19/4 19/9 21/25 53/22 60/20 64/6 74/18
minimal [1] 7/15
minutes [2] 20/25 82/6
misled [1] 24/13
missed [2] 63/6 63/7
mistaken [1] 86/11
Mm [14] 5/13 21/1 23/8 27/7 31/14 49/8 55/5 63/1 66/24 68/24 72/1 79/2 79/19 83/16
Mm-hm [8] 5/13 23/8 27/7 31/14 55/5 66/24 79/2 79/19
Moderate [2] 28/11 28/12
Moloney [3] 67/18 67/19 94/6
moment [4] 47/17 53/6 80/4 80/25
Monday [2] 1/1 76/8
month [1] 39/25
months [1] 63/21
more [6] 3/3 55/23 55/24 57/16 71/12 83/8
morning [5] 16/9 56/19 82/13 92/8 93/12
most [4] 15/19 50/11 57/17 93/7
mostly [1] 7/14
mother [8] 84/14 84/22 84/24 85/1 85/7 85/13 85/21 88/18
motivated [1] 25/24
move [3] 35/11 75/13 78/12
moved [1] 46/6
moving [1] 59/21
Mr [12] 1/3 1/7 50/19 67/18 67/19 67/23 84/11 84/12 94/4 94/5 94/6 94/8
Mr Carr [6] 1/3 1/7 50/19 67/23 94/4 94/5
Mr Moloney [3] 67/18 67/19 94/6
Mr Straw [3] 84/11 84/12 94/8
Ms [6] 27/1 60/15 73/8 73/9 82/2 94/7
Ms Birtles [2] 27/1 60/15
Ms Cartwright [4] 73/8 73/9 82/2 94/7
much [5] 38/21 73/7 83/25 88/21 90/7
Multi [1] 73/25
mum [1] 86/8
must [2] 45/4 68/20
my [36] 6/3 14/6 18/6 20/22 21/25 34/7 34/9 38/16 41/21 59/20 61/22 63/23 64/6 65/5 66/3 66/9 67/16 69/23 69/24 74/14 76/1 76/3 80/7 80/15 83/21 84/7 86/13 88/24 88/25 89/7 89/7 91/2 91/5 91/17 92/5 92/9

N

named [2] 45/3 91/23
National [1] 42/19
nature [1] 75/21
nearest [1] 87/20
nearly [1] 64/7
necessarily [6] 20/7 34/2 70/8 81/21 81/22 93/6
necessary [1] 4/23
need [9] 35/9 37/10 38/18 41/1 55/20 61/6 61/23 77/19 92/25
needed [7] 4/17 5/6 29/8 29/10 48/6 59/22 61/23
needs [6] 7/13 37/8 50/9 61/8 61/24 88/23
neighbour [2] 17/10 17/21
neighbouring [1] 19/3
neighbours [1] 43/15
network [2] 49/17 76/24
never [2] 20/11 36/12
new [7] 59/21 61/8 61/9 61/14 62/20 82/14 83/13
next [13] 4/1 4/5 4/14 25/14 25/18 35/24 37/5 37/5 47/15 49/15 49/20 54/4 82/25
NHFT0000066 [1] 78/5
NHFT0000168 [2] 16/21 81/25
NHS [1] 78/17
night [5] 90/6 90/6 91/2 91/4 91/8
nitty [1] 33/21
nitty-gritty' [1] 33/21
no [85] 2/22 2/23 7/11 7/20 7/22 13/6 13/6 13/17 15/5 16/2 16/18 20/4 20/4 20/12

N

no... [71] 21/24 21/25 22/23 22/23 24/4 36/20 37/9 37/10 37/13 38/3 38/15 39/25 41/1 41/1 41/7 41/22 43/2 44/5 44/13 46/20 46/23 46/23 46/25 46/25 47/13 47/13 48/17 49/12 49/19 49/19 50/14 51/25 54/2 54/3 56/7 56/10 56/10 56/16 56/21 57/22 60/8 60/16 61/7 61/20 62/12 63/6 63/8 64/8 64/17 66/1 66/1 67/14 69/7 69/25 70/10 70/10 70/10 72/18 73/6 76/9 76/24 78/11 82/22 85/1 86/1 86/21 87/9 88/17 91/2 92/1 93/1
nobody [2] 81/13 81/14
Noel [1] 7/1
non [11] 22/24 23/9 26/11 51/19 52/22 52/25 53/2 54/9 56/2 64/23 65/2
non-adherence [2] 51/19 56/2
non-compliant [1] 52/22
non-concordance [1] 53/2
non-concordant [7] 22/24 23/9 26/11 52/25 54/9 64/23 65/2
noncompliance [1] 28/11
none [2] 52/11 59/1
nonsense [1] 62/17
normal [3] 21/15 38/9 41/16
normally [1] 41/6
nose [1] 91/1
not [141]
note [11] 24/25 30/22 80/22 82/16 83/7 83/15 83/25 86/1 86/4 88/24 90/19
noted [4] 44/24 59/13 60/3 60/5
notes [14] 12/15 12/18 19/24 25/18 45/7 54/23 58/12 65/24 69/5 69/18 69/21 80/21 80/25 81/8
nothing [5] 49/9 65/24 78/20 86/12 92/3
notice [2] 90/15 91/11
notification [1] 78/14
Nottingham [2] 31/16 76/24
Nottinghamshire [1] 10/17
notwithstanding [1] 80/5
November [3] 1/12 23/24 71/24
November 2020 [2] 23/24 71/24
November 2025 [1] 1/12
now [32] 3/6 10/23 17/14 24/7 26/2 26/16 27/8 28/23 31/10 35/24 37/14 43/17 44/9 44/20 45/24 45/25 47/1 53/14 54/13 57/7 60/5 63/11 68/13 70/18 71/18 77/9 86/1 86/21 87/7 87/11 87/14 87/25
number [6] 11/5 16/22 34/22 43/5 51/2 84/5
number 3.8 [1] 11/5
Number 8 [1] 34/22
nurse [4] 45/3 51/4 60/22 91/22
nurses [2] 44/25 69/5
nursing [7] 44/7 44/9 44/18 50/1 54/15 55/8 92/7

O

oath [2] 86/13 87/4
observation [1] 8/1
observations [1] 5/18
observe [2] 9/23 64/19
obtain [7] 10/6 10/14 11/14 29/1 40/22 42/18 85/25
obtained [2] 28/24 85/11
obtaining [3] 4/23 11/17 85/18
obviously [1] 9/23
occasion [6] 13/2 49/6 50/16 53/18 54/2 68/17
occasions [1] 50/17
occupational [1] 7/24
occur [1] 45/8
occurred [4] 63/8 91/1 91/2 91/8
October [38] 2/4 2/12 2/15 2/17 5/23 6/4 6/7 6/13 6/21 7/21 18/25 43/8 44/17 46/13 46/15 49/5 53/8 53/14 54/21 56/23 59/9 63/12 63/16 67/21 68/11 69/20 71/2 72/20 73/20 73/24 75/8 76/18 77/16 78/7 82/9 83/12 90/13 91/20
October 2021 [5] 2/4 5/23 6/4 6/7 6/21
off [5] 12/16 28/20 54/5 68/5 78/16
offer [1] 48/23
offered [6] 45/21 48/22 49/4 49/10 49/12 50/16
offering [1] 48/18
offers [1] 51/4
officer [1] 25/20
oh [4] 13/10 19/25 53/13 74/7
okay [5] 12/20 54/25 60/4 76/5 90/7
omission [1] 85/6
on [187]
once [3] 23/18 28/20 30/10
one [61] 3/1 3/19 7/1 9/17 11/13 11/21 14/12 15/9 19/18 32/6 32/16 35/20 37/15 38/25 39/24 42/9 43/5 43/7 44/11 44/11 44/18 44/18 44/25 44/25 45/1 45/1 45/4 45/4 45/6 45/6 45/10 45/10 45/16 45/16 45/19 45/19 45/21 45/22 45/22 47/17 49/20 50/1 50/1 50/3 51/3 51/3 55/8 55/8 55/20 66/21 66/22 67/2 68/14 70/5 70/12 72/7 72/8 76/17 83/8 88/21 89/12
one-year [1] 39/24
ongoing [3] 40/2 41/9 41/17
only [17] 11/23 12/6 15/9 15/19 24/5 28/25 33/7 38/13 39/6 45/10 45/20 50/3 58/6 72/5 72/10 72/19 87/4
onto [1] 59/14
onwards [1] 25/18
open [1] 68/19
operated [1] 12/9
operating [1] 10/20
opportunity [1] 74/19
optimisation [1] 35/22
optimised [1] 35/18
option [4] 33/7 39/14 81/21 84/3
options [3] 67/4 67/9 67/10
or [95]
order [12] 7/13 10/10 16/22 24/14 24/17 26/14 61/3 66/14 67/11 71/18 71/18 74/20
OT [1] 57/21
other [19] 3/2 16/17 19/8 40/22 45/10 48/21 49/12 52/2 55/14 55/19 55/20 56/16 64/10 69/25 73/2 82/3 83/25 88/20 92/16
others [5] 21/10 21/14 28/10 31/7 72/21
otherwise [2] 42/5 50/15
ought [4] 6/17 23/18 66/7 73/2
our [6] 13/11 41/3 41/4 41/23 65/4 92/25
out [21] 8/23 13/11 22/9 24/17 26/14 27/16 35/14 41/25 43/6 49/25 51/15 52/6 55/25 61/2 65/11 76/4 79/9 79/12 80/23 86/6 89/1
outpatient [1] 78/18
over [13] 14/1 14/1 28/4 34/23 39/16 46/3 70/11 71/9 82/2 82/10 90/23 91/1 93/2
overall [2] 8/11 51/8
overnight [3] 81/18 81/22 92/6
overreacted [2] 53/18 68/17
overspeaking [32] 12/11 12/22 12/24 13/5 13/7 13/10 19/13 24/23 25/5 27/8 29/16 29/18 33/13 46/24 49/2 57/22 59/25 60/23 60/25 61/10 63/22 66/2 66/7 67/6 77/16 81/11 81/13 83/19 88/16 90/5 90/20 91/3
overview [1] 2/11
own [6] 10/25 21/14 31/6 47/24 48/4 55/15

P

page [80] 3/13 3/14 4/1 4/1 4/14 4/14 4/15 6/25 8/11 8/23 8/24 9/7 9/7 9/11 9/12 11/5 11/21 11/22 17/1 17/2 17/6 17/7 18/7 18/21 18/23 19/17 20/17 22/5 22/10 23/2 23/21 24/1 24/25 25/7 26/23 26/24 27/15 28/9 29/22 31/2 31/2 33/16 34/22 35/12 36/3 37/6 41/24 43/11 43/24 43/25 44/16 44/17 45/11 47/2 52/2 52/6 53/15 53/16 57/10 57/11 57/12 59/18 67/23 70/24 70/25 71/9 75/6 76/22 77/4 78/13 79/5 82/1 82/9 82/10 83/6 83/8 83/9 90/12 91/22 94/2
page 1 [3] 8/11 17/1 83/9
page 10 [1] 4/1
page 11 [3] 4/14 18/7 29/22
page 13 [1] 8/23
page 138 [1] 23/21
Page 15 [1] 9/7
page 16 [1] 9/11
page 167 [1] 24/25
page 17 [1] 18/21
page 193 [1] 82/1
page 2 [6] 6/25 52/6 76/22 77/4 83/6 90/12
page 21 [1] 19/17
page 3 [10] 17/6 26/23 31/2 31/2 36/3 45/11 53/15 57/10 67/23 75/6
page 39 [1] 70/24
page 4 [4] 11/5 27/15 34/22 57/11
page 5 [3] 11/21 35/12 44/16
page 55 [1] 59/18
page 56 [1] 22/5
page 58 [1] 23/2
page 8 [1] 41/24
page 9 [1] 3/13
page two [1] 28/9
PAGR [2] 75/5 75/6
PAGR0000003 [1] 28/9
PAGR0000004 [1] 29/21
PAGR0000006 [1] 26/22
PAGR0000010 [1] 56/1
PAGR0000012 [1] 76/19
PAGR0000013 [1] 35/25
PAGR0000014 [1] 73/13
PAGR0000016 [1] 30/23
PAGR0000025 [3] 44/15 83/5 83/7
PAGR0000028 [1] 90/12
PAGR0000033 [1] 11/2
PAGR0000159 [3] 53/9 53/13 67/22
PAGR0000160 [2] 56/24 59/9

P

PAGR0000163 [1] 79/16
PAGR0000165 [1] 43/4
PAGR0000171 [1] 45/24
pain [1] 17/12
paper [1] 75/16
paperwork [1] 18/2
paragraph [29] 3/18 4/5 4/14 5/16 7/7 7/8 9/1 22/14 23/25 25/14 25/18 27/23 31/2 31/3 31/23 33/4 33/15 35/15 36/4 37/14 41/25 42/12 54/4 59/18 67/25 70/23 70/25 71/8 72/14
paragraph 145 [1] 70/25
paragraph 151 [1] 71/8
paragraph 206 [1] 59/18
paragraph 25 [1] 41/25
paragraph 3 [2] 31/2 31/3
paragraph 6 [1] 33/15
paragraph 8 [1] 72/14
paragraphs [3] 4/2 7/6 52/8
paragraphs 6 [1] 7/6
paranoia [1] 19/10
paranoid [9] 19/8 21/25 22/2 29/25 36/25 37/3 60/23 93/1 93/2
parcel [1] 22/4
Pardon [1] 76/15
part [16] 2/9 8/1 22/4 26/21 32/24 38/11 45/2 48/8 48/15 51/8 57/17 61/1 62/4 62/5 73/25 77/3
Partial [1] 35/5
particular [9] 4/22 5/2 7/23 7/24 23/25 42/22 42/24 64/23 72/18
particularly [4] 11/13 18/9 25/2 37/17
Parton [1] 43/10
passed [1] 16/14
password [1] 12/17
passwords [1] 13/2
past [6] 22/11 42/20 52/14 65/11 68/3 71/13
patient [46] 4/6 7/11 7/12 8/25 9/2 9/14 9/25 10/7 10/24 11/8 11/12 11/24 12/8 13/8 14/6 14/9 16/24 18/17 18/23 25/22 26/3 26/22 28/3 29/2 30/18 30/19 33/8 33/10 34/1 42/14 56/21 65/9 66/15 73/21 73/22 75/5 78/5 78/7 79/3 79/8 79/11 80/11 82/25 87/22 89/13 89/18
patient's [3] 42/6 53/15 67/15
patients [18] 3/16 10/17 15/1 16/9 16/10 21/15 34/11 38/10 48/24 50/11 55/11 55/12 55/15 55/17 55/19 64/11 85/16 89/17
pattern [5] 38/10 41/16 52/18 58/23 59/2
patterns [1] 52/14
Pause [1] 42/13
pausing [1] 17/14
PC [1] 68/21
PC Pritchard [1] 68/21
penultimate [2] 36/4 45/11
people [7] 18/24 19/4 19/8 19/12 21/13 66/10 70/16
perceives [1] 37/10
perhaps [2] 68/19 78/16
period [18] 23/11 28/22 29/7 33/6 33/11 34/6 39/16 39/22 39/24 39/25 58/17 58/22 63/21 64/7 64/13 64/20 65/4 87/10
periods [1] 6/3
permanently [1] 20/23
permitted [1] 54/16
person [6] 7/24 22/2 48/4 68/2 78/11 79/21
personal [1] 92/18
perspective [1] 3/2
persuade [1] 66/18
phone [9] 13/9 19/21 79/23 80/3 85/8 88/6 88/19 89/1 89/23
physical [1] 7/15
pick [5] 13/8 81/1 82/21 89/1 89/23
picked [4] 59/21 80/20 81/3 92/11
picture [1] 26/3
pictures [1] 92/22
PICU [3] 29/7 29/12 64/15
piece [2] 19/5 19/7
place [18] 2/23 32/11 32/19 36/1 39/4 51/3 53/11 57/4 60/1 64/25 65/6 74/11 74/23 79/25 82/21 86/24 88/9 88/15
placed [2] 74/23 83/17
plan [34] 6/1 6/2 6/11 6/11 6/16 30/3 30/9 32/3 32/16 43/5 43/9 45/25 46/1 46/2 46/2 46/6 46/7 46/10 46/12 46/15 47/1 47/5 47/7 47/14 48/8 48/15 49/22 50/1 50/3 51/2 51/7 64/24 66/4 83/1
planned [3] 31/20 76/9 78/17
planning [1] 47/10
plans [9] 43/6 46/22 51/12 61/19 75/18 86/20 86/25 87/23 87/23
plaster [5] 90/17 91/12 91/15 91/19 92/8
plausible [1] 60/20
play [1] 9/21
pleasant [2] 33/20 34/1
please [34] 1/4 3/12 3/14 6/23 6/25 8/4 8/22 9/7 16/21 22/5 34/18 43/4 43/24 45/24 50/22 51/13 67/21 67/22 70/11 70/24 70/25 73/13 75/3 76/18 76/21 78/12 78/15 79/5 81/25 82/1 82/6 83/5 83/9 89/6
plenty [1] 40/15
pm [5] 1/2 17/7 50/23 50/25 93/13
PNC [1] 42/18
point [34] 4/19 4/22 11/12 12/20 13/20 14/23 22/20 33/5 33/14 36/11 36/19 41/2 42/8 44/3 44/25 46/19 54/23 56/22 61/20 61/20 61/21 62/23 62/23 63/16 63/17 66/3 66/20 70/19 70/22 71/19 73/4 86/17 89/2 89/20
points [3] 22/24 54/10 71/7
police [18] 22/15 25/20 40/23 41/1 41/3 41/12 41/15 41/20 42/2 42/5 42/10 42/15 42/16 42/19 42/21 43/21 53/19 68/18
policy [4] 10/25 11/2 12/21 13/12
polite [4] 25/9 25/15 25/23 26/7
politely [2] 25/16 48/20
poor [1] 28/2
position [2] 3/3 6/6
positive [1] 72/23
possible [3] 11/18 35/15 75/18
possibly [3] 22/20 35/3 86/7
post [2] 8/7 8/8
post-dates [2] 8/7 8/8
potential [5] 11/9 31/25 52/15 52/19 59/7
potentially [2] 21/9 32/21
power [1] 74/20
powers [1] 67/11
practice [1] 12/21
practitioners [1] 73/2
pre [2] 52/7 52/9
pre-date [1] 52/9
pre-dates [1] 52/7
predicted [1] 53/5
preferred [2] 68/5 68/11
preferring [1] 54/4
preoccupied [1] 47/24
prepared [3] 1/9 2/25 76/3
prescribed [1] 54/8
present [5] 26/7 56/11 90/21 91/21 93/1
presentation [5] 29/5 63/25 64/6 64/18 77/18
presenting [1] 25/23
presumably [5] 13/8 18/8 72/13 84/18 84/24
pretend [1] 24/16
pretty [4] 21/9 23/9 45/13 88/2
prevent [1] 85/17
previous [13] 8/7 8/18 9/3 9/17 11/8 33/19 37/21 42/25 43/1 43/3 52/24 58/1 91/22
previously [6] 11/13 46/1 46/9 54/8 56/4 72/16
Prince [1] 7/1
printed [2] 14/17 14/21
prior [15] 3/23 5/21 5/22 6/7 6/13 23/3 24/24 32/11 40/24 41/22 80/3 86/18 87/6 87/20 92/4
Priory [39] 1/22 1/24 2/6 2/11 3/4 3/6 6/19 7/2 7/9 7/19 9/22 10/12 10/25 11/23 15/10 20/6 26/18 28/5 29/21 30/24 30/25 31/16 32/8 38/13 43/7 51/13 52/9 54/17 55/4 65/1 69/18 78/3 78/18 78/18 79/21 81/7 82/11 82/20 92/7
Pritchard [1] 68/21
private [1] 75/12
proactive [2] 55/23 55/24
probably [5] 18/25 63/9 82/6 87/2 88/3
problem [1] 39/20
procedure [1] 12/20
process [1] 57/5
professional [1] 1/19
professionals [2] 34/12 55/12
profile [1] 69/11
progressing [2] 47/8 87/1
prompt [1] 72/18
prompting [1] 50/9
proper [1] 34/3
properly [1] 81/19
property [8] 17/9 25/12 59/21 61/9 61/14 75/17 80/24 92/18
prosecution [2] 41/22 43/3
prosecutions [1] 42/20
protect [1] 64/25
Protecting [1] 65/8
prove [1] 86/12
provide [8] 4/17 5/6 6/1 6/11 14/17 20/7 44/9 45/4
provided [10] 6/1 6/2 7/14 13/21 20/3 20/5 29/21 30/25 74/8 78/4
provision [1] 4/10
Psychiatric [2] 2/3 28/14
psychiatrist [3] 1/20 18/11 18/16
psychoeducation [3] 38/20 38/23 38/25
psychological [3] 7/16 38/22 38/25
psychology [3] 49/22 57/21 64/16
psychosis [5] 33/24 34/9 34/10 36/5 36/21
psychotherapy [1] 38/22
psychotic [7] 18/17 24/16 36/14 36/25 37/4 38/19 40/2
public [4] 64/25 65/3

P

public... [2] 65/8 75/24
pull [1] 78/16
punishment [2] 18/15 18/19
purposes [4] 11/17 20/13 21/20 56/16
pursuant [1] 74/1
pushing [1] 22/11
put [14] 6/24 11/1 16/20 26/2 30/19 32/11 32/19 33/8 39/4 51/3 64/25 65/6 80/22 92/13
putting [1] 92/22

Q

quarter [1] 50/21
Queens [4] 78/7 78/25 82/15 83/2
Queens Road [1] 78/7
question [9] 6/3 11/25 14/6 46/4 54/20 65/5 69/17 89/7 91/17
questionable [1] 27/6
Questioned [11] 1/7 67/19 73/9 84/12 90/10 94/4 94/5 94/6 94/7 94/8 94/9
questions [5] 67/16 73/12 89/7 91/10 92/20
quickly [1] 87/17
quite [15] 6/16 21/14 21/17 21/18 39/21 39/23 47/23 48/3 48/4 55/11 66/3 66/11 66/13 87/17 88/18

R

raised [4] 3/9 3/15 4/22 6/16
raising [2] 9/2 33/17
ran [1] 28/25
rang [1] 82/11
ranked [1] 56/4
raped [1] 43/15
rather [4] 8/6 45/19 66/11 85/22
rating [2] 8/11 8/12
rationale [1] 15/23
read [17] 6/5 8/23 11/23 12/6 13/19 13/22 13/25 14/9 14/10 14/11 14/16 15/6 27/18 35/14 40/4 42/13 45/12
reading [14] 9/16 12/15 13/20 14/13 14/19 14/19 14/21 15/8 15/11 15/11 19/24 41/21 48/3 92/5
readmitted [1] 23/11
reads [2] 5/8 36/4
ready [4] 33/12 81/19 89/4 89/11
real [1] 7/11
realise [1] 88/25
really [22] 6/14 6/17 16/16 20/8 36/12 38/18 44/24 54/20 58/21 64/11 64/13 67/12 69/7 69/8 69/22 87/18 87/19 89/21 90/13 90/16 91/13 92/23
reason [11] 2/25 36/19 41/13 64/17 76/9 87/4 87/7 87/17 89/3 89/21 89/25
reasonable [1] 52/19
reasonably [3] 34/5 39/16 64/14
reasons [8] 33/3 35/20 55/18 55/21 88/11 88/21 89/8 89/12
reassure [2] 89/13 89/15
recall [4] 13/18 65/21 69/7 74/21
receive [1] 93/8
received [4] 5/12 16/15 18/2 26/18
receiving [4] 5/20 10/23 11/12 41/7
recent [2] 72/4 72/7
recently [6] 13/22 13/25 14/1 14/2 19/24 72/9
recognise [1] 7/16
recollect [2] 85/5 90/16
recollection [11] 12/15 13/20 13/22 14/19 15/6 18/6 20/1 20/12 54/3 59/20 86/22
recommend [3] 31/20 32/2 32/23
recommendation [3] 5/25 32/13 65/19
recommended [2] 57/20 57/20
record [3] 4/3 9/8 9/9
recorded [4] 60/17 76/22 81/8 83/12
recording [1] 75/19
records [59] 11/7 11/15 11/24 12/2 12/4 12/13 12/22 12/24 13/11 13/12 13/13 13/16 13/19 13/21 13/25 14/3 14/7 14/9 14/11 14/13 14/15 14/16 14/17 14/18 14/20 14/24 15/4 15/11 16/4 16/13 16/20 17/6 17/15 18/21 22/5 24/24 25/1 26/2 28/24 29/1 29/11 29/14 29/18 29/20 42/19 42/19 44/15 49/3 50/7 52/24 58/13 59/14 60/3 60/6 64/21 75/4 79/16 80/5 88/24
recover [1] 7/14
recovered [2] 27/4 31/24
recovery [5] 70/19 70/22 71/7 71/19 73/4
red [2] 20/25 21/2
reduced [3] 51/18 56/3 75/4
reducing [3] 51/21 56/6 57/5
refer [1] 14/3
reference [17] 5/2 17/8 18/13 21/2 22/15 24/2 27/1 30/1 30/15 34/23 35/3 35/14 36/11 39/1 40/9 43/25 44/18
references [1] 25/9
referral [5] 10/12 16/16 18/2 26/21 28/24
referred [2] 33/17 70/7
referring [10] 5/3 14/13 32/14 46/14 46/16 47/12 47/14 56/9 77/3 77/13
refers [3] 17/2 34/22 54/4
reflect [2] 6/5 9/20
reflected [1] 62/10
reflecting [1] 66/8
refused [1] 50/15
refusing [1] 35/21
regular [9] 16/8 34/6 39/13 65/11 88/3 88/6 88/18 90/6 93/7
regularly [3] 46/20 58/13 90/4
reinforce [1] 71/9
relapse [2] 53/17 68/16
relapsed [2] 39/21 39/23
relapses [1] 39/24
relapsing [2] 40/1 65/13
relates [1] 51/24
relation [4] 4/22 67/24 68/11 71/21
relations [1] 71/16
relationship [2] 66/14 66/18
relative [1] 87/20
relatively [2] 58/17 64/19
release [3] 32/11 33/12 66/25
released [3] 23/13 24/14 33/2
relevant [5] 16/11 16/13 20/10 73/16 79/4
reliant [1] 71/15
relieving [1] 71/13
reluctant [3] 66/11 77/1 77/7
remain [3] 55/15 57/16 92/25
remained [1] 25/15
remanded [1] 42/17
remember [13] 6/9 9/24 14/19 15/3 15/12 16/16 19/23 60/16 60/21 86/10 86/15 86/23 87/2
remind [1] 50/12
reminded [1] 19/24
repeat [3] 11/25 68/22 78/22
repeated [1] 25/16
report [10] 4/8 5/12 5/25 6/5 8/5 8/6 8/22 9/3 9/24 40/4
reported [5] 61/24 62/1 70/1 75/12 90/23
reporting [2] 9/12 21/13
reports [3] 18/18 41/21 92/5
represent [1] 84/13
representation [2] 7/18 21/7
request [5] 11/7 54/11 70/18 86/16 87/24
requested [1] 29/9
requesting [2] 57/25 58/4
require [2] 29/8 37/8
required [6] 6/10 10/6 10/9 62/7 62/8 79/7
requirement [1] 11/14
requires [6] 13/12 33/2 33/6 33/10 62/9 81/17
rescind [2] 63/11 76/4
rescinded [3] 2/14 57/15 75/15
rescinding [2] 57/8 76/2
resident [2] 22/11 76/25
resisted [1] 50/15
resistive [2] 66/4 67/14
resolving [2] 47/24 48/1
respect [12] 6/3 7/9 8/15 13/15 16/20 21/23 40/22 41/18 49/25 64/22 74/3 87/24
respond [1] 84/5
responsibility [6] 14/11 15/8 51/8 51/9 51/11 74/5
responsible [8] 2/7 51/6 62/6 66/6 69/16 73/16 73/19 84/21
rest [5] 14/12 16/5 16/11 16/14 46/19
restrained [1] 22/12
restrictive [1] 31/11
result [3] 10/3 25/24 42/4
resume [1] 37/12
returned [2] 17/17 92/17
returning [3] 47/10 47/25 59/23
review [10] 6/10 18/8 18/22 26/22 53/10 76/3 76/7 77/17 77/23 91/21
reviewed [5] 18/11 20/13 20/16 46/20 75/10
reviews [3] 18/9 29/2 29/4
Revocation [1] 75/8
right [19] 1/15 2/5 4/24 9/19 9/24 15/13 50/21 54/25 55/10 61/21 73/15 73/23 82/7 84/4 87/8 87/20 87/22 93/9 93/11
RiO [30] 12/2 12/13 12/15 12/16 12/18 12/22 12/24 13/16 13/19 14/3 14/7 14/9 14/13 14/17 14/20 14/23 15/3 15/11 15/12 15/14 15/15 15/16 15/18 15/19 15/20 16/3 16/13 16/20 20/8 24/24
RiOs [1] 81/25
risk [58] 3/20 8/25 9/2 9/4 24/21 24/22 26/10 28/8 28/10 28/11 28/13 28/14 28/20 28/22 38/16 39/2 51/13 51/14 51/17 51/24 52/2 52/12 52/12 52/14 52/15 52/16 52/18 52/19 52/21 52/25 53/1 53/4 53/7 53/11 55/25 56/17 59/1 62/7 62/9 62/11 62/19 62/20 63/2 64/11 65/1 65/1 65/3 75/23 75/24 76/11 76/12 76/16 77/5 77/10 77/15 77/24 78/1 78/10
risk factor [3] 24/22

R

risk factor... [2] 53/1 77/10
risk factors [1] 52/2
risking [1] 62/24
risks [8] 3/14 3/16 11/9 28/17 39/6 51/24 56/2 64/22
Road [5] 78/7 78/25 82/15 83/2 84/2
role [3] 8/2 45/2 45/2
room [4] 54/16 54/24 75/10 93/4
rooms [1] 55/16
round [6] 46/20 47/15 57/3 77/12 82/12 90/16
rounds [1] 84/16
rucksack [1] 59/14
rude [1] 70/12
rum [2] 20/25 21/2
running [5] 28/24 29/1 29/11 29/20 49/3

S

s3 [1] 31/20
safe [15] 4/17 5/6 7/11 8/15 43/9 46/2 46/9 46/12 46/14 49/22 79/7 80/19 81/16 82/19 88/15
safely [1] 31/11
safety [10] 4/4 4/6 4/9 4/19 5/21 8/19 9/8 9/10 9/14 31/7
said [36] 18/15 24/2 24/5 24/5 31/5 34/19 34/20 35/7 36/5 36/6 36/17 37/7 37/23 53/18 54/6 58/6 58/9 60/3 65/15 68/6 68/15 68/17 68/25 72/5 72/9 72/15 73/1 73/14 80/6 85/12 85/19 86/7 87/6 87/13 87/14 90/23
salivate [2] 54/6 68/6
salivating [1] 69/3
salivation [3] 69/19 70/7 70/14
salvation [1] 69/5
same [5] 9/17 28/7 53/7 55/25 58/23
satisfy [1] 74/2
save [1] 72/15
saw [6] 20/2 69/19 70/18 72/8 72/13 90/15
say [27] 4/25 13/9 13/24 27/25 31/19 33/21 35/6 38/25 39/23 41/9 42/24 46/4 50/14 52/17 54/2 57/23 59/19 73/24 74/16 74/18 78/11 86/14 87/5 87/18 89/6 89/17 90/3
saying [11] 18/14 36/12 37/24 48/21 55/6 72/23 74/24 77/7 77/13 77/19 86/21
says [8] 7/5 18/23 27/17 30/4 34/24 57/14 68/1 91/14
sceptical [3] 60/21 73/3 73/5
schizophrenia [3] 22/1 22/3 29/25
screen [5] 6/24 6/25 12/1 14/21 20/18
scroll [1] 46/21
scrutinising [2] 10/1 81/3
search [4] 59/23 70/5 70/13 70/17
second [11] 1/14 23/3 23/25 24/1 27/3 41/24 41/25 59/18 71/24 89/3 89/10
section [53] 2/9 2/13 2/13 30/5 30/8 30/11 30/12 30/16 30/18 32/9 32/10 32/13 32/19 32/24 33/1 33/5 33/7 33/8 33/9 33/9 36/2 36/3 37/9 37/11 38/2 38/3 47/8 53/16 57/8 57/13 57/15 58/7 60/25 61/14 63/11 66/20 66/21 67/5 72/6 72/10 73/18 73/18 74/1 74/9 74/19 74/21 74/24 75/8 75/15 75/25 76/2 76/4 81/17
Section 17 [2] 47/8 81/17
section 172 [1] 74/1
Section 2 [3] 30/11 32/9 33/8
section 3 [23] 2/9 2/13 30/5 30/8 30/12 30/16 30/18 32/10 32/13 32/24 33/5 33/7 36/3 57/8 57/13 63/11 73/18 74/9 74/21 74/24 75/8 75/15 75/25
secure [1] 75/17
secured [1] 61/9
see [51] 3/14 3/17 4/2 7/5 8/5 8/11 8/12 8/24 11/2 12/10 13/11 13/12 13/13 17/1 17/8 18/13 19/22 21/15 22/9 25/8 26/24 27/9 27/17 28/10 29/24 29/24 30/9 31/8 35/15 37/10 37/20 40/9 43/10 44/17 45/10 46/21 46/21 51/15 56/1 56/23 66/9 72/22 73/18 75/7 76/6 78/24 79/20 81/7 82/14 83/11 88/22
Seedat [2] 19/18 19/20
seeing [3] 20/12 72/9 72/20
seek [2] 17/20 42/1
seeking [1] 55/8
seem [2] 5/3 92/21
seems [3] 9/16 23/10 91/16
seen [13] 19/25 20/4 20/11 21/20 25/8 33/15 34/11 44/11 58/5 63/18 64/22 65/18 69/22
sense [2] 7/12 19/15
sent [4] 6/12 10/13 19/21 28/7
sentence [7] 24/1 31/23 36/8 36/23 37/5 42/18 68/14
September [8] 25/2 26/23 28/8 28/23 28/25 35/24 40/6 74/9
September 2021 [1] 25/2
serious [5] 11/9 18/5 34/13 34/15 34/16
seriously [1] 39/23
seriousness [1] 53/25
service [6] 4/3 4/6 9/9 9/14 41/4 41/5
services [2] 8/15 37/13
session [10] 44/9 44/19 44/25 45/1 45/4 45/6 45/10 45/12 45/17 45/19
sessions [4] 44/11 45/22 48/18 55/9
set [3] 22/9 41/25 49/25
sets [1] 52/6
severe [5] 21/8 21/24 22/1 22/2 37/4
severely [1] 39/21
share [5] 14/18 85/16 86/20 87/9 87/23
shared [2] 51/9 51/10
sharing [3] 4/24 40/20 85/22
sharp [1] 92/16
she [39] 27/3 31/4 31/6 31/20 32/1 32/22 32/23 33/20 33/23 58/12 58/12 63/20 65/19 82/23 82/23 82/24 86/10 86/14 86/18 86/18 86/21 86/22 87/2 87/2 87/6 87/7 87/19 87/22 88/2 88/6 88/7 88/11 88/18 89/9 89/23 90/2 90/3 90/4 90/5
she's [3] 86/15 86/22 87/3
Shoilekova [4] 27/16 31/4 31/24 65/18
Shoilekova's [2] 63/19 63/19
short [3] 32/11 50/24 58/17
shortly [4] 22/7 26/17 31/15 34/21
should [27] 10/24 11/7 15/11 20/5 20/10 30/5 30/7 55/23 55/24 60/9 60/10 60/13 60/14 60/22 61/25 62/1 62/19 62/20 63/1 64/2 66/5 66/8 76/1 78/9 79/22 81/17 82/20
shoulders [1] 15/9
shouldn't [2] 53/23 61/25
show [5] 37/14 49/3 78/13 79/25 82/16
showed [1] 40/1
shows [7] 27/21 27/24 34/13 36/13 36/15 37/19 82/19
sic [1] 67/11
side [9] 37/11 54/6 69/2 69/11 69/14 70/2 70/6 70/13 71/5
significance [2] 24/12 64/9
significant [20] 21/4 21/6 24/7 24/9 24/21 24/22 29/6 37/17 43/22 46/24 53/20 56/22 70/18 70/22 71/7 71/19 73/4 74/5 74/22 76/21
significantly [1] 73/20
signs [1] 40/2
similar [1] 9/2
simply [7] 7/10 24/17 54/16 56/12 56/18 70/5 93/4
since [5] 1/24 18/25 27/2 29/11 46/15
six [2] 64/8 64/20
six weeks [2] 64/8 64/20
smash [1] 17/9
so [207]
some [31] 3/12 7/4 13/20 13/21 13/23 14/10 14/20 15/13 15/14 16/11 18/5 19/25 20/9 22/20 22/24 26/18 40/2 42/9 44/25 48/21 48/21 51/12 52/23 57/20 61/4 64/16 65/15 69/21 71/5 73/1 89/25
somebody [9] 21/7 33/1 33/6 60/22 61/18 62/13 67/12 67/14 87/24
Somehow [1] 91/4
someone [6] 26/4 26/7 26/10 26/13 43/15 84/20
something [12] 16/4 23/18 37/24 45/7 62/13 66/5 66/6 69/5 72/21 92/6 92/16 92/22
sometimes [5] 12/16 14/17 14/17 50/9 50/11
soon [1] 88/4
sorry [28] 9/6 11/25 13/24 14/13 15/17 32/13 33/14 43/4 46/4 46/4 46/18 54/18 57/11 62/14 62/22 63/4 64/15 69/12 74/17 76/14 77/3 77/3 78/22 80/2 83/8 89/6 89/16 89/18
sort [4] 13/11 29/4 73/1 91/12
sought [1] 73/24
sounds [1] 62/17
speak [2] 85/10 86/16
special [3] 3/7 10/4 10/5
specialties [1] 51/10
specific [2] 5/4 7/13
specifically [2] 6/3 52/17
specified [1] 59/6
spending [1] 54/24
spent [2] 51/12 52/22
spoke [2] 43/13 90/4
stable [2] 39/16 64/19
staff [14] 3/15 6/18 15/19 15/20 35/1 43/21 50/12 55/22 62/5 64/10 69/25 79/13 88/7 88/7
staff' [1] 43/14
stage [5] 56/24 57/17 60/24 68/20 87/19
start [4] 33/4 43/8 45/20 93/11
started [1] 66/22
starting [1] 11/12
starts [1] 34/23
state [4] 9/21 27/15 57/11 65/12
stated [3] 37/11 43/14 68/4
statement [11] 7/1 11/20 11/21 12/2 41/24 41/25 42/12 59/17 59/18 65/20 70/23
statements [3] 1/10

S

statements... [2] 1/16 2/25
states [3] 4/8 11/6 31/10
stating [2] 20/20 71/12
Station [1] 92/8
statutory [2] 74/3 75/19
stay [7] 2/20 34/21 39/8 44/20 46/3 54/16 55/3
staying [1] 81/24
step [2] 32/10 32/16
stepped [1] 32/7
steps [12] 5/20 5/22 5/24 6/7 6/9 38/12 40/21 54/13 54/14 55/6 64/24 65/5
still [11] 19/17 39/20 56/11 57/17 60/23 60/24 60/25 76/22 85/23 85/24 89/16
stop [1] 23/6
stopgap [1] 32/11
stopped [8] 23/14 36/6 36/7 36/17 36/20 36/22 72/16 72/18
straight [2] 21/5 35/9
straightforward [1] 70/5
Straw [3] 84/11 84/12 94/8
stressed [2] 53/18 68/17
strip [1] 22/16
strongly [1] 21/10
struggling [2] 34/10 70/1
students [2] 34/12 55/12
studies [4] 37/12 48/1 48/2 61/4
subject [3] 60/25 67/1 74/21
submit [1] 10/9
subsequent [1] 52/12
substance [1] 46/12
such [10] 7/10 21/16 32/8 41/7 48/25 56/10 57/21 70/9 71/3 89/22
suffer [1] 38/10
suffered [4] 17/21 18/4 21/24 36/12
suffering [5] 21/7 22/2 34/16 37/3 38/19
suffers [2] 33/24 34/8
suggest [6] 56/11 65/24 69/18 77/24 80/18 82/18
suggested [3] 32/6 57/15 71/11
suggesting [1] 71/6
suggestion [1] 61/8
suggests [1] 78/9
sum [1] 71/1
summarised [1] 29/4
summarises [1] 29/17
summarising [1] 31/3
summary [5] 19/20 20/17 45/22 68/8 83/20
superficial [2] 27/5 33/18
support [9] 49/17 49/22 76/24 82/4 88/16 88/17 88/20 88/21 88/23
supported [1] 61/2
supporting [1] 38/20
supportive [1] 38/4
suppose [1] 3/21
supposed [4] 44/23 45/7 79/4 79/21
sure [10] 5/24 6/1 7/11 12/14 33/23 36/10 51/6 59/5 69/9 90/2
surely [1] 6/10
surprised [2] 7/25 87/1
surrounding [1] 42/23
survivors [1] 73/12
swapping [1] 57/3
swear [1] 87/4
sworn [3] 1/6 86/13 94/3
symptoms [11] 7/17 22/3 22/4 24/15 36/19 36/21 38/17 38/19 52/3 58/2 71/14
system [2] 11/24 16/3

T

table [1] 49/5
tablet [1] 66/12
take [25] 5/20 7/23 24/1 25/22 35/7 37/23 38/12 40/16 50/17 50/21 54/13 54/14 55/6 64/24 67/22 67/25 70/23 74/24 74/25 76/17 79/10 79/16 79/25 82/5 82/18
taken [9] 5/22 5/24 6/7 6/9 40/17 40/21 57/4 76/20 82/21
takes [1] 66/13
taking [16] 23/6 23/14 24/11 38/5 38/14 39/6 39/9 39/15 39/17 40/15 56/17 58/6 58/9 58/11 58/13 67/1
talking [6] 5/4 14/4 18/14 68/22 70/11 88/7
team [36] 14/12 15/10 16/5 16/12 16/14 23/24 27/12 27/17 44/6 44/7 47/19 49/22 56/20 65/10 65/16 66/16 66/17 67/8 71/23 73/25 74/11 78/17 79/23 80/3 80/12 80/16 80/16 81/9 81/10 82/10 82/17 83/24 83/24 84/20 90/4 92/25
teams [2] 4/16 5/5
technical [2] 13/1 13/7
telephone [1] 84/5
telling [1] 72/21
tend [3] 55/12 55/14 55/15
tennis [1] 49/5
term [1] 38/5
terms [30] 5/4 10/23 14/11 29/11 34/4 34/7 38/20 45/5 48/4 49/13 53/2 55/10 55/22 59/3 62/22 63/7 64/9 64/12 65/3 65/7 67/9 69/11 71/13 74/17 77/21 87/23 87/25 88/17 88/20 89/14
text [6] 19/20 20/2 20/11 20/23 20/24 21/20
than [5] 16/17 20/16 45/19 85/22 92/16
thank [16] 50/22 67/16 67/17 73/7 75/6 75/9 78/13 82/8 82/10 83/8 83/10 84/9 84/10 90/7 93/9 93/10
that [540]
that's [133]
their [13] 5/17 7/13 10/14 11/15 12/13 20/22 38/11 45/2 48/24 55/13 55/15 55/16 61/19
them [14] 7/13 15/6 15/8 16/7 16/12 16/20 20/13 20/16 42/2 45/21 50/12 63/3 63/5 89/13
theme [1] 55/3
themselves [1] 55/17
then [47] 4/13 9/1 9/11 10/19 13/8 17/6 17/17 18/7 18/21 23/21 24/24 25/18 30/12 30/18 31/23 32/23 42/18 44/7 45/4 46/25 55/15 61/19 70/6 71/8 72/4 72/7 72/13 76/5 76/7 76/11 78/2 78/9 78/15 79/15 80/9 81/11 81/25 82/3 82/16 82/21 83/5 83/9 85/15 87/24 91/4 91/8 92/11
therapeutic [4] 48/13 66/14 66/18 71/16
therapies [9] 39/1 47/19 48/9 49/14 51/4 51/4 57/22 64/2 64/16
therapy [6] 7/25 49/12 54/15 55/8 55/22 57/20
there [82] 10/12 13/1 13/15 16/4 16/4 16/13 17/8 17/14 21/25 22/14 22/15 24/12 26/24 26/25 27/17 32/3 32/4 33/25 39/14 39/25 40/9 40/15 41/1 41/22 42/3 43/2 43/25 44/2 44/3 44/8 44/17 45/19 46/23 47/7 48/11 48/11 49/4 49/9 49/12 49/12 50/17 51/25 52/8 53/11 53/15 56/6 56/10 58/10 58/14 59/7 63/8 64/8 64/17 66/20 66/21 68/22 69/7 69/17 69/21 69/21 73/13 73/18 75/7 76/2 76/9 77/6 77/17 78/9 78/16 80/20 81/1 82/14 82/19 83/1 85/22 89/8 90/16 90/17 90/18 90/19 93/1 93/11
there'd [1] 17/15
there's [24] 8/24 32/15 41/7 44/18 45/20 46/23 46/23 46/25 46/25 52/7 61/20 65/24 67/14 69/9 70/12 73/6 74/21 76/25 77/7 83/18 83/22 86/1 86/12 91/22
thereafter [1] 34/21
these [8] 5/23 5/23 5/24 6/16 17/15 18/21 22/3 81/3
they [63] 4/17 5/6 6/17 8/19 8/20 8/21 9/20 10/1 10/1 13/23 13/25 14/17 14/18 15/24 15/25 18/18 20/5 20/7 20/9 20/10 20/16 20/16 20/20 20/21 21/4 21/4 21/6 21/15 21/16 21/17 21/17 21/18 21/21 25/19 41/9 41/16 42/9 44/11 47/22 48/17 50/11 51/5 53/1 55/12 55/13 55/14 55/18 55/19 65/10 66/10 66/11 67/7 67/7 68/4 79/13 79/14 79/22 82/17 83/24 88/5 89/14 89/14 89/15
they'd [1] 72/18
They've [1] 20/2
thing [2] 27/18 58/23
things [9] 3/3 9/13 10/1 48/21 55/20 76/8 82/20 87/17 90/9
think [22] 14/23 20/2 20/4 20/5 20/21 21/21 27/4 31/24 34/4 44/11 47/23 48/17 48/20 50/19 57/2 57/24 83/8 86/6 86/10 86/23 88/1 92/2
thinking [1] 20/25
thinks [2] 18/24 19/12
third [3] 22/14 43/18 58/16
this [175]
those [25] 1/16 3/12 6/8 8/18 9/20 14/7 14/9 16/6 20/10 21/4 21/20 26/13 28/23 34/1 41/20 43/3 46/22 49/11 51/5 67/4 67/6 67/9 67/10 67/16 74/3
thought [6] 16/5 19/4 62/17 64/2 68/3 76/5
thoughts [5] 18/18 21/9 21/10 43/15 61/19
three [4] 2/20 25/8 39/1 49/4
thrice [1] 85/9
through [12] 9/16 14/20 21/11 21/16 41/21 45/12 50/7 52/23 64/21 65/15 65/17 67/23
throughout [4] 29/5 55/3 64/13 65/4
Thursday [1] 75/18
time [30] 2/11 3/6 6/6 9/21 16/16 19/25 21/8 21/15 21/16 29/10 38/8 50/19 50/20 51/3 51/12 51/25 52/9 52/23 53/7 54/24 58/16 58/19 58/19 61/15 61/15 66/10 70/12 72/15 82/2 84/10
times [5] 40/18 50/5 64/15 64/15 93/7
tired [1] 24/6
today [3] 20/14 23/5 75/16
together [1] 80/13
told [6] 24/4 71/23

T

told... [4] 72/21 74/11 92/2 92/2
tolerant [1] 71/13
tomorrow [1] 93/12
too [6] 12/14 36/10 53/18 55/19 59/5 68/17
took [9] 8/8 8/18 36/1 37/20 53/11 60/1 68/15 74/10 74/23
tool [3] 28/13 79/18 80/6
top [6] 9/12 11/22 27/16 44/16 52/6 78/24
total [1] 2/20
totally [1] 60/19
touch [1] 47/9
towards [9] 8/24 17/7 29/22 41/14 44/7 47/2 47/5 57/11 64/10
town [1] 43/12
track [3] 4/3 9/7 9/9
training [1] 7/14
transfer [7] 11/3 78/6 78/23 79/3 79/11 83/17 83/23
transferred [5] 2/2 2/12 26/18 31/11 31/15
transition [2] 57/1 57/2
traumatic [1] 21/17
treating [7] 24/13 26/13 34/2 37/18 44/6 74/11 83/24
treatment [20] 7/19 11/8 31/22 32/1 33/2 37/8 37/9 38/2 48/6 48/8 48/15 51/20 56/2 58/22 67/11 72/6 72/10 73/21 74/20 75/23
trial [2] 57/25 76/5
tribunal [11] 30/2 30/6 30/10 30/22 31/5 34/19 35/13 35/20 37/20 63/18 72/13
tricky [1] 66/13
tried [4] 17/17 47/22 48/24 85/8
true [1] 1/16
Trust [7] 10/18 12/6 12/10 13/4 13/9 16/1 16/2
Trust's [1] 11/23
truthful [1] 24/11
try [4] 19/3 21/18 42/18 48/17
trying [7] 17/9 19/12 21/12 21/13 34/13 89/25 90/2
Tuhina [1] 23/23
turn [7] 4/1 11/5 17/6 28/9 43/4 50/8 50/11
turned [1] 64/4
turning [6] 50/4 70/18 70/22 71/7 71/19 73/4
twice [1] 85/9
two [22] 1/9 2/14 2/25 9/20 28/9 38/25 44/20 45/21 52/8 66/25 67/4 67/9 67/10 78/4 80/20 81/1 82/4 82/6 83/18 88/11 89/7 89/8
two weeks [1] 44/20
types [1] 49/13

U

unclear [3] 22/22 57/23 90/4
under [14] 2/9 7/5 7/7 9/12 18/13 18/23 23/23 25/7 30/18 52/2 58/7 67/4 86/13 88/1
undermined [1] 53/24
underneath [1] 9/1
underplaying [1] 53/20
understand [10] 5/16 7/16 17/14 21/12 21/18 28/13 30/16 30/17 54/20 89/16
understanding [18] 16/24 18/4 29/13 34/7 38/23 41/21 52/15 52/19 56/19 56/20 66/3 74/14 80/7 80/15 83/21 91/2 92/6 92/9
understatement [1] 43/22
understood [1] 71/10
undertake [1] 64/3
undertaken [1] 42/8
unexplained [2] 90/14 91/25
unit [8] 2/3 6/6 28/15 28/18 28/21 29/3 30/10 32/8
university [5] 37/12 40/23 47/9 55/12 75/13
unless [1] 27/25
unmedicated [2] 26/4 58/19
until [10] 35/10 36/19 42/8 46/18 50/21 54/23 63/14 72/17 83/25 93/14
untoward [1] 92/3
unused [1] 22/16
unusual [1] 55/17
unwell [1] 55/20
up [30] 11/2 13/9 16/20 34/5 42/8 50/4 50/8 50/12 54/23 59/21 60/7 60/18 62/23 64/4 66/17 71/1 72/15 78/17 78/20 79/5 79/6 80/12 80/20 81/1 82/21 83/1 89/1 89/23 92/11 92/22
update [1] 52/8
updated [1] 78/10
updates [3] 46/21 46/22 46/23
upon [2] 25/19 59/23
us [6] 13/12 25/12 41/1 81/15 83/16 85/17
use [4] 4/18 5/1 5/7 70/2
used [2] 62/14 62/14
uses [1] 70/5

V

valid [1] 61/15
variance [1] 73/1
various [1] 55/18
VC [109]
VC's [40] 2/6 2/11 3/6 3/23 5/22 8/8 13/19 14/3 15/3 16/13 17/21 18/7 18/22 19/21 26/16 27/1 28/14 29/2 31/6 33/18 34/18 35/22 44/20 46/3 63/11 63/17 63/25 64/25 66/25 69/18 70/22 71/7 71/19 71/20 73/4 82/12 84/13 84/14 85/7 86/8
version [1] 61/19
very [10] 10/1 17/2 28/2 31/6 38/16 44/8 56/7 70/4 73/7 90/7
view [9] 30/12 32/21 35/20 35/21 37/15 63/19 63/23 63/24 66/9
viewed [1] 14/15
views [4] 39/18 53/15 74/14 74/14
vigilant [2] 38/18 92/25
violence [7] 25/24 42/22 51/17 51/22 56/9 58/19 64/9
violent [6] 25/19 26/5 26/8 52/1 56/2 62/24
visible [3] 90/17 91/13 93/8
visit [3] 3/22 8/6 9/3
visited [1] 41/4
visits [1] 8/6
voices [2] 24/5 72/16
voices' [1] 71/4
voluntarily [1] 50/18

W

wait [1] 35/9
walking [1] 49/6
wall [1] 92/22
want [15] 7/7 13/13 23/25 34/18 35/8 41/19 44/1 44/8 47/3 55/18 64/5 70/12 76/21 85/12 86/19
wanted [4] 12/18 20/23 61/3 90/8
wanting [1] 60/6
wants [2] 70/12 84/4
ward [27] 4/16 5/5 10/16 10/20 12/9 15/13 15/21 18/8 18/9 18/21 19/19 24/4 31/12 46/20 47/15 56/8 57/2 57/18 59/15 64/4 72/20 77/12 82/12 82/24 84/16 88/7 90/16
was [338]
wasn't [32] 3/7 3/23 7/2 12/18 13/4 22/21 23/9 23/16 25/16 28/20 39/12 47/23 49/9 49/10 49/11 50/13 54/15 57/18 57/18 57/19 58/12 59/10 60/19 61/13 61/15 62/2 65/5 86/18 87/6 87/7 88/10 90/3
watching [2] 18/24 20/21
way [9] 17/12 22/11 30/3 41/7 67/14 78/20 83/14 89/22 90/1
we [131]
we'll [11] 26/21 47/16 50/21 76/13 78/25 79/25 80/4 80/13 80/24 93/11 93/11
we're [3] 17/1 45/25 47/1
we've [7] 34/11 50/2 63/18 64/21 64/22 76/22 83/13
weapon [2] 62/14 92/16
week [6] 2/20 28/4 37/18 44/9 44/12 45/20
weekend [4] 14/1 60/2 76/6 91/1
weekly [3] 44/23 45/8 47/15
weeks [9] 2/14 23/6 44/20 57/16 64/7 64/8 64/20 72/19 93/3
well [64] 3/16 4/7 5/3 6/2 9/15 9/23 14/21 15/12 16/8 19/11 23/2 24/10 24/12 27/22 32/16 34/5 35/3 36/8 37/2 37/23 38/16 41/24 44/2 48/25 50/7 53/4 53/4 54/21 55/10 56/18 59/5 60/20 61/9 62/8 64/5 64/11 64/13 65/3 65/9 65/14 73/24 74/16 76/6 76/8 76/9 77/24 79/15 81/13 82/23 83/5 85/19 86/12 87/1 87/14 87/15 87/16 88/2 88/7 88/8 89/12 90/19 91/9 91/14 92/14
went [11] 8/19 19/3 25/13 65/15 65/17 68/4 68/25 69/1 78/14 80/23 93/2
were [58] 2/6 8/15 10/1 10/5 10/6 10/17 10/20 13/1 13/23 13/25 17/20 19/4 22/3 22/5 22/9 22/22 23/18 25/6 27/12 27/12 27/13 28/7 32/7 34/1 38/8 40/7 40/21 43/6 44/12 46/9 49/4 49/4 50/17 56/17 56/22 57/5 57/7 60/20 64/8 65/16 67/4 67/4 67/7 67/7 68/8 69/21 71/15 72/4 72/19 73/5 82/17 88/5 88/7 89/8 90/11 90/21 91/21 93/1
weren't [2] 21/22 57/7
what [68] 4/8 5/20 6/4 6/5 6/25 7/5 7/13 14/3 15/23 18/4 18/14 20/17 21/2 22/25 26/25 27/17 30/3 31/5 32/14 33/5 33/10 34/19 34/20 36/2 38/12 39/4 39/17 40/18 40/21 41/18 42/14 43/20 43/25 44/5 44/7 46/15 47/2 47/8 48/5 51/21 52/11 52/11 53/5 56/4 56/6 56/17 57/3 59/8 61/23 63/16 63/18 63/25 64/22 64/24 64/24 65/5 68/20 70/10 72/22 73/1 76/14 77/13 79/13 79/13 81/10 81/17 82/11 85/22
what's [6] 6/24 21/18 44/3 56/20 59/24 79/7
whatever [1] 92/15
when [48] 2/22 9/13 10/23 11/12 14/3 14/6 14/9 14/13 18/14 20/7 21/15 21/16 23/11 26/4 46/18 50/16 50/17 52/22 53/19 55/13 59/25 61/2 62/22 62/24 64/15 68/4 68/18 69/1 70/1 72/16 72/17 73/25 74/13 74/25 74/25 75/4 76/8 77/18 83/3

W

when... [9] 84/4 84/6 85/4 89/18 90/13 91/11 92/5 92/7 92/12
whenever [1] 12/18
where [23] 7/8 12/8 18/1 18/10 34/22 37/23 42/3 42/5 58/5 67/1 68/1 68/15 74/19 75/19 75/20 75/20 75/22 75/23 78/2 80/23 81/23 81/23 83/25
whether [33] 8/15 14/14 14/21 15/8 15/9 15/10 16/23 22/22 34/8 36/10 36/11 38/18 46/14 54/3 57/23 59/6 69/7 69/17 69/22 69/23 72/22 72/25 73/2 73/3 76/25 85/7 86/8 88/15 88/15 88/23 90/16 90/17 92/25
whether I [1] 54/3
which [39] 7/23 10/16 31/16 32/10 36/1 36/15 37/5 40/2 40/6 42/1 47/20 47/24 47/25 49/1 50/1 50/2 52/7 55/3 58/1 58/1 61/4 62/16 63/24 67/21 69/15 72/13 77/3 77/13 78/15 79/7 80/22 80/24 80/24 83/14 83/14 83/22 83/23 90/12 90/21
while [5] 19/23 39/11 58/10 66/13 81/3
whilst [13] 28/14 28/21 32/6 36/1 37/9 38/3 38/13 69/18 72/6 72/10 73/24 74/21 81/18
who [31] 7/12 11/8 11/13 12/8 15/16 15/18 16/6 17/21 18/18 21/7 23/22 25/22 26/4 26/7 26/10 26/13 27/1 33/2 33/17 33/17 34/1 34/1 38/10 62/6 62/13 66/17 73/17 79/21 81/13 81/16 91/9
whole [3] 10/20 27/18 56/20
why [25] 2/25 19/3 19/7 24/9 42/12 44/23 44/24 54/13 54/18 55/6 58/4 58/7 61/17 63/9 70/16 80/18 85/15 87/1 87/15 87/17 87/18 89/3 89/8 89/20 89/21
widely [1] 28/1
will [6] 21/18 31/22 33/15 44/7 70/7 75/15
willing [3] 37/2 39/8 84/7
willingness [1] 72/24
window [2] 17/11 17/22
wish [2] 56/25 67/15
withholding [1] 13/4
within [7] 8/22 22/14 23/13 30/23 37/18 39/24 39/25
WITN0102002 [1] 70/24
WITN0187001 [1] 6/24
witness [6] 1/9 7/1 11/21 59/17 59/18 65/20
woefully [1] 77/25
won't [5] 68/22 70/7 72/15 74/25 89/22
work [4] 1/22 16/3 47/5 75/16
worker [2] 44/19 45/3
working [2] 23/23 75/11
would [77] 5/11 5/14 6/11 10/13 13/11 13/13 14/16 15/10 16/6 16/12 18/9 18/10 18/16 18/20 22/18 25/2 26/12 27/24 28/1 29/9 30/17 31/6 32/1 32/23 35/7 35/8 37/11 37/23 39/21 39/23 40/12 40/13 41/9 41/10 41/16 41/19 42/1 42/18 44/3 46/21 46/21 47/18 49/1 49/16 49/21 50/14 50/15 50/15 50/20 52/18 53/22 53/24 55/24 60/16 62/8 66/11 69/16 70/14 74/3 74/6 74/8 74/12 78/21 79/25 80/5 80/14 80/19 86/4 86/6 88/3 88/4 88/15 88/24 92/11 92/17 92/19 93/1
wouldn't [15] 7/20 18/17 25/3 27/24 40/12 41/15 42/21 44/2 70/14 71/21 80/15 81/22 84/3 86/4 89/5
written [1] 63/18
wrong [2] 9/13 76/14

Y

yeah [25] 3/17 3/21 3/25 4/8 5/24 11/11 18/6 27/24 32/5 32/20 37/2 43/19 44/5 50/11 53/4 55/23 56/18 60/4 63/23 70/4 79/17 89/12 90/20 91/5 91/11
year [2] 39/16 39/24
yes [220]
you [377]
you'd [5] 71/19 80/22 85/19 85/19 89/5
you're [14] 1/19 5/11 11/12 45/3 46/15 73/24 73/25 77/13 77/19 82/2 86/21 87/11 90/2 91/23
you've [13] 11/20 11/22 12/1 20/13 56/25 56/25 65/18 73/14 76/20 77/8 81/8 83/12 86/1
young [3] 31/21 34/11 55/11
younger [1] 66/10
your [58] 1/16 1/19 3/1 3/2 3/3 3/10 4/12 4/20 5/21 6/6 6/18 7/1 8/12 9/4 10/5 11/20 12/2 14/6 14/9 15/6 15/9 15/10 16/5 16/14 16/24 16/25 18/4 20/13 21/21 29/13 37/15 41/24 41/24 42/12 51/6 52/11 52/25 53/8 59/1 59/17 59/17 60/5 62/4 62/10 65/20 65/20 70/21 70/23 75/3 75/7 75/19 75/24 77/24 78/25 80/25 81/7 83/5 89/16
yours [1] 51/5
yourself [1] 74/2

Z

zeros [2] 73/14 75/5