

Tuesday, 19 May 2026

1
2 (1.50 pm)
3 **THE CHAIR:** Thank you. Yes, Mr Weston.
4 **MR WESTON:** Mr Devlin, before the break we looked at an
5 overview of board functioning from 2019 or 2020, when
6 you joined, to around 2024. I'd like to go back in time
7 and I'd like to focus upon one of the regulatory
8 requirements made by the CQC in 2019, please.
9 **A.** Yes.
10 **Q.** Can I take you back to that report, please, NHFT0002015,
11 page 13. You can see there, five points down, one of
12 the requirements from the CQC is that:
13 "The trust must ensure risk assessments are in place
14 ..."
15 **A.** Yes.
16 **Q.** "... and that they contain all relevant risk
17 information."
18 That was a mandatory requirement from the CQC.
19 **A.** Yes, it was.
20 **Q.** Clinical risk assessments, Mr Devlin, are a function to
21 be undertaken by clinical staff.
22 **A.** Absolutely, yes.
23 **Q.** To do that, they need clinical training and they need
24 guidance?
25 **A.** Yes.

1

1 "should dos", from the CQC. I would be asking questions
2 about the action plans in relation to those, how they
3 would then be being evidenced through the governance
4 structures of the Trust, some of which I would expect to
5 come back to the full board, some of which I would have
6 expected to have had oversight within committees and
7 probably for some, oversight within teams or other parts
8 of the organisation.
9 But I would have expected there to be a detailed
10 action plan. Whilst I wouldn't be wanting to track
11 personally every item, I'd want to know that that was
12 there and that would be part of the evidence that I
13 would be seeking.
14 **Q.** You've told us before that you had concerns about Board
15 functioning when you came to the Trust?
16 **A.** Yes.
17 **Q.** The action plan was devised by others, wasn't it?
18 **A.** Yes, it was.
19 **Q.** How did you reassure yourself that the action plan and
20 the steps that were taken were ones that you thought
21 were necessary to meet the CQC requirement?
22 **A.** So if I say -- I will talk about -- the assurance for me
23 would have been to first of all look to see that there
24 were clear actions in place and to be testing out what
25 the steps were that were in place and how we would know

3

1 **Q.** If a single clinician is not doing a risk assessment,
2 that's clearly not an issue for the Board?
3 **A.** Yes.
4 **Q.** But if the risk assessments are not being done because
5 of policy, training or support reasons, or may not be
6 being done because of policy, training or support
7 reasons, that is an issue for the Board, isn't it?
8 **A.** Yes, it is.
9 **Q.** Also, if the CQC are raising it, it's in itself an issue
10 for the Board?
11 **A.** Yes.
12 **Q.** You gave evidence earlier about the importance of asking
13 questions, setting off chains of enquiry, being
14 inquisitive. This CQC Report was received a few months
15 before your time as Chair. You were no doubt aware of
16 this recommendation.
17 **A.** Yes, that's right.
18 **Q.** This requirement, I should say. What questions did you
19 and the Board ask when you came in about where the
20 clinical risk assessments were being done and whether
21 they were being done properly at the Trust?
22 **A.** For me personally, what I would have been doing would
23 have been asking questions about -- asking for sight of
24 the action plan, and understanding that I would be
25 expecting every single -- both the "must dos" and the

2

1 whether or not actions had been successfully delivered
2 or not.
3 **Q.** So you would be looking to see if the regulatory side of
4 things were being met in terms of the action plan. But
5 what about understanding the issue of risk assessments,
6 clinical risk assessments? Did you ask whether this was
7 a recurring theme, something that was happening
8 throughout the Trust? Did you make those enquiries?
9 **A.** I don't recollect whether I did or did not. I think
10 my -- in relation to any CQC "must dos" or "should dos",
11 I would always be seeking to say is this something that
12 is unique to a particular service, or is this something
13 that is wider across the organisation?
14 So I think that is a question that I would have been
15 asking whether or not there was something more broadly
16 across the organisation. I'm afraid I don't recollect
17 specifically what I may have asked at the time.
18 **Q.** So you're not -- I couldn't quite understand that bit of
19 your evidence, and it may be that memory is difficult,
20 but you can't recall whether you did ask whether this
21 was a wider systemic issue or not, or ...?
22 **A.** I'm saying that in relation to the specific -- the
23 specific bullet point you've drawn my attention to,
24 I don't recollect whether I had specifically asked about
25 risk assessments. What I was trying to say was that I

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1 would be confident that what I would have done would
 2 have been saying: have we checked as an organisation
 3 whether or not these were isolated incidents or wider
 4 incidents? And that's what I would have been asking in
 5 relation to all of the feedback from the CQC.
 6 **Q.** Can you recall what you were told about risk
 7 assessments?
 8 **A.** No.
 9 **Q.** If you'd have been told that it was a recurring theme,
 10 an ongoing concern, you'd remember that, wouldn't you?
 11 **A.** I hope I would. I honestly can't give you that -- can't
 12 give you that reflection.
 13 **Q.** Can I take you, please, to WITN0410045. This is a board
 14 meeting from before your time.
 15 **A.** Yes, it is.
 16 **Q.** 28 February 2019. Can I take you to page 8, please. At
 17 the bottom there you can see that a "Learning from
 18 deaths and mortality surveillance -- quarter ...
 19 2018/19" was presented to the Board. You would have
 20 gone back and looked at these Board meetings when you
 21 started as Chair, wouldn't you? This is the year -- the
 22 12 months beforehand.
 23 **A.** I would not necessarily have gone through every set of
 24 minutes of every Board in that previous year.
 25 **Q.** The report that was presented is at WITN0410046.

5

1 about whether there are concerns more generally at the
 2 Trust about risk assessment?
 3 **A.** Yes, absolutely.
 4 **Q.** Had you been asked that question, you would have been
 5 told this was a recurring theme, when you started in
 6 January 2020.
 7 **A.** Yes, the fact that I didn't ask the question doesn't
 8 mean I didn't know it -- would not have known it was
 9 a recurring theme, and also that I would not have given
 10 that, realised that that was a serious statement. It
 11 was part of a CQC "must do" response. Those are serious
 12 for us as a Board to take account of.
 13 **Q.** If you'd have known this was a recurring theme in 2020,
 14 you'd have wanted to get more information, wouldn't you?
 15 **A.** Yes.
 16 **Q.** You could have done or organised through the executives
 17 an audit, a risk assessment?
 18 **A.** I could have had the conversation to seek out such an
 19 audit yes.
 20 **Q.** Dip sampling?
 21 **A.** Yes.
 22 **Q.** We've heard about deep dives. That could have been done
 23 by the Board if you felt it was necessary?
 24 **A.** Yes.
 25 **Q.** But when we look at the Board activity from 2020 to June

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1 Page 4, please. I'm just waiting for that to come on
 2 the screen.
 3 **A.** Yes. *(Pause)*
 4 **Q.** I'm grateful. Page 4, please. Section 4, towards the
 5 bottom of the page, "Learning from Deaths".
 6 **A.** Yes.
 7 **Q.** "A number of recurring themes have been identified", at
 8 the end of that paragraph, and if you just turn over the
 9 page, please, one of the recurring themes was "Risk
 10 assessment".
 11 **A.** Yes, it was.
 12 **Q.** If you'd have asked other members of the Board, or asked
 13 anyone in the management, whether risk assessment was
 14 a recurring theme, this would have been part of the
 15 corporate memory, wouldn't it, this report?
 16 **A.** I think it will have been part of the corporate memory,
 17 whether or not I'd asked, yes.
 18 **Q.** If you'd have asked, you would have been told, wouldn't
 19 you, that risk assessments are a recurring theme?
 20 **A.** Yes. I also suspect that I would have seen risk
 21 assessments being a recurring theme once I had arrived
 22 in the organisation, rather than having to look back
 23 through previous -- through the previous year as well.
 24 **Q.** But it's the CQC Report, isn't it. That should be
 25 a trigger for an active Chair to start asking questions

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1 of 2023, clinical risk assessments just don't feature
 2 there, do they?
 3 **A.** They do not, and you're very aware of some of the
 4 context around that in relation to the governance of the
 5 organisation, because during that period we were also
 6 dealing with the first two waves of the pandemic as
 7 well, and the governance expectations from NHS England.
 8 I'm absolutely not taking away from the importance
 9 of the point you're making about risk assessment,
 10 clinical risk assessment not having been on those
 11 agendas. There were other priorities that were being
 12 pushed as well.
 13 **Q.** Risk assessment is a crucial part of managing Covid,
 14 isn't it?
 15 **A.** Absolutely.
 16 **Q.** So if you'd known that there was a recurring theme about
 17 actually risk assessments being undertaken and done,
 18 that would have been highly relevant to the dominant
 19 issue in the Board in 2020 and 2021, wouldn't it?
 20 **A.** Yes, and there was -- again, it's not the sole driver
 21 for us having conversations about risk in the context of
 22 the pandemic, either.
 23 **Q.** Did you have insight in your first year at the Trust as
 24 to where the Trust sat comparatively in terms of serious
 25 incidents?

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1 A. To a point of being able to say -- not -- not to say to
 2 a point of direct data. However, as an organisation,
 3 I knew that we absolutely had serious incidents, as had
 4 my other trusts, the Lincolnshire Partnership, as indeed
 5 had every other mental health providing trust across the
 6 country.

7 Q. But no idea where you sat comparatively to other
 8 organisations; more, less, similar?

9 A. My understanding was that we were in a similar -- at
 10 a similar level for comparative organisations. The
 11 comparative piece is quite difficult, I think, to be
 12 able to measure.

13 Q. Well, serious incidents are recorded, aren't they?

14 A. Yes, they are.

15 Q. There's always a data number in terms of the number of
 16 serious incidents in any particular trust?

17 A. Yes, I also think there's the -- my apologies.

18 Q. -- no, no, please.

19 A. There's also the context of the range of services that
 20 different trusts provide and I think that -- and the
 21 size and scale of those services. I think that's a part
 22 of that that makes comparison is not quite as simple as
 23 there were X number in this trust and Y number in that
 24 trust.

25 Q. Can I take you, please, to document WITN0223001, page 1
 9

1 in terms of us having the highest number of serious
 2 incidents across the Nottingham and Nottinghamshire
 3 system, that in itself is not saying that we were an
 4 outlier compared with other mental health providers in
 5 other systems. There aren't the other mental health
 6 providers in that Nottingham and Nottinghamshire system.

7 I understand the point that you're making in terms
 8 of the Trust being -- having the highest number of those
 9 serious incidents, of course, but I think it's just to
 10 be clear that there's not a direct comparison in terms
 11 of those services.

12 Q. To even start the comparison, you need to ask about the
 13 numbers elsewhere and then you can adjust things and
 14 make the comparison, can't you?

15 Just to go back to my question: did you enquire
 16 about the comparative position; what the numbers were
 17 elsewhere in the local area? Is that an enquiry you
 18 made of the Board?

19 A. It would have been conversations that we had across the
 20 broader -- the broader region and across the country.
 21 So actually trying to find comparator -- to get a sense
 22 of comparison with similar providers, not with very
 23 different providers, which would be the only ones in the
 24 Nottingham and Nottinghamshire system.

25 Q. Can I please take you to NHFT0003346, page 91. This is
 11

1 to begin with. This is the first witness statement of
 2 Amanda Sullivan, who is the Chief Executive and
 3 Accountable Officer of the NHS and Nottinghamshire
 4 Integrated Care Board?

5 A. Yes.

6 Q. Can I take you to paragraph 119 of her report at page
 7 47.

8 "Throughout the rest of 2020 the CCG continued to
 9 note ..."

10 The CCG was in place before the Integrated Care
 11 Board, wasn't it?

12 A. Yes, it was.

13 Q. "... continued to note concerns regarding workforce
 14 capacity, governance maturity and the pace of
 15 improvements, particularly in adult mental health and
 16 community services. NHFT also consistently reported the
 17 highest number of serious incidents across the local NHS
 18 system, with a significant portion linked to self-harm,
 19 falls, and suboptimal care of deteriorating patients."

20 So the ICB were aware of this. Did you make any
 21 enquiries of the ICB, or anyone else, as to where you
 22 sat comparatively to other organisations?

23 A. Again, I think it's important for me to point out that,
 24 across the local NHS system, there weren't directly
 25 comparative organisations in terms of the services. So
 10

1 a document dated 13 December 2022.

2 A. Yes.

3 Q. It's a briefing pack for the Quality & Mental Health
 4 Legislation Committee, that's one of the committees that
 5 sit below the Board.

6 A. That's correct, yes.

7 Q. Meeting to be held on 13 December. Point three that's
 8 highlighted there.

9 A. Yes.

10 Q. "Risk assessments including absence of clearly
 11 documented risk assessment; not considering key
 12 risk factors; communication of risk assessment within
 13 teams and to other interested persons."

14 Now, this is a report, as I say, to a committee
 15 below the Board.

16 A. Yes.

17 Q. Was this concern from the Patient Safety Report, was
 18 this brought to the attention of the Board?

19 A. It will have been -- I don't know honestly whether or
 20 not that was reflected in the highlight report from the
 21 Quality Committee. However, everybody around that Board
 22 table will have been alert to the document and many
 23 members around that table would have been members of
 24 that committee. Obviously I was not a member of that
 25 committee. But, yes.
 12

1 Q. So in 2022, in December 2022, were you aware of this
2 ongoing concern with risk assessments, the absence of
3 clearer documented risk assessments?
4 A. Yes.
5 Q. You were aware of that?
6 A. Yes.
7 Q. Did that lead to a discussion about risk assessment
8 policy?
9 A. (Pause) My hesitation is just, again, not quite
10 remembering. It will have done at either the Board or
11 that particular committee, in terms of that policy, and
12 it will have led to questions being asked about, "So
13 what can be done to try and fix a problem that has
14 clearly been identified as an ongoing challenge for the
15 organisation?"
16 Q. When I asked earlier whether clinical risk assessment
17 was something that was discussed at board level between
18 2020 and June of 2023, I understood that you'd said it
19 wasn't.
20 A. I don't think I -- if that's how my answers came across,
21 it wasn't --
22 Q. Maybe I misunderstood. That's what I understood your
23 evidence to be.
24 A. My intent was to say that it may well have been.
25 I could not give you -- I couldn't say definitely: yes,

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1 the Board, that policy would have been updated.
2 A. I would have hoped so. I think the expectations around
3 policy updates, I think, again, across the organisation,
4 there were clear expectations on when policies should be
5 reviewed and when they should be updated, and again,
6 aside from a period where there was some recognised
7 guidance from NHS England on some policies being allowed
8 to be extended beyond their deadline, I would expect
9 policies to be updated in that way.
10 Q. We've heard it was out of date; do you agree with that?
11 A. Yes.
12 Q. Yes. Can I take you to the CQC Review of this issue.
13 It's from the special review in 2024, it's CQCM0013499.
14 A. Yes.
15 Q. Can I take you to page 4, please. Recommendation 1(a),
16 at the bullet point:
17 "all patients receive appropriate ongoing assessment
18 of their risks including those waiting to receive
19 treatment and care.
20 "appropriate and effective risk management plans are
21 formulated and implemented."
22 Those recommendations were made because there was
23 considered to be a lack of proper and rigorous risk
24 assessment, clinical risk assessment, at the Trust.
25 A. Yes.

15

1 we had an item on that. I think that's different from
2 me saying it was not discussed.
3 Q. But you're aware that risk assessment is a crucial issue
4 that --
5 A. Absolutely.
6 Q. -- the Inquiry is looking at.
7 A. Yes, I am.
8 Q. You had access to the notes and probably gone back and
9 looked at some of the previous board meeting, haven't
10 you?
11 A. Yes, I have.
12 Q. When was clinical risk assessment discussed at the Board
13 level between January 2020 and June of 2023?
14 A. I can't give you a specific answer to that, I'm afraid.
15 Q. Had it been discussed, the fact that the policy had not
16 been updated -- and we've heard it was out of date by
17 this point -- that would have been brought up, wouldn't
18 it? Someone would have brought that up?
19 A. I would have had expected that, yes.
20 Q. We can draw the inference, can't we, that risk
21 assessments, clinical risk assessments, just weren't
22 discussed, or if they were discussed they were very low
23 on the priority, weren't they?
24 A. (Pause) That inference can be drawn.
25 Q. If risk assessments were something that was a focus of

14

1 Q. Page 28, please:
2 "Managing Risk
3 "How well staff assessed and managed risk in
4 community mental health and crisis services varied, and
5 the approach to risk assessment was inconsistent. In
6 our review of records, we found that many people who use
7 services did not have an updated crisis or risk plan."
8 Then over the page, please, to 29, at the bottom
9 there's a box, in terms of:
10 "Key points
11 "... a lot of changes in leadership in recent years,
12 with 3 out of 7 executive directors having taken up post
13 since 2023."
14 "Leaders were aware of some of the current risks in
15 safety and quality of services but we were concerned
16 senior leaders did not appear to have a clear oversight
17 of these risks."
18 Do you agree that you did not have a clear oversight
19 of the issue of clinical risk assessment at the Trust,
20 Mr Devlin?
21 A. I do in the context of this Section 48 Review from the
22 CQC, yes.
23 Q. Well, what other context do you agree --
24 A. Purely because that's the document you put in front of
25 me.

16

- 1 Q. "While there was evidence of the trust taking action to
2 address safety concerns including those raised by our
3 review, we are concerned that the trust activities are
4 predominantly reactive."
5 That may have been a reference to steps that were
6 taken since June 2023, since the attacks.
7 A. Yes, and I think it's important for the Trust to
8 absolutely be responding to new evidence that comes
9 through. I think it's about as -- the concern about
10 being predominantly reactive, I absolutely accept.
11 I think it's also important that that plays to the
12 importance of us seeking to respond to new evidence that
13 gets raised with us, notwithstanding whether that's
14 something that we ought to have known ourselves
15 previously.
16 Q. Risk assessment raised as an issue in 2019 by the CQC.
17 Risk assessment raised as an issue in 2024 by the CQC.
18 A. Yes.
19 Q. It doesn't seem, based upon the inference that we just
20 discussed, that this was discussed at board level.
21 Given the findings of the CQC in 2024, this needed to be
22 discussed at board level. This was a systemic issue,
23 wasn't it?
24 A. Yes.
25 Q. The fact it wasn't discussed, despite the fact -- or

17

- 1 "... is designed to focus on a small number of
2 high-level strategic risks".
3 Those are really business level risks, aren't they?
4 A. They are strategic risks that would be regarded as
5 affecting the whole organisation, yes.
6 Q. "This does not preclude a specific operational risk
7 coming to the attention of a Board Committee or the
8 Board, if escalation requires that ..."
9 A. Yes.
10 Q. It means:
11 "... the Board holds its strategic responsibility
12 and does not get drawn into managing local operational
13 risks."
14 A. Yes.
15 Q. "Clinical risk assessment for individual patients sits
16 with clinicians and, in terms of governance, does not
17 get Board scrutiny."
18 This systemic issue did not get Board scrutiny.
19 A. Yes, I think in the way I was describing in
20 paragraph 169 there, I was trying to present clinical
21 risk assessment about the individual patient, and saying
22 that that does not come through to the Board, and that
23 that is proper.
24 Q. This is a clinical issue that, Mr Devlin, you didn't at
25 the time think was something that needed Board scrutiny?

19

- 1 raised at all, it seems -- despite the fact it was
2 raised by the CQC at the book ends before and after,
3 that is a failure in governance?
4 A. I think, in terms of that -- the Board oversight piece,
5 I agree with that statement. I think that there may
6 well -- there will have been other work being done in
7 other parts of the organisation about that risk
8 assessment. But in terms of that being able to evidence
9 clear board oversight of risk assessment in this way,
10 I agree with that statement.
11 Q. So a systemic failure to consider clinical risk -- or
12 systemic issue with clinical risk assessment, and
13 a failure at the Board level to understand that systemic
14 problem; do you agree?
15 A. Yes.
16 Q. Can I take you to your witness statement, please,
17 WITN0390001, paragraph 168. It's page 63. So
18 paragraph 168.
19 A. Yes.
20 Q. "The organisation has many risks that are captured
21 through operational risk registers. However, the BAF
22 ..."
23 What's the BAF, please?
24 A. It's The Board Assurance Framework.
25 Q. Thank you.

18

- 1 A. I -- did not need to be raised as part of the Board
2 Assurance Framework.
3 Q. Because it was clinical --
4 A. Yes.
5 Q. -- and not, in your view, business or strategic; that's
6 why it wasn't looked at.
7 A. No, in terms of individual patient clinical risk, no.
8 I think the broader point about clinical risk assessment
9 I've agreed with you that that had not had the level of
10 scrutiny.
11 Q. We've heard that part of the 2024 improvement plan, when
12 you're working with NHS England, was that there should
13 be more clinical acumen at the top of the organisation.
14 Do you consider that in the period before June 2023,
15 that the Board was too focused on strategic risk and
16 didn't have enough focus on clinical risk, because of
17 the make-up and constitution of the Board that you
18 oversaw?
19 A. I don't think the -- that causal link is there, no.
20 Q. Because quite simply, Mr Devlin, if you had asked the
21 right questions back in the beginning of 2020 about risk
22 assessment, this would have been an issue on the Board,
23 wouldn't it?
24 A. Yes.
25 Q. We've looked at some internal communications, we've

20

1 looked at the CQC reports that identified issues with
2 safety. I want to look at another source of information
3 coming from outside of the Trust --

4 **A.** Okay.

5 **Q.** -- if I may. Can I take you to WITN0356017. This is
6 a document that other witnesses have been taken to, but
7 I just want to understand it from your perspective,
8 please.

9 This is a meeting with the Senior Coroner on
10 16 December 2021, follow up to previous issues. The
11 attendants, in terms of executives, is Anne-Maria
12 Newham, Executive Director of Nursing; Sue Elcock,
13 Executive Director and Director of Forensic Services.

14 **A.** Yes.

15 **Q.** "Family Involvement", first bullet point:

16 "Family involvement in care, including risk
17 assessment, history taking, decision making.
18 Highlighted that there'd been several cases where the
19 family had communicated during the inquest process that
20 they had information to share and concerns but had not
21 been given the opportunity."

22 Further down under "Risk assessment":

23 "Noted that the documentation relating to risk
24 assessment, detail of risk factors, decision making
25 rationale and agreed outcomes was lacking within the RiO

21

1 2:

2 "Risk assessments including absence of clearly
3 documented risk assessment; not taking into account key
4 risk factors; communication of risk assessment within
5 teams ..."

6 So this update, there was information coming to the
7 Board about risk assessment here.

8 **A.** Yes, there was there.

9 **Q.** But no plan put in place in relation to it.

10 **A.** In -- I think there were significant plans put in place
11 in relation to the facts as they were raised by the
12 coroners. So I think risk assessment will have been
13 picked up as part of the concerns being raised by the
14 coroners as an important other source of information as
15 you describe.

16 **Q.** It was picking up the theme from 2019 --

17 **A.** -- (*overspeaking*) -- (*unclear*)

18 **Q.** -- in the CQC, we discussed earlier the various
19 different matters which could be done if this issue was
20 live in the minds of the Board: dip sampling, audit,
21 investigation, deep dive; none of that was done, was it?

22 **A.** Not as -- under instruction from the Board, no. And
23 I don't know whether or not those were done. From an
24 operational point of view, there are others who will be
25 better placed than me to be able to give you that

23

1 records potential[ly] impacting on a patient's pathway
2 between services and explanation of outcome to others".

3 This is the coroner obviously reporting about cases
4 which have ended in deaths.

5 **A.** Yes, it is.

6 **Q.** Were you aware of the coroner's concerns in
7 December 2021 or at any point?

8 **A.** Yes, I was, and will have been aware of them in
9 December '21.

10 **Q.** Can I take you to the discussion of this at board level,
11 please, NHHNB0012321. (*Pause*)

12 If you can go to page 2, please. There is
13 a discussion there -- sorry, just the date of this is
14 1 March 2022.

15 **A.** Yes.

16 **Q.** So a few months after that meeting with the coroner --

17 **A.** Yes.

18 **Q.** -- the Board is being updated about the coroner's views.

19 **A.** Yes, it is.

20 **Q.** The executive summary, explains what a PFD, a preventing
21 future deaths report is, under Regulation 28 of the
22 Coroners rules, and then it goes on to say:

23 "There are several strong ... themes that have
24 emerged from the learning identified within the main
25 body of this report".

22

1 information.

2 **Q.** WITN0263001, please, page 67. Paragraph 279, I should
3 apologies, this is Mr Majid's statement.

4 **A.** Yes.

5 **Q.** "PFDs are sent directly from the coroner to myself as
6 the CEO and I am responsible for the acceptance and
7 response to the report. As the new CEO at Notts
8 Healthcare I had concerns about the volume of PFDs
9 compared to what I was familiar with from being the CEO
10 of a neighbouring NHS mental health trust."

11 Were you aware of Mr Majid's concerns about that?

12 **A.** Yes, I was, and I shared them, if I may say that."

13 **Q.** "All PFDs were reported to the Trust Executive Team
14 meeting which is where this concern arose."

15 280:

16 "During 2023 the trust received a significant
17 increase in PFDs-- 8 in total. During the preceding
18 five years from 2018 to 2022 it had received a total of
19 5 PFDs."

20 So in terms of the eight PFDs in 2023, what were the
21 numbers for the following years before you left?

22 **A.** The numbers in later years were decreasing, and in terms
23 of the coroners, my recollection in my final year was
24 that we were getting explicit feedback from coroners who
25 were saying that they -- I can think of at least

24

1 a couple of occasions where coroners, having considered
2 whether or not a PFD was appropriate, had been minded
3 not to judge a Prevention of Future Deaths Notice
4 explicitly saying that because they had confidence in
5 the way that the organisation was embedding its changes.

6 **Q.** Do you know the numbers for 2024?

7 **A.** I don't know the numbers. I'm sure that they are in the
8 evidence.

9 **Q.** So reducing PFDs, progress is being made, and you likely
10 think that's because of steps that were taken inside the
11 Trust?

12 **A.** Yes.

13 **Q.** Had those steps been taken earlier, these concerns could
14 have been allayed earlier, couldn't they?

15 **A.** They may have been, yes.

16 **Q.** Beyond the coroner's concerns, you, as the Chair, were
17 made aware of serious incidents that resulted in death
18 or very serious injury, weren't you?

19 **A.** Yes, I am, yes.

20 **Q.** Can I take you, please, to INQY0000034, page 2, please.
21 This is an Inquiry Legal Team document that --

22 **A.** Yes.

23 **Q.** -- provides information in an anonymous form about
24 several incidents being considered by various CPs in
25 terms of the detailed information there?

25

1 **A.** Yes.

2 **Q.** The delay, as I understand it, and perhaps you can
3 assist, was because you were awaiting for the end of the
4 police investigation?

5 **A.** I think that was a key factor and I think you've heard
6 in previous evidence from Mr Majid about what's been put
7 in place to change those arrangements, but that's my
8 understanding, yes.

9 **Q.** That's since June 2023, isn't it --

10 **A.** Yes, it is.

11 **Q.** -- those arrangements.

12 I just want to focus upon the position in 2022, if
13 I may, because were you aware at the time that you were
14 awaiting a police investigation?

15 **A.** I will have been, yes.

16 **Q.** Did you question whether it was wise to wait?

17 **A.** My recollection is that it was that it wasn't a matter
18 of whether it was wise or not; it was an instruction,
19 and there was a legal framework in there. I think the
20 framework -- it appears that the Partnership has
21 developed since then and there is a different way of
22 operating. But that was what I understood at the time
23 was that this wasn't a matter of choice, this was an
24 instruction rather than a matter of choice for the
25 Trust.

27

1 **A.** Yes.

2 **Q.** Just so you know what you're looking at. It was not
3 a document that was produced by you or the Trust.

4 **A.** Thank you, yes, I'm aware of the document.

5 **Q.** It's been considered by those for the Trust.

6 Can I first of all just touch upon Patient 1. We
7 can see that the information in paragraph 1 came to
8 light in 2022, certainly the first information we have
9 there is August 2022. Related to an incident just
10 a little time, a few days before that, actually.

11 **A.** Yes.

12 **Q.** This was a mental health related homicide, wasn't it?

13 **A.** I believe so. The anonymising of these examples in this
14 case made it a little more difficult for me to correlate
15 to the specifics, but I believe so, yes.

16 **Q.** Any death that arises from a previous patient of the
17 Trust is a very serious concern for the Board, isn't it?

18 **A.** Yes, it is.

19 **Q.** Paragraph 3:

20 "A patient safety incident investigation was ...
21 approved on 2 May 2025."

22 Do you see that?

23 **A.** I do.

24 **Q.** So two years and nine months for a patient safety plan,
25 or the patient safety action plan, to be signed off.

26

1 **Q.** A death as a result of a -- or at the hands of a former
2 patient --

3 **A.** Yes.

4 **Q.** -- you want to learn lessons from this as soon as
5 reasonably practicable, don't you?

6 **A.** Yes.

7 **Q.** If you're being told that there's a legal framework, did
8 you take legal advice about that framework?

9 **A.** I don't believe we did.

10 **Q.** So you didn't challenge the information that was coming
11 in relation to why you had to wait for this Patient
12 Safety Investigation and Patient Safety Action plan; is
13 that fair?

14 **A.** Yes.

15 **Q.** Can I just take you to the findings of that
16 investigation, it's paragraph 9, so that's over the
17 page, please:

18 "The Patient Safety Incident Investigation
19 identified two key findings: ... a lack of 'curious
20 enquiry' by staff; and ... an 'emphasis on "opt-in"
21 engagement with services' ..."

22 **A.** Yes.

23 **Q.** "... in the context of individuals where the threshold
24 for a Mental Health Act assessment had not yet been
25 reached."

28

1 So there's quite important learning there, isn't
2 there, about Assertive Outreach towards patients, isn't
3 there?

4 **A.** Yes.

5 **Q.** The alternative is to have opt-in where patients are
6 approached, even if they are choosing to opt out.
7 That's the alternative model, broadly?

8 **A.** Yes.

9 **Q.** So just taking you over the page, please, paragraph 10:
10 "Related learning in the Safety Action Plan included
11 considering alternatives to 'opt-in' engagement, such as
12 phone calls or referrals to other mental health
13 services."

14 Then paragraph 11:

15 "Other changes following the incident including
16 improving clinical risk assessments, and amending the
17 clinical supervision template."

18 So this incident, August of 2022, raised an issue
19 about clinical risk assessments as well.

20 **A.** Yes.

21 **Q.** And this was brought -- this particular incident was
22 brought to the particular attention of the Broad (*sic*)
23 shortly if it had happened.

24 **A.** Yes.

25 **Q.** Can I take you to that board meeting, please.

29

1 investigation." (*As read*)

2 So in line with what we discussed, you were awaiting
3 for the police investigation.

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

5 **Q.** That's the plan in terms of what the log said?

6 **A.** Yes.

7 **Q.** It was reporting matters, it wasn't an investigation as
8 such; it's a log alerting the Board to matters.

9 **A.** Yes.

10 **Q.** And the investigation was waiting for the police.

11 **A.** Yes.

12 **Q.** So if that was the plan from the log, just looking at
13 the Board notes again:

14 "The Board received assurance from the report."

15 So you had details of a fatal incident, no
16 investigation was going to be undertaken until the
17 police said you could, and indeed that turned out to be
18 years later.

19 **A.** Yes, it did.

20 **Q.** How was the Board then assured from the report?

21 **A.** I think at the time, that relates to an assurance that
22 the usual processes were under way. I think what we had
23 learned subsequently, and is now the case, is exactly
24 what you're saying about those delays being far too
25 long, and being able to have developed a different

31

1 TCLT0000374, a meeting of 6 September 2022. Page 3. If
2 I can take you to page 3 please, there is a section 7:
3 "Reportable Issues Log Assurance".

4 **A.** Yes.

5 **Q.** "TD presented the Reportable Issues Log to ensure the
6 Board [were] ... aware of the most serious incidents and
7 other significant issues within the Trust.

8 "The Board received assurance from the report."

9 Now, that log -- I'm not going to take you to it,
10 it's got personal information in it.

11 **A.** Yes.

12 **Q.** But that log informed that there had been a fatal
13 attack, and that it happened after the perpetrator had
14 previously had contact with the Trust's mental health
15 services, and there was an issue raised, or at least
16 a mention of discharge in there.

17 **A.** Yes.

18 **Q.** Do you recall that?

19 **A.** I -- it relates to one of the patient examples, it
20 gives -- it's more detail, yes.

21 **Q.** So previous contact and then discharge.

22 **A.** Yes.

23 **Q.** Now, the log simply states at the end in terms of what's
24 happening next, it says:

25 "Concise investigation once police have concluded

30

1 operating model with that. I think the assurance with
2 my recollection is that the processes that were in place
3 at that time were being followed in that way, which
4 I appreciate does not bring a great deal of assurance,
5 looking back at that.

6 **Q.** You've referred to "the usual processes".

7 **A.** Yes.

8 **Q.** The process that was going on was a police
9 investigation.

10 **A.** Yes, and what I was meaning by that was the usual
11 process of, because of the police investigation, there
12 was an instruction that we were not able to therefore do
13 that follow-up work ourselves.

14 **Q.** So the usual processes was a police process?

15 **A.** No, what I'm meaning is the combination of the two. So
16 that usual piece of having to wait for the police
17 investigation, that's the usual process --

18 **Q.** Okay, I understand.

19 **A.** -- that I was referring to.

20 **Q.** Because the Trust weren't doing anything about this
21 until the police came back to them, were they?

22 **A.** I don't know. I don't know if that is fair. I think
23 there will have been a lot of looking at the
24 circumstances of that. From an operational team
25 perspective, that will have been being looked at. The

32

1 formal investigative route, however, was -- would -- was
 2 regarded as having to be on hold because of that police
 3 investigation.

4 **Q.** Did you ask whether other steps were being taken, for
 5 example, informal analysis before the investigation took
 6 place? Did you ask about that?

7 **A.** In relation to the specific case, I don't know whether
 8 I will have done. It is a conversation we had had at
 9 the Board in relation to other serious incidents,
 10 because this obviously applied to other situations too.

11 **Q.** To undertake any investigation, you need to speak to the
 12 people involved, don't you?

13 **A.** They need to be spoken to by the investigation, yes.

14 **Q.** And we were told that the reason that the clinical
 15 investigation couldn't take place before the police was
 16 not to pollute the evidence line.

17 **A.** That's -- that was my understanding of that particular
 18 process at that time, yes.

19 **Q.** So the people involved with this particular case
 20 wouldn't have been spoken to at this stage, would they?
 21 Because that would have been contrary to the processes
 22 that you'd understood to be proper.

23 **A.** That's correct.

24 **Q.** In terms of any other kind of -- I think you referred to
 25 informal analysis of this, what was done?

33

1 **Q.** This was a missed opportunity, wasn't it?

2 **A.** Yes, it was.

3 **Q.** Even with a police investigation, even with the concern
 4 about polluting the evidential line, you could ask for
 5 some analysis, some higher-level analysis, about, for
 6 example, discharge policies. That could have been asked
 7 for by the Board, couldn't it?

8 **A.** Yes, it could.

9 **Q.** There could have been a request for a review of other
 10 discharges in this period.

11 **A.** There could have.

12 **Q.** It's a serious incident this, isn't it: a death from
 13 a former patient?

14 **A.** It absolutely is.

15 **Q.** These are the sorts of steps that should have been taken
 16 in September 2022 when this matter was put before the
 17 Board.

18 **A.** Yes.

19 **Q.** Can I take you to the next incident, please, that's
 20 touched upon in that document. So it's back to
 21 INQY0000034, page 4, please. Patient 2. This is
 22 another fatal incident.

23 **A.** Yes.

24 **Q.** Came to the attention of the executives in February of
 25 2023. Just turning over the page, please, to page 5,

35

1 **A.** Er, I --

2 **Q.** -- (*overspeaking*) -- (*unclear*) specifically?

3 **A.** I would have expected that what was done would have been
 4 for senior leaders to be, notwithstanding having those
 5 conversations with those -- with the people who the
 6 police would have had interest in, would have been to
 7 try and see if there were lessons that could be learned
 8 from that.

9 **Q.** Nothing in the Board minutes that that should be done,
 10 are there?

11 **A.** Not at that stage, no.

12 **Q.** And indeed, it says there was assurance from the report
 13 but I think you've accepted that there wasn't really
 14 proper assurance at that stage.

15 **A.** Not in relation to the content of those cases, no.

16 **Q.** So from a Board level, not enough was done in relation
 17 to this incident in August of 2022.

18 **A.** I accept that.

19 **Q.** We're a few weeks before VC's discharge, when he was
 20 discharged from the Trust to the GP.

21 **A.** Yes.

22 **Q.** We've got a case here that involves a former patient and
 23 some issue about discharge, but no meaningful steps are
 24 being taken by the Board at this stage; do you agree?

25 **A.** Yes.

34

1 paragraph 15. Apologies, paragraph 14:
 2 "... initial Management Review completed on
 3 24 February ..."

4 So that's completed quite quickly, the initial
 5 management review.

6 **A.** Yes.

7 **Q.** But in terms of a comprehensive investigation report,
 8 that wasn't completed until July of 2024, so some
 9 17 months later.

10 **A.** Yes.

11 **Q.** The Initial Management Review, it's on a template
 12 document, isn't it?

13 **A.** Yes.

14 **Q.** And under the heading "Lessons learned" it just says,
 15 "None currently".

16 **A.** I take your word for that.

17 **Q.** Whereas when the actual comprehensive report is done, we
 18 have quite a number of findings and lessons.
 19 Can I take you over the page, please, to
 20 paragraph 20:
 21 "Learning points identified by the investigation
 22 report related to matters including:
 23 "... staff understanding of mental capacity;
 24 "... Early Intervention in Psychosis medication drop
 25 off;

36

1 "... risk formulation and management;
 2 "... information-sharing with the police; and
 3 "... community forensic referrals."
 4 Those are findings that are all relevant to the VC
 5 case, aren't they?
 6 **A.** They are, yes.
 7 **Q.** But the findings, the learning, was a year after the
 8 attacks, despite this event happening several months
 9 beforehand?
 10 **A.** Yes.
 11 **Q.** That's far too late, from a governance perspective,
 12 isn't it?
 13 **A.** It -- it is.
 14 **Q.** Far too late to assist those that were harmed in the
 15 interim?
 16 **A.** Yes, and also therefore as part of what drove through
 17 these reviews to be able to change the practice to make
 18 these timeframes shorter, as is the case now.
 19 **Q.** When Mr Majid was giving evidence yesterday about these
 20 incidents, he -- his evidence was that it was a serious
 21 failure of governance as regards the delay in taking
 22 actions following the incidents in 2022 and 2023; do you
 23 agree?
 24 **A.** Yes, I do.
 25 **Q.** That serious failure in governance was one that the

37

1 the Board meeting of 25 May 2023, as we can see on the
 2 first page, and we can see that you were there --
 3 **A.** Of course.
 4 **Q.** -- as well as the CEO, of course. Can I take you to
 5 page 3, please:
 6 "Reportable Issues Log ...
 7 "The Board of Directors receive the Reportable
 8 Issues Log to ensure awareness of the most serious
 9 incidents and other significant issues within the Trust
 10 for information and discussion as appropriate.
 11 "YM highlighted incident 501667 ..."
 12 That's not this incident that we were just talking
 13 about.
 14 **A.** No.
 15 **Q.** "... advising [that] media coverage was expected, but
 16 the Trust had not been mentioned to date. A briefing
 17 statement will be available and has been drafted ready.
 18 "AMN advised the Trust had reviewed twenty-two
 19 investigations of serious incidents which would be
 20 reported through to the Quality Committee. MD commented
 21 that this was a particularly important piece of work
 22 given the Trust relationship with the coroner. PD
 23 enforced the Trust needed to do as much as it could to
 24 reduce the number of serious incidents."
 25 Clearly that's a sentiment that everyone would agree

39

1 Board had sight of albeit not proper oversight of; do
 2 you agree?
 3 **A.** I do agree, yes.
 4 **Q.** Third case, third patient, please, if I may, page 7,
 5 paragraph 24. This is a non-fatal attack.
 6 **A.** Yes.
 7 **Q.** First discussed or first raised in terms of the
 8 documentation April 2023; do you see that at
 9 paragraph 24?
 10 **A.** Yes, I do.
 11 **Q.** The investigation into this, or at least the concise
 12 investigation, was done quite quickly in June 2023; do
 13 you see that?
 14 **A.** Yes, I do.
 15 **Q.** That's the sort of speed you want the investigation done
 16 to meet the Government requirements; do you agree?
 17 **A.** I would ideally want that, yes.
 18 **Q.** From the documents we have -- and certainly from this
 19 document -- it doesn't seem that this specific incident
 20 was discussed at board level. Given the previous two
 21 incidents, you'd expect something like this to be raised
 22 with the Board, wouldn't you?
 23 **A.** Yes, I would.
 24 **Q.** There was a discussion of incidents in May 2023 at board
 25 level. Can I take you please to TCLT0000353. This is

38

1 with.
 2 **A.** Yes.
 3 **Q.** That much needs to be done to reduce the number of
 4 serious incidents and from this it appears that the
 5 thing that was being done is that there had been review
 6 of 22 investigations of serious incidents --
 7 **A.** (*The witness nodded*).
 8 **Q.** -- which were going to be reported through to the
 9 Quality Committee. That was the step there.
 10 **A.** That was the specific step there, yes.
 11 **Q.** If there was a lot more to the plan in terms of trying
 12 to avoid -- reduce the number of serious incidents, that
 13 would be in the Board minutes here, wouldn't it?
 14 **A.** Not necessarily, because I think that review work would
 15 have gone through to the Quality Committee itself, and
 16 wouldn't necessarily be reflected in the minute of the
 17 Board.
 18 **Q.** No sense from the minute that there's a discussion, an
 19 active challenge, a to-and-fro about this particular
 20 issue?
 21 **A.** No.
 22 **Q.** Your contribution is to say that the number of serious
 23 incidents should be reduced, but you don't suggest any
 24 other plans or way forwards in relation to this, do you?
 25 **A.** Not that are minuted there, no.

40

1 Q. Just going back to the second paragraph, the other
2 incident, the main concern there was:
3 "... advising media coverage would be expected, but
4 the Trust had not been mentioned to date".

5 The main concern there is reputational, isn't it?

6 A. That was the role of that particular person to
7 absolutely focus on that. That wouldn't necessarily be
8 a reflection that the Board -- that was the priority for
9 the Board in looking at that incident.

10 Q. It then goes on to talk about the 22 investigations of
11 serious incidents, and it then says:

12 "MD commented this was a particularly important
13 piece of work given the Trust relationship with the
14 coroner."

15 A. Yes.

16 Q. Again, a reputational concern that's focused upon there.

17 A. I don't think that was about a reputational piece; that
18 was actually trying to draw a link back to the concerns
19 that the coroner had been raising and the conversations
20 we were having with the coroner about improving what we
21 were doing. I think that was more about a correlation
22 rather than being concerned about a reputational matter.

23 Q. There were the systemic issues about risk assessment,
24 there were the concerns raised by the coroner. There
25 are now these deaths that are being reported to the

41

1 there something in the system that's going to come
2 forward in due course? That's what would have been the
3 most important piece of work here --

4 A. Yes.

5 Q. -- to reassure yourself.

6 After the attacks in June of 2023, work was done to
7 understand --

8 A. Yes.

9 Q. -- the incidents. As well as some others. Can I take
10 you, please, to the "Thematic review of homicides and
11 attempted homicides", NHFT0000518. Dated August of
12 2024.

13 A. Yes.

14 Q. So some time after the attacks in June of 2023. Can
15 I take you to page 7, please. These are the
16 recommendations of this thematic review. Number 1:

17 "The Trust's Serious Incident Policy needs to be
18 re-written and should include process for Executive
19 oversight of the most serious incidents and include the
20 following:

21 "... Process for sign-off.

22 "... Process for the appointment of panel members.

23 "... Understanding when a 'tabletop' review is
24 acceptable.

25 "A method of approving the recommendations and the

43

1 Board, which I think you've accepted in at least 22 of
2 them more should have been done and the Board should
3 have had oversight?

4 In terms of what more could have been done, you
5 would have wanted the investigations of those incidents
6 to be expedited, wouldn't you, so you could learn from
7 patient issues as quickly as possible?

8 A. That would be one factor, yes.

9 Q. You would have wanted a review of policies that are
10 relevant to those deaths?

11 A. I would have expected that to have been part of that
12 work, yes.

13 Q. That would include the policies as regards risk
14 assessment?

15 A. In those cases, yes.

16 Q. Policies as regards discharge --

17 A. Yes.

18 Q. Policies and processes as regards discharge.

19 You could have asked for a review as to whether
20 discharges in recent times had been safe.

21 A. Yes.

22 Q. That would have been a logical piece of work when the
23 report is of previous patients causing fatal or very
24 serious injuries to others, wouldn't it?

25 To avoid this, are we awaiting for another one? Is

42

1 accompanying QIP".

2 Number 3:

3 "That an audit is designed to identify those
4 patients who have a risk history and have been
5 discharged following a period of disengagement so they
6 can be identified, re-reviewed and options considered."

7 Those are lessons that could have been learned from
8 the three cases that we looked at before.

9 A. Yes, they are.

10 Q. And those steps that we just touched upon a moment ago,
11 considering policy, considering process, discharge, risk
12 assessment, they could have been ordered back in
13 25 May -- or should have been ordered back on
14 25 May 2023, when this was before the Board.

15 A. Yes.

16 Q. Indeed, going back to September of 2022, a very serious
17 incident involving a former patient; that should have
18 been the trigger point to review the policies, shouldn't
19 it?

20 A. Yes.

21 Q. That should have been the moment when an audit was
22 undertaken to check whether discharge policies were
23 safe, and whether anyone else was potentially being
24 discharged in an unsafe way; do you agree?

25 A. Yes, there's the recommendations that were put forward

44

1 in this piece of work. I accept that those could have
 2 been brought in at those earlier stages.
 3 **Q.** Post-June of 2023, we've got a series of new policies,
 4 two in particular. I think it's a nine-step discharge
 5 policy that was brought in?
 6 **A.** Yes.
 7 **Q.** And the new risk policy, the out of date risk assessment
 8 policy was updated in 2024.
 9 Those policies, Mr Devlin, were aimed at trying to
 10 avoid attacks like VC's happening again, weren't they?
 11 **A.** Yes, they were.
 12 **Q.** Those policies were required, because the practices and
 13 processes as regards risk assessment and discharge were
 14 not fit for purpose before, as per the CQC Report and
 15 the Theemis Report.
 16 **A.** Yes.
 17 **Q.** The Trust were aware, and the Board were aware, of the
 18 concerns with risk assessment, potential issues with
 19 discharge. By September of 2022 you've said that these
 20 policies should have been reviewed.
 21 Had that opportunity been taken, these policies
 22 would have been in place or some learning would have
 23 been in place long before June 2023.
 24 **A.** Yes, some learning would have been.
 25 **Q.** If there'd been an audit of unsafe discharges, as

45

1 based place of safety, forensic services, and adult
 2 acute admission wards. The trust risk register listed
 3 staffing as a major risk and the trust had a robust
 4 recruitment and retention strategy in place."
 5 Now you would agree: you were no doubt aware of this
 6 particular concern of the CQC when you started as the
 7 Chair of the Trust?
 8 **A.** I was, yes.
 9 **Q.** Can I take you, please, to NHHNB0004596. Page 14. So
 10 this is the "NHS Long Term Plan [for] Investment in
 11 Mental Health", dated 1 February 2020. And we can see
 12 as part of the overall NHS plan, in terms of Community
 13 Mental Health Teams, it says that:
 14 "If the funding is not available to support service
 15 development and transformation, people with mental
 16 ill health will continue to have significant waits to be
 17 diagnosed and access treatment. This can lead to
 18 deterioration in their condition and potentially
 19 a mental health inpatient admission. It will also mean
 20 that community teams will not have capacity to accept
 21 referrals and step downs from mental health inpatient
 22 services and specialist teams for example crisis
 23 resolution and home treatment."
 24 I'm sure you'd agree with all of those difficulties
 25 that can come from a lack of funding and lack of support

47

1 I think you agree should have happened in September of
 2 2022, that process would have picked up VC's case,
 3 wouldn't it?
 4 **A.** It may well have done, yes.
 5 **Q.** And steps could have been taken to avoid the attacks in
 6 June of 2023.
 7 **A.** It may be the case, yes.
 8 **Q.** They certainly would have been aimed, those steps, to
 9 avoid this kind of incident, wouldn't they?
 10 **A.** In terms of -- in terms of the discharge element, yes.
 11 **Q.** I want to move on to a different topic, if I may:
 12 community staffing and resources, or particularly
 13 staffing and resources at the Trust, please.
 14 **A.** Okay.
 15 **Q.** Can I take you, please, to NHFT0002015. This is --
 16 we're going back again, so I'm looking at the issues and
 17 going back and then we'll work through chronologically
 18 as we've done with the risk assessment and safety point.
 19 Can I take you back to 2019 so we can see what the
 20 situation is when you started at the Trust. Page 7,
 21 please. Down the page a little, please.
 22 "Are services safe?"
 23 The penultimate bullet point:
 24 "The Trust did not meet safe staffing levels across
 25 the three services inspected. These were the health

46

1 and development?
 2 **A.** Yes.
 3 **Q.** Further down:
 4 "Early Intervention in Psychosis:
 5 "Funding for EIP is essential to main the current
 6 performance against the access standard. Without
 7 investment the EIP service will not be delivered in line
 8 with NICE standards and will not achieve the MHFYFV ..."
 9 Can you just assist with what that is?
 10 **A.** I can't, actually.
 11 **Q.** "... or LTP standards"? Can you assist there?
 12 **A.** Long-term plan standards, I would guess.
 13 **Q.** I'm most grateful.
 14 So this the NHS plan urging trusts to consider the
 15 issue of funding in the sorts of teams that we are
 16 concerned about in this Inquiry.
 17 **A.** It's broader than that, if I may say so, because the
 18 funding doesn't sit with the Trust; the funding sits
 19 with the commissioners.
 20 So the fact that the funding is essential, I would
 21 agree with a statement like that. It's not that we are
 22 sitting there with funding that we can put into that;
 23 that's a negotiation with commissioners.
 24 **Q.** A negotiation you would have, in particular, with the
 25 commissioners?

48

1 A. The -- the operational leaders would have. It would be
 2 -- it would not be for me personally to be having that
 3 specific negotiation. I might well raise concerns about
 4 mental health funding in the broader NHS funding, but it
 5 would be for the operational leaders who would be
 6 involved in contract negotiations to be talking about
 7 the detail of that.

8 Q. If you were concerned that there needed to be more
 9 funding, that's something that you could lead as the
 10 Chair, couldn't you? That was something that you could
 11 ask others to do, that's an issue that you could lead?

12 A. Yes.

13 Q. Can I please take you to WITN0380054. This is an
 14 email --

15 A. Yes.

16 Q. -- from Mr Brewin, you're cc'd --

17 A. I am.

18 Q. -- we can see further down. And the third paragraph:
 19 "... reached a point where ... services are not safe
 20 and we need an immediate response to help support them.
 21 "There is a sense of despondency that despite
 22 flagging this since at least June nothing has happened.
 23 "And that if [the] CQC arrived we would be
 24 threatened with closure, so let's work on the principle
 25 that this has happened.

49

1 "JB updated the Board [that] there were concerns at
 2 Highbury Hospital with regards to the staffing situation
 3 on the Adult Mental Health wards, advising a plan would
 4 be pulled together with some specific outputs from the
 5 Executive Team meeting, assuring Board members would be
 6 kept updated".

7 Next paragraph talks about some background details
 8 being gathered. Can I take you over the page, please,
 9 second paragraph:

10 "JB stated that one of the fundamental questions
 11 that would be asked is why concerns had not been spotted
 12 sooner which he believed would be the correct challenge
 13 and is an issue the Executives were very aware of."

14 Do you agree that was a concern, that these issues
 15 should have been spotted sooner?

16 A. Yes.

17 Q. Going down the page, the third paragraph from the bottom
 18 there's a contribution from you, Mr Devlin:
 19 "PD supported the actions in moving staff around,
 20 advising if the solution required funding then that
 21 should be provided, reaffirming staff/patient safety was
 22 of the utmost importance."
 23 You say there if the solution required funding, then
 24 that should be provided. Funding would certainly have
 25 helped, wouldn't it?

51

1 "So from a 'can do, solution-focused and optimistic'
 2 position I would like the following to happen from next
 3 week for starters".

4 Then there is a series of measures --

5 A. There are.

6 Q. -- put in by Mr Brewin -- Dr Brewin. Apologies,
 7 I called him Mr Brewin.

8 That's a very concerning picture, isn't it?

9 A. It absolutely was and it's wider within the actions
 10 taken with some immediacy after that.

11 Q. Indeed, it was discussed at the Board of Directors,
 12 wasn't it, this concern?

13 A. It was discussed, there was -- this was on a Friday that
 14 this email was sent. The Board of Directors was meeting
 15 on the following Tuesday and it was raised appropriately
 16 as an urgent verbal matter there, and then came back in
 17 a formal, written report with plans and updates to the
 18 following board meeting.

19 Q. Can I take you to that board meeting, please. It's
 20 NHFT0002204, page 5. So we can see there the dates, as
 21 you've said, the Tuesday, 2 November --

22 A. Yes.

23 Q. -- 2021. Part 5:
 24 "CEO update
 25 "Assurance

50

1 A. Apologies, I didn't catch that.

2 Q. Funding would have helped. That was an important part
 3 of the solution, wasn't it?

4 A. Yes.

5 Q. Were any steps taken to secure further funding for this
 6 particular problem?

7 A. You would have to take me to the follow-through document
 8 from the following board meeting to give me a prompt
 9 about that. I'm afraid I can't say that. I think this
 10 reflects my concerns about the staffing matter and
 11 basically saying that if this was going to cost us in
 12 that short term, we needed to make -- we needed to take
 13 steps on that. That is still my perception and the
 14 operational leaders will have taken that.

15 Q. The position at Highbury Hospital was very concerning,
 16 I think you've accepted that in terms of --

17 A. Absolutely, yes.

18 Q. Was a wider piece of work done to understand whether
 19 that was a concern trust-wide, a systemic issue?

20 A. Yes.

21 Q. As the Board you do that because you want to make sure
 22 that you've got all the information before you that
 23 could be affecting patient safety in a systemic sense?

24 A. That's one of the key drivers, yes.

25 Q. You want to know if there are systemic problems that are

52

1 affecting patient safety?
 2 **A.** Yes.
 3 **Q.** You need to know that, as a board, don't you?
 4 **A.** Yes.
 5 **Q.** We've heard evidence during the Inquiry of various
 6 matters being raised by staff at the Trust as regards
 7 the capacity, particularly on the EIP team. Emma
 8 Robinson described that managers had an inability to
 9 access psychologists, available to the Local Mental
 10 Health Team. We've heard about care coordinator
 11 caseloads that were in excess of the recommended
 12 caseload of 15, and a lack of administrative support, so
 13 notes weren't taken at MDT meetings.
 14 **A.** *(The witness nodded).*
 15 **Q.** Were you aware of any of that?
 16 **A.** At the time, I wasn't, and certainly -- well, I think
 17 the challenges around staffing in many mental health
 18 services are something that trusts wrestle with a great
 19 deal. Some of those, for example, there are some roles
 20 where the specific roles there are -- the pool of people
 21 to fill those roles is relatively small. There are lots
 22 of challenges around staffing across services is
 23 something that both myself and the Board were very aware
 24 of, staffing was a regular item. There were no
 25 quick-fixes.

53

1 first of those --
 2 **Q.** Yes.
 3 **A.** -- in terms of the staffing. In terms of the caseload
 4 piece and the specific of that, I suspect not. I would
 5 have expected that to have been part of what the
 6 operational leaders were scrutinising.
 7 **Q.** Via the Safer Staffing Meeting?
 8 **A.** For example.
 9 **Q.** There was another issue that I raised: lack of admin
 10 support so that MDTs weren't noted; were you aware of
 11 that at the time?
 12 **A.** I was not.
 13 **Q.** Can I take you to your witness statement, please,
 14 WITN0390001. Page 96, please.
 15 **A.** Yeah.
 16 **Q.** Paragraph 264:
 17 "The Safer Staffing Meeting was an operational
 18 meeting that operated from 2020 to 2024 and focused upon
 19 reviewing staffing across clinical areas."
 20 So if information was coming up, as we understand
 21 some of it was from the staff about concerns, this is
 22 the meeting it would be considered at?
 23 **A.** I believe so, yes.
 24 **Q.** You go on to say at paragraph 265:
 25 "It was an operational group that I [had] ... no

55

1 **Q.** We've got quite a lot of evidence about that in your
 2 witness statement which is before the Inquiry.
 3 **A.** Yes.
 4 **Q.** I just want to focus on the Board oversight of these
 5 particular issues.
 6 **A.** Okay.
 7 **Q.** So we've got three particular matters being referred
 8 there. You said you weren't aware of them at the time.
 9 When did you become aware of these concerns?
 10 **A.** I will have become aware of them in the -- in that
 11 December meeting with the actual paper, I think. I may
 12 well have -- I may well have been aware of them through
 13 a conversation, a one-to-one conversation with the Chief
 14 Executive, Dr Brewin, at the time, but formally, through
 15 the Board meeting.
 16 **Q.** Sorry, I think I may have -- we may be at cross
 17 purposes.
 18 **A.** Okay.
 19 **Q.** I asked you before about whether there was information
 20 coming to the Inquiry that there was an inability to
 21 access psychologists available to the Local Mental
 22 Health Team, and there were an overcapacity, care
 23 coordinators were over the caseload of 15. Did you know
 24 about these things at the time?
 25 **A.** I will have -- I expect I will have known about the

54

1 direct knowledge of, including its membership, attendees
 2 or specific powers, though I believe it reported to the
 3 Quality Committee."
 4 You should have had direct knowledge of the Safer
 5 Staffing Meetings, at least where it was in the
 6 reporting structure, Mr Devlin.
 7 **A.** Yes, and that's what I think I was reflecting there was
 8 my understanding of that. In terms of the specifics of
 9 that, it's -- what I was trying to convey there was that
 10 that, as an operational group, it would not have been
 11 for me to be party to the detail of that particular
 12 body.
 13 **Q.** I can see that, but you're not quite saying that there,
 14 are you; you're saying that you didn't know it's
 15 membership, you didn't know it's attendees, you didn't
 16 know it's specific powers. You believe, but you don't
 17 confirm, despite the fact that you've had --
 18 **A.** *(overspeaking)* -- That's correct.
 19 **Q.** -- a lot of time to prepare this witness statement, you
 20 believe it reported to the Quality Committee.
 21 **A.** Yes, that's correct.
 22 **Q.** The fact you didn't know all of this about the Safer
 23 Staffing Meeting that's receiving this kind of
 24 information suggests that issues about patient safety
 25 being raised by staff were under-prioritised, weren't

56

1 they, in terms of the structure and in terms of your
2 knowledge?
3 **A.** I think that's a broad -- that's a broad conclusion to
4 come from that one point, because of the other routes
5 for being aware of Safer Staffing matters that did come
6 to the Board's attention.
7 **Q.** No one knows better than the clinicians, do they, in
8 terms of this kind of information at the time?
9 **A.** Of which information?
10 **Q.** The granular information about where there are staff
11 shortages. The staff really are on top of that, aren't
12 they?
13 **A.** Yes. I think it's not solely them, though, but yes.
14 **Q.** And that's fed up to this meeting which you had little
15 awareness of or understanding of?
16 **A.** Yes. However, there were other -- I think there were
17 other bodies that I was aware of. So for example, the
18 People Committee of the Board was very much was focused
19 on, would have been considering staffing matters, and
20 indeed, as I indicate in this witness statement, that
21 Board discussion around staffing was, and continues to
22 be, a very regular item for the Board.
23 So I think my awareness of what was happening in
24 this particular group wasn't -- that wasn't the sole
25 place where issues relating to staffing were being

57

1 through the Safer Staffing Reviews that were carried out
2 as a Board and by operational leaders. But yes, I agree
3 that is an option.
4 **Q.** Another way, in the absence of national guidance, is to
5 look at comparators, discuss with other trusts?
6 **A.** Yes.
7 **Q.** Did you do that?
8 **A.** As an organisation, that comparative work will have been
9 done. Not by me personally.
10 **Q.** When the CQC reported in 2024, they certainly identified
11 a staffing issue. That was something you had identified
12 throughout your time as Chair?
13 **A.** Yes, and continued right through to when I left the
14 Trust. Staffing issues are a major concern, I would
15 suggest, not just for Nottinghamshire Healthcare, but
16 for the bulk of other mental health providers throughout
17 the country as well.
18 **MR WESTON:** Chair, those are all the questions I have.
19 **THE CHAIR:** Yes.
20 **MR WESTON:** Is now a potentially good time to break?
21 **THE CHAIR:** I think so. We'll take a break now until 3.25.
22 Thank you.
23 **MR WESTON:** Thank you.

(3.11 pm)

(A short break)

59

1 considered in the organisation.
2 **Q.** Risk assessments, deaths that weren't properly followed
3 up, staffing committees that you weren't on top of in
4 terms of their function: all of that suggests that
5 patient safety was not sufficiently prioritised by the
6 Trust and by the Board.
7 **A.** I see the reflection that you're making there. I don't
8 think that that, as a statement, is -- across the whole
9 organisation, and in terms of us not prioritising
10 patient safety is a fair, full description to come to.
11 **Q.** Can I take you back, please, to page 91. Paragraph 245,
12 you reflect upon staffing issues. At the bottom of 245,
13 you say this:
14 "However, there is no national guidance on expected
15 staffing levels against numbers or acuity of mental
16 health patients, which is different from the position in
17 physical health settings."
18 Do you think, from your perspective as a Chair,
19 there should be national guidance on those expected
20 levels?
21 **A.** I think that would be a very helpful thing for us, yes.
22 **Q.** Of course, the alternative to there being national
23 guidance is to speak to the staff.
24 **A.** That is one of the alternatives. Another alternative is
25 for us to be constantly trying to review staffing levels

58

1 (3.25 pm)

2 **MR WESTON:** I've been asked to clarify one matter.
3 **A.** Okay.
4 **Q.** September 2022, Patient 1. You can't assist with the
5 exact contours of when the patient was having links with
6 the Trust or when they were in contact with the Trust at
7 the particular time, can you?
8 **A.** No.
9 **Q.** It's not something that you've read the records of?
10 **A.** I may well have read the records of. It's about the
11 particular document you placed in front of me was that
12 anonymised document, and it was about making the
13 cross-reference to the individual who obviously I would
14 have been aware of the name that was there, but I --
15 obviously you weren't wanting to bring those names into
16 the Inquiry public space.
17 **Q.** But in terms of your recall of the detail, that's not
18 something that you can assist with now, in terms of what
19 the detail was about that particular case?
20 **A.** No.
21 **MR WESTON:** Yes.
22 **THE CHAIR:** I think, Mr Weston, we can always pick that up
23 with another witness, if necessary.
24 Yes, Mr Moloney.

Questioned by MR MOLONEY

60

1 **MR MOLONEY:** I'd like to ask you about one matter that
 2 relates to VC's case, please. You were aware that VC
 3 was admitted to Priory Arnold in October 2021.
 4 **A.** Yes.
 5 **Q.** Yeah. Was the Board aware that, in March 2021, Priory
 6 Arnold had had a CQC inspection and that inspection had
 7 resulted in restrictions being applied?
 8 **A.** It will have been if that was in the public domain. I'm
 9 not totally sure, forgive me, in terms of the timing of
 10 when that was actually in the public domain. We will
 11 have been, once it was in the public domain.
 12 **Q.** Was the structure that the Quality Assurance Group was
 13 dealing with contracting?
 14 **A.** Yes, I believe so.
 15 **Q.** Yeah, and was it reporting to the Board through the
 16 Executive Leadership Team or into the executive --
 17 **A.** Yes, it would have come through the Executive Leadership
 18 Team.
 19 **Q.** In reality, when VC was in Priory Arnold, in
 20 October 2021, you were contracting out care from your
 21 services which, as we've seen from an email, was thought
 22 to be unsafe by some Ward Managers, to private services
 23 which required restrictions by the CQC.
 24 May I ask you this: was it questioned whether that
 25 was the right thing to do for patients or public safety?

61

1 this particular case.
 2 And even if there were concerns that had been raised
 3 about an out-of-area provider, I would have expected
 4 that our operational leaders would have been wanting to
 5 have considered the pros and cons in relation to that
 6 care, yes.
 7 **Q.** Should this issue have been visible at board level, the
 8 idea of going out to an out-of-area provider about which
 9 concerns had been expressed?
 10 **A.** I would say that as a Board member I was aware of that
 11 as a possibility. I would not expect the Board to have
 12 been aware of a single specific example. In terms of
 13 a provider, once it was in the public domain, yes,
 14 I would expect that the Board would be aware of that.

15 **MR MOLONEY:** Thank you very much, Mr Devlin.

16 **THE WITNESS:** Thank you.

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

18 **Questioned by MS CARTWRIGHT**

19 **MS CARTWRIGHT:** Good afternoon, Mr Devlin.

20 **A.** Hello.

21 **Q.** Mr Devlin, can I start first of all with just a very
 22 peripheral issue but one of importance to those
 23 I represent.

24 **A.** Yes.

25 **Q.** Obviously your background of roles and responsibilities

63

1 **A.** So my understanding, Mr Moloney, was that the -- in
 2 terms of where the Priory was with the CQC, that any new
 3 admissions had to be approved by the CQC themselves and,
 4 as I understand it, the discussion around VC and the
 5 potential of VC going there would have been -- was taken
 6 to the CQC for them specifically to advise whether or
 7 not that was appropriate.

8 So those concerns, organisationally, we were aware
 9 of. My understanding is that one of the operational
 10 leaders who is coming up before the Inquiry, I think
 11 later this week, can give you more detail of that.

12 **Q.** Yeah. But just in terms of the Board's appreciation of
 13 potential risks, did the Board consider it necessary to
 14 think about any formal criteria for enhanced supervision
 15 or guaranteed engagement and oversight of placements and
 16 safe discharge, for example, when patients were going
 17 out of area into institutions that were subject to
 18 restrictions in that way, or was it left to operations?

19 **A.** I would expect that that was a part of what the
 20 operational leaders would absolutely have done, when
 21 faced with that challenge of somebody who needed
 22 a service that we were not able to provide. And then,
 23 if there were challenges of the safety or quality of
 24 those services, absolutely I would expect that those
 25 would have been raised with the CQC to seek guidance in

62

1 include that you had a role with Headway, the brain
 2 injury charity?

3 **A.** Yes, I do.

4 **Q.** Can you assist, before there were the visits to those I
 5 represent and in particular Mr Birkett, had anyone
 6 sought to speak to you about what might be needed for
 7 a meeting where you had someone who had sustained
 8 a brain injury, bearing in mind your background and
 9 experience?

10 **A.** No, they had not.

11 **Q.** Now, can I ask you, then, please, in respect of your
 12 paragraph 51 of your witness statement, which is
 13 at page 16, just to understand, I think, the changes of
 14 cultures from chair to chair, I think you give a very
 15 practical example of a change that you introduced. So
 16 paragraph 51, please.

17 **A.** Yes.

18 **Q.** So you describe:

19 "An important function as Chair is how visible I am
 20 in the organisation ... to those using our services. In
 21 a Trust as complex as [Nottingham Health Foundation
 22 Trust] with a workforce of over 11,000 staff, true
 23 visibility can be difficult to achieve. However, I took
 24 deliberate steps to be as visible as I could be,
 25 including ..."

64

1 One of the examples you have given is:
 2 "... changing access to the Chair's electronic
 3 calendar so all members of staff could see exactly what
 4 I was doing, when, and where, on behalf of [the Trust]".
 5 Is that correct?

6 **A.** That is correct.

7 **Q.** Would it be fair to say, therefore, that hadn't been the
 8 access arrangements for your predecessor?

9 **A.** That's my understanding, yes.

10 **Q.** I think you have also dealt with how you reduced your
 11 private, I suppose, consultancy role when you took on
 12 the role of Chair at Nottingham Foundation Trust?

13 **A.** That was a very deliberate decision, in order for me to
 14 feel confident at being able to carry out the two chair
 15 functions for that overlap period.

16 **Q.** Thank you. Then can I also ask you this, because
 17 certainly, through your consultancy that you now work
 18 through, you've obviously written blogs and written
 19 blogs that existed from earlier in time, and certainly
 20 that seems to give an impression of the sort of Chair
 21 you are, and the approach to being a Chair, which almost
 22 seems to be everyone's equal type of role, I think you
 23 describe a sort of cooperative mode. That may be an
 24 unfair analysis, but certainly in a blog you wrote you
 25 talked about that being the way you'd approach being

65

1 scrutinise those that had an operational role to ensure
 2 that there really was the proper oversight and
 3 operational delivery of matters?

4 **A.** I do believe that, yes.

5 **Q.** You do. All right. Well, perhaps then we'll look at
 6 that when we look at the thematic together.

7 Can we then just briefly pick up on the theme on
 8 risk assessment and the approach and how it was fed back
 9 to the Board, please, together. Can I just pick up part
 10 of the chronology you dealt with around the Risk
 11 Committee and go to paragraph 94, please. It's at
 12 page 34. And obviously we know you commenced your
 13 duties in the January of 2020. You say this:

14 "In October 2020 a Risk Committee was established
 15 ... and Minutes of the Risk Committee meeting ... This
 16 was set up as an operational group ..."

17 **A.** Yes.

18 **Q.** "... rather than a formal Board Committee (so was not
 19 part of the formal Board Governance), though was
 20 observed by a Non-Executive Director to ensure that
 21 possible content which needed to be considered in
 22 a formal Board Committee was duly escalated. This was
 23 in direct response to one of the recommendations of the
 24 Grant Thornton Well-Led Report of the [Trust] ...from
 25 August [of] 2020."

67

1 a Chair.

2 So perhaps could you just typify how you would
 3 describe, how you approach the role of being a Chair
 4 when you were at Nottingham?

5 **A.** Do you mean in terms of around the Board table?

6 **Q.** Yes.

7 **A.** Yes, absolutely I would be talking about the unitary
 8 Board that I discussed with the counsel earlier, and
 9 that I would see around that table that all of those
 10 voices had an equal value and that part of my job,
 11 therefore, was to try and ensure that all of those
 12 voices were brought out around that table.

13 **Q.** Thank you. And obviously the Board of a Foundation
 14 Trust should operate as a unitary body, and would you
 15 agree that means that both the Executive Directors and
 16 the Non-Executive Directors, all have a similar duty to
 17 act on behalf of the Trust, and to ensure that you're
 18 all working together as one team?

19 **A.** Yes.

20 **Q.** Thank you. And then can I ask similarly, with that
 21 being the approach, do you think during your time at
 22 Nottingham -- and I'm going to pick up one of the issues
 23 you dealt with around the thematic reviews from the
 24 homicides -- do you actually think, when you were in the
 25 role of a Chair, you actually did sufficiently

66

1 So can I ask you about that, please. One of the
 2 things that the Grant Thornton report had said is that
 3 many Trusts had an executive-led Risk Committee.

4 **A.** Yes.

5 **Q.** But yet that's not what was implemented following that
 6 report. And so essentially it's -- there's a function
 7 of someone observing it but it's not directly reporting
 8 to the Board, is it?

9 **A.** It is exactly what -- my understanding is it is exactly
 10 what Grant Thornton had proposed, which was
 11 an executive-led committee, and the non-executive -- if
 12 it had been a formal Board committee, by definition
 13 a non-executive would have been chairing that.

14 So I -- as I understand it, it was -- we were
 15 absolutely implementing the recommendation that
 16 Grant Thornton themselves had put in that Well Led.

17 **Q.** So can I ask, then, just practically --

18 **A.** Yes.

19 **Q.** -- from when this committee was established, how did the
 20 Board have oversight for what essentially was the issue
 21 of risk management that had been identified by the
 22 Grant Thornton review?

23 **A.** It would have come through from the Executive Team, and
 24 the additional piece was the Non-Executive Director who
 25 has an observation role --

68

- 1 Q. Thank you.
- 2 A. -- of that.
- 3 Q. Can we, just bearing in mind the significance of that
4 report, can we just briefly look, please, at
5 WITN0356018.
- 6 Thank you. If we can go to page 7, please. We
7 obviously can see a red rating --
- 8 A. Yes.
- 9 Q. -- for "... clear and effective processes for managing
10 risk, issues and performance".
- 11 Then if we can perhaps move forward to I think it's
12 page 28, thank you.
- 13 There's obviously comments about the Board Assurance
14 Framework in respect of risk, but can I ask you about
15 this, please: it's the final paragraph on page 28:
- 16 "The Trust needs to review the presentation of its
17 [Board Assurance Framework] ... Many Trusts do not
18 present their [Board Assurance Framework] ... as a 'cut'
19 from the risk management system (Ulysses) ..."
- 20 Just pausing there, Ulysses is a system that
21 essentially collates the incident reports; that's
22 correct, isn't it?
- 23 A. Yes.
- 24 Q. And previous incidents --
- 25 A. Yes.

69

- 1 is not the one you appended to your statement, but
2 perhaps just to contextualise that and your concerns,
3 can we look at your paragraph 107 of your witness
4 statement, please, at page 40.
- 5 A. Yeah. So paragraph 107, page 40. You say this:
6 "In the 26 September 2024 private board [...] we
7 discussed the Thematic review of homicides and attempted
8 homicides 2019-2023. I was concerned at that time that
9 some of the poor practice in robustly investigating and
10 reporting on those incidents may have included not
11 escalating them to the Board in a timely fashion."
- 12 A. Yes.
- 13 Q. "Whilst it is clear that incident reporting had since
14 improved (demonstrated by the more detailed reports that
15 now include specific sections on lessons learned, and
16 clear timelines of actions taken in reviewing and
17 overseeing each serious incident) this analysis of some
18 less good practice prior to 2023 helped drive the
19 development of the current more robust investigating and
20 reporting to Board practices".
- 21 And essentially, they followed, essentially, after
22 VC's attacks; would that be right?
- 23 A. Yes.
- 24 Q. But can we then just go back to the report you were
25 taken to, NHFT0000518. Thank you.

71

- 1 Q. -- for the Trust to identify areas where there's been
2 issues relating to risk and also actions that need to be
3 taken as a result of Datix incidents; is that correct?
- 4 A. Yes.
- 5 Q. And then if we go on, it says:
6 "We have shared reports with your Risk Manager from
7 some of the best performing Trusts we have worked with
8 to assist your development of this."
- 9 So would it be fair to say that this report was also
10 raising an issue about how the Trust was dealing with
11 Datix incidents and the operation of the Ulysses system?
- 12 A. I don't know if it would quite say that. I think it was
13 more about the Board oversight and the way that the --
14 that the BAF was operating.
- 15 Q. Can you help us who the Risk Manager was in August of
16 2020?
- 17 A. You'd need to check with colleagues. I think it was
18 Virginia, I can't remember Virginia's surname.
- 19 Q. All right. To the best of your knowledge, did that Risk
20 Manager remain as the same person right through to your
21 retirement from the Trust?
- 22 A. Yes.
- 23 Q. Thank you. Can we just, then, with the theme of
24 incident reports, can we just go back to the thematic
25 review you were taken to. So the reference we're using

70

- 1 In terms of just identifying Mr Warren, he is
2 someone with relevant experience from another Trust; is
3 that correct?
- 4 A. That is correct, yes.
- 5 Q. Thank you. If we can move forward, please, to page 2.
6 Thank you. Obviously that review identified, when
7 looking at this cohort that had been part of the review,
8 I think research that we've already heard about, about
9 the increased risk of violence in those living with
10 schizophrenia. But then if we can please look at
11 "Quality of reports" -- and certainly when we look over
12 the page in a minute at the timeline and you were just
13 asked a question about one of the patients -- each of
14 the investigation reports that had been conducted in
15 respect of these homicides or near-miss homicides were
16 all completed during your time as Chair, weren't they?
- 17 A. I believe so.
- 18 Q. We can see this:
19 "The prerequisite to fulfilling the Terms of
20 Reference was having high quality, well written reviews
21 from which to draw themes and understand learning. We
22 were aware from the start that the small sample size of
23 seven would limit our capacity to draw generalised
24 themes but felt that this would be possible."
25 If we go over the page, please.

72

1 "We were also hopeful to see good evidence of
2 organisational learning via the Quality Improvement
3 Plans ... We were disappointed to find that several of
4 the reports were of poor quality and not delivered or
5 finalised in a timely fashion. Many had panel members
6 without the appropriate expertise or a limited scope and
7 remarkably two consisted only of a desktop notes
8 review."

9 Then there's an outline of the summary there of
10 those matters.

11 So can I again just contextualise this, as well as
12 each of those reports being completed at the time you
13 were Chair, each of those reports also were completed
14 after the Trust had its responsibility of the statutory
15 duty of candour; would you agree?

16 **A.** Yes.

17 **Q.** So what that requires is a duty on every Trust, is the
18 necessity for essentially appropriate investigations
19 and, would you agree, if a Trust can't get it right, on
20 an investigation into a homicide, then it's a real
21 indicator of how it's dealing with other incidents where
22 there's not a homicide?

23 **A.** I think what I would say, I think the disappointment
24 that was referenced by Jonathan Warren is
25 a disappointment I was sharing, and I think the fact

73

1 a homicide that the Trust had conducted in respect of
2 these homicide cases?

3 **A.** I would agree with that, and indeed at the time that is
4 why, on the back of this review, some of those were
5 revisited, because we were so concerned about the
6 quality of what had happened at the time.

7 **Q.** And so can you just help us with those, just so we're
8 absolutely clear, because you made clear from
9 a perspective of you being a Chair and not being
10 operationally involved, can you just help us just so
11 we're clear: we've got Executive Director there; are you
12 able to help us with those, who the Executive Director,
13 who the General Manager, who the Associate Director of
14 Nursing were that signed off those reports which are
15 criticised in this document?

16 **A.** I would not know, without looking at the documents, the
17 General Manager or the Executive Director, and in terms
18 of the Associate Director of Nursing, it would relate to
19 who was in post at the time. I would need to look back
20 to be absolutely confident. That person I would --
21 would have been a member of the Board.

22 **Q.** So can you help us then with this: when the Board
23 received this report and the concerns you've expressed
24 what steps did you take to speak to the authors and
25 those that had signed off these inadequate reports to

75

1 that some of those reports were both of poor quality and
2 also had not been escalated in the way that I was
3 wanting them to -- would have expected them to,
4 rather -- was very concerning.

5 I don't think I would draw quite such a broad
6 conclusion.

7 **Q.** Perhaps then, if we -- and I appreciate, to be
8 completely fair to you, there's very summary information
9 on this table, but in terms of, if we look at the scope
10 of the investigations that the Trust had completed in
11 these seven reviews, "3 months prior" -- sorry, back to
12 the table, please: "3 months prior" for that
13 comprehensive homicide review.

14 For an "Attempted murder", a case note review only.
15 Similarly for a homicide.

16 **A.** Yes.

17 **Q.** Then we have obviously the incident involving VC where
18 there's "Full care".

19 Another homicide, simply looking at "15 days prior
20 [to the] incident"; another homicide, "3 months prior
21 [to the] incident".

22 And so would you agree that with what we look at
23 later in what was found, and I may not be able to deal
24 with it, there was a real issue about first of all the
25 robustness and thoroughness, even in the event of

74

1 understand why on earth they had closed down some of
2 these reports in the way that are criticised for their
3 inadequacies? Did that take place?

4 **A.** I -- yes, it would have done. Yes, it did, rather. And
5 that would have been led by the operational leader, so
6 that's something that Mr Majid would have made sure was
7 happening.

8 **Q.** And is there an audit trail that sits around those
9 issues of sign-off being raised with those individuals
10 that signed off each of these reports?

11 **A.** I would expect so, but I can't direct you to that.

12 **Q.** All right. Then can we look then just later down in the
13 page, obviously I think this review confirms the
14 position that you've already had explored with you: that
15 the fact that there's police involvement we see in the
16 following paragraph, that goes over the page, doesn't
17 mean it should hinder the investigation. So
18 essentially, that's Mr Warren saying that.

19 **A.** Yes.

20 **Q.** But then you asked about this:

21 "We were unclear as to the process[es] of how the
22 completed reports were challenged and signed off. Most
23 trusts reports of such serious incidents would go to
24 either the Trust Board or to its Quality Committee, and
25 reported by the Chair of the committee to the full

76

1 Board. This does not seem to have happened except for
2 the last report."

3 Which is the VC report.

4 So can you help us with that: did those other six
5 reports come to you during the time you were Chair?

6 **A.** Not in terms of them coming to the Trust Board and, for
7 some of those cases, I was aware of those incidents.

8 But that actually, on the back of this Warren report, on
9 the back of that, a number of changes were subsequently
10 made so that the Board is now made alert in exactly that
11 way through the Quality Committee. And indeed, as part
12 of that, thematic lessons learned are identified as part
13 of that.

14 **Q.** All right. So are you able to give us any further
15 detail then, insofar as you seem to be saying you had
16 some knowledge of these cases, the full extent of that?

17 I just want to understand, in your role of Chair,
18 and the questions you've already been asked by Mr Weston
19 about the ability of the Board to have identified these
20 themes and issues and trends, particularly as it picked
21 up around discharge, and also those that are then
22 withdrawing from engagement, whether they were picked up
23 at any point by you during your time as Chair before the
24 attack by VC?

25 **A.** The ones that I was aware of will have been raised, and

77

1 change required from these homicides?

2 **A.** They did not deliver that meaningful change, no.

3 **Q.** Again, why did the Board not pick up on that?

4 **A.** It goes back to the point I was saying about the level
5 of awareness and the fact, just to contextualise
6 slightly, this is a review that we commissioned and
7 instigated, and on the back of that, because we had
8 concerns that we needed to look back and have a better
9 understanding. What came through from Mr Warren's
10 report absolutely raised some significant concerns and
11 board practice, and trust practice changed on the back
12 of that.

13 **THE CHAIR:** Ms Cartwright, you've had two and a half times
14 your allocated time.

15 **MS CARTWRIGHT:** I do apologise.

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

17 **MS CARTWRIGHT:** Thank you very much. And perhaps I'm not
18 going to have time --

19 **THE CHAIR:** No, we've got (unclear) of the time. Thank you.

20 **MS CARTWRIGHT:** Thank you. Thank you for your indulgence.

21 Thank you.

22 **THE WITNESS:** Thank you.

23 **THE CHAIR:** Yes, Ms Heaven.

24 **Questioned by MS HEAVEN**

25 **MS HEAVEN:** Good afternoon, Mr Devlin. A very short

79

1 I would have absolutely had conversations with the Chief
2 Executive and I would expect that they would have been
3 considered somewhere in Board or its committees.

4 I can't be specific in relation to the other six
5 examples that Mr Warren had looked at.

6 **Q.** Then can we look at page 6, please, regarding the
7 quality improvement, which is obviously part of the
8 purpose of the investigation. The review found this:

9 "We reviewed the [Quality Improvement Plans] for the
10 reports. In many of the updates the actions bore little
11 resemblance to the recommendations ..."

12 **A.** Yes.

13 **Q.** "... actions included ..." and then there's obviously
14 some specific actions there.

15 "The panel is of the view that few of the changes
16 cited will have had any meaningful change in the
17 practice of the staff involved in the incident, let
18 alone the wider Trust. We could find no evidence of the
19 Trust measuring or understanding the changes in practice
20 that were recommended having happened outside of changes
21 to forms, policies, procedures and standard operating
22 procedures ..."

23 Would you agree that that is evidence, essentially,
24 of investigation reports and plans that are completely
25 meaningless because they've not resulted in meaningful

78

1 question on behalf of VC's family, and it relates to
2 communication with the families, carers.

3 I want to go back to some of the coronial paperwork.
4 Mr Weston read to you, I don't know if you recall, the
5 briefing notes for the meeting with the senior coroner
6 for December 2021.

7 Let's see if I can jog your memory. The very first
8 thing that were mentioned on that document were concerns
9 around family involvement and care.

10 **A.** Yes.

11 **Q.** Do you remember that, it was read to you?

12 **A.** Yes, I do.

13 **Q.** Mr Weston also took you to the Board minutes, 1
14 March 2022, I think it was. In those board minutes we
15 can see there was very detailed discussion around these
16 issues that there were concerns about family involvement
17 in care?

18 **A.** Yes.

19 **Q.** This was coming up in numerous inquests, and one of the
20 other issues that was raised was that families were not
21 being given crisis plans or safety plans?

22 **A.** Yes.

23 **Q.** Would you accept that from me?

24 **A.** Yes, I do.

25 **Q.** Just in terms of some of the coronial documents then,

80

1 please, can we just go to -- this is February 2022 so it
 2 slightly pre-dates the Board minutes but it feeds in to
 3 what I think was being updated to the Board. It's
 4 NHHB0012044, and it's page 1, thank you.
 5 You see there "General Learning" down at the bottom.
 6 Just to situate you: at the top this is 8 February, so
 7 we just jump down. It's from CIRCLE. Who is CIRCLE?
 8 **A.** CIRCLE was, it was an acronym for one of the bodies
 9 within the Trusts that was responsible for oversight of
 10 the --
 11 **Q.** I see. So we see there, don't we:
 12 "Lack of involvement of family members, carers ..."
 13 **A.** Yes.
 14 **Q.** "... (including absence of consideration and
 15 documentation of family concerns, not providing families
 16 with crisis/care plan/involving family in crisis safety
 17 planning/risk assessment ..."
 18 So it seems as though that was the information that
 19 formed the basis of what was fed into the Board in the
 20 March 2022 that I have just taken you to; is that fair?
 21 **A.** It will be fair, yeah.
 22 **Q.** Another one, please. Sorry, before we get to that, it's
 23 clearly clear, isn't it, that long before VC is
 24 discharged in September 2022, the Board were well aware
 25 that there was this long-standing problem around

81

1 **A.** Yes.
 2 **Q.** "Family support workers".
 3 But here again, we have it being raised with the
 4 Board in March, the problem is recurring in the May, and
 5 being brought to the Trust's attention.
 6 Does that suggest there was a lack of urgency, after
 7 the Board became aware in the March, moving through,
 8 really, the whole of 2022? Because we see the same
 9 problems recurring.
 10 **A.** I don't think it necessarily indicates a lack of
 11 urgency. I think we were very aware and concerned, and
 12 actually it was one of the factors that then drove us
 13 really trying to review better the learning from
 14 coroners and how we could make use of that.
 15 **Q.** Well, the Theemis Report and the CQC Reports, after the
 16 June 2023, identified long-standing systemic failure --
 17 **A.** Yes.
 18 **Q.** -- around communication with families.
 19 **A.** Yes.
 20 **Q.** It talked about a lack of safety planning, a lack of
 21 crisis management planning --
 22 **A.** *(The witness nodded).*
 23 **Q.** -- including in VC's case. That problem was clearly
 24 known to the Board well before June 2023, wasn't it?
 25 **A.** Yes, I do accept that.

83

1 communication with families, including not providing
 2 families with crisis plans and safety plans?
 3 **A.** Yes.
 4 **Q.** Okay. Let's move forward in time, please, to
 5 5 May 2022, this is NHFT0009667. This is 5 May Quality
 6 Operational Group, and if we could have a look at
 7 page 8, please. So learning from inquests again.
 8 This is a specific case that's now being raised on
 9 the 5 May by the coroner, "Family involvement in patient
 10 care":
 11 "In this case the family were not offered
 12 involvement in crisis safety planning/risk assessment."
 13 If you look to the right there, if you can read it,
 14 it says:
 15 "These points have been fed back to the
 16 directorate."
 17 What's that -- what does that mean there, "the
 18 directorate"? Was that you?
 19 **A.** No, no, that would be into the operational structure,
 20 those who would be providing services.
 21 **Q.** Okay.
 22 "Family involvement in care is again identified and
 23 there is a working group already dedicated to making
 24 improvements in this area."
 25 And there's reference to the "Triangle of Care".

82

1 **Q.** There was an opportunity, wasn't there, I think as has
 2 already been established, to introduce that nine-point
 3 discharge plan well before June 2023?
 4 **A.** Yes, I've acknowledged the missed opportunity there.
 5 **MS HEAVEN:** Thank you very much.
 6 Thank you, Chair.
 7 **THE WITNESS:** Thank you.
 8 **THE CHAIR:** Thank you.
 9 Yes, Mr Beer.
 10 **Representations by MR BEER**
 11 **MR BEER:** Chair, I've come up to say that I'm not asking
 12 questions. That's not because there are no issues that
 13 arise from the evidence, but it's because in relation to
 14 in particular some questions that were put on the basis
 15 of the INQY0000034 document re Patients 1, 2 and 3,
 16 can't properly be addressed without infringing upon the
 17 restriction that's been properly imposed by the Inquiry
 18 on referring to the individual circumstances of Patients
 19 1, 2 and 3, and therefore I'll have to take up with the
 20 Inquiry Legal Team separately how that matter is
 21 addressed.
 22 **THE CHAIR:** Yes, I think it's really more the dates and
 23 contact, isn't it? You don't have to necessarily
 24 disclose the names and further --
 25 **MR BEER:** Definitely not names and referrals, but some of

84

1 the questions were put on the basis in particular that
 2 Patient 1 involved a discharge from the Trust services,
 3 and that that was an opportunity that was missed to
 4 review past recent discharges.

5 I won't say any more about it.

6 **THE CHAIR:** Well, I think if there are any issues with that
 7 then they should be taken up and, if any correction is
 8 necessary, then it should be done within the parameters
 9 that have already been set.

10 **MR BEER:** Yes. Thank you very much.

11 **THE CHAIR:** Thank you.

12 **Questioned by THE CHAIR**

13 **THE CHAIR:** Yes, Mr Devlin. I just wanted to ask about
 14 whether there was a risk register that was gone through
 15 at board meetings.

16 **A.** There are a number of risk registers in the
 17 organisation. The key risk document that the Board
 18 looked at was The Board Assurance Framework which is
 19 a strategic risk register, and is informed by other
 20 operational -- (*overspeaking*) --

21 **THE CHAIR:** Does it have regular updates?

22 **A.** Absolutely.

23 **THE CHAIR:** As far as the risks that have been referred to,
 24 so, for example, systemic failure in clinical risk
 25 assessment, do you recall what the potential damage

1 recorded in them in the different parts of the
 2 organisation. So I and my non-executive colleagues
 3 would not have been aware of all of the elements of
 4 that. Some will have been aware of some of those,
 5 depending on which committees they were on, and
 6 obviously Executive Directors will have been aware of
 7 those risks, both for their areas of particular
 8 expertise, but also for that executive-led risk review
 9 body.

10 **THE CHAIR:** So when you were seeing the thematic review of
 11 homicides, was any work done as to whether that should
 12 appear in the risk register that the Board should look
 13 at?

14 **A.** I think, again, not specifically. However, as a Board,
 15 we were very alert to the risk elements that were coming
 16 through from that thematic review, as indeed with the
 17 other reviews that have informed a number of the pieces
 18 of work of your Inquiry, Chair.

19 **THE CHAIR:** Yes, thank you. Right, well, we'll finish there
 20 for today and we'll start again tomorrow at 10.00.

21 Thank you.

22 **(4.03 pm)**

23 **(The hearing adjourned until 10.00 am the following day)**

24

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1 would be other than reputational to the Trust?

2 **A.** It would --

3 **THE CHAIR:** Did it include risk to the public?

4 **A.** It should have. I can't say that it did have. It would
 5 not have been raised -- flagged in that way at the Board
 6 Assurance Framework, but I think in the context of what
 7 the Inquiry has looked at, that is a key risk.

8 **THE CHAIR:** Yes. You say it wouldn't have been flagged at
 9 the Board Assurance Framework. Why not?

10 **A.** Because of the strategic nature of that Board Assurance
 11 Framework. So whilst I absolutely accept that is a big
 12 risk, in terms of the strategic risk across the whole
 13 organisation, that wouldn't reach the Board Assurance
 14 Framework. It would still be -- should still have been
 15 getting robust scrutiny, though.

16 **THE CHAIR:** Where would it appear as a risk?

17 **A.** That would have appeared in operational risk registers,
 18 would have been picked up through the Risk Committee,
 19 the executive group that was being referred to
 20 previously, and potentially would have been raised
 21 through one of the Board committees.

22 **THE CHAIR:** Were you, as Chair, and/or the Board, unitary
 23 Board, made aware of all of those other risk registers?

24 **A.** We're absolutely aware of all of those other risk
 25 registers. There are many hundreds of risks that are

I N D E X

	Page
3 Questioned by MR MOLONEY	60
4 Questioned by MS CARTWRIGHT	63
5 Questioned by MS HEAVEN	79
6 Representations by MR BEER	84
7 Questioned by THE CHAIR	85

8

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13

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MR BEER: [3] 84/11 84/25 85/10	19 [2] 1/1 5/19	40 [2] 71/4 71/5 47 [1] 10/7 48 [1] 16/21	29/10 actions [10] 3/24 4/1 37/22 50/9 51/19 70/2 71/16 78/10 78/13 78/14 active [2] 6/25 40/19 activities [1] 17/3 activity [1] 7/25 actual [2] 36/17 54/11 actually [10] 8/17 11/21 26/10 41/18 48/10 61/10 66/24 66/25 77/8 83/12 acuity [1] 58/15 acumen [1] 20/13 acute [1] 47/2 additional [1] 68/24 address [1] 17/2 addressed [2] 84/16 84/21 adjourned [1] 87/23 adjust [1] 11/13 admin [1] 55/9 administrative [1] 53/12 admission [2] 47/2 47/19 admissions [1] 62/3 admitted [1] 61/3 adult [3] 10/15 47/1 51/3 advice [1] 28/8 advise [1] 62/6 advised [1] 39/18 advising [4] 39/15 41/3 51/3 51/20 affecting [3] 19/5 52/23 53/1 afraid [3] 4/16 14/14 52/9 after [11] 18/2 22/16 30/13 37/7 43/6 43/14 50/10 71/21 73/14 83/6 83/15 afternoon [2] 63/19 79/25 again [16] 8/20 10/23 13/9 15/3 15/5 31/13 41/16 45/10 46/16 73/11 79/3 82/7 82/22 83/3 87/14 87/20 against [2] 48/6 58/15 agendas [1] 8/11 ago [1] 44/10 agree [25] 15/10 16/18 16/23 18/5 18/10 18/14 34/24 37/23 38/2 38/3 38/16 39/25 44/24 46/1 47/5 47/24 48/21 51/14 59/2 66/15 73/15 73/19 74/22 75/3 78/23 agreed [2] 20/9 21/25	aimed [2] 45/9 46/8 albeit [1] 38/1 alert [3] 12/22 77/10 87/15 alerting [1] 31/8 all [28] 1/16 3/23 5/5 15/17 18/1 24/13 26/6 37/4 47/24 52/22 56/22 58/4 59/18 63/21 65/3 66/9 66/11 66/16 66/18 67/5 70/19 72/16 74/24 76/12 77/14 86/23 86/24 87/3 allayed [1] 25/14 allocated [1] 79/14 allowed [1] 15/7 almost [1] 65/21 alone [1] 78/18 already [6] 72/8 76/14 77/18 82/23 84/2 85/9 also [20] 2/9 6/20 7/9 8/5 9/17 9/19 10/16 17/11 37/16 47/19 65/10 65/16 70/2 70/9 73/1 73/13 74/2 77/21 80/13 87/8 alternative [4] 29/5 29/7 58/22 58/24 alternatives [2] 29/11 58/24 always [3] 4/11 9/15 60/22 am [6] 14/7 24/6 25/19 49/17 64/19 87/23 Amanda [1] 10/2 amending [1] 29/16 AMN [1] 39/18 analysis [6] 33/5 33/25 35/5 35/5 65/24 71/17 Anne [1] 21/11 Anne-Maria [1] 21/11 anonymised [1] 60/12 anonymising [1] 26/13 anonymous [1] 25/23 another [11] 21/2 35/22 42/25 55/9 58/24 59/4 60/23 72/2 74/19 74/20 81/22 answer [1] 14/14 answers [1] 13/20 any [19] 4/10 9/16 10/20 22/7 26/16 33/11 33/24 40/23 52/5 53/15 62/2 62/14 77/14 77/23 78/16 85/5 85/6 85/7 87/11 anyone [4] 6/13 10/21 44/23 64/5 anything [1] 32/20
MR MOLONEY: [2] 61/1 63/15	2	5		
MR WESTON: [6] 1/4 59/18 59/20 59/23 60/2 60/21	20 [1] 36/20 2018 [1] 24/18 2018/19 [1] 5/19 2019 [6] 1/5 1/8 5/16 17/16 23/16 46/19 2019-2023 [1] 71/8 2020 [15] 1/5 7/6 7/13 7/25 8/19 10/8 13/18 14/13 20/21 47/11 55/18 67/13 67/14 67/25 70/16 2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1	5 May [1] 82/5 5 May 2022 [1] 82/5 501667 [1] 39/11 51 [2] 64/12 64/16		
MS CARTWRIGHT: [4] 63/19 79/15 79/17 79/20	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1	6		
MS HEAVEN: [2] 79/25 84/5	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1	6 September 2022 [1] 30/1 63 [1] 18/17 67 [1] 24/2		
THE CHAIR: [22] 1/3 59/19 59/21 60/22 63/17 79/13 79/16 79/19 79/23 84/8 84/22 85/6 85/11 85/13 85/21 85/23 86/3 86/8 86/16 86/22 87/10 87/19	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1	9		
THE WITNESS: [3] 63/16 79/22 84/7	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1	91 [2] 11/25 58/11 94 [1] 67/11 96 [1] 55/14		
' 21 [1] 22/9	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1	A		
' can [1] 50/1	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1	ability [1] 77/19 able [12] 9/1 9/12 18/8 23/25 31/25 32/12 37/17 62/22 65/14 74/23 75/12 77/14 about [92] absence [5] 12/10 13/2 23/2 59/4 81/14 absolutely [23] 1/22 7/3 8/8 8/15 9/3 14/5 17/8 17/10 35/14 41/7 50/9 52/17 62/20 62/24 66/7 68/15 75/8 75/20 78/1 79/10 85/22 86/11 86/24 accept [7] 17/10 34/18 45/1 47/20 80/23 83/25 86/11 acceptable [1] 43/24 acceptance [1] 24/6 accepted [3] 34/13 42/1 52/16 access [7] 14/8 47/17 48/6 53/9 54/21 65/2 65/8 accompanying [1] 44/1 account [2] 7/12 23/3 Accountable [1] 10/3 achieve [2] 48/8 64/23 acknowledged [1] 84/4 acronym [1] 81/8 across [15] 4/13 4/16 9/5 10/17 10/24 11/2 11/19 11/20 13/20 15/3 46/24 53/22 55/19 58/8 86/12 act [2] 28/24 66/17 action [10] 2/24 3/2 3/10 3/17 3/19 4/4 17/1 26/25 28/12		
' curious [1] 28/19	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1			
' cut' [1] 69/18	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1			
' emphasis [1] 28/20	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1			
' opt [1] 29/11	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1			
' opt-in' [1] 29/11	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1			
' tabletop' [1] 43/23	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1			
-	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1			
-- it [1] 49/2	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1			
...	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26/8 26/9 27/12 29/18 30/1 34/17 35/16 37/22 44/16 45/19 46/2 60/4 80/14 81/1 81/20 81/24 82/5 83/8 2023 [26] 8/1 13/18 14/13 16/13 17/6 20/14 24/16 24/20 27/9 35/25 37/22 38/8 38/12 38/24 39/1 43/6 43/14 44/14 45/3 45/23 46/6 71/8 71/18 83/16 83/24 84/3 2024 [12] 1/6 15/13 17/17 17/21 20/11 25/6 36/8 43/12 45/8 55/18 59/10 71/6 2025 [1] 26/21 2026 [1] 1/1			
... from [1] 67/24	2021 [8] 8/19 21/10 22/7 50/23 61/3 61/5 61/20 80/6 2022 [23] 12/1 13/1 13/1 22/14 24/18 26			

<p>A</p> <p>apologies [5] 9/17 24/3 36/1 50/6 52/1</p> <p>apologise [1] 79/15</p> <p>appear [3] 16/16 86/16 87/12</p> <p>appeared [1] 86/17</p> <p>appears [2] 27/20 40/4</p> <p>appended [1] 71/1</p> <p>applied [2] 33/10 61/7</p> <p>appointment [1] 43/22</p> <p>appreciate [2] 32/4 74/7</p> <p>appreciation [1] 62/12</p> <p>approach [6] 16/5 65/21 65/25 66/3 66/21 67/8</p> <p>approached [1] 29/6</p> <p>appropriate [7] 15/17 15/20 25/2 39/10 62/7 73/6 73/18</p> <p>appropriately [1] 50/15</p> <p>approved [2] 26/21 62/3</p> <p>approving [1] 43/25</p> <p>April [1] 38/8</p> <p>April 2023 [1] 38/8</p> <p>are [64] 1/13 1/20 2/4 2/9 6/19 7/1 7/11 9/13 9/14 15/20 17/3 17/3 18/20 19/3 19/4 22/23 23/24 24/5 25/7 29/5 29/6 34/10 34/23 35/15 37/4 37/4 37/6 40/25 41/25 41/25 42/9 42/25 43/15 44/7 44/9 46/22 48/15 48/21 49/19 50/5 52/25 52/25 53/18 53/19 53/20 53/21 56/14 57/10 57/11 59/14 59/18 65/21 75/11 75/14 76/2 77/12 77/14 77/21 78/24 84/12 85/6 85/16 86/25 86/25</p> <p>area [5] 11/17 62/17 63/3 63/8 82/24</p> <p>areas [3] 55/19 70/1 87/7</p> <p>aren't [5] 9/13 11/5 19/3 37/5 57/11</p> <p>arise [1] 84/13</p> <p>arises [1] 26/16</p> <p>Arnold [3] 61/3 61/6 61/19</p> <p>arose [1] 24/14</p> <p>around [21] 1/6 8/4 12/21 12/23 15/2 51/19 53/17 53/22</p> <p>57/21 62/4 66/5 66/9 66/12 66/23 67/10 76/8 77/21 80/9 80/15 81/25 83/18</p> <p>arrangements [3] 27/7 27/11 65/8</p> <p>arrived [2] 6/21 49/23</p> <p>as [111]</p> <p>aside [1] 15/6</p> <p>ask [18] 2/19 4/6 4/20 7/7 11/12 33/4 33/6 35/4 49/11 61/1 61/24 64/11 65/16 66/20 68/1 68/17 69/14 85/13</p> <p>asked [18] 4/17 4/24 6/12 6/12 6/17 6/18 7/4 13/12 13/16 20/20 35/6 42/19 51/11 54/19 60/2 72/13 76/20 77/18</p> <p>asking [8] 2/12 2/23 2/23 3/1 4/15 5/4 6/25 84/11</p> <p>Assertive [1] 29/2</p> <p>assessed [1] 16/3</p> <p>assessment [47] 2/1 6/10 6/13 7/2 7/17 8/9 8/10 8/13 12/11 12/12 13/7 13/16 14/3 14/12 15/17 15/24 15/24 16/5 16/19 17/16 17/17 18/8 18/9 18/12 19/15 19/21 20/8 20/22 21/17 21/22 21/24 23/3 23/4 23/7 23/12 28/24 41/23 42/14 44/12 45/7 45/13 45/18 46/18 67/8 81/17 82/12 85/25</p> <p>assessments [22] 1/13 1/20 2/4 2/20 4/5 4/6 4/25 5/7 6/19 6/21 8/1 8/17 12/10 13/2 13/3 14/21 14/21 14/25 23/2 29/16 29/19 58/2</p> <p>assist [8] 27/3 37/14 48/9 48/11 60/4 60/18 64/4 70/8</p> <p>Associate [2] 75/13 75/18</p> <p>assurance [21] 3/22 18/24 20/2 30/3 30/8 31/14 31/21 32/1 32/4 34/12 34/14 50/25 61/12 69/13 69/17 69/18 85/18 86/6 86/9 86/10 86/13</p> <p>assured [1] 31/20</p> <p>assuring [1] 51/5</p> <p>at [122]</p> <p>at page 16 [1] 64/13</p> <p>attack [3] 30/13 38/5</p>	<p>77/24</p> <p>attacks [7] 17/6 37/8 43/6 43/14 45/10 46/5 71/22</p> <p>attempted [3] 43/11 71/7 74/14</p> <p>attendants [1] 21/11</p> <p>attendees [2] 56/1 56/15</p> <p>attention [7] 4/23 12/18 19/7 29/22 35/24 57/6 83/5</p> <p>audit [7] 7/17 7/19 23/20 44/3 44/21 45/25 76/8</p> <p>August [6] 26/9 29/18 34/17 43/11 67/25 70/15</p> <p>August 2022 [1] 26/9</p> <p>August of [1] 29/18</p> <p>authors [1] 75/24</p> <p>available [4] 39/17 47/14 53/9 54/21</p> <p>avoid [5] 40/12 42/25 45/10 46/5 46/9</p> <p>awaiting [4] 27/3 27/14 31/2 42/25</p> <p>aware [45] 2/15 8/3 10/20 13/1 13/5 14/3 16/14 22/6 22/8 24/11 25/17 26/4 27/13 30/6 45/17 45/17 47/5 51/13 53/15 53/23 54/8 54/9 54/10 54/12 55/10 57/5 57/17 60/14 61/2 61/5 62/8 63/10 63/12 63/14 72/22 77/7 77/25 81/24 83/7 83/11 86/23 86/24 87/3 87/4 87/6</p> <p>awareness [4] 39/8 57/15 57/23 79/5</p> <p>away [1] 8/8</p>	<p>B</p> <p>back [35] 1/6 1/10 3/5 5/20 6/22 11/15 14/8 20/21 32/5 32/21 35/20 41/1 41/18 44/12 44/13 44/16 46/16 46/17 46/19 50/16 58/11 67/8 70/24 71/24 74/11 75/4 75/19 77/8 77/9 79/4 79/7 79/8 79/11 80/3 82/15</p> <p>background [3] 51/7 63/25 64/8</p> <p>BAF [3] 18/21 18/23 70/14</p> <p>based [2] 17/19 47/1</p> <p>basically [1] 52/11</p> <p>basis [3] 81/19 84/14 85/1</p> <p>be [113]</p> <p>bearing [2] 64/8 69/3</p> <p>became [1] 83/7</p> <p>because [31] 2/4 2/6 8/5 15/22 16/24 20/3 20/16 20/20 25/4 25/10 27/3 27/13 32/11 32/20 33/2 33/10 33/21 40/14 45/12 48/17 52/21 57/4 65/16 75/5 75/8 78/25 79/7 83/8 84/12 84/13 86/10</p> <p>become [2] 54/9 54/10</p> <p>been [123]</p> <p>Beer [3] 84/9 84/10 88/6</p> <p>before [27] 1/4 2/15 3/14 5/14 10/10 18/2 20/14 24/21 26/10 33/5 33/15 34/19 35/16 44/8 44/14 45/14 45/23 52/22 54/2 54/19 62/10 64/4 77/23 81/22 81/23 83/24 84/3</p> <p>beforehand [2] 5/22 37/9</p> <p>begin [1] 10/1</p> <p>beginning [1] 20/21</p> <p>behalf [3] 65/4 66/17 80/1</p> <p>being [57] 2/4 2/6 2/13 2/20 2/21 3/3 4/4 6/21 8/11 8/17 9/1 11/8 13/12 15/7 17/10 18/6 18/8 22/18 23/13 24/9 25/9 25/24 28/7 31/24 31/25 32/3 32/25 33/4 34/24 40/5 41/22 41/25 44/23 51/8 53/6 54/7 56/25 57/5 57/25 58/22 61/7 65/14 65/21 65/25 65/25 66/3 66/21 73/12 75/9 75/9 76/9 80/21 81/3 82/8 83/3 83/5 86/19</p> <p>believe [10] 26/13 26/15 28/9 55/23 56/2 56/16 56/20 61/14 67/4 72/17</p> <p>believed [1] 51/12</p> <p>below [2] 12/5 12/15</p> <p>best [2] 70/7 70/19</p> <p>better [4] 23/25 57/7 79/8 83/13</p> <p>between [3] 13/17 14/13 22/2</p> <p>beyond [2] 15/8 25/16</p> <p>big [1] 86/11</p> <p>Birkett [1] 64/5</p> <p>bit [1] 4/18</p> <p>blog [1] 65/24</p> <p>blogs [2] 65/18 65/19</p>	<p>board [150]</p> <p>Board's [2] 57/6 62/12</p> <p>bodies [2] 57/17 81/8</p> <p>body [4] 22/25 56/12 66/14 87/9</p> <p>book [1] 18/2</p> <p>bore [1] 78/10</p> <p>both [5] 2/25 53/23 66/15 74/1 87/7</p> <p>bottom [6] 5/17 6/5 16/8 51/17 58/12 81/5</p> <p>box [1] 16/9</p> <p>brain [2] 64/1 64/8</p> <p>break [4] 1/4 59/20 59/21 59/25</p> <p>Brewin [5] 49/16 50/6 50/6 50/7 54/14</p> <p>briefing [3] 12/3 39/16 80/5</p> <p>briefly [2] 67/7 69/4</p> <p>bring [2] 32/4 60/15</p> <p>broad [4] 29/22 57/3 57/3 74/5</p> <p>broader [5] 11/20 11/20 20/8 48/17 49/4</p> <p>broadly [2] 4/15 29/7</p> <p>brought [9] 12/18 14/17 14/18 29/21 29/22 45/2 45/5 66/12 83/5</p> <p>bulk [1] 59/16</p> <p>bullet [4] 4/23 15/16 21/15 46/23</p> <p>business [2] 19/3 20/5</p> <p>but [55] 2/4 3/9 4/4 4/20 6/24 7/25 9/7 11/9 12/25 14/3 16/15 18/8 21/6 21/20 23/9 26/15 27/7 27/22 30/12 34/13 34/23 36/7 37/7 39/15 40/23 41/3 49/4 54/14 56/13 56/16 57/13 59/2 59/15 60/14 60/17 62/12 63/22 65/24 68/5 68/7 69/14 71/1 71/24 72/10 72/24 74/9 76/11 76/20 77/8 81/2 83/3 84/13 84/25 86/6 87/8</p>	<p>C</p> <p>calendar [1] 65/3</p> <p>called [1] 50/7</p> <p>calls [1] 29/12</p> <p>came [8] 2/19 3/15 13/20 26/7 32/21 35/24 50/16 79/9</p> <p>can [93]</p> <p>can't [15] 4/20 5/11 5/11 11/14 14/14 14/20 48/10 52/9 60/4 70/18 73/19 76/11 78/4 84/16 86/4</p>
--	--	--	--	---

<p>C</p> <p>candour [1] 73/15</p> <p>capacity [5] 10/14 36/23 47/20 53/7 72/23</p> <p>captured [1] 18/20</p> <p>care [16] 10/4 10/10 10/19 15/19 21/16 53/10 54/22 61/20 63/6 74/18 80/9 80/17 81/16 82/10 82/22 82/25</p> <p>carers [2] 80/2 81/12</p> <p>carried [1] 59/1</p> <p>carry [1] 65/14</p> <p>Cartwright [4] 63/17 63/18 79/13 88/4</p> <p>case [17] 26/14 31/23 33/7 33/19 34/22 37/5 37/18 38/4 46/2 46/7 60/19 61/2 63/1 74/14 82/8 82/11 83/23</p> <p>caseload [3] 53/12 54/23 55/3</p> <p>caseloads [1] 53/11</p> <p>cases [8] 21/18 22/3 34/15 42/15 44/8 75/2 77/7 77/16</p> <p>catch [1] 52/1</p> <p>causal [1] 20/19</p> <p>causing [1] 42/23</p> <p>cc'd [1] 49/16</p> <p>CCG [2] 10/8 10/10</p> <p>CEO [5] 24/6 24/7 24/9 39/4 50/24</p> <p>certainly [10] 26/8 38/18 46/8 51/24 53/16 59/10 65/17 65/19 65/24 72/11</p> <p>chains [1] 2/13</p> <p>chair [32] 2/15 5/21 6/25 25/16 47/7 49/10 58/18 59/12 59/18 64/14 64/14 64/19 65/12 65/14 65/20 65/21 66/1 66/3 66/25 72/16 73/13 75/9 76/25 77/5 77/17 77/23 84/6 84/11 85/12 86/22 87/18 88/7</p> <p>Chair's [1] 65/2</p> <p>chairing [1] 68/13</p> <p>challenge [5] 13/14 28/10 40/19 51/12 62/21</p> <p>challenged [1] 76/22</p> <p>challenges [3] 53/17 53/22 62/23</p> <p>change [6] 27/7 37/17 64/15 78/16 79/1 79/2</p> <p>changed [1] 79/11</p> <p>changes [8] 16/11</p>	<p>25/5 29/15 64/13 77/9 78/15 78/19 78/20</p> <p>changing [1] 65/2</p> <p>charity [1] 64/2</p> <p>check [2] 44/22 70/17</p> <p>checked [1] 5/2</p> <p>Chief [3] 10/2 54/13 78/1</p> <p>choice [2] 27/23 27/24</p> <p>choosing [1] 29/6</p> <p>chronologically [1] 46/17</p> <p>chronology [1] 67/10</p> <p>CIRCLE [3] 81/7 81/7 81/8</p> <p>circumstances [2] 32/24 84/18</p> <p>cited [1] 78/16</p> <p>clarify [1] 60/2</p> <p>clear [13] 3/24 11/10 15/4 16/16 16/18 18/9 69/9 71/13 71/16 75/8 75/8 75/11 81/23</p> <p>clearer [1] 13/3</p> <p>clearly [7] 2/2 12/10 13/14 23/2 39/25 81/23 83/23</p> <p>clinical [28] 1/20 1/21 1/23 2/20 4/6 8/1 8/10 13/16 14/12 14/21 15/24 16/19 18/11 18/12 19/15 19/20 19/24 20/3 20/7 20/8 20/13 20/16 29/16 29/17 29/19 33/14 55/19 85/24</p> <p>clinician [1] 2/1</p> <p>clinicians [2] 19/16 57/7</p> <p>closed [1] 76/1</p> <p>closure [1] 49/24</p> <p>cohort [1] 72/7</p> <p>collates [1] 69/21</p> <p>colleagues [2] 70/17 87/2</p> <p>combination [1] 32/15</p> <p>come [12] 3/5 6/1 19/22 43/1 47/25 57/4 57/5 58/10 61/17 68/23 77/5 84/11</p> <p>comes [1] 17/8</p> <p>coming [10] 19/7 21/3 23/6 28/10 54/20 55/20 62/10 77/6 80/19 87/15</p> <p>commenced [1] 67/12</p> <p>commented [2] 39/20 41/12</p> <p>comments [1] 69/13</p> <p>commissioned [1] 79/6</p> <p>commissioners [3]</p>	<p>48/19 48/23 48/25</p> <p>committee [26] 12/4 12/14 12/21 12/24 12/25 13/11 19/7 39/20 40/9 40/15 56/3 56/20 57/18 67/11 67/14 67/15 67/18 67/22 68/3 68/11 68/12 68/19 76/24 76/25 77/11 86/18</p> <p>committees [6] 3/6 12/4 58/3 78/3 86/21 87/5</p> <p>communicated [1] 21/19</p> <p>communication [5] 12/12 23/4 80/2 82/1 83/18</p> <p>communications [1] 20/25</p> <p>community [6] 10/16 16/4 37/3 46/12 47/12 47/20</p> <p>comparative [5] 9/10 9/11 10/25 11/16 59/8</p> <p>comparatively [3] 8/24 9/7 10/22</p> <p>comparator [1] 11/21</p> <p>comparators [1] 59/5</p> <p>compared [2] 11/4 24/9</p> <p>comparison [5] 9/22 11/10 11/12 11/14 11/22</p> <p>completed [8] 36/2 36/4 36/8 72/16 73/12 73/13 74/10 76/22</p> <p>completely [2] 74/8 78/24</p> <p>complex [1] 64/21</p> <p>comprehensive [3] 36/7 36/17 74/13</p> <p>concern [15] 5/10 12/17 13/2 17/9 24/14 26/17 35/3 41/2 41/5 41/16 47/6 50/12 51/14 52/19 59/14</p> <p>concerned [8] 16/15 17/3 41/22 48/16 49/8 71/8 75/5 83/11</p> <p>concerning [3] 50/8 52/15 74/4</p> <p>concerns [30] 3/14 7/1 10/13 17/2 21/20 22/6 23/13 24/8 24/11 25/13 25/16 41/18 41/24 45/18 49/3 51/1 51/11 52/10 54/9 55/21 62/8 63/2 63/9 71/2 75/23 79/8 79/10 80/8 80/16 81/15</p> <p>concise [2] 30/25 38/11</p> <p>concluded [1] 30/25</p> <p>conclusion [2] 57/3 74/6</p>	<p>condition [1] 47/18</p> <p>conducted [2] 72/14 75/1</p> <p>confidence [1] 25/4</p> <p>confident [3] 5/1 65/14 75/20</p> <p>confirm [1] 56/17</p> <p>confirms [1] 76/13</p> <p>cons [1] 63/5</p> <p>consider [4] 18/11 20/14 48/14 62/13</p> <p>consideration [1] 81/14</p> <p>considered [10] 15/23 25/1 25/24 26/5 44/6 55/22 58/1 63/5 67/21 78/3</p> <p>considering [5] 12/11 29/11 44/11 44/11 57/19</p> <p>consisted [1] 73/7</p> <p>consistently [1] 10/16</p> <p>constantly [1] 58/25</p> <p>constitution [1] 20/17</p> <p>consultancy [2] 65/11 65/17</p> <p>contact [4] 30/14 30/21 60/6 84/23</p> <p>contain [1] 1/16</p> <p>content [2] 34/15 67/21</p> <p>context [7] 8/4 8/21 9/19 16/21 16/23 28/23 86/6</p> <p>contextualise [3] 71/2 73/11 79/5</p> <p>continue [1] 47/16</p> <p>continued [3] 10/8 10/13 59/13</p> <p>continues [1] 57/21</p> <p>contours [1] 60/5</p> <p>contract [1] 49/6</p> <p>contracting [2] 61/13 61/20</p> <p>contrary [1] 33/21</p> <p>contribution [2] 40/22 51/18</p> <p>conversation [4] 7/18 33/8 54/13 54/13</p> <p>conversations [5] 8/21 11/19 34/5 41/19 78/1</p> <p>convey [1] 56/9</p> <p>cooperative [1] 65/23</p> <p>coordinator [1] 53/10</p> <p>coordinators [1] 54/23</p> <p>coroner [11] 21/9 22/3 22/16 24/5 39/22 41/14 41/19 41/20 41/24 80/5 82/9</p> <p>coroner's [3] 22/6 22/18 25/16</p>	<p>coroners [7] 22/22 23/12 23/14 24/23 24/24 25/1 83/14</p> <p>coronial [2] 80/3 80/25</p> <p>corporate [2] 6/15 6/16</p> <p>correct [11] 12/6 33/23 51/12 56/18 56/21 65/5 65/6 69/22 70/3 72/3 72/4</p> <p>correction [1] 85/7</p> <p>correlate [1] 26/14</p> <p>correlation [1] 41/21</p> <p>cost [1] 52/11</p> <p>could [31] 7/16 7/18 7/22 13/25 23/19 25/13 31/17 34/7 35/4 35/6 35/8 35/9 35/11 39/23 42/4 42/6 42/19 44/7 44/12 45/1 46/5 49/9 49/10 49/11 52/23 64/24 65/3 66/2 78/18 82/6 83/14</p> <p>couldn't [6] 4/18 13/25 25/14 33/15 35/7 49/10</p> <p>counsel [1] 66/8</p> <p>country [3] 9/6 11/20 59/17</p> <p>couple [1] 25/1</p> <p>course [5] 11/9 39/3 39/4 43/2 58/22</p> <p>coverage [2] 39/15 41/3</p> <p>Covid [1] 8/13</p> <p>CPs [1] 25/24</p> <p>CQC [30] 1/8 1/12 1/18 2/9 2/14 3/1 3/21 4/10 5/5 6/24 7/11 15/12 16/22 17/16 17/17 17/21 18/2 21/1 23/18 45/14 47/6 49/23 59/10 61/6 61/23 62/2 62/3 62/6 62/25 83/15</p> <p>CQC Review [1] 15/12</p> <p>CQCM0013499 [1] 15/13</p> <p>crisis [9] 16/4 16/7 47/22 80/21 81/16 81/16 82/2 82/12 83/21</p> <p>crisis/care [1] 81/16</p> <p>criteria [1] 62/14</p> <p>criticised [2] 75/15 76/2</p> <p>cross [2] 54/16 60/13</p> <p>cross-reference [1] 60/13</p> <p>crucial [2] 8/13 14/3</p> <p>cultures [1] 64/14</p> <p>current [3] 16/14 48/5 71/19</p> <p>currently [1] 36/15</p>
--	--	--	---	--

<p>D</p> <p>damage [1] 85/25</p> <p>data [2] 9/2 9/15</p> <p>date [6] 14/16 15/10 22/13 39/16 41/4 45/7</p> <p>dated [3] 12/1 43/11 47/11</p> <p>dates [3] 50/20 81/2 84/22</p> <p>Datix [2] 70/3 70/11</p> <p>day [1] 87/23</p> <p>days [2] 26/10 74/19</p> <p>deadline [1] 15/8</p> <p>deal [3] 32/4 53/19 74/23</p> <p>dealing [4] 8/6 61/13 70/10 73/21</p> <p>dealt [3] 65/10 66/23 67/10</p> <p>death [4] 25/17 26/16 28/1 35/12</p> <p>deaths [8] 5/18 6/5 22/4 22/21 25/3 41/25 42/10 58/2</p> <p>December [8] 12/1 12/7 13/1 21/10 22/7 22/9 54/11 80/6</p> <p>December '21 [1] 22/9</p> <p>December 2021 [2] 22/7 80/6</p> <p>December 2022 [1] 13/1</p> <p>decision [3] 21/17 21/24 65/13</p> <p>decreasing [1] 24/22</p> <p>dedicated [1] 82/23</p> <p>deep [2] 7/22 23/21</p> <p>Definitely [1] 84/25</p> <p>definitely: [1] 13/25</p> <p>definitely: yes [1] 13/25</p> <p>definition [1] 68/12</p> <p>delay [2] 27/2 37/21</p> <p>delays [1] 31/24</p> <p>deliberate [2] 64/24 65/13</p> <p>deliver [1] 79/2</p> <p>delivered [3] 4/1 48/7 73/4</p> <p>delivery [1] 67/3</p> <p>demonstrated [1] 71/14</p> <p>depending [1] 87/5</p> <p>describe [4] 23/15 64/18 65/23 66/3</p> <p>described [1] 53/8</p> <p>describing [1] 19/19</p> <p>description [1] 58/10</p> <p>designed [2] 19/1 44/3</p> <p>desktop [1] 73/7</p> <p>despite [5] 17/25 18/1 37/8 49/21 56/17</p> <p>despondency [1]</p>	<p>49/21</p> <p>detail [8] 21/24 30/20 49/7 56/11 60/17 60/19 62/11 77/15</p> <p>detailed [4] 3/9 25/25 71/14 80/15</p> <p>details [2] 31/15 51/7</p> <p>deteriorating [1] 10/19</p> <p>deterioration [1] 47/18</p> <p>developed [2] 27/21 31/25</p> <p>development [4] 47/15 48/1 70/8 71/19</p> <p>devised [1] 3/17</p> <p>Devlin [13] 1/4 1/20 16/20 19/24 20/20 45/9 51/18 56/6 63/15 63/19 63/21 79/25 85/13</p> <p>diagnosed [1] 47/17</p> <p>did [39] 2/18 3/19 4/6 4/8 4/9 4/9 4/20 8/23 10/20 11/15 13/7 16/7 16/16 16/18 19/18 20/1 27/16 28/7 28/9 31/19 33/4 33/6 46/24 54/9 54/23 57/5 59/7 62/13 66/25 68/19 70/19 75/24 76/3 76/4 77/4 79/2 79/3 86/3 86/4</p> <p>didn't [10] 7/7 7/8 19/24 20/16 28/10 52/1 56/14 56/15 56/15 56/22</p> <p>different [9] 9/20 11/23 14/1 23/19 27/21 31/25 46/11 58/16 87/1</p> <p>difficult [4] 4/19 9/11 26/14 64/23</p> <p>difficulties [1] 47/24</p> <p>dip [2] 7/20 23/20</p> <p>direct [6] 9/2 11/10 56/1 56/4 67/23 76/11</p> <p>directly [3] 10/24 24/5 68/7</p> <p>Director [10] 21/12 21/13 21/13 67/20 68/24 75/11 75/12 75/13 75/17 75/18</p> <p>directorate [2] 82/16 82/18</p> <p>directors [7] 16/12 39/7 50/11 50/14 66/15 66/16 87/6</p> <p>disappointed [1] 73/3</p> <p>disappointment [2] 73/23 73/25</p> <p>discharge [17] 30/16 30/21 34/19 34/23 35/6 42/16 42/18 44/11 44/22 45/4</p>	<p>45/13 45/19 46/10 62/16 77/21 84/3 85/2</p> <p>discharged [4] 34/20 44/5 44/24 81/24</p> <p>discharges [4] 35/10 42/20 45/25 85/4</p> <p>disclose [1] 84/24</p> <p>discuss [1] 59/5</p> <p>discussed [18] 13/17 14/2 14/12 14/15 14/22 14/22 17/20 17/20 17/22 17/25 23/18 31/2 38/7 38/20 50/11 50/13 66/8 71/7</p> <p>discussion [9] 13/7 22/10 22/13 38/24 39/10 40/18 57/21 62/4 80/15</p> <p>disengagement [1] 44/5</p> <p>dive [1] 23/21</p> <p>dives [1] 7/22</p> <p>do [49] 1/23 7/11 8/2 8/3 15/10 16/18 16/21 16/23 18/14 20/14 25/6 26/22 26/23 30/18 32/12 34/24 37/22 37/24 38/1 38/3 38/8 38/10 38/12 38/14 38/16 39/23 40/24 44/24 49/11 50/1 51/14 52/21 57/7 58/18 59/7 61/25 64/3 66/5 66/21 66/24 67/4 67/5 69/17 79/15 80/11 80/12 80/24 83/25 85/25</p> <p>document [18] 9/25 12/1 12/22 16/24 21/6 25/21 26/3 26/4 35/20 36/12 38/19 52/7 60/11 60/12 75/15 80/8 84/15 85/17</p> <p>documentation [3] 21/23 38/8 81/15</p> <p>documented [3] 12/11 13/3 23/3</p> <p>documents [3] 38/18 75/16 80/25</p> <p>does [9] 19/6 19/12 19/16 19/22 32/4 77/1 82/17 83/6 85/21</p> <p>doesn't [5] 7/7 17/19 38/19 48/18 76/16</p> <p>doing [5] 2/1 2/22 32/20 41/21 65/4</p> <p>domain [4] 61/8 61/10 61/11 63/13</p> <p>dominant [1] 8/18</p> <p>don't [26] 4/9 4/16 4/24 8/1 12/19 13/20 20/19 23/23 25/7 28/5 28/9 32/22 32/22 33/7 33/12 40/23 41/17 53/3 56/16 58/7 70/12 74/5 80/4 81/11 83/10</p>	<p>84/23</p> <p>done [35] 2/4 2/6 2/20 2/21 5/1 7/16 7/22 8/17 13/10 13/13 18/6 23/19 23/21 23/23 33/8 33/25 34/3 34/9 34/16 36/17 38/12 38/15 40/3 40/5 42/2 42/4 43/6 46/4 46/18 52/18 59/9 62/20 76/4 85/8 87/11</p> <p>dos [4] 2/25 3/1 4/10 4/10</p> <p>doubt [2] 2/15 47/5</p> <p>down [10] 1/11 21/22 46/21 48/3 49/18 51/17 76/1 76/12 81/5 81/7</p> <p>downs [1] 47/21</p> <p>Dr [2] 50/6 54/14</p> <p>Dr Brewin [2] 50/6 54/14</p> <p>drafted [1] 39/17</p> <p>draw [5] 14/20 41/18 72/21 72/23 74/5</p> <p>drawn [3] 4/23 14/24 19/12</p> <p>drive [1] 71/18</p> <p>driver [1] 8/20</p> <p>drivers [1] 52/24</p> <p>drop [1] 36/24</p> <p>drove [2] 37/16 83/12</p> <p>due [1] 43/2</p> <p>duly [1] 67/22</p> <p>during [9] 8/5 21/19 24/16 24/17 53/5 66/21 72/16 77/5 77/23</p> <p>duties [1] 67/13</p> <p>duty [3] 66/16 73/15 73/17</p>	<p>embedding [1] 25/5</p> <p>emerged [1] 22/24</p> <p>Emma [1] 53/7</p> <p>end [3] 6/8 27/3 30/23</p> <p>ended [1] 22/4</p> <p>ends [1] 18/2</p> <p>enforced [1] 39/23</p> <p>engagement [4] 28/21 29/11 62/15 77/22</p> <p>England [3] 8/7 15/7 20/12</p> <p>enhanced [1] 62/14</p> <p>enough [2] 20/16 34/16</p> <p>enquire [1] 11/15</p> <p>enquiries [2] 4/8 10/21</p> <p>enquiry [2] 2/13 11/17</p> <p>enquiry' [1] 28/20</p> <p>ensure [7] 1/13 30/5 39/8 66/11 66/17 67/1 67/20</p> <p>equal [2] 65/22 66/10</p> <p>Er [1] 34/1</p> <p>es [1] 76/21</p> <p>escalated [2] 67/22 74/2</p> <p>escalating [1] 71/11</p> <p>escalation [1] 19/8</p> <p>essential [2] 48/5 48/20</p> <p>essentially [8] 68/6 68/20 69/21 71/21 71/21 73/18 76/18 78/23</p> <p>established [3] 67/14 68/19 84/2</p> <p>even [6] 11/12 29/6 35/3 35/3 63/2 74/25</p> <p>event [2] 37/8 74/25</p> <p>every [6] 2/25 3/11 5/23 5/24 9/5 73/17</p> <p>everybody [1] 12/21</p> <p>everyone [1] 39/25</p> <p>everyone's [1] 65/22</p> <p>evidence [19] 2/12 3/12 4/19 13/23 17/1 17/8 17/12 18/8 25/8 27/6 33/16 37/19 37/20 53/5 54/1 73/1 78/18 78/23 84/13</p> <p>evidenced [1] 3/3</p> <p>evidential [1] 35/4</p> <p>exact [1] 60/5</p> <p>exactly [5] 31/23 65/3 68/9 68/9 77/10</p> <p>example [10] 33/5 35/6 47/22 53/19 55/8 57/17 62/16 63/12 64/15 85/24</p> <p>examples [4] 26/13 30/19 65/1 78/5</p> <p>except [1] 77/1</p>
---	--	--	--	--

<p>E</p> <p>excess [1] 53/11</p> <p>executive [29] 10/2 16/12 21/12 21/13 22/20 24/13 43/18 51/5 54/14 61/16 61/16 61/17 66/15 66/16 67/20 68/3 68/11 68/11 68/13 68/23 68/24 75/11 75/12 75/17 78/2 86/19 87/2 87/6 87/8</p> <p>executive-led [2] 68/3 87/8</p> <p>executives [4] 7/16 21/11 35/24 51/13</p> <p>existed [1] 65/19</p> <p>expect [10] 3/4 15/8 38/21 54/25 62/19 62/24 63/11 63/14 76/11 78/2</p> <p>expectations [3] 8/7 15/2 15/4</p> <p>expected [12] 3/6 3/9 14/19 34/3 39/15 41/3 42/11 55/5 58/14 58/19 63/3 74/3</p> <p>expecting [1] 2/25</p> <p>expedited [1] 42/6</p> <p>experience [2] 64/9 72/2</p> <p>expertise [2] 73/6 87/8</p> <p>explains [1] 22/20</p> <p>explanation [1] 22/2</p> <p>explicit [1] 24/24</p> <p>explicitly [1] 25/4</p> <p>explored [1] 76/14</p> <p>expressed [2] 63/9 75/23</p> <p>extended [1] 15/8</p> <p>extent [1] 77/16</p>	<p>21/16 21/19 80/1 80/9 80/16 81/12 81/15 81/16 82/9 82/11 82/22 83/2</p> <p>far [4] 31/24 37/11 37/14 85/23</p> <p>fashion [2] 71/11 73/5</p> <p>fatal [5] 30/12 31/15 35/22 38/5 42/23</p> <p>feature [1] 8/1</p> <p>February [6] 5/16 35/24 36/3 47/11 81/1 81/6</p> <p>February 2020 [1] 47/11</p> <p>February 2022 [1] 81/1</p> <p>fed [4] 57/14 67/8 81/19 82/15</p> <p>feedback [2] 5/5 24/24</p> <p>feeds [1] 81/2</p> <p>feel [1] 65/14</p> <p>felt [2] 7/23 72/24</p> <p>few [5] 2/14 22/16 26/10 34/19 78/15</p> <p>fill [1] 53/21</p> <p>final [2] 24/23 69/15</p> <p>finalised [1] 73/5</p> <p>find [3] 11/21 73/3 78/18</p> <p>findings [6] 17/21 28/15 28/19 36/18 37/4 37/7</p> <p>finish [1] 87/19</p> <p>first [14] 3/23 8/6 8/23 10/1 21/15 26/6 26/8 38/7 38/7 39/2 55/1 63/21 74/24 80/7</p> <p>fit [1] 45/14</p> <p>five [2] 1/11 24/18</p> <p>five years [1] 24/18</p> <p>fix [1] 13/13</p> <p>fixes [1] 53/25</p> <p>flagged [2] 86/5 86/8</p> <p>flagging [1] 49/22</p> <p>focus [7] 1/7 14/25 19/1 20/16 27/12 41/7 54/4</p> <p>focused [5] 20/15 41/16 50/1 55/18 57/18</p> <p>follow [3] 21/10 32/13 52/7</p> <p>follow-through [1] 52/7</p> <p>follow-up [1] 32/13</p> <p>followed [3] 32/3 58/2 71/21</p> <p>following [12] 24/21 29/15 37/22 43/20 44/5 50/2 50/15 50/18 52/8 68/5 76/16 87/23</p> <p>forensic [3] 21/13 37/3 47/1</p>	<p>forgive [1] 61/9</p> <p>form [1] 25/23</p> <p>formal [7] 33/1 50/17 62/14 67/18 67/19 67/22 68/12</p> <p>formally [1] 54/14</p> <p>formed [1] 81/19</p> <p>former [4] 28/1 34/22 35/13 44/17</p> <p>forms [1] 78/21</p> <p>formulated [1] 15/21</p> <p>formulation [1] 37/1</p> <p>forward [5] 43/2 44/25 69/11 72/5 82/4</p> <p>forwards [1] 40/24</p> <p>found [3] 16/6 74/23 78/8</p> <p>Foundation [3] 64/21 65/12 66/13</p> <p>framework [14] 18/24 20/2 27/19 27/20 28/7 28/8 69/14 69/17 69/18 85/18 86/6 86/9 86/11 86/14</p> <p>Friday [1] 50/13</p> <p>fro [1] 40/19</p> <p>front [2] 16/24 60/11</p> <p>fulfilling [1] 72/19</p> <p>full [5] 3/5 58/10 74/18 76/25 77/16</p> <p>function [4] 1/20 58/4 64/19 68/6</p> <p>functioning [2] 1/5 3/15</p> <p>functions [1] 65/15</p> <p>fundamental [1] 51/10</p> <p>funding [16] 47/14 47/25 48/5 48/15 48/18 48/18 48/20 48/22 49/4 49/4 49/9 51/20 51/23 51/24 52/2 52/5</p> <p>further [6] 21/22 48/3 49/18 52/5 77/14 84/24</p> <p>future [2] 22/21 25/3</p>	<p>given [8] 7/9 17/21 21/21 38/20 39/22 41/13 65/1 80/21</p> <p>gives [1] 30/20</p> <p>giving [1] 37/19</p> <p>go [13] 1/6 11/15 22/12 55/24 67/11 69/6 70/5 70/24 71/24 72/25 76/23 80/3 81/1</p> <p>goes [4] 22/22 41/10 76/16 79/4</p> <p>going [16] 30/9 31/16 32/8 40/8 41/1 43/1 44/16 46/16 46/17 51/17 52/11 62/5 62/16 63/8 66/22 79/18</p> <p>gone [5] 5/20 5/23 14/8 40/15 85/14</p> <p>good [5] 59/20 63/19 71/18 73/1 79/25</p> <p>got [8] 30/10 34/22 45/3 52/22 54/1 54/7 75/11 79/19</p> <p>governance [10] 3/3 8/4 8/7 10/14 18/3 19/16 37/11 37/21 37/25 67/19</p> <p>Government [1] 38/16</p> <p>GP [1] 34/20</p> <p>Grant [5] 67/24 68/2 68/10 68/16 68/22</p> <p>Grant Thornton [5] 67/24 68/2 68/10 68/16 68/22</p> <p>granular [1] 57/10</p> <p>grateful [1] 6/4 48/13</p> <p>great [2] 32/4 53/18</p> <p>group [8] 55/25 56/10 57/24 61/12 67/16 82/6 82/23 86/19</p> <p>guaranteed [1] 62/15</p> <p>guess [1] 48/12</p> <p>guidance [7] 1/24 15/7 58/14 58/19 58/23 59/4 62/25</p>	<p>have [187]</p> <p>have it [1] 83/3</p> <p>haven't [1] 14/9</p> <p>having [15] 6/22 8/10 8/21 11/1 11/8 16/12 25/1 32/16 33/2 34/4 41/20 49/2 60/5 72/20 78/20</p> <p>he [4] 34/19 37/20 51/12 72/1</p> <p>heading [1] 36/14</p> <p>Headway [1] 64/1</p> <p>health [26] 9/5 10/15 11/4 11/5 12/3 16/4 24/10 26/12 28/24 29/12 30/14 46/25 47/11 47/13 47/16 47/19 47/21 49/4 51/3 53/10 53/17 54/22 58/16 58/17 59/16 64/21</p> <p>Healthcare [2] 24/8 59/15</p> <p>heard [8] 7/22 14/16 15/10 20/11 27/5 53/5 53/10 72/8</p> <p>hearing [1] 87/23</p> <p>Heaven [3] 79/23 79/24 88/5</p> <p>held [1] 12/7</p> <p>Hello [1] 63/20</p> <p>help [7] 49/20 70/15 75/7 75/10 75/12 75/22 77/4</p> <p>helped [3] 51/25 52/2 71/18</p> <p>helpful [1] 58/21</p> <p>her [1] 10/6</p> <p>here [5] 23/7 34/22 40/13 43/3 83/3</p> <p>hesitation [1] 13/9</p> <p>high [2] 19/2 72/20</p> <p>high-level [1] 19/2</p> <p>Highbury [2] 51/2 52/15</p> <p>higher [1] 35/5</p> <p>higher-level [1] 35/5</p> <p>highest [3] 10/17 11/1 11/8</p> <p>highlight [1] 12/20</p> <p>highlighted [3] 12/8 21/18 39/11</p> <p>highly [1] 8/18</p> <p>him [1] 50/7</p> <p>hinder [1] 76/17</p> <p>his [1] 37/20</p> <p>history [2] 21/17 44/4</p> <p>hold [1] 33/2</p> <p>holds [1] 19/11</p> <p>home [1] 47/23</p> <p>homicide [9] 26/12 73/20 73/22 74/13 74/15 74/19 74/20 75/1 75/2</p> <p>homicides [9] 43/10 43/11 66/24 71/7 71/8</p>
(27) excess - homicides				

<p>H</p> <p>homicides... [4] 72/15 72/15 79/1 87/11</p> <p>honestly [2] 5/11 12/19</p> <p>hope [1] 5/11</p> <p>hoped [1] 15/2</p> <p>hopeful [1] 73/1</p> <p>Hospital [2] 51/2 52/15</p> <p>how [17] 3/2 3/19 3/25 13/20 16/3 31/20 64/19 65/10 66/2 66/3 67/8 68/19 70/10 73/21 76/21 83/14 84/20</p> <p>however [8] 9/2 12/21 18/21 33/1 57/16 58/14 64/23 87/14</p> <p>hundreds [1] 86/25</p> <hr/> <p>I</p> <p>I absolutely [2] 17/10 86/11</p> <p>I accept [2] 34/18 45/1</p> <p>I again [1] 73/11</p> <p>I agree [2] 18/5 18/10</p> <p>I also [3] 6/20 9/17 65/16</p> <p>I am [4] 24/6 25/19 49/17 64/19</p> <p>I and [1] 87/2</p> <p>I appreciate [2] 32/4 74/7</p> <p>I ask [4] 61/24 64/11 68/1 69/14</p> <p>I asked [2] 13/16 54/19</p> <p>I believe [2] 26/13 56/2</p> <p>I called [1] 50/7</p> <p>I can [3] 24/25 30/2 80/7</p> <p>I can't [6] 14/14 48/10 52/9 76/11 78/4 86/4</p> <p>I could [3] 7/18 13/25 64/24</p> <p>I couldn't [2] 4/18 13/25</p> <p>I did [1] 4/9</p> <p>I didn't [3] 7/7 7/8 52/1</p> <p>I discussed [1] 66/8</p> <p>I do [6] 16/21 26/23 38/3 64/3 67/4 79/15</p> <p>I don't [17] 4/9 4/16 4/24 12/19 13/20 20/19 23/23 25/7 32/22 32/22 33/7 41/17 58/7 70/12 74/5 80/4 83/10</p>	<p>I expect [1] 54/25</p> <p>I first [1] 26/6</p> <p>I had [3] 4/24 6/21 24/8</p> <p>I have [1] 59/18</p> <p>I honestly [1] 5/11</p> <p>I hope [1] 5/11</p> <p>I indicate [1] 57/20</p> <p>I just [6] 21/7 27/12 54/4 67/9 77/17 85/13</p> <p>I knew [1] 9/3</p> <p>I left [1] 59/13</p> <p>I may [12] 4/17 21/5 24/12 27/13 38/4 46/11 48/17 54/11 54/12 54/16 60/10 74/23</p> <p>I might [1] 49/3</p> <p>I misunderstood [1] 13/22</p> <p>I represent [1] 63/23</p> <p>I say [2] 3/22 12/14</p> <p>I see [2] 58/7 81/11</p> <p>I shared [1] 24/12</p> <p>I should [1] 24/2</p> <p>I start [1] 63/21</p> <p>I suppose [1] 65/11</p> <p>I suspect [1] 55/4</p> <p>I take [15] 1/10 10/6 15/12 15/15 21/5 29/25 36/16 38/25 39/4 43/9 43/15 46/15 46/19 47/9 51/8</p> <p>I think [64] 4/9 4/14 6/16 9/11 9/20 9/21 10/23 11/9 14/1 15/2 17/7 17/9 17/11 18/4 18/5 19/19 20/8 23/10 23/12 27/5 27/19 31/21 31/22 32/1 32/22 33/24 34/13 40/14 41/21 42/1 45/4 46/1 52/9 52/16 53/16 54/11 54/16 56/7 57/3 57/13 57/16 57/23 58/21 59/21 60/22 62/10 64/14 65/10 65/22 69/11 70/12 72/8 73/23 73/23 73/25 76/13 80/14 81/3 83/11 84/1 84/22 85/6 86/6 87/14</p> <p>I took [1] 64/23</p> <p>I understand [3] 11/7 32/18 62/4</p> <p>I understand it [1] 68/14</p> <p>I understood [3] 13/18 13/22 27/22</p> <p>I want [3] 21/2 46/11 80/3</p> <p>I was [17] 4/25 12/24 19/19 19/20 24/9 24/12 32/10 47/8 55/12 56/7 56/9 63/10 65/4 71/8 73/25 77/7</p>	<p>79/4</p> <p>I wasn't [1] 53/16</p> <p>I will [6] 3/22 27/15 33/8 54/10 54/25 54/25</p> <p>I would [37] 2/22 3/1 3/4 3/5 3/9 5/1 5/4 5/11 5/23 14/19 15/2 15/8 34/3 38/17 38/23 42/11 48/12 48/20 50/2 55/4 59/14 60/13 62/19 62/24 63/3 63/10 63/11 63/14 66/7 73/23 74/5 75/3 75/16 75/19 76/11 78/1 78/2</p> <p>I wouldn't [1] 3/10</p> <p>I'd [5] 1/6 1/7 3/11 6/17 61/1</p> <p>I'll [1] 84/19</p> <p>I'm [18] 4/16 4/22 6/1 6/4 8/8 14/14 25/7 26/4 30/9 32/15 46/16 47/24 48/13 52/9 61/8 66/22 79/17 84/11</p> <p>I've [4] 20/9 60/2 84/4 84/11</p> <p>ICB [2] 10/20 10/21</p> <p>idea [2] 9/7 63/8</p> <p>ideally [1] 38/17</p> <p>identified [15] 6/7 13/14 21/1 22/24 28/19 36/21 44/6 59/10 59/11 68/21 72/6 77/12 77/19 82/22 83/16</p> <p>identify [2] 44/3 70/1</p> <p>identifying [1] 72/1</p> <p>if [64] 2/1 2/4 2/9 3/22 4/3 5/9 6/8 6/12 6/18 7/13 7/23 8/16 13/20 14/22 14/25 19/8 20/20 21/5 22/12 23/19 24/12 27/12 28/7 29/6 29/23 30/1 31/12 32/22 34/7 38/4 40/11 45/25 46/11 47/14 48/17 49/8 49/23 51/20 51/23 52/11 52/25 55/20 60/23 61/8 62/23 63/2 68/11 69/6 69/11 70/5 70/12 72/5 72/10 72/25 73/19 74/7 74/9 80/4 80/7 82/6 82/13 82/13 85/6 85/7</p> <p>ill [1] 47/16</p> <p>ill health [1] 47/16</p> <p>immediacy [1] 50/10</p> <p>immediate [1] 49/20</p> <p>impacting [1] 22/1</p> <p>implemented [2] 15/21 68/5</p> <p>implementing [1] 68/15</p> <p>importance [5] 2/12</p>	<p>8/8 17/12 51/22 63/22</p> <p>important [10] 10/23 17/7 17/11 23/14 29/1 39/21 41/12 43/3 52/2 64/19</p> <p>imposed [1] 84/17</p> <p>impression [1] 65/20</p> <p>improved [1] 71/14</p> <p>improvement [4] 20/11 73/2 78/7 78/9</p> <p>improvements [2] 10/15 82/24</p> <p>improving [2] 29/16 41/20</p> <p>in' [1] 29/11</p> <p>inability [2] 53/8 54/20</p> <p>inadequacies [1] 76/3</p> <p>inadequate [1] 75/25</p> <p>incident [27] 26/9 26/20 28/18 29/15 29/18 29/21 31/15 34/17 35/12 35/19 35/22 38/19 39/11 39/12 41/2 41/9 43/17 44/17 46/9 69/21 70/24 71/13 71/17 74/17 74/20 74/21 78/17</p> <p>incidents [35] 5/3 5/4 8/25 9/3 9/13 9/16 10/17 11/2 11/9 25/17 25/24 30/6 33/9 37/20 37/22 38/21 38/24 39/9 39/19 39/24 40/4 40/6 40/12 40/23 41/11 42/5 43/9 43/19 69/24 70/3 70/11 71/10 73/21 76/23 77/7</p> <p>include [6] 42/13 43/18 43/19 64/1 71/15 86/3</p> <p>included [3] 29/10 71/10 78/13</p> <p>including [12] 12/10 15/18 17/2 21/16 23/2 29/15 36/22 56/1 64/25 81/14 82/1 83/23</p> <p>inconsistent [1] 16/5</p> <p>increase [1] 24/17</p> <p>increased [1] 72/9</p> <p>indeed [9] 9/4 31/17 34/12 44/16 50/11 57/20 75/3 77/11 87/16</p> <p>indicate [1] 57/20</p> <p>indicates [1] 83/10</p> <p>indicator [1] 73/21</p> <p>individual [5] 19/15 19/21 20/7 60/13 84/18</p> <p>individuals [2] 28/23 76/9</p>	<p>indulgence [1] 79/20</p> <p>inference [3] 14/20 14/24 17/19</p> <p>informal [2] 33/5 33/25</p> <p>information [24] 1/17 7/14 21/2 21/20 23/6 23/14 24/1 25/23 25/25 26/7 26/8 28/10 30/10 37/2 39/10 52/22 54/19 55/20 56/24 57/8 57/9 57/10 74/8 81/18</p> <p>information-sharing [1] 37/2</p> <p>informed [3] 30/12 85/19 87/17</p> <p>infringing [1] 84/16</p> <p>initial [3] 36/2 36/4 36/11</p> <p>injuries [1] 42/24</p> <p>injury [3] 25/18 64/2 64/8</p> <p>inpatient [2] 47/19 47/21</p> <p>inquest [1] 21/19</p> <p>inquests [2] 80/19 82/7</p> <p>Inquiry [12] 14/6 25/21 48/16 53/5 54/2 54/20 60/16 62/10 84/17 84/20 86/7 87/18</p> <p>inquisitive [1] 2/14</p> <p>INQY0000034 [3] 25/20 35/21 84/15</p> <p>inside [1] 25/10</p> <p>insight [1] 8/23</p> <p>insofar [1] 77/15</p> <p>inspected [1] 46/25</p> <p>inspection [2] 61/6 61/6</p> <p>instigated [1] 79/7</p> <p>institutions [1] 62/17</p> <p>instruction [4] 23/22 27/18 27/24 32/12</p> <p>Integrated [2] 10/4 10/10</p> <p>intent [1] 13/24</p> <p>interest [1] 34/6</p> <p>interested [1] 12/13</p> <p>interim [1] 37/15</p> <p>internal [1] 20/25</p> <p>Intervention [2] 36/24 48/4</p> <p>into [10] 19/12 23/3 38/11 48/22 60/15 61/16 62/17 73/20 81/19 82/19</p> <p>introduce [1] 84/2</p> <p>introduced [1] 64/15</p> <p>investigating [2] 71/9 71/19</p> <p>investigation [32] 23/21 26/20 27/4 27/14 28/12 28/16</p>
--	--	---	--	--

<p>I</p> <p>investigation... [26] 28/18 30/25 31/1 31/3 31/7 31/10 31/16 32/9 32/11 32/17 33/3 33/5 33/11 33/13 33/15 35/3 36/7 36/21 38/11 38/12 38/15 72/14 73/20 76/17 78/8 78/24</p> <p>investigations [6] 39/19 40/6 41/10 42/5 73/18 74/10</p> <p>investigative [1] 33/1</p> <p>investment [2] 47/10 48/7</p> <p>involved [6] 33/12 33/19 49/6 75/10 78/17 85/2</p> <p>involvement [9] 21/15 21/16 76/15 80/9 80/16 81/12 82/9 82/12 82/22</p> <p>involves [1] 34/22</p> <p>involving [3] 44/17 74/17 81/16</p> <p>is [148]</p> <p>isn't [15] 2/7 6/24 8/14 26/17 27/9 29/1 29/2 35/12 36/12 37/12 41/5 50/8 69/22 81/23 84/23</p> <p>isolated [1] 5/3</p> <p>issue [32] 2/2 2/7 2/9 4/5 4/21 8/19 14/3 15/12 16/19 17/16 17/17 17/22 18/12 19/18 19/24 20/22 23/19 29/18 30/15 34/23 40/20 48/15 49/11 51/13 52/19 55/9 59/11 63/7 63/22 68/20 70/10 74/24</p> <p>issues [27] 21/1 21/10 30/3 30/5 30/7 39/6 39/8 39/9 41/23 42/7 45/18 46/16 51/14 54/5 56/24 57/25 58/12 59/14 66/22 69/10 70/2 76/9 77/20 80/16 80/20 84/12 85/6</p> <p>it [183]</p> <p>it's [46] 2/9 6/24 8/20 10/23 11/9 12/3 15/13 15/13 17/7 17/9 17/11 18/17 18/24 26/5 28/16 30/10 30/20 31/8 35/12 35/20 36/11 45/4 48/17 48/21 50/9 50/19 56/9 56/14 56/15 56/16 57/13 60/9 60/10 67/11 68/6 68/7 69/11 69/15 73/20 73/21</p>	<p>81/3 81/4 81/7 81/22 84/13 84/22</p> <p>item [4] 3/11 14/1 53/24 57/22</p> <p>its [7] 19/11 25/5 56/1 69/16 73/14 76/24 78/3</p> <p>itself [3] 2/9 11/3 40/15</p> <p>J</p> <p>January [3] 7/6 14/13 67/13</p> <p>January 2020 [1] 14/13</p> <p>JB [2] 51/1 51/10</p> <p>job [1] 66/10</p> <p>jog [1] 80/7</p> <p>joined [1] 1/6</p> <p>Jonathan [1] 73/24</p> <p>judge [1] 25/3</p> <p>July [1] 36/8</p> <p>jump [1] 81/7</p> <p>June [16] 7/25 13/18 14/13 17/6 20/14 27/9 38/12 43/6 43/14 45/3 45/23 46/6 49/22 83/16 83/24 84/3</p> <p>June 2023 [6] 20/14 27/9 45/23 83/16 83/24 84/3</p> <p>June of [1] 13/18</p> <p>just [55] 6/1 6/8 8/1 11/9 11/15 13/9 14/21 17/19 21/7 22/13 26/2 26/6 26/9 27/12 28/15 29/9 31/12 35/25 36/14 39/12 41/1 44/10 48/9 54/4 59/15 62/12 63/21 64/13 66/2 67/7 67/9 68/17 69/3 69/4 69/20 70/23 70/24 71/2 71/24 72/1 72/12 73/11 75/7 75/7 75/10 75/10 76/12 77/17 79/5 80/25 81/1 81/6 81/7 81/20 85/13</p> <p>K</p> <p>kept [1] 51/6</p> <p>key [8] 12/11 16/10 23/3 27/5 28/19 52/24 85/17 86/7</p> <p>kind [4] 33/24 46/9 56/23 57/8</p> <p>knew [1] 9/3</p> <p>know [22] 3/11 3/25 7/8 12/19 23/23 25/6 25/7 26/2 32/22 32/22 33/7 52/25 53/3 54/23 56/14 56/15 56/16 56/22 67/12 70/12 75/16 80/4</p> <p>knowledge [5] 56/1 56/4 57/2 70/19 77/16</p> <p>known [6] 7/8 7/13</p>	<p>8/16 17/14 54/25 83/24</p> <p>knows [1] 57/7</p> <p>L</p> <p>lack [11] 15/23 28/19 47/25 47/25 53/12 55/9 81/12 83/6 83/10 83/20 83/20</p> <p>lacking [1] 21/25</p> <p>last [1] 77/2</p> <p>late [2] 37/11 37/14</p> <p>later [6] 24/22 31/18 36/9 62/11 74/23 76/12</p> <p>lead [3] 13/7 49/9 49/11</p> <p>leader [1] 76/5</p> <p>leaders [11] 16/14 16/16 34/4 49/1 49/5 52/14 55/6 59/2 62/10 62/20 63/4</p> <p>leadership [3] 16/11 61/16 61/17</p> <p>learn [2] 28/4 42/6</p> <p>learned [6] 31/23 34/7 36/14 44/7 71/15 77/12</p> <p>learning [14] 5/17 6/5 22/24 29/1 29/10 36/21 37/7 45/22 45/24 72/21 73/2 81/5 82/7 83/13</p> <p>least [6] 24/25 30/15 38/11 42/1 49/22 56/5</p> <p>led [8] 13/12 47/17 67/24 68/3 68/11 68/16 76/5 87/8</p> <p>left [3] 24/21 59/13 62/18</p> <p>legal [5] 25/21 27/19 28/7 28/8 84/20</p> <p>Legislation [1] 12/4</p> <p>less [2] 9/8 71/18</p> <p>lessons [7] 28/4 34/7 36/14 36/18 44/7 71/15 77/12</p> <p>let [1] 78/17</p> <p>let's [3] 49/24 80/7 82/4</p> <p>level [16] 9/10 13/17 14/13 17/20 17/22 18/13 19/2 19/3 20/9 22/10 34/16 35/5 38/20 38/25 63/7 79/4</p> <p>levels [4] 46/24 58/15 58/20 58/25</p> <p>light [1] 26/8</p> <p>like [7] 1/6 1/7 38/21 45/10 48/21 50/2 61/1</p> <p>likely [1] 25/9</p> <p>limit [1] 72/23</p> <p>limited [1] 73/6</p> <p>Lincolnshire [1] 9/4</p> <p>line [4] 31/2 33/16 35/4 48/7</p>	<p>link [2] 20/19 41/18</p> <p>linked [1] 10/18</p> <p>links [1] 60/5</p> <p>listed [1] 47/2</p> <p>little [5] 26/10 26/14 46/21 57/14 78/10</p> <p>live [1] 23/20</p> <p>living [1] 72/9</p> <p>local [6] 10/17 10/24 11/17 19/12 53/9 54/21</p> <p>log [10] 30/3 30/5 30/9 30/12 30/23 31/5 31/8 31/12 39/6 39/8</p> <p>logical [1] 42/22</p> <p>long [7] 31/25 45/23 47/10 48/12 81/23 81/25 83/16</p> <p>long-standing [2] 81/25 83/16</p> <p>Long-term [1] 48/12</p> <p>look [20] 3/23 6/22 7/25 21/2 59/5 67/5 67/6 69/4 71/3 72/10 72/11 74/9 74/22 75/19 76/12 78/6 79/8 82/6 82/13 87/12</p> <p>looked [11] 1/4 5/20 14/9 20/6 20/25 21/1 32/25 44/8 78/5 85/18 86/7</p> <p>looking [11] 4/3 14/6 26/2 31/12 32/5 32/23 41/9 46/16 72/7 74/19 75/16</p> <p>lot [5] 16/11 32/23 40/11 54/1 56/19</p> <p>lots [1] 53/21</p> <p>low [1] 14/22</p> <p>LTP [1] 48/11</p> <p>ly [1] 22/1</p> <p>M</p> <p>made [11] 1/8 11/18 15/22 25/9 25/17 26/14 75/8 76/6 77/10 77/10 86/23</p> <p>main [4] 22/24 41/2 41/5 48/5</p> <p>Majid [3] 27/6 37/19 76/6</p> <p>Majid's [2] 24/3 24/11</p> <p>major [2] 47/3 59/14</p> <p>make [8] 4/8 10/20 11/14 20/17 37/17 52/12 52/21 83/14</p> <p>make-up [1] 20/17</p> <p>makes [1] 9/22</p> <p>making [7] 8/9 11/7 21/17 21/24 58/7 60/12 82/23</p> <p>managed [1] 16/3</p> <p>management [9] 6/13 15/20 36/2 36/5 36/11 37/1 68/21</p>	<p>69/19 83/21</p> <p>Manager [5] 70/6 70/15 70/20 75/13 75/17</p> <p>managers [2] 53/8 61/22</p> <p>managing [4] 8/13 16/2 19/12 69/9</p> <p>mandatory [1] 1/18</p> <p>many [9] 12/22 16/6 18/20 53/17 68/3 69/17 73/5 78/10 86/25</p> <p>March [6] 22/14 61/5 80/14 81/20 83/4 83/7</p> <p>March 2021 [1] 61/5</p> <p>March 2022 [1] 80/14</p> <p>Maria [1] 21/11</p> <p>matter [10] 27/17 27/23 27/24 35/16 41/22 50/16 52/10 60/2 61/1 84/20</p> <p>matters [10] 23/19 31/7 31/8 36/22 53/6 54/7 57/5 57/19 67/3 73/10</p> <p>maturity [1] 10/14</p> <p>may [34] 1/1 2/5 4/17 4/19 13/24 17/5 18/5 21/5 24/12 25/15 26/21 27/13 38/4 38/24 39/1 44/13 44/14 46/4 46/7 46/11 48/17 54/11 54/12 54/16 54/16 60/10 61/24 65/23 71/10 74/23 82/5 82/5 82/9 83/4</p> <p>May 2025 [1] 26/21</p> <p>Maybe [1] 13/22</p> <p>MD [2] 39/20 41/12</p> <p>MDT [1] 53/13</p> <p>MDTs [1] 55/10</p> <p>me [16] 2/22 3/22 10/23 14/2 16/25 23/25 26/14 49/2 52/7 52/8 56/11 59/9 60/11 61/9 65/13 80/23</p> <p>mean [5] 7/8 47/19 66/5 76/17 82/17</p> <p>meaning [2] 32/10 32/15</p> <p>meaningful [4] 34/23 78/16 78/25 79/2</p> <p>meaningless [1] 78/25</p> <p>means [2] 19/10 66/15</p> <p>measure [1] 9/12</p> <p>measures [1] 50/4</p> <p>measuring [1] 78/19</p> <p>media [2] 39/15 41/3</p> <p>medication [1] 36/24</p> <p>meet [3] 3/21 38/16 46/24</p> <p>meeting [25] 5/14</p>
---	---	---	--	--

<p>M</p> <p>meeting... [24] 12/7 14/9 21/9 22/16 24/14 29/25 30/1 39/1 50/14 50/18 50/19 51/5 52/8 54/11 54/15 55/7 55/17 55/18 55/22 56/23 57/14 64/7 67/15 80/5</p> <p>meetings [4] 5/20 53/13 56/5 85/15</p> <p>member [3] 12/24 63/10 75/21</p> <p>members [8] 6/12 12/23 12/23 43/22 51/5 65/3 73/5 81/12</p> <p>membership [2] 56/1 56/15</p> <p>memory [4] 4/19 6/15 6/16 80/7</p> <p>mental [24] 9/5 10/15 11/4 11/5 12/3 16/4 24/10 26/12 28/24 29/12 30/14 36/23 47/11 47/13 47/15 47/19 47/21 49/4 51/3 53/9 53/17 54/21 58/15 59/16</p> <p>mention [1] 30/16</p> <p>mentioned [3] 39/16 41/4 80/8</p> <p>met [1] 4/4</p> <p>method [1] 43/25</p> <p>MHFYFV [1] 48/8</p> <p>might [2] 49/3 64/6</p> <p>mind [2] 64/8 69/3</p> <p>minded [1] 25/2</p> <p>minds [1] 23/20</p> <p>minute [3] 40/16 40/18 72/12</p> <p>minuted [1] 40/25</p> <p>minutes [7] 5/24 34/9 40/13 67/15 80/13 80/14 81/2</p> <p>miss [1] 72/15</p> <p>missed [3] 35/1 84/4 85/3</p> <p>misunderstood [1] 13/22</p> <p>mode [1] 65/23</p> <p>model [2] 29/7 32/1</p> <p>Moloney [4] 60/24 60/25 62/1 88/3</p> <p>moment [2] 44/10 44/21</p> <p>months [9] 2/14 5/22 22/16 26/24 36/9 37/8 74/11 74/12 74/20</p> <p>more [18] 4/15 7/1 7/14 9/8 20/13 26/14 30/20 40/11 41/21 42/2 42/4 49/8 62/11 70/13 71/14 71/19 84/22 85/5</p> <p>mortality [1] 5/18</p>	<p>most [6] 30/6 39/8 43/3 43/19 48/13 76/22</p> <p>move [4] 46/11 69/11 72/5 82/4</p> <p>moving [2] 51/19 83/7</p> <p>Mr [38] 1/3 1/4 1/20 16/20 19/24 20/20 24/3 24/11 27/6 37/19 45/9 49/16 50/6 50/7 51/18 56/6 60/22 60/24 60/25 62/1 63/15 63/19 63/21 64/5 72/1 76/6 76/18 77/18 78/5 79/9 79/25 80/4 80/13 84/9 84/10 85/13 88/3 88/6</p> <p>Mr Beer [3] 84/9 84/10 88/6</p> <p>Mr Birkett [1] 64/5</p> <p>Mr Brewin [3] 49/16 50/6 50/7</p> <p>Mr Devlin [13] 1/4 1/20 16/20 19/24 20/20 45/9 51/18 56/6 63/15 63/19 63/21 79/25 85/13</p> <p>Mr Majid [3] 27/6 37/19 76/6</p> <p>Mr Majid's [2] 24/3 24/11</p> <p>Mr Moloney [2] 60/24 62/1</p> <p>Mr Warren [3] 72/1 76/18 78/5</p> <p>Mr Warren's [1] 79/9</p> <p>Mr Weston [5] 1/3 60/22 77/18 80/4 80/13</p> <p>Ms [7] 63/17 63/18 79/13 79/23 79/24 88/4 88/5</p> <p>Ms Cartwright [4] 63/17 63/18 79/13 88/4</p> <p>Ms Heaven [3] 79/23 79/24 88/5</p> <p>much [7] 39/23 40/3 57/18 63/15 79/17 84/5 85/10</p> <p>murder [1] 74/14</p> <p>must [4] 1/13 2/25 4/10 7/11</p> <p>my [25] 4/10 4/23 9/4 9/9 9/17 11/15 13/9 13/20 13/24 24/23 24/23 27/7 27/17 32/2 33/17 52/10 52/13 56/8 57/23 62/1 62/9 65/9 66/10 68/9 87/2</p> <p>myself [2] 24/5 53/23</p> <p>N</p> <p>name [1] 60/14</p> <p>names [3] 60/15</p>	<p>84/24 84/25</p> <p>national [4] 58/14 58/19 58/22 59/4</p> <p>nature [1] 86/10</p> <p>near [1] 72/15</p> <p>near-miss [1] 72/15</p> <p>necessarily [6] 5/23 40/14 40/16 41/7 83/10 84/23</p> <p>necessary [5] 3/21 7/23 60/23 62/13 85/8</p> <p>necessity [1] 73/18</p> <p>need [11] 1/23 1/23 11/12 20/1 33/11 33/13 49/20 53/3 70/2 70/17 75/19</p> <p>needed [10] 17/21 19/25 39/23 49/8 52/12 52/12 62/21 64/6 67/21 79/8</p> <p>needs [3] 40/3 43/17 69/16</p> <p>negotiation [3] 48/23 48/24 49/3</p> <p>negotiations [1] 49/6</p> <p>neighbouring [1] 24/10</p> <p>new [6] 17/8 17/12 24/7 45/3 45/7 62/2</p> <p>Newham [1] 21/12</p> <p>next [4] 30/24 35/19 50/2 51/7</p> <p>NHFT [1] 10/16</p> <p>NHFT0000518 [2] 43/11 71/25</p> <p>NHFT0002015 [2] 1/10 46/15</p> <p>NHFT0002204 [1] 50/20</p> <p>NHFT0003346 [1] 11/25</p> <p>NHFT0009667 [1] 82/5</p> <p>NHNB0004596 [1] 47/9</p> <p>NHNB0012044 [1] 81/4</p> <p>NHNB0012321 [1] 22/11</p> <p>NHS [11] 8/7 10/3 10/17 10/24 15/7 20/12 24/10 47/10 47/12 48/14 49/4</p> <p>NICE [1] 48/8</p> <p>nine [3] 26/24 45/4 84/2</p> <p>nine-point [1] 84/2</p> <p>no [33] 2/15 5/8 9/7 9/18 9/18 20/7 20/7 20/19 23/9 23/22 31/15 32/15 34/11 34/15 34/23 39/14 40/18 40/21 40/25 47/5 53/24 55/25 57/7 58/14 60/8 60/20 64/10 78/18 79/2</p>	<p>79/19 82/19 82/19 84/12</p> <p>nodded [4] 31/4 40/7 53/14 83/22</p> <p>non [7] 38/5 66/16 67/20 68/11 68/13 68/24 87/2</p> <p>non-executive [3] 66/16 68/24 87/2</p> <p>non-executive -- if [1] 68/11</p> <p>non-fatal [1] 38/5</p> <p>none [2] 23/21 36/15</p> <p>not [120]</p> <p>note [3] 10/9 10/13 74/14</p> <p>noted [2] 21/23 55/10</p> <p>notes [5] 14/8 31/13 53/13 73/7 80/5</p> <p>nothing [2] 34/9 49/22</p> <p>Notice [1] 25/3</p> <p>Nottingham [7] 11/2 11/6 11/24 64/21 65/12 66/4 66/22</p> <p>Nottinghamshire [5] 10/3 11/2 11/6 11/24 59/15</p> <p>Notts [1] 24/7</p> <p>notwithstanding [2] 17/13 34/4</p> <p>November [1] 50/21</p> <p>now [15] 12/14 30/9 30/23 31/23 37/18 41/25 47/5 59/20 59/21 60/18 64/11 65/17 71/15 77/10 82/8</p> <p>number [19] 6/7 9/15 9/15 9/23 9/23 10/17 11/1 11/8 19/1 36/18 39/24 40/3 40/12 40/22 43/16 44/2 77/9 85/16 87/17</p> <p>Number 1 [1] 43/16</p> <p>Number 3 [1] 44/2</p> <p>numbers [7] 11/13 11/16 24/21 24/22 25/6 25/7 58/15</p> <p>numerous [1] 80/19</p> <p>Nursing [3] 21/12 75/14 75/18</p> <p>O</p> <p>observation [1] 68/25</p> <p>observed [1] 67/20</p> <p>observing [1] 68/7</p> <p>obviously [17] 12/24 22/3 33/10 60/13 60/15 63/25 65/18 66/13 67/12 69/7 69/13 72/6 74/17 76/13 78/7 78/13 87/6</p> <p>occasions [1] 25/1</p> <p>October [3] 61/3</p>	<p>61/20 67/14</p> <p>October 2020 [1] 67/14</p> <p>October 2021 [2] 61/3 61/20</p> <p>off [9] 2/13 26/25 36/25 43/21 75/14 75/25 76/9 76/10 76/22</p> <p>offered [1] 82/11</p> <p>Officer [1] 10/3</p> <p>Okay [8] 21/4 32/18 46/14 54/6 54/18 60/3 82/4 82/21</p> <p>on [65] 6/1 8/10 12/7 14/1 14/23 15/4 15/7 19/1 20/15 20/16 20/22 21/9 22/1 22/22 26/21 28/20 32/8 33/2 36/2 36/11 39/1 41/7 41/10 44/13 46/11 49/24 50/13 50/15 51/3 52/13 53/7 54/4 55/24 57/11 57/19 58/3 58/14 58/19 65/4 65/11 66/17 67/7 67/7 69/15 70/5 71/10 71/15 73/17 73/19 74/9 75/4 76/1 77/8 77/8 79/3 79/7 79/11 80/1 80/8 82/8 84/14 84/18 85/1 87/5 87/5</p> <p>once [4] 6/21 30/25 61/11 63/13</p> <p>one [31] 1/7 1/11 6/9 12/4 30/19 37/25 42/8 42/25 51/10 52/24 54/13 54/13 57/4 57/7 58/24 60/2 61/1 62/9 63/22 65/1 66/18 66/22 67/23 68/1 71/1 72/13 80/19 81/8 81/22 83/12 86/21</p> <p>ones [3] 3/20 11/23 77/25</p> <p>ongoing [4] 5/10 13/2 13/14 15/17</p> <p>only [3] 11/23 73/7 74/14</p> <p>operate [1] 66/14</p> <p>operated [1] 55/18</p> <p>operating [4] 27/22 32/1 70/14 78/21</p> <p>operation [1] 70/11</p> <p>operational [24] 18/21 19/6 19/12 23/24 32/24 49/1 49/5 52/14 55/6 55/17 55/25 56/10 59/2 62/9 62/20 63/4 67/1 67/3 67/16 76/5 82/6 82/19 85/20 86/17</p> <p>operationally [1] 75/10</p> <p>operations [1] 62/18</p> <p>opportunity [6] 21/21</p>
--	---	---	--	---

<p>O</p> <p>opportunity... [5] 35/1 45/21 84/1 84/4 85/3</p> <p>opt [3] 28/20 29/5 29/6</p> <p>opt-in [2] 28/20 29/5</p> <p>optimistic' [1] 50/1</p> <p>option [1] 59/3</p> <p>options [1] 44/6</p> <p>or [64] 1/5 2/5 2/5 2/6 3/7 4/1 4/2 4/9 4/10 4/12 4/15 4/21 4/21 5/3 5/3 6/12 6/17 7/16 10/21 12/19 13/10 14/22 16/7 17/25 18/11 19/7 20/5 22/7 23/23 25/2 25/18 26/3 26/25 27/18 28/1 29/12 30/15 38/7 38/11 40/24 42/23 44/13 45/22 46/12 48/11 56/2 57/15 58/15 60/6 61/16 61/25 62/6 62/15 62/18 62/23 72/15 73/4 73/6 75/17 76/24 78/3 78/19 80/21 86/22</p> <p>order [1] 65/13</p> <p>ordered [2] 44/12 44/13</p> <p>organisation [21] 3/8 4/13 4/16 5/2 6/22 8/5 9/2 13/15 15/3 18/7 18/20 19/5 20/13 25/5 58/1 58/9 59/8 64/20 85/17 86/13 87/2</p> <p>organisational [1] 73/2</p> <p>organisationally [1] 62/8</p> <p>organisations [4] 9/8 9/10 10/22 10/25</p> <p>organised [1] 7/16</p> <p>other [41] 3/7 6/12 8/11 9/4 9/5 9/7 10/22 11/4 11/5 11/5 12/13 16/23 18/6 18/7 21/6 23/14 29/12 29/15 30/7 33/4 33/9 33/10 33/24 35/9 39/9 40/24 41/1 57/4 57/16 57/17 59/5 59/16 73/21 77/4 78/4 80/20 85/19 86/1 86/23 86/24 87/17</p> <p>others [6] 3/17 22/2 23/24 42/24 43/9 49/11</p> <p>ought [1] 17/14</p> <p>our [5] 16/6 17/2 63/4 64/20 72/23</p> <p>ourselves [2] 17/14 32/13</p> <p>out [17] 3/24 7/18</p>	<p>10/23 14/16 15/10 16/12 29/6 31/17 45/7 59/1 61/20 62/17 63/3 63/8 63/8 65/14 66/12</p> <p>outcome [1] 22/2</p> <p>outcomes [1] 21/25</p> <p>outlier [1] 11/4</p> <p>outline [1] 73/9</p> <p>outputs [1] 51/4</p> <p>Outreach [1] 29/2</p> <p>outside [2] 21/3 78/20</p> <p>over [12] 6/8 16/8 28/16 29/9 35/25 36/19 51/8 54/23 64/22 72/11 72/25 76/16</p> <p>overall [1] 47/12</p> <p>overcapacity [1] 54/22</p> <p>overlap [1] 65/15</p> <p>oversaw [1] 20/18</p> <p>overseeing [1] 71/17</p> <p>oversight [15] 3/6 3/7 16/16 16/18 18/4 18/9 38/1 42/3 43/19 54/4 62/15 67/2 68/20 70/13 81/9</p> <p>overspeaking [4] 23/17 34/2 56/18 85/20</p> <p>overview [1] 1/5</p>	<p>page 6 [1] 78/6</p> <p>page 63 [1] 18/17</p> <p>page 67 [1] 24/2</p> <p>page 7 [4] 38/4 43/15 46/20 69/6</p> <p>page 8 [2] 5/16 82/7</p> <p>page 91 [2] 11/25 58/11</p> <p>Page 96 [1] 55/14</p> <p>pandemic [2] 8/6 8/22</p> <p>panel [3] 43/22 73/5 78/15</p> <p>paper [1] 54/11</p> <p>paperwork [1] 80/3</p> <p>paragraph [31] 6/8 10/6 18/17 18/18 19/20 24/2 26/7 26/19 28/16 29/9 29/14 36/1 36/1 36/20 38/5 38/9 41/1 49/18 51/7 51/9 51/17 55/16 55/24 58/11 64/12 64/16 67/11 69/15 71/3 71/5 76/16</p> <p>paragraph 1 [1] 26/7</p> <p>paragraph 10 [1] 29/9</p> <p>paragraph 107 [2] 71/3 71/5</p> <p>paragraph 11 [1] 29/14</p> <p>paragraph 119 [1] 10/6</p> <p>paragraph 14 [1] 36/1</p> <p>paragraph 15 [1] 36/1</p> <p>paragraph 168 [2] 18/17 18/18</p> <p>paragraph 169 [1] 19/20</p> <p>paragraph 20 [1] 36/20</p> <p>paragraph 24 [2] 38/5 38/9</p> <p>Paragraph 245 [1] 58/11</p> <p>Paragraph 264 [1] 55/16</p> <p>paragraph 265 [1] 55/24</p> <p>Paragraph 279 [1] 24/2</p> <p>Paragraph 3 [1] 26/19</p> <p>paragraph 51 [2] 64/12 64/16</p> <p>paragraph 9 [1] 28/16</p> <p>paragraph 94 [1] 67/11</p> <p>parameters [1] 85/8</p> <p>part [23] 3/12 6/14 6/16 7/11 8/13 9/21 20/1 20/11 23/13</p>	<p>37/16 42/11 47/12 50/23 52/2 55/5 62/19 66/10 67/9 67/19 72/7 77/11 77/12 78/7</p> <p>particular [25] 4/12 9/16 13/11 29/21 29/22 33/17 33/19 40/19 41/6 45/4 47/6 48/24 52/6 54/5 54/7 56/11 57/24 60/7 60/11 60/19 63/1 64/5 84/14 85/1 87/7</p> <p>particularly [6] 10/15 39/21 41/12 46/12 53/7 77/20</p> <p>Partnership [2] 9/4 27/20</p> <p>parts [3] 3/7 18/7 87/1</p> <p>party [1] 56/11</p> <p>past [1] 85/4</p> <p>pathway [1] 22/1</p> <p>patient [29] 12/17 19/21 20/7 26/6 26/16 26/20 26/24 26/25 28/2 28/11 28/12 28/18 30/19 34/22 35/13 35/21 38/4 42/7 44/17 51/21 52/23 53/1 56/24 58/5 58/10 60/4 60/5 82/9 85/2</p> <p>patient's [1] 22/1</p> <p>patients [13] 10/19 15/17 19/15 29/2 29/5 42/23 44/4 58/16 61/25 62/16 72/13 84/15 84/18</p> <p>Pause [4] 6/3 13/9 14/24 22/11</p> <p>pausing [1] 69/20</p> <p>PD [2] 39/22 51/19</p> <p>penultimate [1] 46/23</p> <p>people [7] 16/6 33/12 33/19 34/5 47/15 53/20 57/18</p> <p>per [1] 45/14</p> <p>perception [1] 52/13</p> <p>performance [2] 48/6 69/10</p> <p>performing [1] 70/7</p> <p>perhaps [7] 27/2 66/2 67/5 69/11 71/2 74/7 79/17</p> <p>period [6] 8/5 15/6 20/14 35/10 44/5 65/15</p> <p>peripheral [1] 63/22</p> <p>perpetrator [1] 30/13</p> <p>person [3] 41/6 70/20 75/20</p> <p>personal [1] 30/10</p> <p>personally [4] 2/22 3/11 49/2 59/9</p> <p>persons [1] 12/13</p> <p>perspective [5] 21/7</p>	<p>32/25 37/11 58/18 75/9</p> <p>PFD [2] 22/20 25/2</p> <p>PFDs [7] 24/5 24/8 24/13 24/17 24/19 24/20 25/9</p> <p>PFDs in [1] 24/20</p> <p>phone [1] 29/12</p> <p>physical [1] 58/17</p> <p>pick [5] 60/22 66/22 67/7 67/9 79/3</p> <p>picked [5] 23/13 46/2 77/20 77/22 86/18</p> <p>picking [1] 23/16</p> <p>picture [1] 50/8</p> <p>piece [12] 9/11 18/4 32/16 39/21 41/13 41/17 42/22 43/3 45/1 52/18 55/4 68/24</p> <p>pieces [1] 87/17</p> <p>place [16] 1/13 3/24 3/25 10/10 23/9 23/10 27/7 32/2 33/6 33/15 45/22 45/23 47/1 47/4 57/25 76/3</p> <p>placed [2] 23/25 60/11</p> <p>placements [1] 62/15</p> <p>plan [22] 2/24 3/10 3/17 3/19 4/4 16/7 20/11 23/9 26/24 26/25 28/12 29/10 31/5 31/12 40/11 47/10 47/12 48/12 48/14 51/3 81/16 84/3</p> <p>plan/involving [1] 81/16</p> <p>planning [4] 81/17 82/12 83/20 83/21</p> <p>planning/risk [2] 81/17 82/12</p> <p>plans [12] 3/2 15/20 23/10 40/24 50/17 73/3 78/9 78/24 80/21 80/21 82/2 82/2</p> <p>plays [1] 17/11</p> <p>please [64] 1/8 1/10 5/13 5/16 6/1 6/4 6/9 9/18 9/25 11/25 15/15 16/1 16/8 18/16 18/23 21/8 22/11 22/12 24/2 25/20 25/20 28/17 29/9 29/25 30/2 35/19 35/21 35/25 36/19 38/4 38/25 39/5 43/10 43/15 46/13 46/15 46/21 46/21 47/9 49/13 50/19 51/8 55/13 55/14 58/11 61/2 64/11 64/16 67/9 67/11 68/1 69/4 69/6 69/15 71/4 72/5 72/10 72/25 74/12 78/6 81/1 81/22 82/4 82/7</p> <p>pm [4] 1/2 59/24 60/1 87/22</p>
---	--	---	--	--

<p>P</p> <p>point [21] 4/23 8/9 9/1 9/2 10/23 11/7 12/7 14/17 15/16 20/8 21/15 22/7 23/24 44/18 46/18 46/23 49/19 57/4 77/23 79/4 84/2</p> <p>points [4] 1/11 16/10 36/21 82/15</p> <p>police [17] 27/4 27/14 30/25 31/3 31/10 31/17 32/8 32/11 32/14 32/16 32/21 33/2 33/15 34/6 35/3 37/2 76/15</p> <p>policies [16] 15/4 15/7 15/9 35/6 42/9 42/13 42/16 42/18 44/18 44/22 45/3 45/9 45/12 45/20 45/21 78/21</p> <p>policy [12] 2/5 2/6 13/8 13/11 14/15 15/1 15/3 43/17 44/11 45/5 45/7 45/8</p> <p>pollute [1] 33/16</p> <p>polluting [1] 35/4</p> <p>pool [1] 53/20</p> <p>poor [3] 71/9 73/4 74/1</p> <p>portion [1] 10/18</p> <p>position [6] 11/16 27/12 50/2 52/15 58/16 76/14</p> <p>possibility [1] 63/11</p> <p>possible [3] 42/7 67/21 72/24</p> <p>post [3] 16/12 45/3 75/19</p> <p>Post-June [1] 45/3</p> <p>potential [5] 22/1 45/18 62/5 62/13 85/25</p> <p>potentially [4] 44/23 47/18 59/20 86/20</p> <p>powers [2] 56/2 56/16</p> <p>practicable [1] 28/5</p> <p>practical [1] 64/15</p> <p>practically [1] 68/17</p> <p>practice [7] 37/17 71/9 71/18 78/17 78/19 79/11 79/11</p> <p>practices [2] 45/12 71/20</p> <p>pre [1] 81/2</p> <p>pre-dates [1] 81/2</p> <p>preceding [1] 24/17</p> <p>preclude [1] 19/6</p> <p>predecessor [1] 65/8</p> <p>predominantly [2] 17/4 17/10</p> <p>prepare [1] 56/19</p> <p>prerequisite [1]</p>	<p>72/19</p> <p>present [2] 19/20 69/18</p> <p>presentation [1] 69/16</p> <p>presented [3] 5/19 5/25 30/5</p> <p>preventing [1] 22/20</p> <p>Prevention [1] 25/3</p> <p>previous [11] 5/24 6/23 6/23 14/9 21/10 26/16 27/6 30/21 38/20 42/23 69/24</p> <p>previously [3] 17/15 30/14 86/20</p> <p>principle [1] 49/24</p> <p>prior [5] 71/18 74/11 74/12 74/19 74/20</p> <p>priorities [1] 8/11</p> <p>prioritised [2] 56/25 58/5</p> <p>prioritising [1] 58/9</p> <p>priority [2] 14/23 41/8</p> <p>Priory [4] 61/3 61/5 61/19 62/2</p> <p>private [3] 61/22 65/11 71/6</p> <p>probably [2] 3/7 14/8</p> <p>problem [6] 13/13 18/14 52/6 81/25 83/4 83/23</p> <p>problems [2] 52/25 83/9</p> <p>procedures [2] 78/21 78/22</p> <p>process [12] 21/19 32/8 32/11 32/14 32/17 33/18 43/18 43/21 43/22 44/11 46/2 76/21</p> <p>processes [8] 31/22 32/2 32/6 32/14 33/21 42/18 45/13 69/9</p> <p>produced [1] 26/3</p> <p>progress [1] 25/9</p> <p>prompt [1] 52/8</p> <p>proper [6] 15/23 19/23 33/22 34/14 38/1 67/2</p> <p>properly [4] 2/21 58/2 84/16 84/17</p> <p>proposed [1] 68/10</p> <p>pros [1] 63/5</p> <p>provide [2] 9/20 62/22</p> <p>provided [2] 51/21 51/24</p> <p>provider [3] 63/3 63/8 63/13</p> <p>providers [5] 11/4 11/6 11/22 11/23 59/16</p> <p>provides [1] 25/23</p> <p>providing [4] 9/5 81/15 82/1 82/20</p>	<p>psychologists [2] 53/9 54/21</p> <p>Psychosis [2] 36/24 48/4</p> <p>public [7] 60/16 61/8 61/10 61/11 61/25 63/13 86/3</p> <p>pulled [1] 51/4</p> <p>Purely [1] 16/24</p> <p>purpose [2] 45/14 78/8</p> <p>purposes [1] 54/17</p> <p>pushed [1] 8/12</p> <p>put [11] 16/24 23/9 23/10 27/6 35/16 44/25 48/22 50/6 68/16 84/14 85/1</p> <hr/> <p>Q</p> <p>QIP [1] 44/1</p> <p>quality [21] 12/3 12/21 16/15 39/20 40/9 40/15 56/3 56/20 61/12 62/23 72/11 72/20 73/2 73/4 74/1 75/6 76/24 77/11 78/7 78/9 82/5</p> <p>quarter [1] 5/18</p> <p>question [7] 4/14 7/4 7/7 11/15 27/16 72/13 80/1</p> <p>questioned [9] 60/25 61/24 63/18 79/24 85/12 88/3 88/4 88/5 88/7</p> <p>questions [13] 2/13 2/18 2/23 3/1 6/25 13/12 20/21 51/10 59/18 77/18 84/12 84/14 85/1</p> <p>quick [1] 53/25</p> <p>quick-fixes [1] 53/25</p> <p>quickly [3] 36/4 38/12 42/7</p> <p>quite [13] 4/18 9/11 9/22 13/9 20/20 29/1 36/4 36/18 38/12 54/1 56/13 70/12 74/5</p> <hr/> <p>R</p> <p>raise [1] 49/3</p> <p>raised [28] 17/2 17/13 17/16 17/17 18/1 18/2 20/1 23/11 23/13 29/18 30/15 38/7 38/21 41/24 50/15 53/6 55/9 56/25 62/25 63/2 76/9 77/25 79/10 80/20 82/8 83/3 86/5 86/20</p> <p>raising [3] 2/9 41/19 70/10</p> <p>range [1] 9/19</p> <p>rather [6] 6/22 27/24 41/22 67/18 74/4 76/4</p> <p>rating [1] 69/7</p>	<p>rationale [1] 21/25</p> <p>re [3] 43/18 44/6 84/15</p> <p>re-reviewed [1] 44/6</p> <p>re-written [1] 43/18</p> <p>reach [1] 86/13</p> <p>reached [2] 28/25 49/19</p> <p>reactive [2] 17/4 17/10</p> <p>read [6] 31/1 60/9 60/10 80/4 80/11 82/13</p> <p>ready [1] 39/17</p> <p>reaffirming [1] 51/21</p> <p>real [2] 73/20 74/24</p> <p>realised [1] 7/10</p> <p>reality [1] 61/19</p> <p>really [7] 19/3 34/13 57/11 67/2 83/8 83/13 84/22</p> <p>reason [1] 33/14</p> <p>reasonably [1] 28/5</p> <p>reasons [2] 2/5 2/7</p> <p>reassure [2] 3/19 43/5</p> <p>recall [6] 4/20 5/6 30/18 60/17 80/4 85/25</p> <p>receive [3] 15/17 15/18 39/7</p> <p>received [6] 2/14 24/16 24/18 30/8 31/14 75/23</p> <p>receiving [1] 56/23</p> <p>recent [3] 16/11 42/20 85/4</p> <p>recognised [1] 15/6</p> <p>recollect [3] 4/9 4/16 4/24</p> <p>recollection [3] 24/23 27/17 32/2</p> <p>recommendation [3] 2/16 15/15 68/15</p> <p>recommendations [6] 15/22 43/16 43/25 44/25 67/23 78/11</p> <p>recommended [2] 53/11 78/20</p> <p>recorded [2] 9/13 87/1</p> <p>records [4] 16/6 22/1 60/9 60/10</p> <p>recruitment [1] 47/4</p> <p>recurring [13] 4/7 5/9 6/7 6/9 6/14 6/19 6/21 7/5 7/9 7/13 8/16 83/4 83/9</p> <p>red [1] 69/7</p> <p>reduce [3] 39/24 40/3 40/12</p> <p>reduced [2] 40/23 65/10</p> <p>reducing [1] 25/9</p> <p>reference [5] 17/5</p>	<p>60/13 70/25 72/20 82/25</p> <p>referenced [1] 73/24</p> <p>referrals [4] 29/12 37/3 47/21 84/25</p> <p>referred [5] 32/6 33/24 54/7 85/23 86/19</p> <p>referring [2] 32/19 84/18</p> <p>reflect [1] 58/12</p> <p>reflected [2] 12/20 40/16</p> <p>reflecting [1] 56/7</p> <p>reflection [3] 5/12 41/8 58/7</p> <p>reflects [1] 52/10</p> <p>regarded [2] 19/4 33/2</p> <p>regarding [2] 10/13 78/6</p> <p>regards [7] 37/21 42/13 42/16 42/18 45/13 51/2 53/6</p> <p>region [1] 11/20</p> <p>register [4] 47/2 85/14 85/19 87/12</p> <p>registers [5] 18/21 85/16 86/17 86/23 86/25</p> <p>regular [3] 53/24 57/22 85/21</p> <p>Regulation [1] 22/21</p> <p>regulatory [2] 1/7 4/3</p> <p>relate [1] 75/18</p> <p>related [4] 26/9 26/12 29/10 36/22</p> <p>relates [4] 30/19 31/21 61/2 80/1</p> <p>relating [3] 21/23 57/25 70/2</p> <p>relation [16] 3/2 4/10 4/22 5/5 8/4 23/9 23/11 28/11 33/7 33/9 34/15 34/16 40/24 63/5 78/4 84/13</p> <p>relationship [2] 39/22 41/13</p> <p>relatively [1] 53/21</p> <p>relevant [5] 1/16 8/18 37/4 42/10 72/2</p> <p>remain [1] 70/20</p> <p>remarkably [1] 73/7</p> <p>remember [3] 5/10 70/18 80/11</p> <p>remembering [1] 13/10</p> <p>report [35] 1/10 2/14 5/25 6/15 6/24 10/6 12/14 12/17 12/20 22/21 22/25 24/7 30/8 31/14 31/20 34/12 36/7 36/17 36/22 42/23 45/14 45/15 50/17 67/24 68/2 68/6 69/4 70/9 71/24 75/23</p>
---	--	--	--	---

<p>R</p> <p>report... [5] 77/2 77/3 77/8 79/10 83/15</p> <p>Reportable [4] 30/3 30/5 39/6 39/7</p> <p>reported [9] 10/16 24/13 39/20 40/8 41/25 56/2 56/20 59/10 76/25</p> <p>reporting [8] 22/3 31/7 56/6 61/15 68/7 71/10 71/13 71/20</p> <p>reports [21] 21/1 69/21 70/6 70/24 71/14 72/11 72/14 73/4 73/12 73/13 74/1 75/14 75/25 76/2 76/10 76/22 76/23 77/5 78/10 78/24 83/15</p> <p>represent [2] 63/23 64/5</p> <p>Representations [2] 84/10 88/6</p> <p>reputational [5] 41/5 41/16 41/17 41/22 86/1</p> <p>request [1] 35/9</p> <p>required [5] 45/12 51/20 51/23 61/23 79/1</p> <p>requirement [3] 1/18 2/18 3/21</p> <p>requirements [3] 1/8 1/12 38/16</p> <p>requires [2] 19/8 73/17</p> <p>research [1] 72/8</p> <p>resemblance [1] 78/11</p> <p>resolution [1] 47/23</p> <p>resources [2] 46/12 46/13</p> <p>respect [4] 64/11 69/14 72/15 75/1</p> <p>respond [1] 17/12</p> <p>responding [1] 17/8</p> <p>response [4] 7/11 24/7 49/20 67/23</p> <p>responsibilities [1] 63/25</p> <p>responsibility [2] 19/11 73/14</p> <p>responsible [2] 24/6 81/9</p> <p>rest [1] 10/8</p> <p>restriction [1] 84/17</p> <p>restrictions [3] 61/7 61/23 62/18</p> <p>result [2] 28/1 70/3</p> <p>resulted [3] 25/17 61/7 78/25</p> <p>retention [1] 47/4</p> <p>retirement [1] 70/21</p> <p>review [36] 15/12</p>	<p>15/13 16/6 16/21 17/3 35/9 36/2 36/5 36/11 40/5 40/14 42/9 42/19 43/10 43/16 43/23 44/18 58/25 68/22 69/16 70/25 71/7 72/6 72/7 73/8 74/13 74/14 75/4 76/13 78/8 79/6 83/13 85/4 87/8 87/10 87/16</p> <p>reviewed [5] 15/5 39/18 44/6 45/20 78/9</p> <p>reviewing [2] 55/19 71/16</p> <p>reviews [6] 37/17 59/1 66/23 72/20 74/11 87/17</p> <p>revisited [1] 75/5</p> <p>right [13] 2/17 20/21 59/13 61/25 67/5 70/19 70/20 71/22 73/19 76/12 77/14 82/13 87/19</p> <p>rigorous [1] 15/23</p> <p>RiO [1] 21/25</p> <p>risk [116]</p> <p>risk factors [1] 12/12</p> <p>risks [12] 15/18 16/14 16/17 18/20 19/2 19/3 19/4 19/13 62/13 85/23 86/25 87/7</p> <p>Robinson [1] 53/8</p> <p>robust [3] 47/3 71/19 86/15</p> <p>robustly [1] 71/9</p> <p>robustness [1] 74/25</p> <p>role [10] 41/6 64/1 65/11 65/12 65/22 66/3 66/25 67/1 68/25 77/17</p> <p>roles [4] 53/19 53/20 53/21 63/25</p> <p>route [1] 33/1</p> <p>routes [1] 57/4</p> <p>rules [1] 22/22</p> <p>S</p> <p>safe [6] 42/20 44/23 46/22 46/24 49/19 62/16</p> <p>Safer [6] 55/7 55/17 56/4 56/22 57/5 59/1</p> <p>safety [26] 12/17 16/15 17/2 21/2 26/20 26/24 26/25 28/12 28/12 28/18 29/10 46/18 47/1 51/21 52/23 53/1 56/24 58/5 58/10 61/25 62/23 80/21 81/16 82/2 82/12 83/20</p> <p>said [7] 13/18 31/5 31/17 45/19 50/21 54/8 68/2</p> <p>same [2] 70/20 83/8</p>	<p>sample [1] 72/22</p> <p>sampling [2] 7/20 23/20</p> <p>sat [3] 8/24 9/7 10/22</p> <p>say [28] 2/18 3/22 4/11 4/25 9/1 9/1 12/14 13/24 13/25 22/22 24/12 40/22 48/17 51/23 52/9 55/24 58/13 63/10 65/7 67/13 70/9 70/12 71/5 73/23 84/11 85/5 86/4 86/8</p> <p>saying [14] 4/22 5/2 11/3 14/2 19/21 24/25 25/4 31/24 52/11 56/13 56/14 76/18 77/15 79/4</p> <p>says [7] 30/24 34/12 36/14 41/11 47/13 70/5 82/14</p> <p>scale [1] 9/21</p> <p>schizophrenia [1] 72/10</p> <p>scope [2] 73/6 74/9</p> <p>screen [1] 6/2</p> <p>scrutinise [1] 67/1</p> <p>scrutinising [1] 55/6</p> <p>scrutiny [5] 19/17 19/18 19/25 20/10 86/15</p> <p>second [2] 41/1 51/9</p> <p>section [3] 6/4 16/21 30/2</p> <p>Section 4 [1] 6/4</p> <p>Section 48 [1] 16/21</p> <p>sections [1] 71/15</p> <p>secure [1] 52/5</p> <p>see [29] 1/11 3/23 4/3 5/17 26/7 26/22 34/7 38/8 38/13 39/1 39/2 46/19 47/11 49/18 50/20 56/13 58/7 65/3 66/9 69/7 72/18 73/1 76/15 80/7 80/15 81/5 81/11 81/11 83/8</p> <p>seeing [1] 87/10</p> <p>seek [2] 7/18 62/25</p> <p>seeking [3] 3/13 4/11 17/12</p> <p>seem [4] 17/19 38/19 77/1 77/15</p> <p>seems [4] 18/1 65/20 65/22 81/18</p> <p>seen [2] 6/20 61/21</p> <p>self [1] 10/18</p> <p>self-harm [1] 10/18</p> <p>senior [4] 16/16 21/9 34/4 80/5</p> <p>sense [4] 11/21 40/18 49/21 52/23</p> <p>sent [2] 24/5 50/14</p> <p>sentiment [1] 39/25</p> <p>separately [1] 84/20</p> <p>September [8] 30/1</p>	<p>35/16 44/16 45/19 46/1 60/4 71/6 81/24</p> <p>September 2022 [3] 35/16 60/4 81/24</p> <p>series [2] 45/3 50/4</p> <p>serious [31] 7/10 7/11 8/24 9/3 9/13 9/16 10/17 11/1 11/9 25/17 25/18 26/17 30/6 33/9 35/12 37/20 37/25 39/8 39/19 39/24 40/4 40/6 40/12 40/22 41/11 42/24 43/17 43/19 44/16 71/17 76/23</p> <p>service [4] 4/12 47/14 48/7 62/22</p> <p>services [25] 9/19 9/21 10/16 10/25 11/11 16/4 16/7 16/15 21/13 22/2 29/13 30/15 46/22 46/25 47/1 47/22 49/19 53/18 53/22 61/21 61/22 62/24 64/20 82/20 85/2</p> <p>services' [1] 28/21</p> <p>set [3] 5/23 67/16 85/9</p> <p>setting [1] 2/13</p> <p>settings [1] 58/17</p> <p>seven [2] 72/23 74/11</p> <p>several [5] 21/18 22/23 25/24 37/8 73/3</p> <p>share [1] 21/20</p> <p>shared [2] 24/12 70/6</p> <p>sharing [2] 37/2 73/25</p> <p>short [3] 52/12 59/25 79/25</p> <p>shortages [1] 57/11</p> <p>shorter [1] 37/18</p> <p>shortly [1] 29/23</p> <p>should [33] 2/18 3/1 4/10 6/24 15/4 15/5 20/12 24/2 34/9 35/15 40/23 42/2 42/2 43/18 44/13 44/17 44/21 45/20 46/1 51/15 51/21 51/24 56/4 58/19 63/7 66/14 76/17 85/7 85/8 86/4 86/14 87/11 87/12</p> <p>shouldn't [1] 44/18</p> <p>sic [1] 29/22</p> <p>side [1] 4/3</p> <p>sight [2] 2/23 38/1</p> <p>sign [2] 43/21 76/9</p> <p>sign-off [2] 43/21 76/9</p> <p>signed [5] 26/25 75/14 75/25 76/10 76/22</p> <p>significance [1] 69/3</p> <p>significant [7] 10/18</p>	<p>23/10 24/16 30/7 39/9 47/16 79/10</p> <p>similar [5] 9/8 9/9 9/10 11/22 66/16</p> <p>similarly [2] 66/20 74/15</p> <p>simple [1] 9/22</p> <p>simply [3] 20/20 30/23 74/19</p> <p>since [7] 16/13 17/6 17/6 27/9 27/21 49/22 71/13</p> <p>single [3] 2/1 2/25 63/12</p> <p>sit [2] 12/5 48/18</p> <p>sits [3] 19/15 48/18 76/8</p> <p>sitting [1] 48/22</p> <p>situate [1] 81/6</p> <p>situation [2] 46/20 51/2</p> <p>situations [1] 33/10</p> <p>six [2] 77/4 78/4</p> <p>size [2] 9/21 72/22</p> <p>slightly [2] 79/6 81/2</p> <p>small [3] 19/1 53/21 72/22</p> <p>so [97]</p> <p>sole [2] 8/20 57/24</p> <p>solely [1] 57/13</p> <p>solution [4] 50/1 51/20 51/23 52/3</p> <p>solution-focused [1] 50/1</p> <p>some [40] 3/4 3/5 3/7 8/3 14/9 15/6 15/7 16/14 20/25 34/23 35/5 35/5 36/8 43/9 43/14 45/22 45/24 50/10 51/4 51/7 53/19 53/19 55/21 61/22 70/7 71/9 71/17 74/1 75/4 76/1 77/7 77/16 78/14 79/10 80/3 80/25 84/14 84/25 87/4 87/4</p> <p>somebody [1] 62/21</p> <p>someone [4] 14/18 64/7 68/7 72/2</p> <p>something [18] 4/7 4/11 4/12 4/15 13/17 14/25 17/14 19/25 38/21 43/1 49/9 49/10 53/18 53/23 59/11 60/9 60/18 76/6</p> <p>somewhere [1] 78/3</p> <p>soon [1] 28/4</p> <p>sooner [2] 51/12 51/15</p> <p>sorry [4] 22/13 54/16 74/11 81/22</p> <p>sort [3] 38/15 65/20 65/23</p> <p>sorts [2] 35/15 48/15</p> <p>sought [1] 64/6</p> <p>source [2] 21/2 23/14</p>
--	--	---	--	--

S	46/5 46/8 52/5 52/13 64/24 75/24 still [3] 52/13 86/14 86/14 strategic [8] 19/2 19/4 19/11 20/5 20/15 85/19 86/10 86/12 strategy [1] 47/4 strong [1] 22/23 structure [4] 56/6 57/1 61/12 82/19 structures [1] 3/4 subject [1] 62/17 suboptimal [1] 10/19 subsequently [2] 31/23 77/9 successfully [1] 4/1 such [5] 7/18 29/11 31/8 74/5 76/23 Sue [1] 21/12 sufficiently [2] 58/5 66/25 suggest [3] 40/23 59/15 83/6 suggests [2] 56/24 58/4 Sullivan [1] 10/2 summary [3] 22/20 73/9 74/8 supervision [2] 29/17 62/14 support [8] 2/5 2/6 47/14 47/25 49/20 53/12 55/10 83/2 supported [1] 51/19 suppose [1] 65/11 sure [5] 25/7 47/24 52/21 61/9 76/6 surname [1] 70/18 surveillance [1] 5/18 suspect [2] 6/20 55/4 sustained [1] 64/7 system [9] 10/18 10/24 11/3 11/6 11/24 43/1 69/19 69/20 70/11 systemic [12] 4/21 17/22 18/11 18/12 18/13 19/18 41/23 52/19 52/23 52/25 83/16 85/24 systems [1] 11/5	49/13 50/19 51/8 52/7 52/12 55/13 58/11 59/21 75/24 76/3 84/19 taken [22] 3/20 16/12 17/6 21/6 25/10 25/13 33/4 34/24 35/15 45/21 46/5 50/10 52/5 52/14 53/13 62/5 70/3 70/25 71/16 71/25 81/20 85/7 taking [6] 8/8 17/1 21/17 23/3 29/9 37/21 talk [2] 3/22 41/10 talked [2] 65/25 83/20 talking [3] 39/12 49/6 66/7 talks [1] 51/7 TCLT0000353 [1] 38/25 TCLT0000374 [1] 30/1 TD [1] 30/5 team [12] 24/13 25/21 32/24 51/5 53/7 53/10 54/22 61/16 61/18 66/18 68/23 84/20 teams [7] 3/7 12/13 23/5 47/13 47/20 47/22 48/15 template [2] 29/17 36/11 term [3] 47/10 48/12 52/12 terms [50] 4/4 8/24 9/15 10/25 11/1 11/7 11/10 13/11 16/9 18/4 18/8 19/16 20/7 21/11 24/20 24/22 25/25 30/23 31/5 33/24 36/7 38/7 40/11 42/4 46/10 46/10 47/12 52/16 55/3 55/3 56/8 57/1 57/1 57/8 58/4 58/9 60/17 60/18 61/9 62/2 62/12 63/12 66/5 72/1 72/19 74/9 75/17 77/6 80/25 86/12 testing [1] 3/24 than [8] 6/22 23/25 27/24 41/22 48/17 57/7 67/18 86/1 thank [33] 1/3 18/25 26/4 59/22 59/23 63/15 63/16 65/16 66/13 66/20 69/1 69/6 69/12 70/23 71/25 72/5 72/6 79/16 79/17 79/19 79/20 79/20 79/21 79/22 81/4 84/5 84/6 84/7 84/8 85/10 85/11 87/19 87/21 that [559] that's [52] 2/2 2/17	5/4 9/21 12/4 12/6 12/7 13/20 13/22 14/1 16/24 17/13 20/5 25/10 27/7 27/9 28/16 29/7 31/5 32/17 33/17 33/23 35/19 36/4 37/11 38/15 39/12 39/25 41/16 43/1 43/2 48/23 49/9 49/11 50/8 52/24 56/7 56/18 56/21 56/23 57/3 57/3 57/14 60/17 65/9 68/5 69/21 76/6 76/18 82/8 84/12 84/17 Theemis [2] 45/15 83/15 their [7] 15/8 15/18 47/18 58/4 69/18 76/2 87/7 them [15] 22/8 24/12 32/21 42/2 49/20 54/8 54/10 54/12 57/13 62/6 71/11 74/3 74/3 77/6 87/1 thematic [9] 43/10 43/16 66/23 67/6 70/24 71/7 77/12 87/10 87/16 theme [12] 4/7 5/9 6/14 6/19 6/21 7/5 7/9 7/13 8/16 23/16 67/7 70/23 themes [6] 6/7 6/9 22/23 72/21 72/24 77/20 themselves [2] 62/3 68/16 then [43] 3/3 11/13 16/8 22/22 27/21 29/14 30/21 31/20 41/10 41/11 46/17 50/4 50/16 51/20 51/23 62/22 64/11 65/16 66/20 67/5 67/7 68/17 69/11 70/5 70/23 71/24 72/10 73/9 73/20 74/7 74/17 75/22 76/12 76/12 76/20 77/15 77/21 78/6 78/13 80/25 83/12 85/7 85/8 there [127] there'd [2] 21/18 45/25 there's [20] 9/15 9/17 9/19 11/10 16/9 28/7 29/1 40/18 44/25 51/18 68/6 69/13 70/1 73/9 73/22 74/8 74/18 76/15 78/13 82/25 therefore [5] 32/12 37/16 65/7 66/11 84/19 these [29] 5/3 5/20 16/17 25/13 26/13 35/15 37/17 37/18	37/19 41/25 43/15 45/19 45/21 46/25 51/14 54/4 54/9 54/24 72/15 74/11 75/2 75/25 76/2 76/10 77/16 77/19 79/1 80/15 82/15 they [49] 1/16 1/23 1/23 2/21 3/2 8/2 8/3 9/13 9/14 14/22 14/22 14/23 15/5 19/3 19/4 21/20 23/11 24/25 25/4 25/7 25/14 25/15 29/6 32/21 33/13 33/20 37/5 37/6 44/5 44/9 44/12 45/10 45/11 46/8 46/9 57/1 57/7 57/12 59/10 60/6 64/10 71/21 72/16 76/1 77/22 78/2 79/2 85/7 87/5 they've [1] 78/25 thing [4] 40/5 58/21 61/25 80/8 things [4] 4/4 11/13 54/24 68/2 think [82] 4/9 4/14 6/16 9/11 9/17 9/20 9/21 10/23 11/9 13/20 14/1 15/2 15/3 17/7 17/9 17/11 18/4 18/5 19/19 19/25 20/8 20/19 23/10 23/12 24/25 25/10 27/5 27/5 27/19 31/21 31/22 32/1 32/22 33/24 34/13 40/14 41/17 41/21 42/1 45/4 46/1 52/9 52/16 53/16 54/11 54/16 56/7 57/3 57/13 57/16 57/23 58/8 58/18 58/21 59/21 60/22 62/10 62/14 64/13 64/14 65/10 65/22 66/21 66/24 69/11 70/12 70/17 72/8 73/23 73/23 73/25 74/5 76/13 80/14 81/3 83/10 83/11 84/1 84/22 85/6 86/6 87/14 third [4] 38/4 38/4 49/18 51/17 this [144] Thornton [5] 67/24 68/2 68/10 68/16 68/22 thoroughness [1] 74/25 those [72] 3/2 4/8 7/11 8/10 9/21 11/8 11/11 15/18 15/22 17/2 19/3 23/23 25/13 26/5 27/7 27/11 31/24 34/4 34/5 34/15 37/4 37/14 42/5 42/10
----------	--	---	--	--

<p>T</p> <p>those... [48] 42/15 44/3 44/7 44/10 45/1 45/2 45/9 45/12 46/8 47/24 53/19 53/21 55/1 58/19 59/18 60/15 62/8 62/24 62/24 63/22 64/4 64/20 66/9 66/11 67/1 71/10 72/9 73/10 73/12 73/13 74/1 75/4 75/7 75/12 75/14 75/25 76/8 76/9 77/4 77/7 77/7 77/21 80/14 82/20 86/23 86/24 87/4 87/7</p> <p>though [5] 56/2 57/13 67/19 81/18 86/15</p> <p>thought [2] 3/20 61/21</p> <p>threatened [1] 49/24</p> <p>three [4] 12/7 44/8 46/25 54/7</p> <p>threshold [1] 28/23</p> <p>through [31] 3/3 5/23 6/23 6/23 7/16 17/9 18/21 19/22 37/16 39/20 40/8 40/15 46/17 52/7 54/12 54/14 59/1 59/13 61/15 61/17 65/17 65/18 68/23 70/20 77/11 79/9 83/7 85/14 86/18 86/21 87/16</p> <p>throughout [4] 4/8 10/8 59/12 59/16</p> <p>time [36] 1/6 2/15 4/17 5/14 19/25 26/10 27/13 27/22 31/21 32/3 33/18 43/14 53/16 54/8 54/14 54/24 55/11 56/19 57/8 59/12 59/20 60/7 65/19 66/21 71/8 72/16 73/12 75/3 75/6 75/19 77/5 77/23 79/14 79/18 79/19 82/4</p> <p>timeframes [1] 37/18</p> <p>timeline [1] 72/12</p> <p>timelines [1] 71/16</p> <p>timely [2] 71/11 73/5</p> <p>times [2] 42/20 79/13</p> <p>timing [1] 61/9</p> <p>today [1] 87/20</p> <p>together [4] 51/4 66/18 67/6 67/9</p> <p>told [7] 3/14 5/6 5/9 6/18 7/5 28/7 33/14</p> <p>tomorrow [1] 87/20</p> <p>too [5] 20/15 31/24 33/10 37/11 37/14</p> <p>took [4] 33/5 64/23 65/11 80/13</p>	<p>top [4] 20/13 57/11 58/3 81/6</p> <p>topic [1] 46/11</p> <p>total [2] 24/17 24/18</p> <p>totally [1] 61/9</p> <p>touch [1] 26/6</p> <p>touched [2] 35/20 44/10</p> <p>towards [2] 6/4 29/2</p> <p>track [1] 3/10</p> <p>trail [1] 76/8</p> <p>training [3] 1/23 2/5 2/6</p> <p>transformation [1] 47/15</p> <p>treatment [3] 15/19 47/17 47/23</p> <p>trends [1] 77/20</p> <p>Triangle [1] 82/25</p> <p>trigger [2] 6/25 44/18</p> <p>true [1] 64/22</p> <p>trust [75] 1/13 2/21 3/4 3/15 4/8 7/2 8/23 8/24 9/5 9/16 9/23 9/24 11/8 15/24 16/19 17/1 17/3 17/7 21/3 24/10 24/13 24/16 25/11 26/3 26/5 26/17 27/25 30/7 32/20 34/20 39/9 39/16 39/18 39/22 39/23 41/4 41/13 45/17 46/13 46/20 46/24 47/2 47/3 47/7 48/18 52/19 53/6 58/6 59/14 60/6 60/6 64/21 64/22 65/4 65/12 66/14 66/17 67/24 69/16 70/1 70/10 70/21 72/2 73/14 73/17 73/19 74/10 75/1 76/24 77/6 78/18 78/19 79/11 85/2 86/1</p> <p>Trust's [3] 30/14 43/17 83/5</p> <p>trust-wide [1] 52/19</p> <p>trusts [10] 9/4 9/20 48/14 53/18 59/5 68/3 69/17 70/7 76/23 81/9</p> <p>try [3] 13/13 34/7 66/11</p> <p>trying [9] 4/25 11/21 19/20 40/11 41/18 45/9 56/9 58/25 83/13</p> <p>Tuesday [3] 1/1 50/15 50/21</p> <p>turn [1] 6/8</p> <p>turned [1] 31/17</p> <p>turning [1] 35/25</p> <p>twenty [1] 39/18</p> <p>twenty-two [1] 39/18</p> <p>two [10] 8/6 26/24 28/19 32/15 38/20 39/18 45/4 65/14 73/7 79/13</p> <p>two years [1] 26/24</p>	<p>type [1] 65/22</p> <p>typify [1] 66/2</p> <p>U</p> <p>Ulysses [3] 69/19 69/20 70/11</p> <p>unclear [4] 23/17 34/2 76/21 79/19</p> <p>under [6] 21/22 22/21 23/22 31/22 36/14 56/25</p> <p>under-prioritised [1] 56/25</p> <p>understand [15] 4/18 11/7 18/13 21/7 27/2 32/18 43/7 52/18 55/20 62/4 64/13 68/14 72/21 76/1 77/17</p> <p>understanding [15] 2/24 4/5 9/9 27/8 33/17 36/23 43/23 56/8 57/15 62/1 62/9 65/9 68/9 78/19 79/9</p> <p>understood [4] 13/18 13/22 27/22 33/22</p> <p>undertake [1] 33/11</p> <p>undertaken [4] 1/21 8/17 31/16 44/22</p> <p>unfair [1] 65/24</p> <p>unique [1] 4/12</p> <p>unitary [3] 66/7 66/14 86/22</p> <p>unsafe [3] 44/24 45/25 61/22</p> <p>until [5] 31/16 32/21 36/8 59/21 87/23</p> <p>up [26] 14/17 14/18 16/12 20/17 21/10 23/13 23/16 32/13 46/2 55/20 57/14 58/3 60/22 62/10 66/22 67/7 67/9 67/16 77/21 77/22 79/3 80/19 84/11 84/19 85/7 86/18</p> <p>update [2] 23/6 50/24</p> <p>updated [10] 14/16 15/1 15/5 15/9 16/7 22/18 45/8 51/1 51/6 81/3</p> <p>updates [4] 15/3 50/17 78/10 85/21</p> <p>upon [10] 1/7 17/19 26/6 27/12 35/20 41/16 44/10 55/18 58/12 84/16</p> <p>urgency [2] 83/6 83/11</p> <p>urgent [1] 50/16</p> <p>urging [1] 48/14</p> <p>us [18] 3/14 7/12 8/21 11/1 17/12 17/13 52/11 58/9 58/21 58/25 70/15 75/7 75/10 75/12 75/22</p>	<p>77/4 77/14 83/12</p> <p>use [2] 16/6 83/14</p> <p>using [2] 64/20 70/25</p> <p>usual [6] 31/22 32/6 32/10 32/14 32/16 32/17</p> <p>utmost [1] 51/22</p> <p>V</p> <p>value [1] 66/10</p> <p>varied [1] 16/4</p> <p>various [3] 23/18 25/24 53/5</p> <p>VC [9] 37/4 61/2 61/19 62/4 62/5 74/17 77/3 77/24 81/23</p> <p>VC's [7] 34/19 45/10 46/2 61/2 71/22 80/1 83/23</p> <p>verbal [1] 50/16</p> <p>very [28] 8/3 11/22 14/22 25/18 26/17 42/23 44/16 50/8 51/13 52/15 53/23 57/18 57/22 58/21 63/15 63/21 64/14 65/13 74/4 74/8 79/17 79/25 80/7 80/15 83/11 84/5 85/10 87/15</p> <p>via [2] 55/7 73/2</p> <p>view [3] 20/5 23/24 78/15</p> <p>views [1] 22/18</p> <p>violence [1] 72/9</p> <p>Virginia [1] 70/18</p> <p>Virginia's [1] 70/18</p> <p>visibility [1] 64/23</p> <p>visible [3] 63/7 64/19 64/24</p> <p>visits [1] 64/4</p> <p>voices [2] 66/10 66/12</p> <p>volume [1] 24/8</p> <p>W</p> <p>wait [3] 27/16 28/11 32/16</p> <p>waiting [3] 6/1 15/18 31/10</p> <p>waits [1] 47/16</p> <p>want [13] 3/11 21/2 21/7 27/12 28/4 38/15 38/17 46/11 52/21 52/25 54/4 77/17 80/3</p> <p>wanted [4] 7/14 42/5 42/9 85/13</p> <p>wanting [4] 3/10 60/15 63/4 74/3</p> <p>Ward [1] 61/22</p> <p>wards [2] 47/2 51/3</p> <p>Warren [5] 72/1 73/24 76/18 77/8 78/5</p> <p>Warren's [1] 79/9</p> <p>was [260]</p> <p>wasn't [21] 3/17</p>	<p>10/11 13/19 13/21 17/23 17/25 20/6 26/12 27/17 27/23 31/7 34/13 35/1 36/8 50/12 52/3 53/16 57/24 57/24 83/24 84/1</p> <p>waves [1] 8/6</p> <p>way [17] 15/9 18/9 19/19 25/5 27/21 31/22 32/3 40/24 44/24 59/4 62/18 65/25 70/13 74/2 76/2 77/11 86/5</p> <p>we [105]</p> <p>we'll [5] 46/17 59/21 67/5 87/19 87/20</p> <p>we're [6] 34/19 46/16 70/25 75/7 75/11 86/24</p> <p>we've [17] 7/22 14/16 15/10 20/11 20/25 20/25 34/22 45/3 46/18 53/5 53/10 54/1 54/7 61/21 72/8 75/11 79/19</p> <p>week [2] 50/3 62/11</p> <p>weeks [1] 34/19</p> <p>well [29] 6/23 8/7 8/12 9/13 13/24 16/3 16/23 18/6 29/19 39/4 43/9 46/4 49/3 53/16 54/12 54/12 59/17 60/10 67/5 67/24 68/16 72/20 73/11 81/24 82/15 83/24 84/3 85/6 87/19</p> <p>Well-Led [1] 67/24</p> <p>were [138]</p> <p>weren't [14] 10/24 14/21 14/23 25/18 32/20 45/10 53/13 54/8 55/10 56/25 58/2 58/3 60/15 72/16</p> <p>Weston [5] 1/3 60/22 77/18 80/4 80/13</p> <p>what [56] 2/18 2/22 3/24 4/5 4/17 4/25 5/1 5/4 5/6 11/16 13/13 13/22 16/23 22/20 24/9 24/20 26/2 27/22 31/2 31/5 31/22 31/24 32/10 32/15 33/25 34/3 37/16 41/20 42/4 43/2 46/19 48/9 55/5 56/7 56/9 57/23 60/18 62/19 64/6 65/3 68/5 68/9 68/10 68/20 73/17 73/23 74/22 74/23 75/6 75/24 79/9 81/3 81/19 82/17 85/25 86/6</p> <p>what's [4] 18/23 27/6 30/23 82/17</p> <p>when [40] 1/5 2/19 3/15 5/20 7/5 7/25</p>
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<p>W</p> <p>when... [34] 13/16 14/12 15/4 15/5 20/11 34/19 35/16 36/17 37/19 42/22 43/23 44/14 44/21 46/20 47/6 54/9 59/10 59/13 60/5 60/6 61/10 61/19 62/16 62/20 65/4 65/11 66/4 66/24 67/6 68/19 72/6 72/11 75/22 87/10</p> <p>where [22] 2/19 8/24 9/7 10/21 15/6 21/18 24/14 25/1 28/23 29/5 49/19 53/20 56/5 57/10 57/25 62/2 64/7 65/4 70/1 73/21 74/17 86/16</p> <p>Whereas [1] 36/17</p> <p>whether [31] 2/20 4/1 4/6 4/9 4/15 4/20 4/20 4/24 5/3 6/13 6/17 7/1 12/19 13/16 17/13 23/23 25/2 27/16 27/18 33/4 33/7 42/19 44/22 44/23 52/18 54/19 61/24 62/6 77/22 85/14 87/11</p> <p>which [28] 3/4 3/5 11/23 22/4 23/19 24/14 32/3 39/19 40/8 42/1 51/12 54/2 57/9 57/14 58/16 61/21 61/23 63/8 64/12 65/21 67/21 68/10 72/21 75/14 77/3 78/7 85/18 87/5</p> <p>While [1] 17/1</p> <p>whilst [3] 3/10 71/13 86/11</p> <p>who [19] 10/2 16/6 23/24 24/24 34/5 44/4 49/5 60/13 62/10 62/21 64/7 68/24 70/15 75/12 75/13 75/13 75/19 81/7 82/20</p> <p>whole [4] 19/5 58/8 83/8 86/12</p> <p>why [7] 20/6 28/11 51/11 75/4 76/1 79/3 86/9</p> <p>wide [1] 52/19</p> <p>wider [6] 4/13 4/21 5/3 50/9 52/18 78/18</p> <p>will [32] 3/22 6/16 12/19 12/22 13/10 13/12 18/6 22/8 23/12 23/24 27/15 32/23 32/25 33/8 39/17 47/16 47/19 47/20 48/7 48/8 52/14 54/10 54/25 54/25 59/8 61/8 61/10 77/25 78/16</p>	<p>81/21 87/4 87/6</p> <p>wise [2] 27/16 27/18</p> <p>withdrawing [1] 77/22</p> <p>within [11] 3/6 3/7 12/12 21/25 22/24 23/4 30/7 39/9 50/9 81/9 85/8</p> <p>without [4] 48/6 73/6 75/16 84/16</p> <p>WITN0223001 [1] 9/25</p> <p>WITN0263001 [1] 24/2</p> <p>WITN0356017 [1] 21/5</p> <p>WITN0356018 [1] 69/5</p> <p>WITN0380054 [1] 49/13</p> <p>WITN0390001 [2] 18/17 55/14</p> <p>WITN0410045 [1] 5/13</p> <p>WITN0410046 [1] 5/25</p> <p>witness [13] 10/1 18/16 31/4 40/7 53/14 54/2 55/13 56/19 57/20 60/23 64/12 71/3 83/22</p> <p>witnesses [1] 21/6</p> <p>won't [1] 85/5</p> <p>word [1] 36/16</p> <p>work [17] 18/6 32/13 39/21 40/14 41/13 42/12 42/22 43/3 43/6 45/1 46/17 49/24 52/18 59/8 65/17 87/11 87/18</p> <p>worked [1] 70/7</p> <p>workers [1] 83/2</p> <p>workforce [2] 10/13 64/22</p> <p>working [3] 20/12 66/18 82/23</p> <p>would [148]</p> <p>wouldn't [21] 3/10 5/10 5/21 6/15 6/18 7/14 8/19 14/17 20/23 33/20 38/22 40/13 40/16 41/7 42/6 42/24 46/3 46/9 51/25 86/8 86/13</p> <p>wrestle [1] 53/18</p> <p>written [5] 43/18 50/17 65/18 65/18 72/20</p> <p>wrote [1] 65/24</p> <hr/> <p>Y</p> <p>yeah [6] 55/15 61/5 61/15 62/12 71/5 81/21</p> <p>year [6] 5/21 5/24 6/23 8/23 24/23 37/7</p>	<p>years [6] 16/11 24/18 24/21 24/22 26/24 31/18</p> <p>yes [219]</p> <p>yesterday [1] 37/19</p> <p>yet [2] 28/24 68/5</p> <p>YM [1] 39/11</p> <p>you [310]</p> <p>you'd [13] 5/9 5/10 6/12 6/18 7/13 7/14 8/16 13/18 33/22 38/21 47/24 65/25 70/17</p> <p>you're [14] 4/18 8/3 8/9 11/7 14/3 20/12 26/2 28/7 31/24 49/16 56/13 56/14 58/7 66/17</p> <p>you've [17] 3/14 4/23 27/5 32/6 34/13 42/1 45/19 50/21 52/16 52/22 56/17 60/9 65/18 75/23 76/14 77/18 79/13</p> <p>you: [1] 81/6</p> <p>you: at [1] 81/6</p> <p>your [41] 2/15 4/19 5/14 8/23 13/22 18/16 20/5 21/7 36/16 40/22 54/1 55/13 57/1 58/18 59/12 60/17 61/20 63/25 64/8 64/11 64/12 65/8 65/10 65/17 66/21 67/12 70/6 70/8 70/19 70/20 71/1 71/2 71/3 71/3 72/16 77/17 77/23 79/14 79/20 80/7 87/18</p> <p>yourself [2] 3/19 43/5</p>		
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