

Thursday, 28 May 2026

(10.00 am)

THE CHAIR: Yes, Mr Weston?

Inquiry questionnaire presentation by MR WESTON

MR WESTON: Chair, on 22 May 2025, the Inquiry published a questionnaire inviting family and friends touched by mental health homicides to share their accounts and experiences with the Inquiry.

The aim of the questionnaire process was to contribute to the Inquiry's wider understanding of mental health homicides beyond the attacks carried out by VC in June of 2023. The questionnaire sought information in respect of: the circumstances of other attacks; the perpetrator's history and presentation; and their clinical and forensic background. It also sought to understand: the involvement of state agencies prior to the incidents; and the steps taken after the homicides to investigate and prosecute.

The questionnaire resulted in 67 responses, touching on 44 different cases. Three additional witness statements were also obtained by the Inquiry legal team. Those cases did not strictly meet the criteria for inclusion in the questionnaire but had information that was nonetheless relevant to this review.

In addition to the information received via the

1

the Nottingham Inquiry questionnaire process.

Therefore, whilst percentage summaries are provided and the percentages are based on a large number of cases, the selection of cases means that these percentages cannot be generalised to the total number of relevant events and will not be a complete analysis or representative sample of all such events.

The percentages should be understood, Chair as descriptive of the cohort of material reviewed rather than figures which can be readily generalised to the total population of mental health-related homicides.

Chair, in the report, the names of the victims have not been included. However, you have indicated that where the names of the deceased are known, they will be included in your final report as a mark of respect.

Can I touch in a little more detail on the source material that is the subject of this review. The review has drawn upon three bodies of material which I will address you upon in descending order on the size of that material.

First, we have the 516 published independent reports on mental health homicides in England and Wales. The material is all publicly accessible, largely through the Hundred Families website and the NHS England website. The reports analysed have usually been undertaken after

3

Inquiry questionnaire, the Inquiry legal team reviewed all publicly available independent review reports on mental health homicides since the conclusion of the Ritchie Report in 1994.

The combination of the questionnaire returns and the publicly available reports resulted in a dataset of 540 cases. 528 of those 540 cases were subjected to a structured, qualitative review, and analysed using the numerical and percentage based summaries.

In light of the analysis of all 540 cases, an Inquiry Legal Team Review report into mental health related homicide has been prepared. Chair, that report will be published on the Inquiry website following this hearing.

This morning, Chair, Mr Ndow-Njie and I will present the findings of the review report to the Inquiry.

Chair, the aim of the Inquiry legal team review was to provide a qualitative analysis of the cohort of available cases and to identify recurring themes and patterns across that cohort to assist you when making recommendations. The review covers a substantial proportion of mental health related homicides over the last 30 years. It is not a random sample of such events. Inclusion relies upon a case being subject to a publicly available report or being volunteered through

2

a Trust level report has previously been prepared.

The independent reviews are commissioned by NHS England, domestic homicide reviews, serious case reviews, safeguarding reviews, Inquiry reports and learning summaries relating to fatal incidents involving individuals in contact with mental health services.

The Inquiry Legal Team Review has limited itself to reports that explicitly set out to consider mental health care. Therefore, coroners' reports and sentencing remarks have not been used.

The materials reviewed span the period from 1994, following the publication of the Report of the Inquiry into the Care and Treatment of Christopher Clunis, to 2003 (*sic*).

There have been further incidents since 2003 (*sic*), but the preparation of independent reports in those cases is still awaited.

THE CHAIR: I think 2023.

MR WESTON: Apologies.

THE CHAIR: Thank you.

MR WESTON: Second, the Inquiry has considered a group of cases brought to its attention by the questionnaire process. A total of 44 cases spanning attacks from 2003 to 2024 were identified through this process. Independent and publicly available reports were

4

1 available in relation to 20 of the 44 cases. In respect
2 of a further 12 cases, reports, some independent and
3 some at Trust level, were obtained from NHS England
4 pursuant to a request under Rule 9 of the Inquiry Rules.

5 The reports obtained were used to supplement the
6 Inquiry's understanding of the relevant case. Reports
7 were not available for 12 of the questionnaire cases,
8 these cases have not been included in the structured
9 review, or the numerical and percentage-based summaries
10 derived from it. However, the information provided by
11 all respondents has formed part of the overall Inquiry
12 Legal Team analysis.

13 Third, the Inquiry Legal Team received information
14 relating to a small number of incidents that did not
15 fall within the criteria for inclusion within the
16 questionnaire but which nevertheless provided relevant
17 insight into the issues under consideration.

18 In those circumstances, the Inquiry invited the
19 provision of witness statements so that the relevant
20 counts and experience -- experiences could be documented
21 and considered as part of the overall analysis.

22 A total of three such statements were received and
23 reviewed. These cases have been considered by the
24 Inquiry legal team in preparing the report, but again,
25 have not formed part of the structured review or the

5

1 resources, the effectiveness of organisational systems
2 and processes and discharge planning.

3 There was also, as I've said, consideration of steps
4 taken after the attacks, including the adequacy of Trust
5 internal reviews and criminal justice disposal.

6 Most of the issues in this structured analysis,
7 Chair, were framed as a "Yes/No" type of response. Some
8 fields, however, such as diagnosis, required a narrative
9 input.

10 The legal team applied "Yes", if the available
11 information positively indicated the presence of an
12 issue; "No" if there was no evidence on the point.

13 A negative may therefore not necessarily mean the
14 issue was not present, simply that there was no
15 available evidence of the same. That said, if issues of
16 such importance were completely omitted, the relevance
17 of the issue may have been limited or marginal in any
18 event.

19 Where an issue has not been identified in the body
20 of a report, it has not been recorded as present for the
21 purposes of this analysis. Recommendations, in
22 particular, have been considered with care. However,
23 where a recommendation appears to address a broader or
24 systemic issue rather than one arising from specific
25 facts of the case, a judgement has been made as to

7

1 numerical and percentage-based summaries derived from
2 it.

3 Chair, the total number attacks considered, and
4 which form part of the overall review, is therefore 543.

5 As I've said, reports are available in 528 of those
6 cases. Such reports enabled The Inquiry Legal Team to
7 subject those 528 cases to a structured, issue-based
8 comparison and analysis. The issues were identified
9 following consideration of the points raising in
10 published reports relating to the care and treatment of
11 VC and from other evidence received by the Inquiry.

12 The issues considered as part of the structured
13 analysis included: the date of the attack and the
14 investigation report; the attacker's clinical history,
15 including their diagnosis and any previous reported
16 symptoms of psychosis; any clinical intervention, such
17 as engagement with mental health services, admission or
18 detention in hospital, and the use of medication;
19 patient engagement with mental health services and any
20 relevant medication regime; any concerns identified by
21 the investigation report including issues relating to
22 communication between services, engagement with families
23 and carers, the adequacy of risk assessments, care
24 planning and treatment coordination, the experience
25 levels and supervision of staff, the availability of

6

1 whether it properly reflects a shortcoming identified in
2 that particular case.

3 Only those matters assessed as doing so have been
4 included.

5 Chair, the reports analysed were prepared to
6 investigate clinical and state agency intervention and
7 failures, with a view to identifying good and bad
8 practice and recommendations for improved practice.
9 They were not reports prepared for litigation. The
10 causative link between any identified issue and the
11 death was not generally the core focus of those
12 investigations.

13 Accordingly, a positive return in the structured
14 analysis is evidence that the factor was present in the
15 case and relevant to the investigation, but not
16 necessarily causative.

17 The investigation reports vary in scope, structure,
18 and level of detail. At times, the information provided
19 appeared internally contradictory, vague, or unclear.
20 Further, some of the issues underpinning the Inquiry
21 Legal Team analysis were not clear-cut, when applied to
22 a range of different case reports of differing quality.

23 It is acknowledged that at times a degree of
24 evaluative judgement was required by the Inquiry Legal
25 Team reviewers. As a result, the outcome of the

8

1 structured analysis on particular issues could be open
2 to a reasonable range of interpretations.

3 Auditing of the structured analysis has identified
4 a high level of alignment between reviewers and
5 auditors, with an overall match rate in excess of 95%.

6 The Inquiry Legal Team is therefore satisfied that
7 any differences in interpretation are limited in nature,
8 and do not materially affect the overall patterns
9 identified in the report.

10 It is acknowledged that the material reviewed by the
11 Inquiry is, by its nature, a self-selecting sample. The
12 cases involved are those in which a fatal incident has
13 occurred and which, for the overwhelming majority, has
14 been the subject of an investigation report.

15 In addition, all cases in the structured review
16 involve individuals who had contact with mental health
17 services prior to the incident, as it is this contact
18 which typically gave rise to the commissioning of
19 reports.

20 Such reports should have been prepared in all mental
21 health homicides pursuant to the Health Services
22 Guidelines published in 1994. The limitation,
23 therefore, is not principally that reports are only
24 commissioned in some categories of cases, but that not
25 all reports are now publicly available or otherwise

1 approach was taken.

2 On certain issues, the family and friends of the
3 deceased provided information on matters upon which the
4 report was simply silent. In such circumstances it is
5 presumed, where reasonable to do so, that the family and
6 friends had reliable supplementary information to add to
7 the structured analysis.

8 On certain other issues, for example where there had
9 been incidents of previous intra-familial violence
10 involving the attacker, the respondents had provided
11 information within their knowledge and which was likely
12 to be reliable, this was also included.

13 Where there was disagreement in respect of clinical
14 management of the attacker, this was considered
15 carefully on a case-by-case basis, keeping in mind that
16 the reviewers would have had access to the attacker's
17 clinical records as part of the investigation process.

18 Chair, to assist you, the findings of the Inquiry
19 Legal Team have been broken down into thematic issues.
20 Where relevant data from the cohort is available, that
21 is set out. Further, the review has sought to provide
22 you with a deeper understanding of the material and the
23 issues considered by setting out relevant case studies.
24 The case studies are taken from the body of
25 questionnaire cases and have been assigned a code with

1 accessible for review.

2 It is accepted that publicly available reports could
3 be skewed to cases that have attracted greater public
4 interest and therefore matters where failures by state
5 agencies may be more prominent.

6 The material reviewed may therefore be described,
7 Chair, as a dataset of available investigation reports,
8 with additional information from the questionnaire
9 responses and for three witness statements, rather than
10 a complete sample of mental health homicides.

11 It is acknowledged that the cases have been analysed
12 by a pre-determined set of issues that were deemed
13 relevant by the Inquiry Legal Team. As far as the
14 structured analysis of the 528 cases is concerned, 496
15 relied exclusively on publicly available independent
16 reports. The remaining 32 were cases in which a report
17 was available, independent or Trust level, as well as
18 information being provided by family or friends of the
19 deceased via the questionnaire process.

20 In those 32 cases, the information provided by the
21 questionnaire respondents was integrated into the
22 structured analysis. In the overwhelming majority of
23 those cases, the reports and the questionnaire responses
24 were entirely consistent. Where there was a potential
25 inconsistency, a case-by-case and issue-by-issue

1 the prefix "R". That R number has been communicated to
2 the questionnaire respondents.

3 Chair, the first theme analysed is the attacks
4 themselves. The structured analysis considered 528
5 attacks involving 570 victims. 87% of the attackers
6 were identified as male. This, Chair, is comparable to
7 the findings of the National Confidential Inquiry into
8 Suicide, Safety and Mental Health for the period 2005 to
9 2015, which found that 85% of mental health homicide
10 convictions were of men.

11 The available source material did not consistently
12 record ages or dates of birth of the attackers, nor the
13 ethnicity. As a result, it has not been possible to
14 undertake a reliable analysis of age and ethnicity.

15 The Inquiry was able to examine the relationship
16 between perpetrators and victims across the cases
17 reviewed.

18 Chair, as you can see on the screen, the approach
19 taken was to record the relationship from the
20 perspective of the perpetrator by reference to the
21 closest relationship at the time of the attack.

22 The category of "Partner" includes spouses,
23 unmarried partners and former partners. The category of
24 "Family/Family Unit (not partner[s])", includes
25 relatives, stepfamily members, in-laws and others

1 forming part of the same household or wider family
 2 environment.
 3 The category of "Fellow-patient or fellow-resident
 4 ..." includes individuals connected through supported
 5 accommodation, medical settings, shelters, care homes or
 6 similar welfare-based environments involving placement
 7 referrals, support, supervision, or other forms of
 8 structured oversight.

9 By contrast, flatmates or housemates in ordinary
 10 domestic settings, where not otherwise falling within
 11 another category, were recorded under the category of
 12 persons known to one another before the attack but not
 13 falling within the other defined relationship
 14 categories.

15 Where the available reports did not identify or
 16 clarify the relationship, the case has been recorded as
 17 "Unknown".

18 Chair, as can be seen from the pie chart on screen,
 19 in 79% of cases the attacker and the deceased had
 20 a pre-existing relationship. Family members, including
 21 those within the wider family unit, comprise the largest
 22 category of 33%. Partners, including current and former
 23 partners, accounted for 15% of victims.

24 Smaller proportions included fellow patients or
 25 residents at 6%; friends at 5%; and those providing

1 Families charity. Although only established in 2015,
 2 the Hundred Families has a repository of historic case
 3 reports. It is, however, by no means a compendious
 4 library of all mental health-related homicides.

5 Chair, can I please turn to the next theme, that is
 6 diagnosis and symptomology.

7 Where a diagnosis is recorded for a particular case,
 8 this is based upon it having been reached and identified
 9 either by the treating clinicians prior to the attack
 10 or, on some occasions, reached by psychiatrists after
 11 the event but held to have been extant at the time of
 12 the attack. Similarly, psychotic symptomology was
 13 marked as yes where these was explicitly identified by
 14 treating by clinicians before the attack or after the
 15 attack and identified by psychiatric opinion as having
 16 been present at or before the time of attack.

17 Chair, the key findings are set out on the screen:
 18 diagnosis of schizophrenia was recorded in 283 out of
 19 the 528 cases analysed, representing 54% of the overall
 20 cohort. Psychotic symptomology was identified in 451 of
 21 the 528 cases, corresponding to 85% of the cohort
 22 reviewed.

23 Chair, the questionnaire cases reviewed by the
 24 Inquiry also contained a number of examples illustrating
 25 the manner in which psychosis presented in individual

1 services to the perpetrator, such as healthcare
 2 professionals, at 2%.

3 As with other aspects of the dataset, Chair, the
 4 information available in relation to victim-perpetrator
 5 relationships varies in scope and clarity across
 6 reports. The figures should therefore be understood as
 7 descriptive of the material reviewed, rather than as
 8 a complete account of all relevant cases.

9 The Inquiry considered information on attacks
 10 spanning the period from 1992 to 2023. The number of
 11 attacks per year considered in that period ranged from
 12 1 to 31. This is far fewer than the number of incidents
 13 per year reported by the Confidential Inquiry into
 14 Suicide and Safety and Mental Health for the period 2005
 15 to 2015. The difference is likely accounted for by the
 16 fact that this review has based its analysis largely
 17 upon reports that are available in the public domain.

18 Pursuant to the Community Health Service Guidance
 19 94(27), reports should be prepared in all mental health
 20 homicides since 1994. But not all of the reports were
 21 publicly available at the time of the review. Some of
 22 the most recent are yet to be published.

23 For cases from 2013 onwards, NHS England retains
 24 reports it has commissioned. Obtaining more historic
 25 reports has been greatly assisted by the Hundred

1 cases. I'll now turn to address a couple of relevant
 2 case studies, if I may.

3 Case R38 concerned a fatal incident in which a man
 4 killed his mother and seriously injured his father
 5 whilst experiencing an acute psychotic episode. The
 6 investigation report recorded that the perpetrator had
 7 presented with paranoid delusions and command
 8 hallucinations, including a belief that he was required
 9 to kill his mother in order to protect her from
 10 a perceived threat.

11 At the time of his first admission, he lacked
 12 insight into his condition and did not accept that he
 13 required treatment. He was detained under Section 2 of
 14 the Mental Health Act and later discharged into the
 15 community under a Community Treatment Order following
 16 a period of treatment with antipsychotic medication and
 17 support from Early Intervention Services.

18 The fatal incident occurred following a period of
 19 apparent stability during which antipsychotic medication
 20 had been discontinued. This period coincided with an
 21 increase in illicit substance misuse and a number of
 22 personal stressors, including the breakdown of
 23 a relationship.

24 The investigation concluded that these factors,
 25 taken together, were associated with a relapse into

1 a further acute psychotic episode, during which the
2 perpetrator acted on delusional beliefs and
3 hallucinations.

4 The report identified that notwithstanding the
5 earlier presentation involving threats towards his
6 mother and the known risks associated with relapse,
7 insufficient consideration had been given to the
8 potential for serious violence within the family
9 setting. In particular, the investigation concluded
10 that the risk arising from the interaction between
11 substance misuse, relapse into psychosis, and the
12 perpetrator's continued residence with the family member
13 he had previously threatened had not been fully
14 explored.

15 Case R24 concerned a fatal incident in which a woman
16 carried out a series of unprovoked and sustained attacks
17 in a public setting, using a kitchen knife and
18 improvised weapons. The perpetrator initially struck
19 a man in a public setting before entering a public
20 premises where she stabbed a number of individuals and
21 continued to attack others. One victim who attempted to
22 intervene was subject to repeated blows and later died
23 from blunt force trauma to the head. The investigation
24 report recorded that the perpetrator was suffering from
25 a severe psychotic illness at the time of the incident,

17

1 A percentage of 80%. There was previous contact with
2 the police in 454 of the 528 cases, that's 86%. But the
3 figure for previous convictions for violence was much
4 lower, at 48%.

5 In the analysis, violence was defined as the
6 application of unlawful physical force upon another
7 person, ie, a battery at common law. The requirement of
8 the use of physical force provided a definition that
9 could more easily be applied across a wide range of
10 cases in which a variety of behaviours were described
11 with various levels of detail. Cases involving assaults
12 without the application of unlawful physical force were
13 not included. Violence against property and animals was
14 also not included and self-harm was not included.

15 The figures, Chair, may therefore be an
16 under-representation of the presence of previous
17 violence according to other, wider, definitions of
18 violence.

19 The Inquiry Legal Team analysis indicates that
20 previous violence is present in the vast majority of
21 mental health homicides. This data sits consistently
22 with other evidence heard by the Inquiry, for example
23 the evidence of Professor Fazel.

24 Chair, it is noted that the rate of conviction for
25 violence at 48% is much lower than for previous use of

19

1 later diagnosed as schizophrenia, she experienced
2 persecutory delusions, and auditory hallucinations,
3 including voices telling her that others were going to
4 slit her throat. She had ceased taking her prescribed
5 medication due to its side effects and the period
6 leading up to the incident was described by clinicians
7 as floridly psychotic and tormented by voices.

8 In the hours and days preceding the attack there
9 were clear indicators of acute deterioration. Family
10 members reported that she was in crisis and actively
11 sought assistance from services. Clinical records from
12 a recent admission noted distress, aggression,
13 non-compliance with medication, and active psychotic
14 symptoms. Nursing staff considered that detention under
15 the Mental Health Act was warranted, however this view
16 was not shared by the assessing doctors, who concluded
17 that the criteria for detention was not met.

18 The fatal incident occurred shortly thereafter
19 during a period in which the perpetrator remained
20 untreated and actively psychotic.

21 Chair, I'd like to move on to consider the issue of
22 previous violence and previous contact with the police,
23 please.

24 From our cohort, the perpetrator had previously
25 committed acts of violence in 420 of the 528 cases.

18

1 violence at 80%. Clearly, some acts of violence are not
2 prosecuted because they are not reported to the police
3 in the first place.

4 The smaller dataset of questionnaire cases indicated
5 that events of violence often do not lead to
6 investigation and prosecution, even when reported to the
7 police. The reports to the police of violent incidents
8 prior to the attack in 31 of the 44 questionnaire cases,
9 that is 70%, but only 24 of those 31 cases, so 77% of
10 the 31, involved any police investigation or
11 prosecution.

12 The number of attackers instructed analysis who had
13 previous contact with the police at 86%, even if not
14 convicted, supports the importance of considering more
15 than convictions when taking a forensic history for the
16 purposes of risk assessment.

17 A key source of information about previous violence
18 is, of course, the patient's family. Many of the
19 questionnaire cases detailed earlier incidents of
20 intra-familial violence that were not known to state
21 agencies.

22 Chair, the following questionnaire cases illustrate
23 and elaborate on many of the points that I've just made.

24 Can I start, please, with case R7. In that case,
25 the perpetrator was convicted for the manslaughter of

20

1 her mother on the grounds of diminished responsibility
2 and detained under a hospital and restriction order but
3 later released.

4 Five years post-the initial detention, the
5 perpetrator attacked a young woman with a knife but was
6 fought off. She then moments later obtained a butcher's
7 knife from a shop and stabbed and killed the deceased.

8 The investigation report examined the circumstances
9 in which the perpetrator had presented to hospital
10 shortly before the attack. The investigation panel also
11 considered whether the police should have exercised
12 their powers under Section 136 of the Mental Health Act
13 which permits a police officer to remove a person
14 appearing to be suffering from a mental disorder from
15 a public place to a place of safety for the purposes of
16 enabling a mental health assessment to be carried out.

17 The panel concluded that there had been, at a point
18 at which the statutory criteria for detention under
19 Section 136 was likely met, particularly given the
20 perpetrator's level of agitation and her attempts to
21 leave the hospital environment.

22 Although the officers involved were deemed to have
23 reached their decision in good faith, the investigation
24 concluded that circumstances could reasonably have
25 justified the use of Section 136 powers in order to

21

1 records that this was on the basis that the behaviour
2 was considered to be related to the perpetrator's mental
3 health, and it was assumed that no criminal action would
4 be taken. As a result, the police were not made aware
5 of the incidents and were unable to access or contribute
6 information regarding any prior offending history.

7 The report further notes that this prevented police
8 intervention with the perpetrator, which might have
9 served as a warning that continued threatening or
10 aggressive behaviour could result in arrest. Also,
11 safeguarding referrals were not made and there was
12 limited restriction of the perpetrator's access to
13 potential weapons despite repeated incidents involving
14 such items.

15 Chair, moving on to another issue, a history of
16 alcohol and/or drugs misuse was also a feature in the
17 majority of cases.

18 As can be seen from the screen, this featured in 379
19 of the 528 cases, a figure of 72%.

20 Chair, that figure is closely comparable to the
21 findings of the National Confidential Inquiry into
22 Suicide and Safety in Mental Health. In its annual
23 report for 2017 covering the period of 2005 to 2015,
24 they found that 73% of patients convicted for mental
25 health homicide had a history of alcohol misuse. The

23

1 ensure that the perpetrator remained in a place of
2 safety for assessment.

3 In case R11, the attacker stabbed and killed another
4 resident at the supported housing hostel where they both
5 resided. Both were under the care of the Trust's Early
6 Intervention Service at the time of the incident.
7 A near miss involving a knife occurred five days prior
8 to the killing following a dispute.

9 Case R30 concerned a fatal incident in which
10 a 93-year old care home resident was assaulted in her
11 bed by another resident and later died from her
12 injuries. The investigation report recorded that in the
13 weeks preceding the incident, the perpetrator had
14 exhibited a sustained and significant pattern of violent
15 and aggressive behaviour while admitted to hospital.

16 Between August and September of the year preceding
17 the attack, there were at least 34 recorded incidents
18 involving threats or violence towards staff and other
19 patients. These included the use of objects such as
20 knives, scissors and trays as weapons, repeated threats
21 to kill staff, expressions of paranoid beliefs and
22 multiple episodes of physical aggression requiring
23 intervention.

24 Despite the frequency and seriousness of these
25 incidents, none were reported to the police. The report

22

1 corresponding figure for drug misuse was 78%.

2 Use of drugs and alcohol can obviously worsen
3 dangerous symptomology, it can also hamper medication
4 concordance and cooperation with treatment programmes
5 more generally. An example of intoxicants both
6 worsening symptomology and compliance can be seen in
7 questionnaire case R29.

8 Chair, this concerned a fatal incident in which the
9 perpetrator set fire to the family home during the early
10 hours of the morning, resulting in the death of an
11 elderly relative who had been left inside.

12 The investigation report recorded that shortly
13 before the incidents, police had called after the
14 perpetrator's father reported aggressive behaviour and
15 expressed fear of his son. Although the situation was
16 initially considered to have been de-escalated, the
17 perpetrator subsequently lit a fire under the stairs and
18 left the property.

19 The perpetrator had a history of substance-induced
20 psychosis and had previously been under the care of
21 mental health services. At the time of the incident,
22 however, he was no longer subject to detention under the
23 Mental Health Act and was therefore not required to
24 comply with treatment. The report noted that he had
25 been advised of the risks associated with drug use,

24

1 including the potential to trigger further psychotic
2 episodes. The report recorded that, in this context,
3 the perpetrator did not adhere to his prescribed
4 medication, having left it behind when he moved away
5 from home. It identified the combined effect of ongoing
6 substance misuse, lack of insight into his condition,
7 and the absence of any mechanism to compel treatment as
8 contributing to his non-compliance with the treatment
9 regime and the difficulty in managing risk.

10 Chair, in the smaller dataset of questionnaire
11 cases, the attacker was understood to be under the
12 influence of illicit drugs or alcohol at the time of the
13 incident in 19 of the 44 cases, that's 43%.

14 Some examples of this include case R4. This case
15 concerned a fatal incident in which a man carried out an
16 unprovoked knife attack in a public setting, fatally
17 stabbing one victim outside a shop and subsequently
18 assaulting an elderly man in the street. The
19 investigation report recorded that the perpetrator had
20 left his home armed with a kitchen knife prior to the
21 attack. The court received evidence that at the time of
22 the incident he was acutely intoxicated and psychotic as
23 a result of ingesting a substantial quantity of
24 amphetamines.

25 Case R8 concerned a fatal incident in which the
25

1 experiencing unusual perceptual disturbances and changes
2 in mood, including visual imagery, altered sensory
3 experience, and periods of heightened or "high" mood.

4 In case R36, the deceased's family informed the
5 Inquiry that the attacker could be seen drinking
6 a bottle of vodka on the CCTV footage that immediately
7 preceded the attack. The attacker also had a history of
8 illegal drug use.

9 Chair, we've looked at the attacks, we've looked at
10 the relevant extant diagnoses, the role of drugs and
11 alcohol misuse and the prominence of previous violence
12 and police involvement.

13 The Inquiry Legal Team has also looked in some
14 detail into the nature and quality of the care provided,
15 the clinical care provided, as described in the reports
16 and the information available.

17 Can I please hand over to Mr Ndow-Njie, who will
18 assist you with those issues.

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

20 **Inquiry questionnaire presentation by MR NDOW-NJIE**

21 **MR NDOW-NJIE:** Chair, I will first address you on the
22 Inquiry Legal Team's findings on the broad topic of
23 treatment and intervention.

24 As will be seen on screen, in 524 out of the 528
25 cases analysed, the perpetrator had some previous

27

1 perpetrator repeatedly stabbed the victim at
2 a residential address. He was arrested shortly
3 afterwards and detained under Section 2 of the Mental
4 Health Act before being admitted to hospital. A drug
5 screen conducted following his arrest was positive for
6 multiple substances, including cocaine, amphetamines,
7 methamphetamine, morphine, cannabis, and MDMA.

8 Case R18 concerned a fatal incident in which the
9 perpetrator attacked his parents at the family home
10 following a period of escalating disturbance on the day
11 of the incident. The investigation report recorded that
12 earlier that evening the perpetrator threw what he
13 described as two guns across the garden, behaviour that
14 was witnessed by neighbours, and then smashed a window
15 at his home. He was arrested for the damage and taken
16 by police for assessment at healthcare settings before
17 being returned to police custody and released the
18 following morning.

19 The perpetrator later reported that he had taken
20 cocaine on the morning of the incident, and described
21 using cocaine on a daily basis for approximately
22 nine months prior. He stated that he had little
23 recollection of events that day due to his ongoing drug
24 use.

25 In accounts given after the incident, he described
26

1 contact with mental health services. This represented
2 99% of the cohort. Previous hospital admission was
3 identified in 437 cases, equivalent to 83% of the cohort
4 reviewed. Previous detention under the Mental Health
5 Act was identified in 324 cases, corresponding to 61% of
6 the cohort.

7 505 of the cases, representing 96% of the cohort,
8 were not subject to a Community Treatment Order at the
9 time of the incident. 484 cases, representing 92% of
10 the cohort, had never been subject to a Community
11 Treatment Order at any point prior to the incident. 475
12 out of the 528 cases, representing 90% of the cohort,
13 related to cases whereby the perpetrator had previously
14 been prescribed medication prior to the attack.

15 Chair, you'll observe that nearly all of the
16 attackers had previous contact with mental health
17 services. This is unsurprising, in the context that
18 it's unlikely that a report would be prepared if the
19 perpetrator had not previously been under mental health
20 services.

21 The high proportion of perpetrators that had
22 previously been admitted to hospital is notable. Many
23 of these perpetrators had been the subject of multiple
24 previous admissions. The vast majority of the cohort
25 therefore had high levels of previous mental health

28

1 contact.

2 The attackers had, for the most part, been the
3 subject of multiple previous assessments of their
4 clinical presentation and, if previously known to be
5 violent, the risk they posed to others should have been
6 professionally considered.

7 An example of a case with extensive previous
8 inpatient contact is case R26. This case concerned
9 a fatal incident in which the perpetrator fatally
10 assaulted a member of the public. At the time of the
11 incident he was under the care of the Trust's Community
12 Mental Health Team. The investigation report recorded
13 that the perpetrator had an extensive history of contact
14 with mental health services over a prolonged period of
15 time. Over a ten-year period, he was admitted to
16 hospital on six occasions, each requiring detention
17 under the Mental Health Act, and was discharged on two
18 occasions, subject to a Community Treatment Order.

19 In the two-year period leading up to the incident,
20 there were further admissions associated with violent
21 behaviour towards members of the public. These
22 admissions were described as brief, with the perpetrator
23 stabilising quickly and demonstrating only superficial
24 engagement with staff.

25 There were also concerns regarding non-compliance
29

1 patient's condition before initiating a formal
2 assessment under the Act. The review concluded that
3 there had been a missed opportunity to assess the
4 patient's mental state through the Statutory Framework
5 before the incident occurred.

6 Although the investigation could not conclude that
7 an assessment would necessarily have resulted in
8 compulsory detention or treatment, it emphasised that
9 the absence of such an assessment meant that an
10 important opportunity to evaluate the patient's mental
11 state, and consider possible interventions had been
12 lost.

13 The investigation recommended that the Trust provide
14 further practice-based training to community staff
15 regarding the organisation and use of Mental Health Act
16 Assessments.

17 Case R7 provides a second example. Case R7 has
18 already been referred to by my learned friend, Mr Weston
19 and I'll briefly repeat some of the key points arising
20 that are relevant to treatment and intervention.

21 It concerned a fatal attack that occurred following
22 a series of contacts between the perpetrator and police,
23 and mental health services, on the day of the incident.
24 The investigation report examined the circumstances in
25 which the perpetrator had presented to hospital shortly

31

1 and prescribed antipsychotic medication. The report
2 also recorded continued contact with services shortly
3 before the incident, including an attendance at hospital
4 in the month preceding the attack, where the perpetrator
5 was described as "intoxicated and exhibiting disordered
6 thinking".

7 He was later assessed, denied any mental health
8 concerns, and was discharged with a plan for follow-up
9 by the Community Team.

10 Chair, a number of the analysed cases also concerned
11 failures to exercise powers under the Mental Health Act
12 1983 at or around the time of the attack. R5 and R7
13 provide examples which I shall address in turn.

14 The fatal incident in case R5 occurred when a mental
15 health service user attacked his grandparents at their
16 home, resulting in the death of his grandfather and
17 life-changing injuries to his grandmother.

18 The investigation report considered whether the
19 perpetrator should have been assessed under the Mental
20 Health Act prior to the incident. The review concluded
21 that a number of indicators had emerged in the month
22 leading up to the attack which might reasonably have
23 justified a Mental Health Act Assessment.

24 The investigation noted that professionals appeared
25 to be waiting for a further deterioration in the
30

1 before the attack. At that time, she was known to have
2 a significant history of serious mental health -- mental
3 illness, and had previously been convicted of
4 manslaughter.

5 The investigation panel considered whether the
6 police should have exercised their powers under
7 Section 136 of the Mental Health Act, which permits an
8 officer to remove a person appearing to be suffering
9 from a mental disorder from a public place to a place of
10 safety for the purpose of enabling a mental health
11 assessment to be carried out. The panel concluded that
12 there had been a point in which the statutory criteria
13 was likely to have been met.

14 Chair, I'll now touch upon Community Treatment
15 Orders. CTOs only came into force in 2007. Even with
16 that in mind, they were used very rarely in the cases
17 that we looked at. We saw evidence of CTOs having been
18 in place in only 4% of the cases we looked at. It's
19 further noted that the recommendations in the reviewed
20 reports made little mention of CTOs as an intervention
21 that could or should have been arranged.

22 One case where the use of a CTO was raised by the
23 independent review was case R16. In this case, the
24 perpetrator had been under the care of multiple mental
25 health providers prior to committing a series of fatal

32

1 attacks. The individual had previously been admitted to
2 hospital and had a documented history of non-compliance
3 with medication. The investigation report questioned
4 why the possibility of a Community Treatment Order had
5 not been considered earlier in the patient's treatment
6 pathway, despite there being a known history of
7 non-compliance with medication.

8 The report suggested that the existence of a CTO
9 might have provided a framework through which services
10 could have responded more assertively when the patient
11 indicated that he did not wish to continue taking
12 medication.

13 I'll next address case R13. In that case, the fatal
14 attack occurred when the attacker was subject to a CTO.
15 This matter concerned a fatal incident where the
16 attacker killed another following a period of
17 deterioration in his mental state.

18 The investigation report examined the operation of
19 a CTO in practice and identified a number of significant
20 shortcomings. The individual had been discharged into
21 the community on oral antipsychotic medication, but
22 there was no effective system in place to monitor
23 compliance with that medication. As a result, he ceased
24 taking medication without this being identified or acted
25 upon.

33

1 528 cases, representing 90% of the cohort reviewed.
2 Non-concordance with prescribed medication was
3 identified in 384 cases, equivalent to 73% of the
4 cohort. More specifically, non-concordance with
5 antipsychotic medication was identified in 334 cases,
6 corresponding to 63% of the cohort. Concerns regarding
7 compliance with treatment programmes more generally were
8 identified in 455 out of the 528 cases, or 86% of the
9 cohort reviewed. This could include concerns regarding
10 compliance with medication or compliance with other
11 treatment-related matters.

12 The figure of 73% of cases that demonstrated
13 non-concordance with medication should be scrutinised
14 alongside the data that 90% of attackers had, at some
15 stage, been prescribed medication. Put another way,
16 excluding the small proportion of cases in which
17 medication had never been prescribed, non-concordance
18 featured in approximately 81% of cases where medication
19 formed part of the clinical history.

20 It's worth mentioning that whilst non-concordance
21 with antipsychotic medication was a feature in 63% of
22 cases, this may well be underrepresented, in the context
23 that many of the cases did not clarify the precise
24 medication that was not taken.

25 Chair, in its annual report for 2017, covering the

35

1 The report concluded that the CTO had not been
2 implemented in a manner consistent with its intended
3 purpose. In particular, there was a failure to monitor
4 adherence to treatment conditions, a lack of effective
5 care planning, and insufficient response to concerns
6 raised by family members regarding the individual's
7 deterioration.

8 The investigation also identified delays in
9 recalling the individual to hospital. These delays were
10 attributed in part to operational factors, including the
11 lack of an available inpatient bed and the manner in
12 which recall processes were managed within the community
13 team.

14 The investigation further observed that the level of
15 engagement with the individual reduced following
16 discharge, with the care coordinator allowing the
17 individual to determine the terms of contact with
18 services. This was inconsistent with the framework of
19 the CTO, which is intended to provide structured and,
20 where necessary, assertive supervision in the community.

21 Chair, I would next like to consider the issue of
22 engagement with treatment. Concerns regarding
23 compliance with treatment was a feature in the majority
24 of cases. As will be seen on screen, perpetrators had
25 been previously prescribed medication in 475 out of the

34

1 period 2005 to 2015, the National Confidential Inquiry
2 into Suicide and Safety in Mental Health, also
3 identified significant levels of patients being
4 non-adherent with treatment programmes and medication.

5 More specifically, within the cohort that they
6 considered, they noted that 49% of patients were either
7 non-adherent to prescribed medication, or had missed
8 their final contact with services and were therefore not
9 in receipt of planned treatment prior to the relevant
10 homicide.

11 They noted 59% of patients with schizophrenia were
12 non-adherent with drug treatment in the month before the
13 relevant homicide, or had missed their final
14 appointment.

15 The material reviewed by the Inquiry Legal Team
16 indicates that difficulties arise not only in relation
17 to medication adherence, but also in relation to the way
18 in which services respond to non-concordance and
19 optimised treatment over time.

20 Investigation reports frequently identify
21 circumstances in which non-concordance with medication
22 was known, or could reasonably have been anticipated,
23 but where limited steps were taken to address the
24 underlying causes of disengagement, or where limited
25 steps were taken to adapt the treatment approach.

36

1 Reports also focus on a failure to recognise or
2 respond to patterns of non-concordance; on limited use
3 of structured or objective approaches to verifying
4 medication adherence; on insufficient monitoring
5 following the initiation or adjustment of medication;
6 and on the lack of adaptation of treatment regimes where
7 patients experience adverse side effects or express
8 reluctance to continue with, or be started on,
9 prescribed medication.

10 This is reflected in questionnaire case R1 in which
11 the respondent described the perpetrator as having
12 been -- and I quote: "Culturally resistant to medication
13 and in denial of her condition".

14 Investigation reports also identify that
15 difficulties in medication management may arise from the
16 interaction between diagnosis and treatment. In some
17 cases, an incomplete or insufficiently reviewed clinical
18 formulation led to a treatment approach that did not
19 adequately address the patient's underlying condition.

20 In those circumstances, opportunities to optimise
21 medication, including the use of alternative
22 pharmacological strategies, were not fully explored.

23 Investigation reports also frequently identified
24 concerns relating to the management of higher-risk
25 medications, including depot antipsychotic injections.

37

1 treatment in order to identify potential adverse
2 effects.

3 No such monitoring arrangements were put in place
4 and the investigation report questioned the decision to
5 commence the patient on a new medication regime prior to
6 the start of the Christmas holiday period when there
7 would have been reduced primary and secondary care
8 services available.

9 The investigation also noted that the general
10 practitioner had not been informed of the new medication
11 until after the incident, limiting the opportunity for
12 primary care to contribute to monitoring or support.

13 In addition, the report identified that the patient
14 had exhibited potential indicators of psychosis,
15 including auditory hallucinations, prior to the
16 incident. However, there had been no comprehensive
17 reassessment of her presentation nor any engagement with
18 specialist Early Intervention Services.

19 The investigation concluded that the absence of
20 structured monitoring following the initiation of
21 medication, coupled with a failure to reassess the
22 underlying clinical presentation, meant that
23 opportunities to identify deterioration or adverse
24 effects were not taken at an early stage.

25 Case R22. This case concerned a fatal incident in

39

1 In some cases, there was a lack of clear protocols for
2 responding to missed doses or failures to attend for
3 monitoring. In others, there was limited evidence that
4 alternative treatment options had been explored where
5 patients were unable or unwilling to tolerate depot
6 injections.

7 The themes identified can be observed in a number of
8 the questionnaire cases examined by the Inquiry. I'll
9 now address a selection of those cases by way of
10 illustration.

11 Case R10. This case concerned a fatal incident in
12 which a child was killed by a young person who was
13 receiving care from Child and Adolescent Mental Health
14 Services. The investigation report examined the
15 prescribing and monitoring of antidepressant medication
16 which was initiated shortly before the incident.

17 The treatment plan, which involved a combination of
18 medication and psychological therapy, was broadly
19 consistent with relevant clinical guidelines from
20 moderate to severe depression. However, the report
21 identified concerns regarding the implementation of
22 those guidelines in practice. In particular, the NICE
23 guidance required close monitoring of the patient
24 following the commencement of antidepressant medication,
25 including weekly contact during the initial stages of

38

1 which a man killed his cousin following a period of
2 deterioration in his mental health. The investigation
3 report identified a repeated pattern in which the
4 patient would request reductions in, or cessation of,
5 his prescribed medication, following discharge from the
6 hospital, due to the physical side effects of that
7 medication, which included weight gain.

8 This was in the context that physical fitness was an
9 important part of the patient's identity. Despite
10 clinical advice, he would stop taking medication without
11 supervision, leading to a deterioration in his mental
12 state and disengagement from services. However, there
13 was no evidence that alternative medication regimes were
14 explored in response to these concerns.

15 The investigation concluded that the failure to
16 address the patient's concerns regarding side effects,
17 and to adapt the treatment approach, contributed to
18 repeated cycles of non-concordance and relapse. On the
19 occasion in question, this deterioration was identified
20 as a significant contributing factor in the events
21 leading to the fatal incident.

22 Case R26 is a case that I touched upon earlier and
23 it's also relevant here. The investigation report
24 identified a sustained pattern of apparent engagement
25 with medication services which did not in fact reflect

40

1 actual adherence to treatment.

2 Over a prolonged period, the individual attended
3 weekly appointments to collect prescribed medication
4 from the Community Team base. This increased level of
5 contact had been introduced in part to facilitate closer
6 monitoring following earlier concerns about the
7 patient's presentation and engagement. However,
8 following the incident, police discovered in excess of
9 800 tablets at the individual's home address, which he
10 had not taken. This indicated that, notwithstanding
11 regular collection of medication, he had not been taking
12 it as prescribed.

13 The investigation found that clinicians had relied
14 upon the individual's attendance for medication
15 collection as an indicator of compliance, without
16 implementing objective or structured methods to verify
17 whether medication was being taken. This was of
18 particular significance, given the individual's
19 documented history of limited insight into his condition
20 and previous episodes of non-compliance with medication.

21 The report concluded that there had been no planned
22 interventions to assess or improve adherence, and no
23 systematic approach to monitoring compliance. As a
24 result, opportunities to identify non-concordance and to
25 respond to it through adjustments to treatment or

41

1 The analysis of recommendations within the reports
2 reviewed also contained reoccurring themes relating to
3 risk assessment. Investigation reports frequently
4 recommend the following: strengthening risk assessment
5 processes, including through the use of structured risk
6 assessment tools; the regular updating of assessments
7 when new information emerges; obtaining relevant
8 information from the police where appropriate; and
9 improving the quality assurance and auditing of risk
10 assessment processes.

11 Reports also identify concerns regarding inadequate
12 or incomplete risk assessment, including failures to
13 incorporate historical information; family concerns; or
14 indicators of relapse; failures to verify or test
15 information obtained from patients or from other
16 sources; and failures to update or revisit risk
17 assessments in response to changing circumstances or
18 emerging warning signs.

19 The questionnaire cases examined by the Inquiry
20 provide further illustration of how these issues may
21 arise in practice across a range of factual
22 circumstances. I'll now turn to address some of these
23 examples.

24 Case R9. This case concerned the killing of the
25 a woman by her daughter, both of whom were receiving

43

1 supervision were not taken.

2 Chair, I will now address issues concerning risk
3 assessments.

4 **THE CHAIR:** Yes.

5 **MR NDOW-NJIE:** Risk assessment issues were identified in the
6 vast majority of cases reviewed. Concerns regarding
7 risk assessment were identified in 467 out of the 528
8 cases, representing 88% per cent of the cohort reviewed.
9 Issues concerning recording, record-keeping or auditing
10 were identified in 450 of the 528 cases, representing
11 85% of the cohort reviewed.

12 Risk assessment failures have a long history. The
13 Ritchie Inquiry emphasised the importance of obtaining
14 and considering a full history when assessing
15 dangerousness, and highlighted the need for
16 professionals to have access to accurate records, to
17 consider patterns of behaviour over time, and to ensure
18 that relevant information is shared between clinicians,
19 agencies, and others involved in a patient's care.

20 The Ritchie Inquiry also drew attention to the need
21 for those responsible for assessing risk to be properly
22 trained in doing so. The material reviewed by the
23 Inquiry Legal Team demonstrates that concerns relating
24 to risk assessment and the recording have continued to
25 arise in the years since the Ritchie Inquiry.

42

1 care from the same NHS Trust at the time of the
2 incident. The investigation report identified concerns
3 regarding the extent to which information held by
4 different clinical teams had been brought together in
5 order to assess potential risks.

6 The perpetrator had been receiving treatment from
7 the adult mental health services, while the victim was
8 being supported by an Older People's Community Mental
9 Health Team.

10 The investigation found that although clinicians
11 were aware that the perpetrator was involved in caring
12 for her mother and had been experiencing significant
13 stress in that role, there was limited evidence that
14 this information had been shared between the relevant
15 teams. The report concluded that this lack of
16 information, information sharing, meant that a more
17 comprehensive risk assessment was not undertaken. In
18 particular, the investigation noted that the risks
19 associated with the perpetrator providing care for her
20 mother were not fully explored, despite the
21 perpetrator's ongoing mental health difficulties and the
22 availability of information across the Trust that could
23 have informed a more holistic assessment of the
24 situation.

25 Case R21. Case R21 concerned a fatal incident when

44

1 the perpetrator killed his father at the flat they
2 shared. The relevant investigation report identified
3 concerns regarding the way risk assessments were
4 undertaken over the course of the perpetrator's contact
5 with mental health services.

6 Risk assessments were often completed in response to
7 particular stages of care, such as admission or
8 discharge, but were not consistently updated to reflect
9 developments occurring between those stages. The report
10 also identified concerns regarding the sources of
11 information used to inform the assessment of risk,
12 information provided by family members regarding the
13 perpetrator's behaviour, including concerns about
14 substance misuse, medication non-compliance, aggression,
15 and the carrying of a knife. These were not
16 consistently incorporated into the risk formulation.

17 As a result, the report concluded that the
18 assessment of risk was largely based on information
19 provided by the perpetrator himself, with limited
20 evidence that clinicians had sought to verify that
21 information with family members or other agencies. The
22 panel found that this meant that the Trust's
23 understanding of the risks posed by the perpetrator was
24 incomplete.

25 The report also linked these shortcomings to

45

1 evidence that this had been discussed in
2 multidisciplinary risk planning.

3 The report also found that the patient's
4 psychological formulation was incomplete. At the same
5 time, the clinical team appeared to derive reassurance
6 from specialist input which had not involved a full
7 forensic risk assessment.

8 Chair, risk assessment is only as good as the
9 information upon which it is based. With that said, to
10 follow up on risk assessment, I'll now address issues
11 concerning information sharing.

12 At the outset, it is noted that, as with risk
13 assessment, communication and information-sharing
14 failures are an overwhelming feature of the cases
15 considered. Concerns as to communication, information
16 sharing, or information gathering, were identified in
17 483 cases out of the 528 that we looked at, representing
18 92% of the cohort, and concerns as to inter-agency
19 communication were identified in 440 cases, reflecting
20 83% of the cohort.

21 The following questionnaire cases provide examples
22 demonstrating how failures in information sharing have
23 led to unmanaged risk prior to a fatal attack.

24 Case R25. This case concerned a fatal incident in
25 which a man was killed following a sustained and violent

47

1 a broader failure to assess and use evidence properly in
2 the management of risk. The report emphasised that it
3 was not sufficient merely to record relevant
4 information; the information gathered needed to be
5 actively assessed and synthesised in order to form
6 a coherent assessment of the risks posed by the
7 perpetrator.

8 Case R41. This case concerned the fatal incident in
9 which the perpetrator, an inpatient on a Psychiatric
10 Intensive Care Unit, went absent without leave whilst on
11 escorted leave and, during this period, fatally stabbed
12 a member of the public.

13 The investigation report identified significant
14 deficiencies in the recording and synthesis of risk
15 information. There was no single accessible source
16 bringing together current and historical risks, with
17 staff instead having to rely on multiple documents.
18 This created the potential for inconsistent
19 understanding of the patient's risk profile, as
20 different staff members could rely on different
21 documentation.

22 In particular, the patient had a recent history of
23 carrying knives during periods of absence from the ward.
24 However, this information was not consistently
25 recognised across the clinical team, and there was no

46

1 assault by a family member who had been in recent
2 contact with mental health services. Prior to the fatal
3 incident, there had been an earlier assault involving
4 the same individuals. The investigation report noted
5 that although risk assessments were undertaken following
6 that earlier incident, they largely repeated information
7 from previous assessments, and did not demonstrate that
8 further enquiries had been made into the circumstances
9 of the assault.

10 In particular, there was no evidence that clinicians
11 had sought information from the victim, other family
12 members, or the police, in order to understand the
13 nature and severity of that earlier incident. The
14 perpetrator was reported to have been apologetic, but
15 had provided limited detail and this appeared to have
16 been accepted without further verification.

17 The investigation concluded that the assessment of
18 risk was based on incomplete information and that
19 opportunities had been missed to obtain and incorporate
20 relevant safeguarding and third-party information. As a
21 result, the potential risk of further serious violence,
22 including within a domestic context, was not fully
23 explored or understood.

24 In case R30, previously mentioned by my learned
25 friend, a care home resident in their nineties was

48

1 fatally assaulted by another resident who had previously
2 been admitted to a conventional hospital setting, where
3 he had demonstrated repeated episodes of threatening and
4 violent behaviour towards patients and staff.

5 The investigation report recorded that during
6 a period of hospital admission, there were at least 34
7 documented incidents in which the perpetrator behaved in
8 a violent or threatening manner. Despite this pattern
9 of behaviour, the investigation found that these
10 incidents were not formally analysed in order to
11 understand the risks posed by the perpetrator. In
12 particular, the report noted that no structured risk
13 assessment was undertaken to synthesise the information
14 available regarding the perpetrator's behaviour and
15 mental state.

16 The investigation also identified that some of the
17 incidents involved the use of weapons and that these
18 were not reported to the police or raised as
19 safeguarding concerns with the local authority. Nor
20 were steps taken to establish whether the perpetrator
21 had any previous contact with the criminal justice
22 system. As a result, the investigation concluded that
23 the risks posed by the perpetrator were not fully
24 understood when decisions were later made regarding his
25 placement in a residential care setting.

49

1 perpetrator had been discharged from inpatient and
2 community mental health services. Prior to the
3 incident, family members had repeatedly contacted
4 services expressing concern regarding the perpetrator's
5 deteriorating presentation. The investigation report
6 identified failures relating to the role of the "nearest
7 relative" under the Mental Health Act 1983.

8 Now, this term reflects the statutory framework in
9 force at the time of the events in question. Under the
10 Mental Health Act 2025, the role has been replaced with
11 that of the "nominated person", although the
12 investigation reports reviewed by the Inquiry use the
13 earlier terminology.

14 In particular, this report concluded that the
15 nearest relative had not been informed of her statutory
16 rights, including the right to request a Mental Health
17 Act Assessment. The report also identified a lack of
18 documentation demonstrating that the nearest relative
19 had been informed of decisions relating to the patient's
20 detention or discharge.

21 Chair, I next want to address one of the witness
22 statements provided to the Inquiry further to the
23 questionnaire process. In this statement, a father gave
24 evidence in relation to his daughter, who has
25 a long-standing diagnosis of paranoid schizophrenia,

51

1 One critical source of collateral information,
2 relevant to both clinical care and risk assessment, is
3 the family, carers, and housemates of patients. I'll
4 now turn to address issues concerning engagement with
5 families.

6 A majority of cases recorded problems with
7 communication in this area. In particular, you'll see
8 that concerns regarding communication with carers and
9 family members were identified in 345 out of the 528
10 cases, representing 65% of the cohort. In 46% of the
11 cases the perpetrator's family had expressed concern as
12 to the risk of violence prior to the attack. An example
13 of this can be seen in questionnaire case R42 in which
14 the respondent described the pattern of escalating
15 behaviour, including property damage and aggression.

16 Despite repeated police attendance, the perpetrator
17 was assessed as posing no risk to himself or others, and
18 no further action or follow-up was taken. The
19 respondent emphasised the need for authorities to "take
20 the family pleas for help seriously".

21 Chair, I'll next turn to address case R31, a case
22 where a failure to assist the family to obtain a Mental
23 Health Act Assessment was a feature of the case.

24 This case concerned a fatal attack on a family
25 member that occurred approximately one year after the

50

1 with repeated detention under the Mental Health Act over
2 a period of more than 20 years. The witness was at all
3 material times the individual's nearest relative.

4 The statement addresses a recent relapse in which
5 the individual ceased taking prescribed antipsychotic
6 medication, leading to a deterioration in her mental
7 state characterised by delusions and paranoia.

8 Despite a high level of concerning behaviour
9 reported by the father, an ambulance declined to attend.
10 The witness contacted the police, again providing
11 detailed information regarding his daughter's condition,
12 her lack of medication, and the risks posed to herself
13 and others. The police located her but did not detain
14 her or take her to a place of safety.

15 The statement records that a factor in this decision
16 was the absence of an available out-of-hours crisis
17 response. As a result, the individual remained
18 untreated and continued to move between locations for
19 a period of approximately four weeks while in
20 a psychotic state.

21 The statement records that intervention was
22 ultimately secured only after the witness obtained legal
23 advice and initiated the process for a warrant under
24 Section 135 of the Mental Health Act. Following
25 execution of the warrant, the individual was detained

52

1 and treated with a subsequent improvement in her
2 condition following the reintroduction of antipsychotic
3 medication.

4 Chair, similar concerns were raised in case R44. In
5 that case, the respondent considered that community
6 mental health services did not have the practical
7 capacity to respond rapidly and effectively to acutely
8 psychotic individuals who require urgent intervention.

9 Concerns as regards engagement with the family on
10 the issue of risk assessment also arose in multiple
11 cases. Case R22 provides one such example.

12 Case R22, which has previously been referenced, is
13 also relevant here. The case concerned a fatal incident
14 in which a man killed his cousin, who had become
15 a principal source of support following the death of the
16 perpetrator's mother. The investigation report
17 identified concerns regarding the extent to which family
18 members were involved in the patient's care.

19 Although the Trust's policies emphasised the
20 importance of involving carers in treatment planning,
21 there was no evidence that the patient's family members
22 had been involved in assessments or care planning
23 discussions.

24 The report emphasised that the involvement of
25 families and carers has long been recognised as an

53

1 failures were identified in 466 of those cases,
2 representing 88% of the cohort. Inadequate care
3 planning and coordination was identified in 472 cases,
4 corresponding to 89% of the cohort.

5 Oversight or supervision concerns were identified in
6 349 cases, 66% of the cohort.

7 Concerns regarding inexperienced professionals,
8 training issues, or lack of reflective practice were
9 identified in 304 cases, correlating to 58% of the
10 cohort.

11 Bed availability issues, waiting times, or treatment
12 delays, were identified in 175 cases, 33% of the cohort.

13 Resourcing concerns were identified in 240 cases,
14 correlating to 46%, and concerns regarding policies,
15 systems, processes, or wider organisational issues, were
16 identified in 464 cases, representing 88% of the cases
17 reviewed.

18 The reports analysed therefore show a range of
19 treatment and care planning failures, and equally the
20 Inquiry Legal Team's scrutiny of those reports
21 demonstrates that there was a range of reasons behind
22 this.

23 A structured approach to care coordination has long
24 been intended to provide a framework through which
25 individuals with more complex mental health needs

55

1 important component of effective mental health care.

2 Family members often possess valuable information
3 regarding a patient's behaviour, adherence to treatment,
4 and early signs of relapse.

5 In this case, the absence of family engagement
6 limited the information available to clinicians when
7 assessing the patient's needs and risks.

8 Chair, would this be a good moment for a break?

9 **THE CHAIR:** Yes, thank you. We'll start again at 11.40,
10 thank you.

11 **(11.22 am)**

(A short break)

13 **(11.40 am)**

14 **THE CHAIR:** Yes.

15 **MR NDOW-NJIE:** Chair, I'll resume by addressing treatment
16 and care planning failures.

17 Such issues are closely related to those concerning
18 risk assessment, which was addressed earlier. This is
19 in the context that the assessment and management of
20 risk and the planning and delivery of care are
21 inherently interconnected aspects of mental health care.

22 Risk assessments inform the development of care
23 plans, while care plans provide the framework through
24 which identified risks are managed in practice.

25 From our cohort of 528 cases, general treatment

54

1 receive consistent and coordinated care. Such
2 approaches typically involve the development of
3 a documented care plan, the identification of
4 a clinician responsible for coordinating care, and
5 arrangements for reviewing treatment and responding to
6 deterioration in an individual's condition.

7 Care planning should also incorporate crisis or
8 contingency arrangements and clearly identify the roles
9 of the different professionals involved in supporting
10 that individual. However, the material reviewed by the
11 Inquiry Legal Team indicates that these arrangements
12 were operated inconsistently in practice.

13 Investigation reports frequently identify
14 circumstances in which care plans were incomplete, were
15 not reviewed when new information emerged, or were not
16 effectively implemented across services. In some cases,
17 the absence of a coordinated care plan meant that
18 services lacked a clear strategy for responding to
19 changes in a patient's presentation, or for managing
20 risks associated with relapse.

21 Difficulties in maintaining engagement with patients
22 in the community also arises repeatedly within the
23 reports examined. These difficulties may arise where
24 individuals struggle to recognise the nature of their
25 illness, or the importance of treatment, or where

56

1 services encounter challenges in sustaining contact with
2 patients following their discharge from hospital. In
3 such circumstances, investigation reports frequently
4 identify a lack of escalation or adaptation in the
5 treatment approach when engagement begins to decline.

6 Another witness statement provided to the Inquiry
7 further to the questionnaire process was from the father
8 of a patient with a longstanding diagnosis of
9 schizoaffective disorder. He describes a prolonged
10 history of repeated relapse and readmission to mental
11 health services over a period of approximately 20 years.

12 The evidence records that the individual had been
13 detained under the Mental Health Act on multiple
14 occasions and has, following discharge, repeatedly
15 experienced deterioration in his mental state associated
16 with a discontinuation of prescribed medication.

17 The statement does not fall within the criteria for
18 inclusion in the Inquiry's questionnaire cohort as it
19 does not concern a fatal attack, but it nonetheless
20 provides relevant insight into the operation of services
21 in cases involving chronic relapse and risk.

22 The statement maker describes the pattern in which
23 periods of stability have been followed by relapse after
24 medication is stopped, with subsequent escalation in
25 behaviour, including increasing aggression, police

1 indicators of deterioration in the patient's mental
2 health were not recognised or addressed.

3 Case R30. This case concerned the fatal assault of
4 a care home resident by another resident who had
5 previously been admitted to a conventional hospital
6 setting where there had been repeated episodes of
7 violent and threatening behaviour.

8 In the context of care delivery, the investigation
9 report identified concerns regarding the clinical
10 understanding of the perpetrator's underlying condition.
11 The patient had developed Wernicke-Korsakoff's Syndrome
12 as a consequence of alcohol misuse, a condition which
13 presents distinct clinician challenges and may be
14 associated with behavioural disturbance and aggression.

15 The report concluded that services had not fully
16 explored whether the patient's presentation might also
17 reflect additional underlying mental health needs. As
18 a result, opportunities to consider alternative
19 treatment approaches or more structured support
20 arrangements were not pursued.

21 Case R33. This is also relevant when considering
22 the delivery of care. The case concerned a fatal
23 incident in which a patient violently assaulted another
24 patient on an acute mental health ward, resulting in the
25 victim's death several days later.

1 involvement, and further detention.

2 The witness reports that despite efforts by the
3 family to support adherence to treatment and engagement
4 with services, the cycle has persisted over many years.

5 The themes discussed can also be observed in
6 a number of the questionnaire cases examined by the
7 Inquiry. I intend to refer to three cases which are all
8 cases that I have already addressed today.

9 Case R9. This case concerned a fatal incident in
10 which a woman was killed by her daughter. At the time
11 of the incident, both individuals were receiving care
12 from the same NHS Trust. The investigation report
13 identified concerns regarding the continuity of care
14 following a reconfiguration of mental health services
15 within the Trust.

16 Prior to the reorganisation, the patient had been
17 receiving a relatively intensive level of support from
18 specialist services. Following the reconfiguration, the
19 level of support available to her was significantly
20 reduced.

21 The investigation found that this change had not
22 been accompanied by a clear reassessment of the
23 patient's needs or by the development of a structured
24 plan for monitoring her mental state following the
25 transition between services. As a result, early

1 The investigation report identified concerns
2 regarding the absence of a structured care plan
3 following the perpetrator's admission to the ward.
4 Although the patient had been admitted due to a
5 deterioration in his mental state, there was no evidence
6 that a care plan or observation and engagement plan had
7 been developed during the early stages of his admission.

8 The investigation emphasised that a care plan serves
9 as a central document through which clinicians identify
10 the patient's needs, determine the interventions
11 required to support recovery, and clarify the roles of
12 professionals involved in providing care.

13 In this case, the absence of an agreed care plan
14 meant that the clinical team lacked a clear framework
15 through which the patient's needs and risks could be
16 assessed and managed.

17 The report also noted that the patient had not been
18 provided with one-to-one engagement time with nursing
19 staff during his admission. Such engagement may have
20 assisted clinicians in developing a clearer
21 understanding of the patient's presentation, and in
22 establishing a therapeutic relationship that could
23 inform treatment planning.

24 Chair, I will now turn to address issues concerning
25 mental capacity. Mental capacity and the issue of

1 assessment of capacity was rarely identified as an issue
 2 within the cohort considered. It was also rarely
 3 considered by the post-incident investigations.
 4 From our cohort of 528 cases, concerns over capacity
 5 or incapacity of perpetrators under the Mental Capacity
 6 Act were noted in 31 cases, correlating to 6% of cases.
 7 In one of the statements provided to the Inquiry,
 8 previously referred to when addressing treatment and
 9 care planning failures, the father of a patient
 10 expressed concern that in circumstances where his son's
 11 insight was limited and there was a well-established
 12 pattern of relapse linked to non-adherence with
 13 a treatment plan, reliance on patient choice may
 14 undermine the effectiveness of treatment and increase
 15 the risk of further deterioration.
 16 Mental capacity assessment was also relevant in
 17 relation to case R20. This case concerned a fatal
 18 incident in which the perpetrator drove a vehicle
 19 into a group of pedestrians, resulting in the death of
 20 a child and multiple injuries.
 21 The investigation report identified a prolonged
 22 period of contact between the individual and mental
 23 health services, during which he was assessed under the
 24 Mental Health Act on multiple occasions. But the report
 25 identified a failure to adequately consider the

61

1 monitor and manage risk in the community.
 2 The material reviewed suggests that discharge
 3 represents a point at which previously identified risks
 4 may not be adequately mitigated, particularly where
 5 there's limited planning for non-engagement, relapse, or
 6 deterioration in the individual's condition.
 7 From our cohort of 528 cases, in 477 of these cases
 8 the perpetrator had previously been discharged from
 9 hospital or community services, correlating to 90% of
 10 the cohort.
 11 Concerns regarding discharge planning were
 12 identified in 402 cases, correlating to 76% of the
 13 cohort, and there was either no discharge or treatment
 14 plan, or an inadequate one, recorded in 345 cases,
 15 correlating to 65% of the cohort.
 16 These issues related to discharge planning are also
 17 closely linked to matters considered earlier. In
 18 particular, shortcomings in risk assessment, care
 19 planning and medication management often become most
 20 acute at the point of discharge, where individuals
 21 transition from more structured and supervised
 22 environments into the community.
 23 A number of recurring themes emerge from the
 24 investigation reports reviewed by the Inquiry. These
 25 include the absence of clearly defined discharge plans,

63

1 individual's mental capacity.
 2 Despite a pattern of disengagement from the services
 3 and the denial of illness, there was limited evidence
 4 that a structured assessment of capacity had been
 5 undertaken in relation to his decision making. The
 6 investigation noted that this limited the ability of
 7 services to determine whether further statutory
 8 intervention or protective measures were required.
 9 The investigation concluded that these shortcomings
 10 reflected a broader failure to apply Statutory
 11 Frameworks in a manner that fully addressed the risks
 12 arising from the individual's presentation, including
 13 the interaction between capacity, engagement, and the
 14 use of compulsory powers.
 15 Chair, I will now turn to address discharge
 16 planning.
 17 **THE CHAIR:** Yes.
 18 **MR NDOW-NJIE:** Discharge from inpatient or custodial
 19 settings, or between community teams, represents
 20 a critical stage in the care pathway for individuals
 21 receiving mental health treatment.
 22 Effective discharge planning requires not only the
 23 identification of ongoing clinical needs, but also the
 24 coordination of services, the involvement of relevant
 25 stakeholders, and the implementation of arrangements to

62

1 lack of consultation with family or primary care in
 2 discharge planning, variability in multidisciplinary and
 3 multi-agency input into discharge decisions, failures to
 4 respond to concerns raised following discharge, limited
 5 coordination between agencies, and discharge decisions
 6 made in the context of known non-engagement with
 7 services.
 8 In some cases, non-engagement appears to have become
 9 an operative factor in discharge decision making, rather
 10 than a trigger for enhanced efforts to maintain
 11 engagement or to implement more structured forms of
 12 supervision.
 13 I'll now turn to some of the questionnaire cases
 14 examined by the Inquiry to illustrate some of the issues
 15 that have arisen in the context of discharge planning.
 16 Case R15. This case concerned a fatal incident in
 17 which the perpetrator killed his mother shortly after
 18 being discharged from an inpatient mental health ward.
 19 The investigation report identified shortcomings in the
 20 discharge process. In particular, there was no
 21 documented discharge care plan. Although the individual
 22 was understood by the treating team to be subject to the
 23 Care Programme Approach, this was not formally recorded
 24 on the clinical system and the required CPA
 25 documentation had not been completed.

64

1 The report also identified a lack of involvement of
2 the individual's family in discharge planning. Family
3 members were not provided with a care plan or
4 contingency plan, and no carer's assessment had been
5 completed, notwithstanding that the individual was
6 returning to live with his mother, who was both frail
7 and acting as his primary carer.

8 Further concerns were identified in relation to
9 communication with primary care. There was no evidence
10 that the individual's general practitioner had been
11 notified of his discharge at the relevant time.

12 The investigation concluded that at the point of
13 discharge, there was a lack of clarity as to how mental
14 health services would support the individual in the
15 community, and that the arrangements in place did not
16 adequately address the risks associated with his return
17 to a vulnerable home environment.

18 Case R21. Case R21 was previously discussed when we
19 looked at risk assessment but it's also relevant for
20 discharge planning.

21 This concerned a fatal incident in which a father
22 was killed by his son following a period of treatment
23 under the Mental Health Act. The investigation report
24 identified concerns regarding the management of the
25 discharge process. In particular, the absence of

65

1 the result was not acted upon or incorporated into
2 discharge decision making. The investigation concluded
3 that this may have warranted further consideration of
4 medication compliance, dosage, or broader clinical
5 management prior to discharge.

6 Chair, the Inquiry Legal Team has also carried out
7 analysis to understand how the actions of the attackers
8 were disposed of in the criminal courts. I'll now
9 proceed to address that analysis.

10 With respect to offence outcomes, the breakdown is
11 as appears on screen. The perpetrator was found guilty
12 of murder in 22.9% of the cohort reviewed. The
13 perpetrator was found guilty of manslaughter on the
14 basis of diminished responsibility in 53.4% of the cases
15 reviewed. In 3.8% of the cases the perpetrator was
16 unfit to plead. 19.9% of cases were classified as
17 "Other" and this category requires brief explanation.

18 In the majority of cases, this classification does
19 not reflect a distinct category of outcome, but rather
20 limitations in the available material. In many
21 instances, the offence outcome was not clearly
22 identified or confirmed in the response; in others, the
23 death or suicide of the perpetrator rendered the
24 criminal process obsolete.

25 There were also cases in which the precise form of

67

1 effective liaison with the family in relation to the
2 individual's return to the home environment and the
3 risks arising from that placement.

4 Following discharge, there was a pattern of
5 declining engagement with services, including missed
6 appointments, non-participation in rehabilitative
7 activities, and non-compliance with medication.

8 The investigation found that warning signs of
9 escalating risk, including aggression, substance misuse,
10 and other concerning behaviour within the home were not
11 recognised as indicators of risks to others but were
12 instead addressed primarily as clinical matters. The
13 report found that because of this, there was not an
14 appropriate response which would have included increased
15 home visits and further hospital appointments.

16 Case R34. This case concerned a fatal incident
17 involving an individual who had recently been discharged
18 from inpatient care into supported accommodation.

19 In the context of discharge planning, the
20 investigation identified concerns regarding the clinical
21 management of the individual's medication at the point
22 of discharge. In particular, the individual's clozapine
23 levels were significantly below the range advised by the
24 manufacturer in the period immediately prior to
25 discharge. Although a blood test had been undertaken,

68

1 manslaughter was not specified, or not confirmed to be
2 on the basis of diminished responsibility, as well as
3 a small number involving alternative offence outcomes,
4 such as findings of insanity or other offences.

5 Chair, I will now turn to look at the disposal of
6 the cases analysed. The breakdown will also be shown on
7 the screen.

8 A "hospital order" is an order under Section 37 of
9 the Mental Health Act 1983 authorising admission to, and
10 detention in, hospital. A "restriction order" is
11 an order under Section 41 of the Mental Health Act 1983,
12 authorising special restrictions for offenders that are
13 detained under Section 37, and we can see that this was
14 used in just under half of the cases, or 49.6% to be
15 more precise.

16 A "hybrid order" is an order made under Section 45A
17 of the Mental Health Act 1983, under which an offender
18 is taken to hospital for treatment but treated as if
19 they were transferred from prison. This provision came
20 into force on 1 October 1997, yet we can see that this
21 was used in just 2.3% of the cases within our cohort.

22 The category of "Other" within the disposal data
23 similarly reflects limitations in the available
24 material, rather than a discrete category of outcome.

25 In many cases, the disposal was not clearly identified

68

1 or confirmed in the available report. In others, the
2 death or suicide of the perpetrator also rendered
3 disposal unnecessary.

4 A small number of cases involved alternative
5 disposals, such as conditional discharge or subsequent
6 transfer from prison to hospital detention. 19.7% of
7 cases in the cohort were categorised as "Other".

8 Mr Julian Hendy, founder of the Hundred Families
9 charity, has stated that the families he supports would
10 like to see a greater use of hybrid orders to ensure
11 a penal element is attached to the disposal of mental
12 health homicides.

13 He also notes a dissonance between family
14 expectations at sentencing hearings, when hospital
15 orders are said to be "indefinite", and the outcome
16 wherein the vast majority of patients are released in
17 less than 10 years.

18 **THE CHAIR:** We're going to hear from Mr Hendy this
19 afternoon, aren't we?

20 **MR NDOW-NJIE:** That's correct.

21 Amidst the smaller subset of questionnaire cases, 38
22 out of 67, that's 57% of total respondents informed the
23 Inquiry that they were dissatisfied with the sentence or
24 court order.

25 In multiple questionnaire cases, including cases R2,
69

1 perpetrator was discharged into the community. The
2 fatal attack on the deceased occurred in 2011, just
3 five years after being given a hospital and restriction
4 order for a previous manslaughter.

5 Several of the respondents to the Inquiry's
6 questionnaire considered that the outcome of their cases
7 should have been murder and not manslaughter on the
8 basis of diminished responsibility. And examples are
9 cases R14 and R19.

10 The respondents in cases R2, R11, R15, R22, R39 and
11 R40 also reported their concern the hybrid orders were
12 not used.

13 The respondents in R2 and R11 specifically reported
14 that the duration of the hospital order imposed at the
15 sentencing hearing, which was described as indefinite,
16 had not been properly explained to them, and that they
17 were deeply concerned by the speed with which release
18 was considered thereafter.

19 Chair, the respondent in case R10 also described
20 Parole Board hearings after sentencing as
21 re-traumatising.

22 **THE CHAIR:** Yes.

23 **MR NDOW-NJIE:** Chair, I'll now turn to address the extent to
24 which concerns were noted in respect of the Trust
25 investigation carried out after the events.

71

1 R4, R12, R17, R19, R20, R25, R32 and R36, respondents
2 all indicated that the sentence or disposal imposed was
3 not sufficiently severe.

4 Respondents in cases including R6, R23, and R28 also
5 expressed concern about the management of the
6 perpetrator following sentence, including the speed of
7 progression through to less secure settings and the
8 condition under which leave or release was permitted.
9 These concerns were often framed in terms of a perceived
10 lack of reassurance as to future public protection.

11 Another witness statement provided to the Inquiry
12 further to the questionnaire process, describes how the
13 perpetrator of the attack was sentenced to imprisonment,
14 but then transferred to a medium secure hospital on the
15 very same day as sentencing. The family of the deceased
16 were not informed until two months later. Concerns were
17 raised within that statement regarding the lack of
18 clarity surrounding the basis of the transfer, the
19 processes governing future decision-making, and the
20 circumstances in which the perpetrator might be
21 released.

22 Chair, similarly, in case R7, the perpetrator had
23 previously been convicted of manslaughter on the grounds
24 of diminished responsibility and was given a hospital
25 and restriction order. Less than three years later, the
70

1 The analysis of this issue was limited to cases in
2 which an independent report was available. Such
3 independent reports were generally preceded by
4 a Trust-level report and the independent reviewers
5 regularly commented on the quality of the earlier
6 investigation. This reduced the cohort considered to
7 524 cases.

8 The analysis revealed that the independent
9 investigations noted concerns with the Trust-level
10 reports in just over half of the cases, being 267 cases
11 or 51%. The nature of the criticisms were varied.
12 Particular concerns included failures to engage the
13 family of the deceased, failures to obtain key records
14 or accounts, and failures to consider important clinical
15 issues.

16 With respect to the questionnaire respondents, 57
17 out of 67, which is 85% of the questionnaire
18 respondents, informed the Inquiry that they were
19 dissatisfied with the information shared with them by
20 the relevant Trust. A common theme was respondents
21 reporting that they felt they had to struggle or fight
22 to get relevant information or any investigation at all.

23 For example, this was reported to us in cases R3,
24 R4, R11, R13, R24, R27, R35 and R36.

25 Long delays in contact from the relevant Trust were
72

1 also a feature of several cases. For example, in case
2 R29 it had taken two years for the family to get sight
3 of an internal investigation. In case R33, at the time
4 the questionnaire was completed, three years had already
5 passed and they were still waiting for a Trust-level
6 report.

7 Several cases complained that they had no contact at
8 all from the relevant Trust. This included cases R7,
9 R18, and R43. A number of respondents reported that
10 they had to wait for other investigations, such as
11 coronial investigations, before getting any information
12 or answers. This was reported in cases R22, R24 and
13 R35.

14 A number of respondents were concerned that the
15 Trusts involved were keen to minimise their
16 responsibility. This was reported to us in cases R10
17 and R37.

18 Chair, I have spoken primarily about Trust-level
19 reports, but I will now say a brief word about
20 independent reports.

21 The average time between incident and independent
22 report, where that information was available, was over
23 three years.

24 In 66 identified cases, the independent report was
25 delayed by over five years.

73

1 recommendations were a particular feature in relation to
2 depot injections and clozapine.

3 Fifth, greater family engagement, including the
4 development of Trust policies as regards contact and
5 interaction with family and caregivers and greater
6 professional trust for family views.

7 A number of reports also explicitly recommend steps
8 to promote patient engagement, including assertive
9 outreach.

10 The issues mentioned appear over the course of the
11 period considered by the Inquiry Legal Team's Review,
12 but there are some types of recommendations that are
13 more prominent in particular periods.

14 First, from the 1990s to the early 2000s. There was
15 increased prominence of recommendations concerning the
16 establishment and implementation of the Care Programme
17 Approach and basic risk assessment protocols.

18 Second, from the early 2000s up to around 2015,
19 there's a greater focus in recommendations on structured
20 risk assessment tools, Assertive Outreach and Crisis
21 Resolution Teams, as well as multi-agency risk
22 frameworks.

23 Third, from around 2015 onwards, the last decade or
24 so has seen a greater focus on recommendations
25 concerning workforce capacity, quality assurance,

75

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

2 **MR NDOW-NJIE:** Chair, the final area I would like to address
3 before you relates to recommendations that the Inquiry
4 Legal Team has reviewed in the reports under
5 consideration. The recommendations made are, as would
6 be expected, varied. But several recommendation types
7 were more prominent, and I'll address five types that we
8 observed in no particular order.

9 First, strengthening risk assessments and risk
10 management plans, including standardisation of approach,
11 the use of tools, gathering adequate information,
12 updating risk assessments in light of new information,
13 quality assurance, and auditing of risk assessments.

14 Second, improved care planning and adherence to the
15 Care Programme Approach and Section 117 Mental Health
16 Act aftercare.

17 Third, more comprehensive discharge planning,
18 including a multidisciplinary approach, consultant
19 oversight, engagement with the social and family
20 context, clear lines of responsibility, routes of
21 escalation, provision of information to community teams
22 and GPs, monitoring plans, and follow-up.

23 Fourth, development of protocols for oversight and
24 monitoring of medication concordance, as well as
25 escalation pathways where necessary. Such

74

1 governance, information sharing, and multi-agency
2 working.

3 Professor Appleby, Director of the Confidential
4 Inquiry into Suicide and Safety in Mental Health has
5 referred in his witness statement to research undertaken
6 by his Inquiry into past mental health homicide
7 investigations. One of the conclusions of that research
8 was that recommendations lacked specificity, were vague
9 and difficult for Mental Health Trusts to implement or
10 monitor.

11 It was also opined that reports often lacked an
12 implementation plan with deadlines to ensure delivery
13 and the recommendations were often repeated from one
14 report to another, suggesting that the investigation
15 system was not leading to changes in care.

16 **THE CHAIR:** Again, we're going to explore that with
17 Professor Appleby tomorrow. Thank you.

18 **MR NDOW-NJIE:** From the questionnaire cases, we can see that
19 recent recommendations as regards discharge planning
20 tend towards pointing Trusts to follow basic steps,
21 legislation or local policy, rather than assisting with
22 specific structures or measures to put in place.

23 Alternative cases R15 and R3. Case R15 includes
24 a recommendation for the admission and discharge process
25 to be reviewed to reflect any known CPA status, to

76

1 ensure risk assessments and care planning is held and
2 documented before discharge and shared with consented
3 significant others.

4 Case R3 also includes a recommendation which states:
5 "Conduct post-discharge follow-ups in accordance
6 with policy and national guidance."

7 Risk assessment recommendations in recent years have
8 generally been reluctant to specify one type of risk
9 assessment approach over another, or to point to one
10 model or guideline to follow. Recommendations are
11 instead at best, a statement of good principles of risk
12 assessment; at worst, they are a statement that risk
13 assessments need to improve.

14 I'll now address some examples from the
15 questionnaire cases, being cases R30, R33, and R26.

16 Case R30 includes a recommendation which states:

17 "The Trust should introduce risk formulation using,
18 for example, and amongst others: history; analysis of
19 antecedents; behaviours and consequences, and patients'
20 own accounts of why they behaved in such a way; the
21 impact of recent events and associated mental and
22 medical conditions into risk assessments. The risk
23 formulation should be used to establish levels of risk
24 and risk mitigation plans."

25 Case R33 includes the following recommendation:

77

1 new information."

2 Chair, finally, recent recommendations on the issue
3 of medication compliance and monitoring point towards
4 the need for additional guidance, governance, and
5 planning at Trust level.

6 Cases R34 and R26 provide examples. Case R34
7 includes the following recommendations:

8 "Carry out an audit of individuals who are
9 prescribed Clozapine in the community to assess the
10 pathway from blood test to medical review, to delivery
11 of any change in prescription.

12 "Implement a system which facilitates easy access to
13 the most recent serum Clozapine levels for routine
14 consideration against prescribed dose and current
15 symptomology at ward rounds."

16 Case R26 also includes the following recommendation:

17 "The team derived false assurance about [the
18 perpetrator's] compliance with medication from the
19 weekly collection of medication. We had additional
20 concerns about medication reconciliation and review
21 within the community team.

22 "The Trust must ensure that patients who receive
23 their medication from the [Community Mental Health Team]
24 have a plan in place outlining the requirements of this,
25 including the monitoring and review arrangements.

79

1 "Risk assessment and risk management is a key aspect
2 of mental health practice. The Trust should assure
3 themselves that the systems and arrangements in place on
4 [the] ward effectively maintain the Trust's approach to
5 risk management, and that the quality of risk assessment
6 and safety management plans is robust and meets the
7 standards required."

8 Case R26 includes the following recommendation:

9 "Trust services did not always complete risk
10 assessments in line with policy.

11 "The Trust must review risk management training and
12 guidance to ensure staff know to complete a new risk
13 assessment and risk management plan when risks change,
14 or when new risks are identified. This training must
15 emphasise the importance of triangulation and seeking
16 and listening to the views of who know the patient best.
17 Training should include formulation skills, ensuring
18 that staff can bring together historical risk factors,
19 current clinical presentation and additional risk
20 information from other agencies and services to inform
21 care planning and risk management.

22 "All service users must have a comprehensive
23 person-centred risk assessment and management plan,
24 completed in line with Trust policy, with reviews
25 undertaken in response to changes in presentation and

78

1 "The Trust should ensure sufficient guidance is
2 available to staff relating to assessing and improving
3 adherence with medicines and monitoring compliance."

4 Chair, in addition to those mentioned orally today,
5 there are further examples within the report that will
6 be published on the Inquiry's website.

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

8 **MR NDOW-NJIE:** Chair, those are the findings of the Inquiry
9 Legal Team Review.

10 **THE CHAIR:** Yes. Before we break for an early lunch,
11 I would like to take the opportunity to thank all those
12 who completed the Inquiry questionnaire or sent in
13 information about their own experiences. I know that
14 providing that information will not have been easy for
15 you, but you have now been publicly heard for the first
16 time, and I hope that you'll see that your accounts have
17 provided invaluable evidence which will assist me in
18 considering recommendations in this Inquiry.

19 I'd also like to thank Professor Spiegelhalter for
20 his assistance in ensuring the integrity of the
21 statistical approach that the Inquiry Legal Team has
22 taken to the material which we have. Thank you.

23 Thank you. We will start again at 1.30.

24 (12.26 pm)

25

(The short adjournment)

80

1		
2		
3	Inquiry questionnaire presentation	Page 1
4	by MR WESTON	
5	Inquiry questionnaire presentation	27
6	by MR NDOW-NJIE	
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		

MR NDOW-NJIE: [9] 27/21 42/5 54/15 62/18 69/20 71/23 74/2 76/18 80/8 MR WESTON: [3] 1/5 4/19 4/21 THE CHAIR: [14] 1/3 4/18 4/20 27/19 42/4 54/9 54/14 62/17 69/18 71/22 74/1 76/16 80/7 80/10	22.9 [1] 67/12 24 [1] 20/9 240 [1] 55/13 267 [1] 72/10 27 [1] 14/19 28 May 2026 [1] 1/1 283 [1] 15/18 3 3.8 [1] 67/15 30 years [1] 2/23 304 [1] 55/9 31 [5] 14/12 20/8 20/9 20/10 61/6 32 [2] 10/16 10/20 324 [1] 28/5 33 [2] 13/22 55/12 334 [1] 35/5 34 [2] 22/17 49/6 345 [2] 50/9 63/14 349 [1] 55/6 37 [2] 68/8 68/13 379 [1] 23/18 38 [1] 69/21 384 [1] 35/3	53.4 [1] 67/14 54 [1] 15/19 540 [3] 2/6 2/7 2/10 543 [1] 6/4 57 [2] 69/22 72/16 570 [1] 12/5 58 [1] 55/9 59 [1] 36/11 6 61 [1] 28/5 63 [2] 35/6 35/21 65 [2] 50/10 63/15 66 [2] 55/6 73/24 67 [3] 1/19 69/22 72/17	access [5] 11/16 23/5 23/12 42/16 79/12 accessible [3] 3/23 10/1 46/15 accommodation [2] 13/5 66/18 accompanied [1] 58/22 accordance [1] 77/5 according [1] 19/17 Accordingly [1] 8/13 account [1] 14/8 accounted [2] 13/23 14/15 accounts [5] 1/7 26/25 72/14 77/20 80/16 accurate [1] 42/16 acknowledged [3] 8/23 9/10 10/11 across [9] 2/20 12/16 14/5 19/9 26/13 43/21 44/22 46/25 56/16 Act [27] 16/14 18/15 21/12 24/23 26/4 28/5 29/17 30/11 30/20 30/23 31/2 31/15 32/7 50/23 51/7 51/10 51/17 52/1 52/24 57/13 61/6 61/24 65/23 68/9 68/11 68/17 74/16 acted [3] 17/2 33/24 67/1 acting [1] 65/7 action [2] 23/3 50/18 actions [1] 67/7 active [1] 18/13 actively [3] 18/10 18/20 46/5 activities [1] 66/7 acts [2] 18/25 20/1 actual [1] 41/1 acute [5] 16/5 17/1 18/9 59/24 63/20 acutely [2] 25/22 53/7 adapt [2] 36/25 40/17 adaptation [2] 37/6 57/4 add [1] 11/6 addition [4] 1/25 9/15 39/13 80/4 additional [6] 1/20 10/8 59/17 78/19 79/4 79/19 address [26] 3/19 7/23 16/1 26/2 27/21 30/13 33/13 36/23 37/19 38/9 40/16 41/9 42/2 43/22 47/10 50/4 50/21 51/21 60/24 62/15 65/16 67/9 71/23 74/2 74/7 77/14 addressed [5] 54/18	58/8 59/2 62/11 66/12 addresses [1] 52/4 addressing [2] 54/15 61/8 adequacy [2] 6/23 7/4 adequate [1] 74/11 adequately [4] 37/19 61/25 63/4 65/16 adhere [1] 25/3 adherence [10] 34/4 36/17 37/4 41/1 41/22 54/3 58/3 61/12 74/14 80/3 adherent [3] 36/4 36/7 36/12 adjournment [1] 80/25 adjustment [1] 37/5 adjustments [1] 41/25 admission [11] 6/17 16/11 18/12 28/2 45/7 49/6 60/3 60/7 60/19 68/9 76/24 admissions [3] 28/24 29/20 29/22 admitted [8] 22/15 26/4 28/22 29/15 33/1 49/2 59/5 60/4 Adolescent [1] 38/13 adult [1] 44/7 adverse [3] 37/7 39/1 39/23 advice [2] 40/10 52/23 advised [2] 24/25 66/23 affect [1] 9/8 after [15] 1/17 3/25 7/4 15/10 15/14 24/13 26/25 39/11 50/25 52/22 57/23 64/17 71/3 71/20 71/25 aftercare [1] 74/16 afternoon [1] 69/19 afterwards [1] 26/3 again [5] 5/24 52/10 54/9 76/16 80/23 against [2] 19/13 79/14 age [1] 12/14 agencies [7] 1/16 10/5 20/21 42/19 45/21 64/5 78/20 agency [5] 8/6 47/18 64/3 75/21 76/1 ages [1] 12/12 aggression [7] 18/12 22/22 45/14 50/15 57/25 59/14 66/9 aggressive [3] 22/15 23/10 24/14 agitation [1] 21/20 agreed [1] 60/13 aim [2] 1/9 2/17
1 1 October 1997 [1] 68/20 1 to [1] 14/12 1.30 [1] 80/23 10 years [1] 69/17 10.00 [1] 1/2 11.22 [1] 54/11 11.40 [2] 54/9 54/13 117 [1] 74/15 12 [2] 5/2 5/7 12.26 [1] 80/24 135 [1] 52/24 136 [4] 21/12 21/19 21/25 32/7 15 [1] 13/23 175 [1] 55/12 19 [1] 25/13 19.7 [1] 69/6 19.9 [1] 67/16 1983 [5] 30/12 51/7 68/9 68/11 68/17 1990s [1] 75/14 1992 [1] 14/10 1994 [4] 2/4 4/11 9/22 14/20 1997 [1] 68/20	4 402 [1] 63/12 41 [1] 68/11 420 [1] 18/25 43 [1] 25/13 437 [1] 28/3 44 [5] 1/20 4/23 5/1 20/8 25/13 440 [1] 47/19 450 [1] 42/10 451 [1] 15/20 454 [1] 19/2 455 [1] 35/8 45A [1] 68/16 46 [2] 50/10 55/14 464 [1] 55/16 466 [1] 55/1 467 [1] 42/7 472 [1] 55/3 475 [2] 28/11 34/25 477 [1] 63/7 48 [2] 19/4 19/25 483 [1] 47/17 484 [1] 28/9 49 [1] 36/6 49.6 [1] 68/14 496 [1] 10/14	7 70 [1] 20/9 72 [1] 23/19 73 [3] 23/24 35/3 35/12 76 [1] 63/12 77 [1] 20/9 78 [1] 24/1 79 [1] 13/19	8 80 [2] 19/1 20/1 800 [1] 41/9 81 [1] 35/18 83 [2] 28/3 47/20 85 [4] 12/9 15/21 42/11 72/17 86 [3] 19/2 20/13 35/8 87 [1] 12/5 88 [2] 55/2 55/16 88% per cent [1] 42/8 89 [1] 55/4	admission [11] 6/17 16/11 18/12 28/2 45/7 49/6 60/3 60/7 60/19 68/9 76/24 admissions [3] 28/24 29/20 29/22 admitted [8] 22/15 26/4 28/22 29/15 33/1 49/2 59/5 60/4 Adolescent [1] 38/13 adult [1] 44/7 adverse [3] 37/7 39/1 39/23 advice [2] 40/10 52/23 advised [2] 24/25 66/23 affect [1] 9/8 after [15] 1/17 3/25 7/4 15/10 15/14 24/13 26/25 39/11 50/25 52/22 57/23 64/17 71/3 71/20 71/25 aftercare [1] 74/16 afternoon [1] 69/19 afterwards [1] 26/3 again [5] 5/24 52/10 54/9 76/16 80/23 against [2] 19/13 79/14 age [1] 12/14 agencies [7] 1/16 10/5 20/21 42/19 45/21 64/5 78/20 agency [5] 8/6 47/18 64/3 75/21 76/1 ages [1] 12/12 aggression [7] 18/12 22/22 45/14 50/15 57/25 59/14 66/9 aggressive [3] 22/15 23/10 24/14 agitation [1] 21/20 agreed [1] 60/13 aim [2] 1/9 2/17
2 2.3 [1] 68/21 20 [1] 5/1 20 years [2] 52/2 57/11 2000s [2] 75/14 75/18 2003 [3] 4/14 4/15 4/23 2005 [4] 12/8 14/14 23/23 36/1 2007 [1] 32/15 2011 [1] 71/2 2013 [1] 14/23 2015 [7] 12/9 14/15 15/1 23/23 36/1 75/18 75/23 2017 [2] 23/23 35/25 2023 [3] 1/12 4/18 14/10 2024 [1] 4/24 2025 [2] 1/5 51/10 2026 [1] 1/1 22 May 2025 [1] 1/5	5 505 [1] 28/7 51 [1] 72/11 516 [1] 3/21 524 [2] 27/24 72/7 528 [21] 2/7 6/5 6/7 10/14 12/4 15/19 15/21 18/25 19/2 23/19 27/24 28/12 35/1 35/8 42/7 42/10 47/17 50/9 54/25 61/4 63/7	9 90 [4] 28/12 35/1 35/14 63/9 92 [2] 28/9 47/18 94 [1] 14/19 95 [1] 9/5 96 [1] 28/7 99 [1] 28/2	A ability [1] 62/6 able [1] 12/15 about [9] 20/17 41/6 45/13 70/5 73/18 73/19 79/17 79/20 80/13 absence [11] 25/7 31/9 39/19 46/23 52/16 54/5 56/17 60/2 60/13 63/25 65/25 absent [1] 46/10 accept [1] 16/12 accepted [2] 10/2 48/16	activities [1] 66/7 acts [2] 18/25 20/1 actual [1] 41/1 acute [5] 16/5 17/1 18/9 59/24 63/20 acutely [2] 25/22 53/7 adapt [2] 36/25 40/17 adaptation [2] 37/6 57/4 add [1] 11/6 addition [4] 1/25 9/15 39/13 80/4 additional [6] 1/20 10/8 59/17 78/19 79/4 79/19 address [26] 3/19 7/23 16/1 26/2 27/21 30/13 33/13 36/23 37/19 38/9 40/16 41/9 42/2 43/22 47/10 50/4 50/21 51/21 60/24 62/15 65/16 67/9 71/23 74/2 74/7 77/14 addressed [5] 54/18

<p>A</p> <p>alcohol [6] 23/16 23/25 24/2 25/12 27/11 59/12</p> <p>alcohol misuse [1] 23/25</p> <p>alignment [1] 9/4</p> <p>all [20] 2/2 2/10 3/7 3/23 5/11 9/15 9/20 9/25 14/8 14/19 14/20 15/4 28/15 52/2 58/7 70/2 72/22 73/8 78/22 80/11</p> <p>allowing [1] 34/16</p> <p>alongside [1] 35/14</p> <p>already [3] 31/18 58/8 73/4</p> <p>also [59] 1/15 1/21 7/3 11/12 15/24 19/14 21/10 23/10 23/16 24/3 27/7 27/13 29/25 30/2 30/10 34/8 36/2 36/17 37/1 37/14 37/23 39/9 40/23 42/20 43/2 43/11 45/10 45/25 47/3 49/16 51/17 53/10 53/13 56/7 56/22 58/5 59/16 59/21 60/17 61/2 61/16 62/23 63/16 65/1 65/19 67/6 67/25 68/6 69/2 69/13 70/4 71/11 71/19 73/1 75/7 76/11 77/4 79/16 80/19</p> <p>altered [1] 27/2</p> <p>alternative [7] 37/21 38/4 40/13 59/18 68/3 69/4 76/23</p> <p>although [11] 15/1 21/22 24/15 31/6 44/10 48/5 51/11 53/19 60/4 64/21 66/25</p> <p>always [1] 78/9</p> <p>am [3] 1/2 54/11 54/13</p> <p>ambulance [1] 52/9</p> <p>Amidst [1] 69/21</p> <p>amongst [1] 77/18</p> <p>amphetamines [2] 25/24 26/6</p> <p>analysed [11] 2/8 3/25 8/5 10/11 12/3 15/19 27/25 30/10 49/10 55/18 68/6</p> <p>analysis [28] 2/10 2/18 3/6 5/12 5/21 6/8 6/13 7/6 7/21 8/14 8/21 9/1 9/3 10/14 10/22 11/7 12/4 12/14 14/16 19/5 19/19 20/12 43/1 67/7 67/9 72/1 72/8 77/18</p> <p>animals [1] 19/13</p>	<p>annual [2] 23/22 35/25</p> <p>another [15] 13/11 13/12 19/6 22/3 22/11 23/15 33/16 35/15 49/1 57/6 59/4 59/23 70/11 76/14 77/9</p> <p>answers [1] 73/12</p> <p>antecedents [1] 77/19</p> <p>anticipated [1] 36/22</p> <p>antidepressant [2] 38/15 38/24</p> <p>antipsychotic [9] 16/16 16/19 30/1 33/21 35/5 35/21 37/25 52/5 53/2</p> <p>any [18] 6/15 6/16 6/19 6/20 7/17 8/10 9/7 20/10 23/6 25/7 28/11 30/7 39/17 49/21 72/22 73/11 76/25 79/11</p> <p>apologetic [1] 48/14</p> <p>Apologies [1] 4/19</p> <p>apparent [2] 16/19 40/24</p> <p>appear [1] 75/10</p> <p>appeared [4] 8/19 30/24 47/5 48/15</p> <p>appearing [2] 21/14 32/8</p> <p>appears [3] 7/23 64/8 67/11</p> <p>Appleby [2] 76/3 76/17</p> <p>application [2] 19/6 19/12</p> <p>applied [3] 7/10 8/21 19/9</p> <p>apply [1] 62/10</p> <p>appointment [1] 36/14</p> <p>appointments [3] 41/3 66/6 66/15</p> <p>approach [16] 11/1 12/18 36/25 37/18 40/17 41/23 55/23 57/5 64/23 74/10 74/15 74/18 75/17 77/9 78/4 80/21</p> <p>approaches [3] 37/3 56/2 59/19</p> <p>appropriate [2] 43/8 66/14</p> <p>approximately [5] 26/21 35/18 50/25 52/19 57/11</p> <p>are [35] 3/2 3/3 3/14 4/2 6/5 9/7 9/12 9/23 9/25 11/24 14/17 14/22 15/17 20/1 20/2 31/20 47/14 54/17 54/20 54/24 58/7 63/16 68/12 69/15 69/16 71/8 74/5 75/12</p>	<p>75/12 77/10 77/12 78/14 79/8 80/5 80/8</p> <p>area [2] 50/7 74/2</p> <p>aren't [1] 69/19</p> <p>arise [5] 36/16 37/15 42/25 43/21 56/23</p> <p>arisen [1] 64/15</p> <p>arises [1] 56/22</p> <p>arising [5] 7/24 17/10 31/19 62/12 66/3</p> <p>armed [1] 25/20</p> <p>arose [1] 53/10</p> <p>around [3] 30/12 75/18 75/23</p> <p>arranged [1] 32/21</p> <p>arrangements [9] 39/3 56/5 56/8 56/11 59/20 62/25 65/15 78/3 79/25</p> <p>arrest [2] 23/10 26/5</p> <p>arrested [2] 26/2 26/15</p> <p>as [100]</p> <p>aspect [1] 78/1</p> <p>aspects [2] 14/3 54/21</p> <p>assault [4] 48/1 48/3 48/9 59/3</p> <p>assaulted [4] 22/10 29/10 49/1 59/23</p> <p>assaulting [1] 25/18</p> <p>assaults [1] 19/11</p> <p>assertive [3] 34/20 75/8 75/20</p> <p>assertively [1] 33/10</p> <p>assess [5] 31/3 41/22 44/5 46/1 79/9</p> <p>assessed [7] 8/3 30/7 30/19 46/5 50/17 60/16 61/23</p> <p>assessing [5] 18/16 42/14 42/21 54/7 80/2</p> <p>assessment [50] 20/16 21/16 22/2 26/16 30/23 31/2 31/7 31/9 32/11 42/5 42/7 42/12 42/24 43/3 43/4 43/6 43/10 43/12 44/17 44/23 45/11 45/18 46/6 47/7 47/8 47/10 47/13 48/17 49/13 50/2 50/23 51/17 53/10 54/18 54/19 61/1 61/16 62/4 63/18 65/4 65/19 75/17 75/20 77/7 77/9 77/12 78/1 78/5 78/13 78/23</p> <p>assessments [19] 6/23 29/3 31/16 42/3 43/6 43/17 45/3 45/6 48/5 48/7 53/22 54/22 74/9 74/12 74/13 77/1 77/13 77/22 78/10</p> <p>assigned [1] 11/25</p> <p>assist [5] 2/20 11/18</p>	<p>27/18 50/22 80/17</p> <p>assistance [2] 18/11 80/20</p> <p>assisted [2] 14/25 60/20</p> <p>assisting [1] 76/21</p> <p>associated [10] 16/25 17/6 24/25 29/20 44/19 56/20 57/15 59/14 65/16 77/21</p> <p>assumed [1] 23/3</p> <p>assurance [4] 43/9 74/13 75/25 79/17</p> <p>assure [1] 78/2</p> <p>at [70] 5/3 8/18 8/23 12/21 13/25 13/25 14/2 14/21 15/11 15/16 16/11 17/25 19/4 19/7 19/25 20/1 20/13 21/17 21/18 22/4 22/6 22/17 24/21 25/12 25/21 26/1 26/9 26/15 26/16 27/9 27/9 28/8 28/11 29/10 30/3 30/12 30/15 32/1 32/17 32/18 35/14 39/24 41/9 44/1 45/1 47/4 47/12 47/17 49/6 51/9 52/2 54/9 58/10 63/3 63/20 65/11 65/12 65/19 66/21 68/5 69/14 71/14 72/22 73/3 73/7 77/11 77/12 79/5 79/15 80/23</p> <p>attached [1] 69/11</p> <p>attack [29] 6/13 12/21 13/12 15/9 15/12 15/14 15/15 15/16 17/21 18/8 20/8 21/10 22/17 25/16 25/21 27/7 28/14 30/4 30/12 30/22 31/21 32/1 33/14 47/23 50/12 50/24 57/19 70/13 71/2</p> <p>attacked [3] 21/5 26/9 30/15</p> <p>attacker [9] 11/10 11/14 13/19 22/3 25/11 27/5 27/7 33/14 33/16</p> <p>attacker's [2] 6/14 11/16</p> <p>attackers [7] 12/5 12/12 20/12 28/16 29/2 35/14 67/7</p> <p>attacks [12] 1/11 1/14 4/23 6/3 7/4 12/3 12/5 14/9 14/11 17/16 27/9 33/1</p> <p>attempted [1] 17/21</p> <p>attempts [1] 21/20</p> <p>attend [2] 38/2 52/9</p> <p>attendance [3] 30/3</p>	<p>41/14 50/16</p> <p>attended [1] 41/2</p> <p>attention [2] 4/22 42/20</p> <p>attracted [1] 10/3</p> <p>attributed [1] 34/10</p> <p>audit [1] 79/8</p> <p>auditing [4] 9/3 42/9 43/9 74/13</p> <p>auditors [1] 9/5</p> <p>auditory [2] 18/2 39/15</p> <p>August [1] 22/16</p> <p>authorising [2] 68/9 68/12</p> <p>authorities [1] 50/19</p> <p>authority [1] 49/19</p> <p>availability [3] 6/25 44/22 55/11</p> <p>available [34] 2/2 2/6 2/19 2/25 4/25 5/1 5/7 6/5 7/10 7/15 9/25 10/2 10/7 10/15 10/17 11/20 12/11 13/15 14/4 14/17 14/21 27/16 34/11 39/8 49/14 52/16 54/6 58/19 67/20 68/23 69/1 72/2 73/22 80/2</p> <p>average [1] 73/21</p> <p>awaited [1] 4/17</p> <p>aware [2] 23/4 44/11</p> <p>away [1] 25/4</p> <hr/> <p>B</p> <p>background [1] 1/15</p> <p>bad [1] 8/7</p> <p>base [1] 41/4</p> <p>based [12] 2/9 3/3 5/9 6/1 6/7 13/6 14/16 15/8 31/14 45/18 47/9 48/18</p> <p>basic [2] 75/17 76/20</p> <p>basis [7] 11/15 23/1 26/21 67/14 68/2 70/18 71/8</p> <p>battery [1] 19/7</p> <p>be [55] 2/13 3/5 3/6 3/8 3/10 3/14 5/20 9/1 10/3 10/5 10/6 11/12 13/18 14/6 14/19 14/22 19/9 19/15 21/14 21/16 23/2 23/4 23/18 24/6 25/11 27/5 27/24 28/18 29/4 30/25 32/8 32/11 34/24 35/13 35/22 37/8 38/7 42/21 46/4 50/13 54/8 58/5 59/13 60/15 63/4 64/22 68/1 68/6 68/14 69/15 70/20 74/6 76/25 77/23 80/6</p> <p>because [2] 20/2 66/13</p> <p>become [3] 53/14</p>
---	--	--	---	--

<p>B</p> <p>become... [2] 63/19 64/8</p> <p>bed [3] 22/11 34/11 55/11</p> <p>been [110]</p> <p>before [18] 13/12 15/14 15/16 17/19 21/10 24/13 26/4 26/16 30/3 31/1 31/5 32/1 36/12 38/16 73/11 74/3 77/2 80/10</p> <p>begins [1] 57/5</p> <p>behaved [2] 49/7 77/20</p> <p>behaviour [17] 22/15 23/1 23/10 24/14 26/13 29/21 42/17 45/13 49/4 49/9 49/14 50/15 52/8 54/3 57/25 59/7 66/10</p> <p>behavioural [1] 59/14</p> <p>behaviours [2] 19/10 77/19</p> <p>behind [2] 25/4 55/21</p> <p>being [14] 2/24 2/25 10/18 26/4 26/17 33/6 33/24 36/3 41/17 44/8 64/18 71/3 72/10 77/15</p> <p>belief [1] 16/8</p> <p>beliefs [2] 17/2 22/21</p> <p>below [1] 66/23</p> <p>best [2] 77/11 78/16</p> <p>between [19] 6/22 8/10 9/4 12/16 17/10 22/16 31/22 37/16 42/18 44/14 45/9 52/18 58/25 61/22 62/13 62/19 64/5 69/13 73/21</p> <p>beyond [1] 1/11</p> <p>birth [1] 12/12</p> <p>blood [2] 66/25 79/10</p> <p>blows [1] 17/22</p> <p>blunt [1] 17/23</p> <p>Board [1] 71/20</p> <p>bodies [1] 3/18</p> <p>body [2] 7/19 11/24</p> <p>both [7] 22/4 22/5 24/5 43/25 50/2 58/11 65/6</p> <p>bottle [1] 27/6</p> <p>break [3] 54/8 54/12 80/10</p> <p>breakdown [3] 16/22 67/10 68/6</p> <p>brief [3] 29/22 67/17 73/19</p> <p>briefly [1] 31/19</p> <p>bring [1] 78/18</p> <p>bringing [1] 46/16</p> <p>broad [1] 27/22</p> <p>broader [4] 7/23 46/1</p>	<p>62/10 67/4</p> <p>broadly [1] 38/18</p> <p>broken [1] 11/19</p> <p>brought [2] 4/22 44/4</p> <p>but [31] 1/23 4/16 5/16 5/24 8/15 9/24 13/12 14/20 15/11 19/2 20/9 21/2 21/5 33/21 36/17 36/23 45/8 48/14 52/13 57/19 61/24 62/23 65/19 66/11 67/19 68/18 70/14 73/19 74/6 75/12 80/15</p> <p>butcher's [1] 21/6</p> <p>C</p> <p>called [1] 24/13</p> <p>came [2] 32/15 68/19</p> <p>can [18] 3/10 3/16 12/18 13/18 15/5 20/24 23/18 24/2 24/3 24/6 27/17 38/7 50/13 58/5 68/13 68/20 76/18 78/18</p> <p>cannabis [1] 26/7</p> <p>cannot [1] 3/5</p> <p>capacity [11] 53/7 60/25 60/25 61/1 61/4 61/5 61/16 62/1 62/4 62/13 75/25</p> <p>care [68] 4/9 4/13 6/10 6/23 7/22 13/5 22/5 22/10 24/20 27/14 27/15 29/11 32/24 34/5 34/16 38/13 39/7 39/12 42/19 44/1 44/19 45/7 46/10 48/25 49/25 50/2 53/18 53/22 54/1 54/16 54/20 54/21 54/22 54/23 55/2 55/19 55/23 56/1 56/3 56/4 56/7 56/14 56/17 58/11 58/13 59/4 59/8 59/22 60/2 60/6 60/8 60/12 60/13 61/9 62/20 63/18 64/1 64/21 64/23 65/3 65/9 66/18 74/14 74/15 75/16 76/15 77/1 78/21</p> <p>carefully [1] 11/15</p> <p>caregivers [1] 75/5</p> <p>carer [1] 65/7</p> <p>carer's [1] 65/4</p> <p>carers [5] 6/23 50/3 50/8 53/20 53/25</p> <p>caring [1] 44/11</p> <p>carried [7] 1/11 17/16 21/16 25/15 32/11 67/6 71/25</p> <p>Carry [1] 79/8</p> <p>carrying [2] 45/15 46/23</p> <p>case [93]</p>	<p>cases [142]</p> <p>categories [2] 9/24 13/14</p> <p>categorised [1] 69/7</p> <p>category [10] 12/22 12/23 13/3 13/11 13/11 13/22 67/17 67/19 68/22 68/24</p> <p>causative [2] 8/10 8/16</p> <p>causes [1] 36/24</p> <p>CCTV [1] 27/6</p> <p>ceased [3] 18/4 33/23 52/5</p> <p>cent [1] 42/8</p> <p>central [1] 60/9</p> <p>centred [1] 78/23</p> <p>certain [2] 11/2 11/8</p> <p>cessation [1] 40/4</p> <p>Chair [53] 1/5 2/12 2/15 2/17 3/8 3/12 6/3 7/7 8/5 10/7 11/18 12/3 12/6 12/18 13/18 14/3 15/5 15/17 15/23 18/21 19/15 19/24 20/22 23/15 23/20 24/8 25/10 27/9 27/21 28/15 30/10 32/14 34/21 35/25 42/2 47/8 50/21 51/21 53/4 54/8 54/15 60/24 62/15 67/6 68/5 70/22 71/19 71/23 73/18 74/2 79/2 80/4 80/8</p> <p>challenges [2] 57/1 59/13</p> <p>change [3] 58/21 78/13 79/11</p> <p>changes [4] 27/1 56/19 76/15 78/25</p> <p>changing [2] 30/17 43/17</p> <p>characterised [1] 52/7</p> <p>charity [2] 15/1 69/9</p> <p>chart [1] 13/18</p> <p>child [3] 38/12 38/13 61/20</p> <p>choice [1] 61/13</p> <p>Christmas [1] 39/6</p> <p>Christopher [1] 4/13</p> <p>chronic [1] 57/21</p> <p>circumstances [15] 1/13 5/18 11/4 21/8 21/24 31/24 36/21 37/20 43/17 43/22 48/8 56/14 57/3 61/10 70/20</p> <p>clarify [3] 13/16 35/23 60/11</p> <p>clarity [3] 14/5 65/13 70/18</p> <p>classification [1] 67/18</p> <p>classified [1] 67/16</p> <p>clear [7] 8/21 18/9</p>	<p>38/1 56/18 58/22 60/14 74/20</p> <p>clear-cut [1] 8/21</p> <p>clearer [1] 60/20</p> <p>clearly [5] 20/1 56/8 63/25 67/21 68/25</p> <p>clinical [27] 1/15 6/14 6/16 8/6 11/13 11/17 18/11 27/15 29/4 35/19 37/17 38/19 39/22 40/10 44/4 46/25 47/5 50/2 59/9 60/14 62/23 64/24 66/12 66/20 67/4 72/14 78/19</p> <p>clinician [2] 56/4 59/13</p> <p>clinicians [11] 15/9 15/14 18/6 41/13 42/18 44/10 45/20 48/10 54/6 60/9 60/20</p> <p>close [1] 38/23</p> <p>closely [3] 23/20 54/17 63/17</p> <p>closer [1] 41/5</p> <p>closest [1] 12/21</p> <p>clozapine [4] 66/22 75/2 79/9 79/13</p> <p>Clunis [1] 4/13</p> <p>cocaine [3] 26/6 26/20 26/21</p> <p>code [1] 11/25</p> <p>coherent [1] 46/6</p> <p>cohort [41] 2/18 2/20 3/9 11/20 15/20 15/21 18/24 28/2 28/3 28/6 28/7 28/10 28/12 28/24 35/1 35/4 35/6 35/9 36/5 42/8 42/11 47/18 47/20 50/10 54/25 55/2 55/4 55/6 55/10 55/12 57/18 61/2 61/4 63/7 63/10 63/13 63/15 67/12 68/21 69/7 72/6</p> <p>coincided [1] 16/20</p> <p>collateral [1] 50/1</p> <p>collect [1] 41/3</p> <p>collection [3] 41/11 41/15 79/19</p> <p>combination [2] 2/5 38/17</p> <p>combined [1] 25/5</p> <p>command [1] 16/7</p> <p>commence [1] 39/5</p> <p>commencement [1] 38/24</p> <p>commented [1] 72/5</p> <p>commissioned [3] 4/2 9/24 14/24</p> <p>commissioning [1] 9/18</p> <p>committed [1] 18/25</p> <p>committing [1] 32/25</p> <p>common [2] 19/7 72/20</p>	<p>communicated [1] 12/1</p> <p>communication [7] 6/22 47/13 47/15 47/19 50/7 50/8 65/9</p> <p>community [29] 14/18 16/15 16/15 28/8 28/10 29/11 29/18 30/9 31/14 32/14 33/4 33/21 34/12 34/20 41/4 44/8 51/2 53/5 56/22 62/19 63/1 63/9 63/22 65/15 71/1 74/21 79/9 79/21 79/23</p> <p>comparable [2] 12/6 23/20</p> <p>comparison [1] 6/8</p> <p>compel [1] 25/7</p> <p>compendious [1] 15/3</p> <p>complained [1] 73/7</p> <p>complete [5] 3/6 10/10 14/8 78/9 78/12</p> <p>completed [6] 45/6 64/25 65/5 73/4 78/24 80/12</p> <p>completely [1] 7/16</p> <p>complex [1] 55/25</p> <p>compliance [20] 18/13 24/6 25/8 29/25 33/2 33/7 33/23 34/23 35/7 35/10 35/10 41/15 41/20 41/23 45/14 66/7 67/4 79/3 79/18 80/3</p> <p>comply [1] 24/24</p> <p>component [1] 54/1</p> <p>comprehensive [4] 39/16 44/17 74/17 78/22</p> <p>comprise [1] 13/21</p> <p>compulsory [2] 31/8 62/14</p> <p>concern [6] 50/11 51/4 57/19 61/10 70/5 71/11</p> <p>concerned [29] 10/14 16/3 17/15 22/9 24/8 25/15 25/25 26/8 29/8 30/10 31/21 33/15 38/11 39/25 43/24 44/25 46/8 47/24 50/24 53/13 58/9 59/3 59/22 61/17 64/16 65/21 66/16 71/17 73/14</p> <p>concerning [10] 42/2 42/9 47/11 50/4 52/8 54/17 60/24 66/10 75/15 75/25</p> <p>concerns [46] 6/20 29/25 30/8 34/5 34/22 35/6 35/9 37/24 38/21 40/14 40/16 41/6 42/6 42/23 43/11 43/13</p>
---	--	--	---	---

<p>C</p> <p>concerns... [30] 44/2 45/3 45/10 45/13 47/15 47/18 49/19 50/8 53/4 53/9 53/17 55/5 55/7 55/13 55/14 58/13 59/9 60/1 61/4 63/11 64/4 65/8 65/24 66/20 70/9 70/16 71/24 72/9 72/12 79/20</p> <p>conclude [1] 31/6 concluded [21] 16/24 17/9 18/16 21/17 21/24 30/20 31/2 32/11 34/1 39/19 40/15 41/21 44/15 45/17 48/17 49/22 51/14 59/15 62/9 65/12 67/2</p> <p>conclusion [1] 2/3 conclusions [1] 76/7 concordance [12] 24/4 35/2 35/4 35/13 35/17 35/20 36/18 36/21 37/2 40/18 41/24 74/24</p> <p>condition [13] 16/12 25/6 31/1 37/13 37/19 41/19 52/11 53/2 56/6 59/10 59/12 63/6 70/8</p> <p>conditional [1] 69/5 conditions [2] 34/4 77/22</p> <p>Conduct [1] 77/5 conducted [1] 26/5 Confidential [5] 12/7 14/13 23/21 36/1 76/3</p> <p>confirmed [3] 67/22 68/1 69/1</p> <p>connected [1] 13/4 consented [1] 77/2 consequence [1] 59/12</p> <p>consequences [1] 77/19</p> <p>consider [8] 4/8 18/21 31/11 34/21 42/17 59/18 61/25 72/14</p> <p>consideration [7] 5/17 6/9 7/3 17/7 67/3 74/5 79/14</p> <p>considered [29] 4/21 5/21 5/23 6/3 6/12 7/22 11/14 11/23 12/4 14/9 14/11 18/14 21/11 23/2 24/16 29/6 30/18 32/5 33/5 36/6 47/15 53/5 61/2 61/3 63/17 71/6 71/18 72/6 75/11</p> <p>considering [4] 20/14 42/14 59/21 80/18</p>	<p>consistent [4] 10/24 34/2 38/19 56/1</p> <p>consistently [5] 12/11 19/21 45/8 45/16 46/24</p> <p>consultant [1] 74/18 consultation [1] 64/1 contact [24] 4/6 9/16 9/17 18/22 19/1 20/13 28/1 28/16 29/1 29/8 29/13 30/2 34/17 36/8 38/25 41/5 45/4 48/2 49/21 57/1 61/22 72/25 73/7 75/4</p> <p>contacted [2] 51/3 52/10</p> <p>contacts [1] 31/22 contained [2] 15/24 43/2</p> <p>context [11] 25/2 28/17 35/22 40/8 48/22 54/19 59/8 64/6 64/15 66/19 74/20</p> <p>contingency [2] 56/8 65/4</p> <p>continue [2] 33/11 37/8</p> <p>continued [6] 17/12 17/21 23/9 30/2 42/24 52/18</p> <p>continuity [1] 58/13 contradictory [1] 8/19</p> <p>contrast [1] 13/9 contribute [3] 1/10 23/5 39/12</p> <p>contributed [1] 40/17 contributing [2] 25/8 40/20</p> <p>conventional [2] 49/2 59/5</p> <p>convicted [5] 20/14 20/25 23/24 32/3 70/23</p> <p>conviction [1] 19/24 convictions [3] 12/10 19/3 20/15</p> <p>cooperation [1] 24/4 coordinated [2] 56/1 56/17</p> <p>coordinating [1] 56/4 coordination [5] 6/24 55/3 55/23 62/24 64/5</p> <p>coordinator [1] 34/16 core [1] 8/11</p> <p>coroners' [1] 4/9 coronial [1] 73/11 correct [1] 69/20 correlating [6] 55/9 55/14 61/6 63/9 63/12 63/15</p> <p>corresponding [5] 15/21 24/1 28/5 35/6 55/4</p> <p>could [16] 5/20 9/1 10/2 19/9 21/24 23/10</p>	<p>27/5 31/6 32/21 33/10 35/9 36/22 44/22 46/20 60/15 60/22</p> <p>counts [1] 5/20 couple [1] 16/1 coupled [1] 39/21 course [3] 20/18 45/4 75/10</p> <p>court [2] 25/21 69/24 courts [1] 67/8</p> <p>cousin [2] 40/1 53/14 covering [2] 23/23 35/25</p> <p>covers [1] 2/21 CPA [2] 64/24 76/25 created [1] 46/18 criminal [5] 7/5 23/3 49/21 67/8 67/24</p> <p>crisis [4] 18/10 52/16 56/7 75/20</p> <p>criteria [6] 1/22 5/15 18/17 21/18 32/12 57/17</p> <p>critical [2] 50/1 62/20 criticisms [1] 72/11 CTO [6] 32/22 33/8 33/14 33/19 34/1 34/19</p> <p>CTOs [3] 32/15 32/17 32/20</p> <p>Culturally [1] 37/12 current [4] 13/22 46/16 78/19 79/14</p> <p>custodial [1] 62/18 custody [1] 26/17 cut [1] 8/21</p> <p>cycle [1] 58/4 cycles [1] 40/18</p> <hr/> <p>D</p> <p>daily [1] 26/21 damage [2] 26/15 50/15</p> <p>dangerous [1] 24/3 dangerousness [1] 42/15</p> <p>data [4] 11/20 19/21 35/14 68/22</p> <p>dataset [5] 2/6 10/7 14/3 20/4 25/10</p> <p>date [1] 6/13 dates [1] 12/12</p> <p>daughter [3] 43/25 51/24 58/10</p> <p>daughter's [1] 52/11 day [4] 26/10 26/23 31/23 70/15</p> <p>days [3] 18/8 22/7 59/25</p> <p>de [1] 24/16 de-escalated [1] 24/16</p> <p>deadlines [1] 76/12 death [8] 8/11 24/10 30/16 53/15 59/25 61/19 67/23 69/2</p>	<p>decade [1] 75/23 deceased [8] 3/14 10/19 11/3 13/19 21/7 70/15 71/2 72/13</p> <p>deceased's [1] 27/4 decision [7] 21/23 39/4 52/15 62/5 64/9 67/2 70/19</p> <p>decision-making [1] 70/19</p> <p>decisions [4] 49/24 51/19 64/3 64/5</p> <p>decline [1] 57/5 declined [1] 52/9 declining [1] 66/5 deemed [2] 10/12 21/22</p> <p>deeper [1] 11/22 deeply [1] 71/17 deficiencies [1] 46/14</p> <p>defined [3] 13/13 19/5 63/25</p> <p>definition [1] 19/8 definitions [1] 19/17</p> <p>degree [1] 8/23 delayed [1] 73/25 delays [4] 34/8 34/9 55/12 72/25</p> <p>delivery [5] 54/20 59/8 59/22 76/12 79/10</p> <p>delusional [1] 17/2 delusions [3] 16/7 18/2 52/7</p> <p>demonstrate [1] 48/7 demonstrated [2] 35/12 49/3</p> <p>demonstrates [2] 42/23 55/21</p> <p>demonstrating [3] 29/23 47/22 51/18</p> <p>denial [2] 37/13 62/3 denied [1] 30/7 depot [3] 37/25 38/5 75/2</p> <p>depression [1] 38/20 derive [1] 47/5 derived [3] 5/10 6/1 79/17</p> <p>descending [1] 3/19 described [13] 10/6 18/6 19/10 26/13 26/20 26/25 27/15 29/22 30/5 37/11 50/14 71/15 71/19</p> <p>describes [3] 57/9 57/22 70/12</p> <p>descriptive [2] 3/9 14/7</p> <p>despite [10] 22/24 23/13 33/6 40/9 44/20 49/8 50/16 52/8 58/2 62/2</p> <p>detail [5] 3/16 8/18 19/11 27/14 48/15</p>	<p>detailed [2] 20/19 52/11</p> <p>detain [1] 52/13 detained [6] 16/13 21/2 26/3 52/25 57/13 68/13</p> <p>detention [14] 6/18 18/14 18/17 21/4 21/18 24/22 28/4 29/16 31/8 51/20 52/1 58/1 68/10 69/6</p> <p>deteriorating [1] 51/5 deterioration [15] 18/9 30/25 33/17 34/7 39/23 40/2 40/11 40/19 52/6 56/6 57/15 59/1 60/5 61/15 63/6</p> <p>determine [3] 34/17 60/10 62/7</p> <p>determined [1] 10/12 developed [2] 59/11 60/7</p> <p>developing [1] 60/20 development [5] 54/22 56/2 58/23 74/23 75/4</p> <p>developments [1] 45/9</p> <p>diagnosed [1] 18/1 diagnoses [1] 27/10 diagnosis [8] 6/15 7/8 15/6 15/7 15/18 37/16 51/25 57/8</p> <p>did [15] 1/22 5/14 12/11 13/15 16/12 25/3 33/11 35/23 37/18 40/25 48/7 52/13 53/6 65/15 78/9</p> <p>died [2] 17/22 22/11 difference [1] 14/15 differences [1] 9/7 different [6] 1/20 8/22 44/4 46/20 46/20 56/9</p> <p>differing [1] 8/22 difficult [1] 76/9 difficulties [5] 36/16 37/15 44/21 56/21 56/23</p> <p>difficulty [1] 25/9 diminished [5] 21/1 67/14 68/2 70/24 71/8</p> <p>Director [1] 76/3 disagreement [1] 11/13</p> <p>discharge [41] 7/2 34/16 40/5 45/8 51/20 57/2 57/14 62/15 62/18 62/22 63/2 63/11 63/13 63/16 63/20 63/25 64/2 64/3 64/4 64/5 64/9 64/15 64/20 64/21 65/2 65/11 65/13 65/20 65/25 66/4 66/19 66/22 66/25 67/2 67/5</p>
--	--	---	--	---

<p>D</p> <p>discharge... [6] 69/5 74/17 76/19 76/24 77/2 77/5</p> <p>discharged [9] 16/14 29/17 30/8 33/20 51/1 63/8 64/18 66/17 71/1</p> <p>discontinuation [1] 57/16</p> <p>discontinued [1] 16/20</p> <p>discovered [1] 41/8</p> <p>discrete [1] 68/24</p> <p>discussed [3] 47/1 58/5 65/18</p> <p>discussions [1] 53/23</p> <p>disengagement [3] 36/24 40/12 62/2</p> <p>disorder [3] 21/14 32/9 57/9</p> <p>disordered [1] 30/5</p> <p>disposal [7] 7/5 68/5 68/22 68/25 69/3 69/11 70/2</p> <p>disposals [1] 69/5</p> <p>disposed [1] 67/8</p> <p>dispute [1] 22/8</p> <p>dissatisfied [2] 69/23 72/19</p> <p>dissonance [1] 69/13</p> <p>distinct [2] 59/13 67/19</p> <p>distress [1] 18/12</p> <p>disturbance [2] 26/10 59/14</p> <p>disturbances [1] 27/1</p> <p>do [3] 9/8 11/5 20/5</p> <p>doctors [1] 18/16</p> <p>document [1] 60/9</p> <p>documentation [3] 46/21 51/18 64/25</p> <p>documented [7] 5/20 33/2 41/19 49/7 56/3 64/21 77/2</p> <p>documents [1] 46/17</p> <p>does [3] 57/17 57/19 67/18</p> <p>doing [2] 8/3 42/22</p> <p>domain [1] 14/17</p> <p>domestic [3] 4/3 13/10 48/22</p> <p>dosage [1] 67/4</p> <p>dose [1] 79/14</p> <p>doses [1] 38/2</p> <p>down [1] 11/19</p> <p>drawn [1] 3/18</p> <p>drew [1] 42/20</p> <p>drinking [1] 27/5</p> <p>drove [1] 61/18</p> <p>drug [6] 24/1 24/25 26/4 26/23 27/8 36/12</p> <p>drugs [4] 23/16 24/2 25/12 27/10</p>	<p>due [4] 18/5 26/23 40/6 60/4</p> <p>duration [1] 71/14</p> <p>during [11] 16/19 17/1 18/19 24/9 38/25 46/11 46/23 49/5 60/7 60/19 61/23</p> <p>E</p> <p>each [1] 29/16</p> <p>earlier [13] 17/5 20/19 26/12 33/5 40/22 41/6 48/3 48/6 48/13 51/13 54/18 63/17 72/5</p> <p>early [11] 16/17 22/5 24/9 39/18 39/24 54/4 58/25 60/7 75/14 75/18 80/10</p> <p>easily [1] 19/9</p> <p>easy [2] 79/12 80/14</p> <p>effect [1] 25/5</p> <p>effective [5] 33/22 34/4 54/1 62/22 66/1</p> <p>effectively [3] 53/7 56/16 78/4</p> <p>effectiveness [2] 7/1 61/14</p> <p>effects [6] 18/5 37/7 39/2 39/24 40/6 40/16</p> <p>efforts [2] 58/2 64/10</p> <p>either [3] 15/9 36/6 63/13</p> <p>elaborate [1] 20/23</p> <p>elderly [2] 24/11 25/18</p> <p>element [1] 69/11</p> <p>emerge [1] 63/23</p> <p>emerged [2] 30/21 56/15</p> <p>emerges [1] 43/7</p> <p>emerging [1] 43/18</p> <p>emphasise [1] 78/15</p> <p>emphasised [7] 31/8 42/13 46/2 50/19 53/19 53/24 60/8</p> <p>enabled [1] 6/6</p> <p>enabling [2] 21/16 32/10</p> <p>encounter [1] 57/1</p> <p>engage [1] 72/12</p> <p>engagement [27] 6/17 6/19 6/22 29/24 34/15 34/22 39/17 40/24 41/7 50/4 53/9 54/5 56/21 57/5 58/3 60/6 60/18 60/19 62/13 63/5 64/6 64/8 64/11 66/5 74/19 75/3 75/8</p> <p>England [5] 3/22 3/24 4/3 5/3 14/23</p> <p>enhanced [1] 64/10</p> <p>enquiries [1] 48/8</p> <p>ensure [8] 22/1 42/17 69/10 76/12 77/1</p>	<p>78/12 79/22 80/1</p> <p>ensuring [2] 78/17 80/20</p> <p>entering [1] 17/19</p> <p>entirely [1] 10/24</p> <p>environment [4] 13/2 21/21 65/17 66/2</p> <p>environments [2] 13/6 63/22</p> <p>episode [2] 16/5 17/1</p> <p>episodes [5] 22/22 25/2 41/20 49/3 59/6</p> <p>equally [1] 55/19</p> <p>equivalent [2] 28/3 35/3</p> <p>escalated [1] 24/16</p> <p>escalating [3] 26/10 50/14 66/9</p> <p>escalation [4] 57/4 57/24 74/21 74/25</p> <p>escorted [1] 46/11</p> <p>establish [2] 49/20 77/23</p> <p>established [2] 15/1 61/11</p> <p>establishing [1] 60/22</p> <p>establishment [1] 75/16</p> <p>ethnicity [2] 12/13 12/14</p> <p>evaluate [1] 31/10</p> <p>evaluative [1] 8/24</p> <p>even [3] 20/6 20/13 32/15</p> <p>evening [1] 26/12</p> <p>event [2] 7/18 15/11</p> <p>events [9] 2/24 3/6 3/7 20/5 26/23 40/20 51/9 71/25 77/21</p> <p>evidence [22] 6/11 7/12 7/15 8/14 19/22 19/23 25/21 32/17 38/3 40/13 44/13 45/20 46/1 47/1 48/10 51/24 53/21 57/12 60/5 62/3 65/9 80/17</p> <p>examine [1] 12/15</p> <p>examined [9] 21/8 31/24 33/18 38/8 38/14 43/19 56/23 58/6 64/14</p> <p>example [10] 11/8 19/22 24/5 29/7 31/17 50/12 53/11 72/23 73/1 77/18</p> <p>examples [9] 15/24 25/14 30/13 43/23 47/21 71/8 77/14 79/6 80/5</p> <p>excess [2] 9/5 41/8</p> <p>excluding [1] 35/16</p> <p>exclusively [1] 10/15</p> <p>execution [1] 52/25</p> <p>exercise [1] 30/11</p> <p>exercised [2] 21/11</p>	<p>32/6</p> <p>exhibited [2] 22/14 39/14</p> <p>exhibiting [1] 30/5</p> <p>existence [1] 33/8</p> <p>existing [1] 13/20</p> <p>expectations [1] 69/14</p> <p>expected [1] 74/6</p> <p>experience [4] 5/20 6/24 27/3 37/7</p> <p>experienced [2] 18/1 57/15</p> <p>experiences [3] 1/8 5/20 80/13</p> <p>experiencing [3] 16/5 27/1 44/12</p> <p>explained [1] 71/16</p> <p>explanation [1] 67/17</p> <p>explicitly [3] 4/8 15/13 75/7</p> <p>explore [1] 76/16</p> <p>explored [7] 17/14 37/22 38/4 40/14 44/20 48/23 59/16</p> <p>express [1] 37/7</p> <p>expressed [4] 24/15 50/11 61/10 70/5</p> <p>expressing [1] 51/4</p> <p>expressions [1] 22/21</p> <p>extant [2] 15/11 27/10</p> <p>extensive [2] 29/7 29/13</p> <p>extent [3] 44/3 53/17 71/23</p> <p>F</p> <p>facilitate [1] 41/5</p> <p>facilitates [1] 79/12</p> <p>fact [2] 14/16 40/25</p> <p>factor [4] 8/14 40/20 52/15 64/9</p> <p>factors [3] 16/24 34/10 78/18</p> <p>facts [1] 7/25</p> <p>factual [1] 43/21</p> <p>failure [8] 34/3 37/1 39/21 40/15 46/1 50/22 61/25 62/10</p> <p>failures [19] 8/7 10/4 30/11 38/2 42/12 43/12 43/14 43/16 47/14 47/22 51/6 54/16 55/1 55/19 61/9 64/3 72/12 72/13 72/14</p> <p>faith [1] 21/23</p> <p>fall [2] 5/15 57/17</p> <p>falling [2] 13/10 13/13</p> <p>false [1] 79/17</p> <p>familial [2] 11/9 20/20</p> <p>families [8] 3/24 6/22</p>	<p>15/1 15/2 50/5 53/25 69/8 69/9</p> <p>family [47] 1/6 10/18 11/2 11/5 12/24 12/24 13/1 13/20 13/21 17/8 17/12 18/9 20/18 24/9 26/9 27/4 34/6 43/13 45/12 45/21 48/1 48/11 50/3 50/9 50/11 50/20 50/22 50/24 51/3 53/9 53/17 53/21 54/2 54/5 58/3 64/1 65/2 65/2 66/1 69/13 70/15 72/13 73/2 74/19 75/3 75/5 75/6</p> <p>Family/Family [1] 12/24</p> <p>far [2] 10/13 14/12</p> <p>fatal [36] 4/5 9/12 16/3 16/18 17/15 18/18 22/9 24/8 25/15 25/25 26/8 29/9 30/14 31/21 32/25 33/13 33/15 38/11 39/25 40/21 44/25 46/8 47/23 47/24 48/2 50/24 53/13 57/19 58/9 59/3 59/22 61/17 64/16 65/21 66/16 71/2</p> <p>fatally [4] 25/16 29/9 46/11 49/1</p> <p>father [8] 16/4 24/14 45/1 51/23 52/9 57/7 61/9 65/21</p> <p>Fazel [1] 19/23</p> <p>fear [1] 24/15</p> <p>feature [7] 23/16 34/23 35/21 47/14 50/23 73/1 75/1</p> <p>featured [2] 23/18 35/18</p> <p>fellow [3] 13/3 13/3 13/24</p> <p>Fellow-patient [1] 13/3</p> <p>fellow-resident [1] 13/3</p> <p>felt [1] 72/21</p> <p>fewer [1] 14/12</p> <p>fields [1] 7/8</p> <p>Fifth [1] 75/3</p> <p>fight [1] 72/21</p> <p>figure [5] 19/3 23/19 23/20 24/1 35/12</p> <p>figures [3] 3/10 14/6 19/15</p> <p>final [4] 3/15 36/8 36/13 74/2</p> <p>finally [1] 79/2</p> <p>findings [8] 2/16 11/18 12/7 15/17 23/21 27/22 68/4 80/8</p> <p>fire [2] 24/9 24/17</p> <p>first [8] 3/21 12/3 16/11 20/3 27/21 74/9</p>
--	---	--	---	---

<p>F</p> <p>first... [2] 75/14 80/15</p> <p>fitness [1] 40/8</p> <p>five [5] 21/4 22/7 71/3 73/25 74/7</p> <p>five years [3] 21/4 71/3 73/25</p> <p>flat [1] 45/1</p> <p>flatmates [1] 13/9</p> <p>floridly [1] 18/7</p> <p>focus [4] 8/11 37/1 75/19 75/24</p> <p>follow [7] 30/8 47/10 50/18 74/22 76/20 77/5 77/10</p> <p>follow-up [3] 30/8 50/18 74/22</p> <p>follow-ups [1] 77/5</p> <p>followed [1] 57/23</p> <p>following [41] 2/13 4/12 6/9 16/15 16/18 20/22 22/8 26/5 26/10 26/18 31/21 33/16 34/15 37/5 38/24 39/20 40/1 40/5 41/6 41/8 43/4 47/21 47/25 48/5 52/24 53/2 53/15 57/2 57/14 58/14 58/18 58/24 60/3 64/4 65/22 66/4 70/6 77/25 78/8 79/7 79/16</p> <p>footage [1] 27/6</p> <p>force [7] 17/23 19/6 19/8 19/12 32/15 51/9 68/20</p> <p>forensic [3] 1/15 20/15 47/7</p> <p>form [3] 6/4 46/5 67/25</p> <p>formal [1] 31/1</p> <p>formally [2] 49/10 64/23</p> <p>formed [3] 5/11 5/25 35/19</p> <p>former [2] 12/23 13/22</p> <p>forming [1] 13/1</p> <p>forms [2] 13/7 64/11</p> <p>formulation [6] 37/18 45/16 47/4 77/17 77/23 78/17</p> <p>fought [1] 21/6</p> <p>found [12] 12/9 23/24 41/13 44/10 45/22 47/3 49/9 58/21 66/8 66/13 67/11 67/13</p> <p>founder [1] 69/8</p> <p>four [1] 52/19</p> <p>four weeks [1] 52/19</p> <p>Fourth [1] 74/23</p> <p>frail [1] 65/6</p> <p>framed [2] 7/7 70/9</p> <p>framework [7] 31/4 33/9 34/18 51/8 54/23 55/24 60/14</p>	<p>frameworks [2] 62/11 75/22</p> <p>frequency [1] 22/24</p> <p>frequently [5] 36/20 37/23 43/3 56/13 57/3</p> <p>friend [2] 31/18 48/25</p> <p>friends [5] 1/6 10/18 11/2 11/6 13/25</p> <p>full [2] 42/14 47/6</p> <p>fully [7] 17/13 37/22 44/20 48/22 49/23 59/15 62/11</p> <p>further [27] 4/15 5/2 8/20 11/21 17/1 23/7 25/1 29/20 30/25 31/14 32/19 34/14 43/20 48/8 48/16 48/21 50/18 51/22 57/7 58/1 61/15 62/7 65/8 66/15 67/3 70/12 80/5</p> <p>future [2] 70/10 70/19</p> <hr/> <p>G</p> <p>gain [1] 40/7</p> <p>garden [1] 26/13</p> <p>gathered [1] 46/4</p> <p>gathering [2] 47/16 74/11</p> <p>gave [2] 9/18 51/23</p> <p>general [3] 39/9 54/25 65/10</p> <p>generalised [2] 3/5 3/10</p> <p>generally [5] 8/11 24/5 35/7 72/3 77/8</p> <p>get [2] 72/22 73/2</p> <p>getting [1] 73/11</p> <p>given [6] 17/7 21/19 26/25 41/18 70/24 71/3</p> <p>going [3] 18/3 69/18 76/16</p> <p>good [5] 8/7 21/23 47/8 54/8 77/11</p> <p>governance [2] 76/1 79/4</p> <p>governing [1] 70/19</p> <p>GPs [1] 74/22</p> <p>grandfather [1] 30/16</p> <p>grandmother [1] 30/17</p> <p>grandparents [1] 30/15</p> <p>greater [6] 10/3 69/10 75/3 75/5 75/19 75/24</p> <p>greatly [1] 14/25</p> <p>grounds [2] 21/1 70/23</p> <p>group [2] 4/21 61/19</p> <p>guidance [6] 14/18 38/23 77/6 78/12 79/4</p>	<p>80/1</p> <p>guideline [1] 77/10</p> <p>guidelines [3] 9/22 38/19 38/22</p> <p>guilty [2] 67/11 67/13</p> <p>guns [1] 26/13</p> <hr/> <p>H</p> <p>had [113]</p> <p>half [2] 68/14 72/10</p> <p>hallucinations [4] 16/8 17/3 18/2 39/15</p> <p>hamper [1] 24/3</p> <p>hand [1] 27/17</p> <p>harm [1] 19/14</p> <p>has [35] 2/12 3/18 4/1 4/7 4/21 5/11 7/19 7/20 7/25 9/3 9/12 9/13 11/21 12/1 12/13 13/16 14/16 14/24 14/25 15/2 27/13 31/17 51/10 51/24 53/12 53/25 55/23 57/14 58/4 67/6 69/9 74/4 75/24 76/4 80/21</p> <p>have [60] 3/12 3/13 3/21 3/25 4/10 4/15 5/8 5/23 5/25 7/17 7/22 8/3 9/20 10/3 10/11 11/16 11/19 11/25 15/11 21/11 21/22 21/24 23/8 24/16 29/5 30/19 30/22 31/7 32/1 32/6 32/13 32/21 33/9 33/10 36/22 39/7 42/12 42/16 42/24 44/23 47/22 48/14 48/15 53/6 57/23 58/8 60/19 64/8 64/15 66/14 67/3 71/7 73/18 77/7 78/22 79/24 80/14 80/15 80/16 80/22</p> <p>having [6] 15/8 15/15 25/4 32/17 37/11 46/17</p> <p>he [29] 16/8 16/11 16/12 16/13 17/13 24/22 24/24 25/4 25/22 26/2 26/12 26/15 26/19 26/22 26/22 26/25 29/11 29/15 30/7 33/11 33/23 40/10 41/9 41/11 49/3 57/9 61/23 69/9 69/13</p> <p>head [1] 17/23</p> <p>health [92]</p> <p>health-related [2] 3/11 15/4</p> <p>healthcare [2] 14/1 26/16</p> <p>hear [1] 69/18</p> <p>heard [2] 19/22 80/15</p> <p>hearing [2] 2/14</p>	<p>71/15</p> <p>hearings [2] 69/14 71/20</p> <p>heightened [1] 27/3</p> <p>held [3] 15/11 44/3 77/1</p> <p>help [1] 50/20</p> <p>Hendy [2] 69/8 69/18</p> <p>her [23] 16/9 18/3 18/4 18/4 21/1 21/20 22/10 22/11 37/13 39/17 43/25 44/12 44/19 51/15 52/6 52/12 52/13 52/14 52/14 53/1 58/10 58/19 58/24</p> <p>here [2] 40/23 53/13</p> <p>herself [1] 52/12</p> <p>high [5] 9/4 27/3 28/21 28/25 52/8</p> <p>higher [1] 37/24</p> <p>higher-risk [1] 37/24</p> <p>highlighted [1] 42/15</p> <p>himself [2] 45/19 50/17</p> <p>his [44] 16/4 16/4 16/9 16/11 16/12 17/5 24/15 25/3 25/6 25/8 25/20 26/5 26/9 26/15 26/23 30/15 30/16 30/17 33/17 40/1 40/2 40/5 40/11 41/19 45/1 49/24 51/24 52/11 53/14 57/15 60/5 60/7 60/19 61/10 62/5 64/17 65/6 65/7 65/11 65/16 65/22 76/5 76/6 80/20</p> <p>historic [2] 14/24 15/2</p> <p>historical [3] 43/13 46/16 78/18</p> <p>history [19] 1/14 6/14 20/15 23/6 23/15 23/25 24/19 27/7 29/13 32/2 33/2 33/6 35/19 41/19 42/12 42/14 46/22 57/10 77/18</p> <p>holiday [1] 39/6</p> <p>holistic [1] 44/23</p> <p>home [14] 22/10 24/9 25/5 25/20 26/9 26/15 30/16 41/9 48/25 59/4 65/17 66/2 66/10 66/15</p> <p>homes [1] 13/5</p> <p>homicide [7] 2/12 4/3 12/9 23/25 36/10 36/13 76/6</p> <p>homicides [13] 1/7 1/11 1/18 2/3 2/22 3/11 3/22 9/21 10/10 14/20 15/4 19/21 69/12</p> <p>hope [1] 80/16</p>	<p>hospital [29] 6/18 21/2 21/9 21/21 22/15 26/4 28/2 28/22 29/16 30/3 31/25 33/2 34/9 40/6 49/2 49/6 57/2 59/5 63/9 66/15 68/8 68/10 68/18 69/6 69/14 70/14 70/24 71/3 71/14</p> <p>hostel [1] 22/4</p> <p>hours [3] 18/8 24/10 52/16</p> <p>household [1] 13/1</p> <p>housemates [2] 13/9 50/3</p> <p>housing [1] 22/4</p> <p>how [5] 43/20 47/22 65/13 67/7 70/12</p> <p>however [13] 3/13 5/10 7/8 7/22 15/3 18/15 24/22 38/20 39/16 40/12 41/7 46/24 56/10</p> <p>Hundred [4] 3/24 14/25 15/2 69/8</p> <p>hybrid [3] 68/16 69/10 71/11</p> <hr/> <p>I</p> <p>I have [2] 58/8 73/18</p> <p>I hope [1] 80/16</p> <p>I intend [1] 58/7</p> <p>I know [1] 80/13</p> <p>I may [1] 16/2</p> <p>I please [2] 15/5 27/17</p> <p>I quote [1] 37/12</p> <p>I shall [1] 30/13</p> <p>I start [1] 20/24</p> <p>I think [1] 4/18</p> <p>I touch [1] 3/16</p> <p>I will [4] 2/15 60/24 68/5 73/19</p> <p>I would [3] 34/21 74/2 80/11</p> <p>I'd [2] 18/21 80/19</p> <p>I'll [15] 16/1 31/19 32/14 33/13 38/8 43/22 47/10 50/3 50/21 54/15 64/13 67/8 71/23 74/7 77/14</p> <p>I've [3] 6/5 7/3 20/23</p> <p>identification [2] 56/3 62/23</p> <p>identified [70] 4/24 6/8 6/20 7/19 8/1 8/10 9/3 9/9 12/6 15/8 15/13 15/15 15/20 17/4 25/5 28/3 28/5 33/19 33/24 34/8 35/3 35/5 35/8 36/3 37/23 38/7 38/21 39/13 40/3 40/19 40/24 42/5 42/7 42/10 44/2 45/2 45/10 46/13 47/16 47/19 49/16 50/9 51/6 51/17</p>
---	---	---	---	---

<p>I</p> <p>identified... [26] 53/17 54/24 55/1 55/3 55/5 55/9 55/12 55/13 55/16 58/13 59/9 60/1 61/1 61/21 61/25 63/3 63/12 64/19 65/1 65/8 65/24 66/20 67/22 68/25 73/24 78/14</p> <p>identify [12] 2/19 13/15 36/20 37/14 39/1 39/23 41/24 43/11 56/8 56/13 57/4 60/9</p> <p>identifying [1] 8/7</p> <p>identity [1] 40/9</p> <p>ie [1] 19/7</p> <p>if [8] 7/10 7/12 7/15 16/2 20/13 28/18 29/4 68/18</p> <p>illegal [1] 27/8</p> <p>illicit [2] 16/21 25/12</p> <p>illness [4] 17/25 32/3 56/25 62/3</p> <p>illustrate [2] 20/22 64/14</p> <p>illustrating [1] 15/24</p> <p>illustration [2] 38/10 43/20</p> <p>imagery [1] 27/2</p> <p>immediately [2] 27/6 66/24</p> <p>impact [1] 77/21</p> <p>implement [3] 64/11 76/9 79/12</p> <p>implementation [4] 38/21 62/25 75/16 76/12</p> <p>implemented [2] 34/2 56/16</p> <p>implementing [1] 41/16</p> <p>importance [6] 7/16 20/14 42/13 53/20 56/25 78/15</p> <p>important [4] 31/10 40/9 54/1 72/14</p> <p>imposed [2] 70/2 71/14</p> <p>imprisonment [1] 70/13</p> <p>improve [2] 41/22 77/13</p> <p>improved [2] 8/8 74/14</p> <p>improvement [1] 53/1</p> <p>improving [2] 43/9 80/2</p> <p>improvised [1] 17/18</p> <p>inadequate [3] 43/11 55/2 63/14</p> <p>incapacity [1] 61/5</p> <p>incident [57] 9/12 9/17 16/3 16/18 17/15</p>	<p>17/25 18/6 18/18 22/6 22/9 22/13 24/8 24/21 25/13 25/15 25/22 25/25 26/8 26/11 26/20 26/25 28/9 28/11 29/9 29/11 29/19 30/3 30/14 30/20 31/5 31/23 33/15 38/11 38/16 39/11 39/16 39/25 40/21 41/8 44/2 44/25 46/8 47/24 48/3 48/6 48/13 51/3 53/13 58/9 58/11 59/23 61/3 61/18 64/16 65/21 66/16 73/21</p> <p>incidents [16] 1/17 4/5 4/15 5/14 11/9 14/12 20/7 20/19 22/17 22/25 23/5 23/13 24/13 49/7 49/10 49/17</p> <p>include [4] 25/14 35/9 63/25 78/17</p> <p>included [15] 3/13 3/15 5/8 6/13 8/4 11/12 13/24 19/13 19/14 19/14 22/19 40/7 66/14 72/12 73/8</p> <p>includes [10] 12/22 12/24 13/4 76/23 77/4 77/16 77/25 78/8 79/7 79/16</p> <p>including [35] 6/15 6/21 7/4 13/20 13/22 16/8 16/22 18/3 25/1 26/6 27/2 30/3 34/10 37/21 37/25 38/25 39/15 43/5 43/12 45/13 48/22 50/15 51/16 57/25 62/12 66/5 66/9 69/25 70/4 70/6 74/10 74/18 75/3 75/8 79/25</p> <p>inclusion [4] 1/23 2/24 5/15 57/18</p> <p>incomplete [6] 37/17 43/12 45/24 47/4 48/18 56/14</p> <p>inconsistency [1] 10/25</p> <p>inconsistent [2] 34/18 46/18</p> <p>inconsistently [1] 56/12</p> <p>incorporate [3] 43/13 48/19 56/7</p> <p>incorporated [2] 45/16 67/1</p> <p>increase [2] 16/21 61/14</p> <p>increased [3] 41/4 66/14 75/15</p> <p>increasing [1] 57/25</p> <p>indefinite [2] 69/15 71/15</p>	<p>independent [16] 2/2 3/21 4/2 4/16 4/25 5/2 10/15 10/17 32/23 72/2 72/3 72/4 72/8 73/20 73/21 73/24</p> <p>indicated [6] 3/13 7/11 20/4 33/11 41/10 70/2</p> <p>indicates [3] 19/19 36/16 56/11</p> <p>indicator [1] 41/15</p> <p>indicators [6] 18/9 30/21 39/14 43/14 59/1 66/11</p> <p>individual [17] 15/25 33/1 33/20 34/9 34/15 34/17 41/2 52/5 52/17 52/25 56/10 57/12 61/22 64/21 65/5 65/14 66/17</p> <p>individual's [14] 34/6 41/9 41/14 41/18 52/3 56/6 62/1 62/12 63/6 65/2 65/10 66/2 66/21 66/22</p> <p>individuals [12] 4/6 9/16 13/4 17/20 48/4 53/8 55/25 56/24 58/11 62/20 63/20 79/8</p> <p>induced [1] 24/19</p> <p>inexperienced [1] 55/7</p> <p>influence [1] 25/12</p> <p>inform [4] 45/11 54/22 60/23 78/20</p> <p>information [64] 1/13 1/23 1/25 5/10 5/13 7/11 8/18 10/8 10/18 10/20 11/3 11/6 11/11 14/4 14/9 20/17 23/6 27/16 42/18 43/7 43/8 43/13 43/15 44/3 44/14 44/16 44/16 44/22 45/11 45/12 45/18 45/21 46/4 46/4 46/15 46/24 47/9 47/11 47/13 47/15 47/16 47/22 48/6 48/11 48/18 48/20 49/13 50/1 52/11 54/2 54/6 56/15 72/19 72/22 73/11 73/22 74/11 74/12 74/21 76/1 78/20 79/1 80/13 80/14</p> <p>information-sharing [1] 47/13</p> <p>informed [8] 27/4 39/10 44/23 51/15 51/19 69/22 70/16 72/18</p> <p>ingesting [1] 25/23</p> <p>inherently [1] 54/21</p> <p>initial [2] 21/4 38/25</p> <p>initially [2] 17/18</p>	<p>24/16</p> <p>initiated [2] 38/16 52/23</p> <p>initiating [1] 31/1</p> <p>initiation [2] 37/5 39/20</p> <p>injections [3] 37/25 38/6 75/2</p> <p>injured [1] 16/4</p> <p>injuries [3] 22/12 30/17 61/20</p> <p>inpatient [7] 29/8 34/11 46/9 51/1 62/18 64/18 66/18</p> <p>input [3] 7/9 47/6 64/3</p> <p>Inquiry [71] 1/4 1/5 1/8 1/21 2/1 2/1 2/11 2/13 2/16 2/17 3/1 4/4 4/7 4/12 4/21 5/4 5/11 5/13 5/18 5/24 6/6 6/11 8/20 8/24 9/6 9/11 10/13 11/18 12/7 12/15 14/9 14/13 15/24 19/19 19/22 23/21 27/5 27/13 27/20 27/22 36/1 36/15 38/8 42/13 42/20 42/23 42/25 43/19 51/12 51/22 55/20 56/11 57/6 58/7 61/7 63/24 64/14 67/6 69/23 70/11 72/18 74/3 75/11 76/4 76/6 80/8 80/12 80/18 80/21 81/3 81/5</p> <p>Inquiry's [5] 1/10 5/6 57/18 71/5 80/6</p> <p>insanity [1] 68/4</p> <p>inside [1] 24/11</p> <p>insight [6] 5/17 16/12 25/6 41/19 57/20 61/11</p> <p>instances [1] 67/21</p> <p>instead [3] 46/17 66/12 77/11</p> <p>instructed [1] 20/12</p> <p>insufficient [3] 17/7 34/5 37/4</p> <p>insufficiently [1] 37/17</p> <p>integrated [1] 10/21</p> <p>integrity [1] 80/20</p> <p>intend [1] 58/7</p> <p>intended [3] 34/2 34/19 55/24</p> <p>intensive [2] 46/10 58/17</p> <p>inter [1] 47/18</p> <p>inter-agency [1] 47/18</p> <p>interaction [4] 17/10 37/16 62/13 75/5</p> <p>interconnected [1] 54/21</p> <p>interest [1] 10/4</p>	<p>internal [2] 7/5 73/3</p> <p>internally [1] 8/19</p> <p>interpretation [1] 9/7</p> <p>interpretations [1] 9/2</p> <p>intervene [1] 17/22</p> <p>intervention [13] 6/16 8/6 16/17 22/6 22/23 23/8 27/23 31/20 32/20 39/18 52/21 53/8 62/8</p> <p>interventions [3] 31/11 41/22 60/10</p> <p>into [31] 2/11 4/13 5/17 10/21 11/19 12/7 14/13 16/12 16/14 16/25 17/11 23/21 25/6 27/14 32/15 33/20 36/2 41/19 45/16 48/8 57/20 61/19 63/22 64/3 66/18 67/1 68/20 71/1 76/4 76/6 77/22</p> <p>intoxicants [1] 24/5</p> <p>intoxicated [2] 25/22 30/5</p> <p>intra [2] 11/9 20/20</p> <p>intra-familial [2] 11/9 20/20</p> <p>introduce [1] 77/17</p> <p>introduced [1] 41/5</p> <p>invaluable [1] 80/17</p> <p>investigate [2] 1/18 8/6</p> <p>investigation [79] 6/14 6/21 8/15 8/17 9/14 10/7 11/17 16/6 16/24 17/9 17/23 20/6 20/10 21/8 21/10 21/23 22/12 24/12 25/19 26/11 29/12 30/18 30/24 31/6 31/13 31/24 32/5 33/3 33/18 34/8 34/14 36/20 37/14 37/23 38/14 39/4 39/9 39/19 40/2 40/15 40/23 41/13 43/3 44/2 44/10 44/18 45/2 46/13 48/4 48/17 49/5 49/9 49/16 49/22 51/5 51/12 53/16 56/13 57/3 58/12 58/21 59/8 60/1 60/8 61/21 62/6 62/9 63/24 64/19 65/12 65/23 66/8 66/20 67/2 71/25 72/6 72/22 73/3 76/14</p> <p>investigations [6] 8/12 61/3 72/9 73/10 73/11 76/7</p> <p>invited [1] 5/18</p> <p>inviting [1] 1/6</p> <p>involve [2] 9/16 56/2</p> <p>involved [14] 9/12 20/10 21/22 38/17</p>
--	---	---	---	---

<p>I</p> <p>involved... [10] 42/19 44/11 47/6 49/17 53/18 53/22 56/9 60/12 69/4 73/15</p> <p>involvement [6] 1/16 27/12 53/24 58/1 62/24 65/1</p> <p>involving [14] 4/5 11/10 12/5 13/6 17/5 19/11 22/7 22/18 23/13 48/3 53/20 57/21 66/17 68/3</p> <p>is [58] 2/23 3/17 3/23 4/17 6/4 8/14 8/23 9/6 9/10 9/11 9/17 9/23 10/2 10/11 10/14 11/4 11/20 11/21 12/3 12/6 14/12 14/15 15/3 15/5 15/7 15/8 19/20 19/24 19/25 20/9 20/18 23/20 28/17 28/22 29/8 34/19 37/10 40/22 42/18 47/8 47/9 47/12 50/2 53/12 54/18 57/24 59/21 67/10 68/8 68/10 68/16 68/18 69/11 72/17 77/1 78/1 78/6 80/1</p> <p>issue [17] 6/7 7/12 7/14 7/17 7/19 7/24 8/10 10/25 10/25 18/21 23/15 34/21 53/10 60/25 61/1 72/1 79/2</p> <p>issue-based [1] 6/7</p> <p>issues [29] 5/17 6/8 6/12 6/21 7/6 7/15 8/20 9/1 10/12 11/2 11/8 11/19 11/23 27/18 42/2 42/5 42/9 43/20 47/10 50/4 54/17 55/8 55/11 55/15 60/24 63/16 64/14 72/15 75/10</p> <p>it [33] 1/15 2/23 5/10 6/2 7/20 8/1 8/23 9/10 9/17 10/2 10/11 11/4 12/13 14/24 15/3 15/8 19/24 23/3 24/3 25/4 25/5 31/8 31/21 41/12 41/25 46/2 47/9 47/12 57/18 57/19 61/2 73/2 76/11</p> <p>it's [5] 28/18 32/18 35/20 40/23 65/19</p> <p>items [1] 23/14</p> <p>its [7] 4/22 9/11 14/16 18/5 23/22 34/2 35/25</p> <p>itself [1] 4/7</p>	<p>8/24</p> <p>Julian [1] 69/8</p> <p>June [1] 1/12</p> <p>just [5] 20/23 68/14 68/21 71/2 72/10</p> <p>justice [2] 7/5 49/21</p> <p>justified [2] 21/25 30/23</p> <p>K</p> <p>keen [1] 73/15</p> <p>keeping [2] 11/15 42/9</p> <p>key [5] 15/17 20/17 31/19 72/13 78/1</p> <p>kill [2] 16/9 22/21</p> <p>killed [12] 16/4 21/7 22/3 33/16 38/12 40/1 45/1 47/25 53/14 58/10 64/17 65/22</p> <p>killing [2] 22/8 43/24</p> <p>kitchen [2] 17/17 25/20</p> <p>knife [7] 17/17 21/5 21/7 22/7 25/16 25/20 45/15</p> <p>knives [2] 22/20 46/23</p> <p>know [3] 78/12 78/16 80/13</p> <p>knowledge [1] 11/11</p> <p>known [10] 3/14 13/12 17/6 20/20 29/4 32/1 33/6 36/22 64/6 76/25</p> <p>Korsakoff's [1] 59/11</p>	<p>46/11 70/8</p> <p>led [2] 37/18 47/23</p> <p>left [4] 24/11 24/18 25/4 25/20</p> <p>legal [28] 1/21 2/1 2/11 2/17 4/7 5/12 5/13 5/24 6/6 7/10 8/21 8/24 9/6 10/13 11/19 19/19 27/13 27/22 36/15 42/23 52/22 55/20 56/11 67/6 74/4 75/11 80/9 80/21</p> <p>legislation [1] 76/21</p> <p>less [3] 69/17 70/7 70/25</p> <p>level [16] 4/1 5/3 8/18 9/4 10/17 21/20 34/14 41/4 52/8 58/17 58/19 72/4 72/9 73/5 73/18 79/5</p> <p>levels [7] 6/25 19/11 28/25 36/3 66/23 77/23 79/13</p> <p>liaison [1] 66/1</p> <p>library [1] 15/4</p> <p>life [1] 30/17</p> <p>life-changing [1] 30/17</p> <p>light [2] 2/10 74/12</p> <p>like [6] 18/21 34/21 69/10 74/2 80/11 80/19</p> <p>likely [4] 11/11 14/15 21/19 32/13</p> <p>limitation [1] 9/22</p> <p>limitations [2] 67/20 68/23</p> <p>limited [19] 4/7 7/17 9/7 23/12 36/23 36/24 37/2 38/3 41/19 44/13 45/19 48/15 54/6 61/11 62/3 62/6 63/5 64/4 72/1</p> <p>limiting [1] 39/11</p> <p>line [2] 78/10 78/24</p> <p>lines [1] 74/20</p> <p>link [1] 8/10</p> <p>linked [3] 45/25 61/12 63/17</p> <p>listening [1] 78/16</p> <p>lit [1] 24/17</p> <p>litigation [1] 8/9</p> <p>little [3] 3/16 26/22 32/20</p> <p>live [1] 65/6</p> <p>local [2] 49/19 76/21</p> <p>located [1] 52/13</p> <p>locations [1] 52/18</p> <p>long [5] 42/12 51/25 53/25 55/23 72/25</p> <p>longer [1] 24/22</p> <p>longstanding [1] 57/8</p> <p>look [1] 68/5</p> <p>looked [7] 27/9 27/9</p>	<p>27/13 32/17 32/18 47/17 65/19</p> <p>lost [1] 31/12</p> <p>lower [2] 19/4 19/25</p> <p>lunch [1] 80/10</p> <p>M</p> <p>made [10] 7/25 20/23 23/4 23/11 32/20 48/8 49/24 64/6 68/16 74/5</p> <p>maintain [2] 64/10 78/4</p> <p>maintaining [1] 56/21</p> <p>majority [10] 9/13 10/22 19/20 23/17 28/24 34/23 42/6 50/6 67/18 69/16</p> <p>maker [1] 57/22</p> <p>making [5] 2/20 62/5 64/9 67/2 70/19</p> <p>male [1] 12/6</p> <p>man [7] 16/3 17/19 25/15 25/18 40/1 47/25 53/14</p> <p>manage [1] 63/1</p> <p>managed [3] 34/12 54/24 60/16</p> <p>management [18] 11/14 37/15 37/24 46/2 54/19 63/19 65/24 66/21 67/5 70/5 74/10 78/1 78/5 78/6 78/11 78/13 78/21 78/23</p> <p>managing [2] 25/9 56/19</p> <p>manner [5] 15/25 34/2 34/11 49/8 62/11</p> <p>manslaughter [7] 20/25 32/4 67/13 68/1 70/23 71/4 71/7</p> <p>manufacturer [1] 66/24</p> <p>many [7] 20/18 20/23 28/22 35/23 58/4 67/20 68/25</p> <p>marginal [1] 7/17</p> <p>mark [1] 3/15</p> <p>marked [1] 15/13</p> <p>match [1] 9/5</p> <p>material [18] 3/9 3/17 3/18 3/20 3/23 9/10 10/6 11/22 12/11 14/7 36/15 42/22 52/3 56/10 63/2 67/20 68/24 80/22</p> <p>materially [1] 9/8</p> <p>materials [1] 4/11</p> <p>matter [1] 33/15</p> <p>matters [6] 8/3 10/4 11/3 35/11 63/17 66/12</p> <p>may [17] 1/1 1/5 7/13 7/17 10/5 10/6 16/2 19/15 35/22 37/15</p>	<p>43/20 56/23 59/13 60/19 61/13 63/4 67/3</p> <p>MDMA [1] 26/7</p> <p>me [1] 80/17</p> <p>mean [1] 7/13</p> <p>means [2] 3/4 15/3</p> <p>meant [6] 31/9 39/22 44/16 45/22 56/17 60/14</p> <p>measures [2] 62/8 76/22</p> <p>mechanism [1] 25/7</p> <p>medical [3] 13/5 77/22 79/10</p> <p>medication [68] 6/18 6/20 16/16 16/19 18/5 18/13 24/3 25/4 28/14 30/1 33/3 33/7 33/12 33/21 33/23 33/24 34/25 35/2 35/5 35/10 35/13 35/15 35/17 35/18 35/21 35/24 36/4 36/7 36/17 36/21 37/4 37/5 37/9 37/12 37/15 37/21 38/15 38/18 38/24 39/5 39/10 39/21 40/5 40/7 40/10 40/13 40/25 41/3 41/11 41/14 41/17 41/20 45/14 52/6 52/12 53/3 57/16 57/24 63/19 66/7 66/21 67/4 74/24 79/3 79/18 79/19 79/20 79/23</p> <p>medications [1] 37/25</p> <p>medicines [1] 80/3</p> <p>medium [1] 70/14</p> <p>meet [1] 1/22</p> <p>meets [1] 78/6</p> <p>member [5] 17/12 29/10 46/12 48/1 50/25</p> <p>members [15] 12/25 13/20 18/10 29/21 34/6 45/12 45/21 46/20 48/12 50/9 51/3 53/18 53/21 54/2 65/3</p> <p>men [1] 12/10</p> <p>mental [108]</p> <p>mention [1] 32/20</p> <p>mentioned [3] 48/24 75/10 80/4</p> <p>mentioning [1] 35/20</p> <p>merely [1] 46/3</p> <p>met [3] 18/17 21/19 32/13</p> <p>methamphetamine [1] 26/7</p> <p>methods [1] 41/16</p> <p>might [5] 23/8 30/22 33/9 59/16 70/20</p> <p>mind [2] 11/15 32/16</p> <p>minimise [1] 73/15</p> <p>miss [1] 22/7</p>
<p>J</p> <p>judgement [2] 7/25</p>	<p>L</p> <p>lack [15] 25/6 34/4 34/11 37/6 38/1 44/15 51/17 52/12 55/8 57/4 64/1 65/1 65/13 70/10 70/17</p> <p>lacked [5] 16/11 56/18 60/14 76/8 76/11</p> <p>large [1] 3/3</p> <p>largely [4] 3/23 14/16 45/18 48/6</p> <p>largest [1] 13/21</p> <p>last [2] 2/23 75/23</p> <p>later [12] 16/14 17/22 18/1 21/3 21/6 22/11 26/19 30/7 49/24 59/25 70/16 70/25</p> <p>law [1] 19/7</p> <p>laws [1] 12/25</p> <p>lead [1] 20/5</p> <p>leading [7] 18/6 29/19 30/22 40/11 40/21 52/6 76/15</p> <p>learned [2] 31/18 48/24</p> <p>learning [1] 4/5</p> <p>least [2] 22/17 49/6</p> <p>leave [4] 21/21 46/10</p>	<p>68/23</p> <p>limited [19] 4/7 7/17 9/7 23/12 36/23 36/24 37/2 38/3 41/19 44/13 45/19 48/15 54/6 61/11 62/3 62/6 63/5 64/4 72/1</p> <p>limiting [1] 39/11</p> <p>line [2] 78/10 78/24</p> <p>lines [1] 74/20</p> <p>link [1] 8/10</p> <p>linked [3] 45/25 61/12 63/17</p> <p>listening [1] 78/16</p> <p>lit [1] 24/17</p> <p>litigation [1] 8/9</p> <p>little [3] 3/16 26/22 32/20</p> <p>live [1] 65/6</p> <p>local [2] 49/19 76/21</p> <p>located [1] 52/13</p> <p>locations [1] 52/18</p> <p>long [5] 42/12 51/25 53/25 55/23 72/25</p> <p>longer [1] 24/22</p> <p>longstanding [1] 57/8</p> <p>look [1] 68/5</p> <p>looked [7] 27/9 27/9</p>	<p>56/19</p> <p>manner [5] 15/25 34/2 34/11 49/8 62/11</p> <p>manslaughter [7] 20/25 32/4 67/13 68/1 70/23 71/4 71/7</p> <p>manufacturer [1] 66/24</p> <p>many [7] 20/18 20/23 28/22 35/23 58/4 67/20 68/25</p> <p>marginal [1] 7/17</p> <p>mark [1] 3/15</p> <p>marked [1] 15/13</p> <p>match [1] 9/5</p> <p>material [18] 3/9 3/17 3/18 3/20 3/23 9/10 10/6 11/22 12/11 14/7 36/15 42/22 52/3 56/10 63/2 67/20 68/24 80/22</p> <p>materially [1] 9/8</p> <p>materials [1] 4/11</p> <p>matter [1] 33/15</p> <p>matters [6] 8/3 10/4 11/3 35/11 63/17 66/12</p> <p>may [17] 1/1 1/5 7/13 7/17 10/5 10/6 16/2 19/15 35/22 37/15</p>	<p>50/25</p> <p>members [15] 12/25 13/20 18/10 29/21 34/6 45/12 45/21 46/20 48/12 50/9 51/3 53/18 53/21 54/2 65/3</p> <p>men [1] 12/10</p> <p>mental [108]</p> <p>mention [1] 32/20</p> <p>mentioned [3] 48/24 75/10 80/4</p> <p>mentioning [1] 35/20</p> <p>merely [1] 46/3</p> <p>met [3] 18/17 21/19 32/13</p> <p>methamphetamine [1] 26/7</p> <p>methods [1] 41/16</p> <p>might [5] 23/8 30/22 33/9 59/16 70/20</p> <p>mind [2] 11/15 32/16</p> <p>minimise [1] 73/15</p> <p>miss [1] 22/7</p>

M	71/7	64/8 66/6 66/7	obtaining [3] 14/24 42/13 43/7	operation [2] 33/18 57/20
missed [6] 31/3 36/7 36/13 38/2 48/19 66/5	must [4] 78/11 78/14 78/22 79/22	non-adherence [1] 61/12	obviously [1] 24/2	operational [1] 34/10
misuse [10] 16/21 17/11 23/16 23/25 24/1 25/6 27/11 45/14 59/12 66/9	my [2] 31/18 48/24	non-adherent [3] 36/4 36/7 36/12	occasion [1] 40/19	operative [1] 64/9
mitigated [1] 63/4	N	non-compliance [8] 18/13 25/8 29/25 33/2 33/7 41/20 45/14 66/7	occasions [5] 15/10 29/16 29/18 57/14 61/24	opined [1] 76/11
mitigation [1] 77/24	names [2] 3/12 3/14	non-concordance	occurred [10] 9/13 16/18 18/18 22/7 30/14 31/5 31/21 33/14 50/25 71/2	opinion [1] 15/15
model [1] 77/10	narrative [1] 7/8	[10] 35/2 35/4 35/13 35/17 35/20 36/18 36/21 37/2 40/18 41/24	October [1] 68/20	opportunities [5] 37/20 39/23 41/24 48/19 59/18
moderate [1] 38/20	national [4] 12/7 23/21 36/1 77/6	non-engagement [3] 63/5 64/6 64/8	off [1] 21/6	opportunity [4] 31/3 31/10 39/11 80/11
moment [1] 54/8	nature [6] 9/7 9/11 27/14 48/13 56/24 72/11	non-participation [1] 66/6	offence [3] 67/10 67/21 68/3	optimise [1] 37/20
moments [1] 21/6	Ndow [4] 2/15 27/17 27/20 81/6	none [1] 22/25	offenders [1] 68/17	optimised [1] 36/19
monitor [4] 33/22 34/3 63/1 76/10	near [1] 22/7	nonetheless [2] 1/24 57/19	offending [1] 23/6	options [1] 38/4
monitoring [15] 37/4 38/3 38/15 38/23 39/3 39/12 39/20 41/6 41/23 58/24 74/22 74/24 79/3 79/25 80/3	nearest [4] 51/6 51/15 51/18 52/3	nor [3] 12/12 39/17 49/19	officer [2] 21/13 32/8	or [123]
month [3] 30/4 30/21 36/12	nearly [1] 28/15	not [107]	officers [1] 21/22	oral [1] 33/21
months [2] 26/22 70/16	necessarily [3] 7/13 8/16 31/7	notable [1] 28/22	often [7] 20/5 45/6 54/2 63/19 70/9 76/11 76/13	orally [1] 80/4
mood [2] 27/2 27/3	necessary [2] 34/20 74/25	noted [17] 18/12 19/24 24/24 30/24 32/19 36/6 36/11 39/9 44/18 47/12 48/4 49/12 60/17 61/6 62/6 71/24 72/9	Older [1] 44/8	order [25] 3/19 16/9 16/15 21/2 21/25 28/8 28/11 29/18 33/4 39/1 44/5 46/5 48/12 49/10 68/8 68/8 68/10 68/11 68/16 68/16 69/24 70/25 71/4 71/14 74/8
more [21] 3/16 10/5 14/24 19/9 20/14 24/5 33/10 35/4 35/7 36/5 44/16 44/23 52/2 55/25 59/19 63/21 64/11 68/15 74/7 74/17 75/13	need [5] 42/15 42/20 50/19 77/13 79/4	notes [2] 23/7 69/13	old [1] 22/10	orders [4] 32/15 69/10 69/15 71/11
morning [4] 2/15 24/10 26/18 26/20	needed [1] 46/4	notified [1] 65/11	Older [1] 44/8	ordinary [1] 13/9
morphine [1] 26/7	needs [7] 54/7 55/25 58/23 59/17 60/10 60/15 62/23	Nottingham [1] 3/1	omitted [1] 7/16	organisation [1] 31/15
most [5] 7/6 14/22 29/2 63/19 79/13	negative [1] 7/13	notwithstanding [3] 17/4 41/10 65/5	on [74] 1/5 1/20 2/2 2/13 3/3 3/16 3/19 3/22 7/12 9/1 10/15 11/2 11/3 11/8 11/15 12/18 13/18 14/9 15/10 15/17 17/2 18/21 20/23 21/1 23/1 23/15 26/10 26/20 26/21 27/6 27/21 27/22 27/24 29/16 29/17 31/23 33/21 34/24 37/1 37/2 37/4 37/6 37/8 39/5 40/18 45/18 46/9 46/10 46/17 46/20 47/10 48/18 50/24 53/9 57/13 59/24 61/13 61/24 64/24 67/11 67/13 68/2 68/6 68/20 70/14 70/23 71/2 71/7 72/5 75/19 75/24 78/3 79/2 80/6	organisational [2] 7/1 55/15
mother [9] 16/4 16/9 17/6 21/1 44/12 44/20 53/16 64/17 65/6	neighbours [1] 26/14	number [22] 3/3 3/5 5/14 6/3 12/1 14/10 14/12 15/24 16/21 17/20 20/12 30/10 30/21 33/19 38/7 58/6 63/23 68/3 69/4 73/9 73/14 75/7	one [17] 7/24 13/12 17/21 25/17 32/22 50/1 50/25 51/21 53/11 60/18 60/18 61/7 63/14 76/7 76/13 77/8 77/9	other [20] 1/13 6/11 11/8 13/7 13/13 14/3 19/17 19/22 22/18 35/10 43/15 45/21 48/11 66/10 67/17 68/4 68/22 69/7 73/10 78/20
move [2] 18/21 52/18	never [2] 28/10 35/17	nursing [2] 18/14 60/18	ongoing [4] 25/5 26/23 44/21 62/23	others [13] 12/25 17/21 18/3 29/5 38/3 42/19 50/17 52/13 66/11 67/22 69/1 77/3 77/18
moved [1] 25/4	nevertheless [1] 5/16	O	only [11] 8/3 9/23 15/1 20/9 29/23 32/15 32/18 36/16 47/8 52/22 62/22	otherwise [2] 9/25 13/10
moving [1] 23/15	new [8] 39/5 39/10 43/7 56/15 74/12 78/12 78/14 79/1	objective [2] 37/3 41/16	onwards [2] 14/23 75/23	our [5] 18/24 54/25 61/4 63/7 68/21
Mr [10] 1/3 1/4 2/15 27/17 27/20 31/18 69/8 69/18 81/4 81/6	NHS [6] 3/24 4/2 5/3 14/23 44/1 58/12	objects [1] 22/19	open [1] 9/1	out [23] 1/11 4/8 11/21 11/23 15/17 15/18 17/16 21/16 25/15 27/24 28/12 32/11 34/25 35/8 42/7 47/17 50/9 52/16 67/6 69/22 71/25 72/17 79/8
Mr Hendy [1] 69/18	NHS Trust [1] 58/12	observe [1] 28/15	operated [1] 56/12	outcome [6] 8/25 67/19 67/21 68/24 69/15 71/6
Mr Julian Hendy [1] 69/8	NICE [1] 38/22	observed [4] 34/14 38/7 58/5 74/8		outcomes [2] 67/10 68/3
Mr Ndow-Njie [4] 2/15 27/17 27/20 81/6	nine [1] 26/22	obsolete [1] 67/24		outlining [1] 79/24
Mr Weston [4] 1/3 1/4 31/18 81/4	nine months [1] 26/22	obtain [3] 48/19 50/22 72/13		outreach [2] 75/9 75/20
much [2] 19/3 19/25	nineties [1] 48/25	obtained [6] 1/21 5/3 5/5 21/6 43/15 52/22		outset [1] 47/12
multi [3] 64/3 75/21 76/1	Njie [4] 2/15 27/17 27/20 81/6			outside [1] 25/17
multi-agency [3] 64/3 75/21 76/1	no [27] 7/7 7/12 7/12 7/14 15/3 23/3 24/22 33/22 39/3 39/16 40/13 41/21 41/22 46/15 46/25 48/10 49/12 50/17 50/18 53/21 60/5 63/13 64/20 65/4 65/9 73/7 74/8			over [17] 2/22 27/17
multidisciplinary [3] 47/2 64/2 74/18	nominated [1] 51/11			
multiple [11] 22/22 26/6 28/23 29/3 32/24 46/17 53/10 57/13 61/20 61/24 69/25	non [26] 18/13 25/8 29/25 33/2 33/7 35/2 35/4 35/13 35/17 35/20 36/4 36/7 36/12 36/18 36/21 37/2 40/18 41/20 41/24 45/14 61/12 63/5 64/6			
murder [2] 67/12				

<p>O</p> <p>over... [15] 29/14 29/15 36/19 41/2 42/17 45/4 52/1 57/11 58/4 61/4 72/10 73/22 73/25 75/10 77/9</p> <p>overall [6] 5/11 5/21 6/4 9/5 9/8 15/19</p> <p>oversight [4] 13/8 55/5 74/19 74/23</p> <p>overwhelming [3] 9/13 10/22 47/14</p> <p>own [2] 77/20 80/13</p>	<p>49/4 50/3 56/21 57/2 69/16 79/22</p> <p>patients' [1] 77/19</p> <p>pattern [9] 22/14 40/3 40/24 49/8 50/14 57/22 61/12 62/2 66/4</p> <p>patterns [4] 2/20 9/8 37/2 42/17</p> <p>pedestrians [1] 61/19</p> <p>penal [1] 69/11</p> <p>People's [1] 44/8</p> <p>per [3] 14/11 14/13 42/8</p> <p>perceived [2] 16/10 70/9</p> <p>percentage [5] 2/9 3/2 5/9 6/1 19/1</p> <p>percentage-based [2] 5/9 6/1</p> <p>percentages [3] 3/3 3/5 3/8</p> <p>perceptual [1] 27/1</p> <p>period [29] 4/11 12/8 14/10 14/11 14/14 16/16 16/18 16/20 18/5 18/19 23/23 26/10 29/14 29/15 29/19 33/16 36/1 39/6 40/1 41/2 46/11 49/6 52/2 52/19 57/11 61/22 65/22 66/24 75/11</p> <p>periods [4] 27/3 46/23 57/23 75/13</p> <p>permits [2] 21/13 32/7</p> <p>permitted [1] 70/8</p> <p>perpetrator [64] 12/20 14/1 14/4 16/6 17/2 17/18 17/24 18/19 18/24 20/25 21/5 21/9 22/1 22/13 23/8 24/9 24/17 24/19 25/3 25/19 26/1 26/9 26/12 26/19 27/25 28/13 28/19 29/9 29/13 29/22 30/4 30/19 31/22 31/25 32/24 37/11 44/6 44/11 44/19 45/1 45/19 45/23 46/7 46/9 48/14 49/7 49/11 49/20 49/23 50/16 51/1 61/18 63/8 64/17 67/11 67/13 67/15 67/23 69/2 70/6 70/13 70/20 70/22 71/1</p> <p>perpetrator's [16] 1/14 17/12 21/20 23/2 23/12 24/14 44/21 45/4 45/13 49/14 50/11 51/4 53/16 59/10 60/3 79/18</p> <p>perpetrators [5] 12/16 28/21 28/23</p>	<p>34/24 61/5</p> <p>persecutory [1] 18/2</p> <p>persisted [1] 58/4</p> <p>person [6] 19/7 21/13 32/8 38/12 51/11 78/23</p> <p>person-centred [1] 78/23</p> <p>personal [1] 16/22</p> <p>persons [1] 13/12</p> <p>perspective [1] 12/20</p> <p>pharmacological [1] 37/22</p> <p>physical [6] 19/6 19/8 19/12 22/22 40/6 40/8</p> <p>pie [1] 13/18</p> <p>place [14] 20/3 21/15 21/15 22/1 32/9 32/9 32/18 33/22 39/3 52/14 65/15 76/22 78/3 79/24</p> <p>placement [3] 13/6 49/25 66/3</p> <p>plan [19] 30/8 38/17 56/3 56/17 58/24 60/2 60/6 60/6 60/8 60/13 61/13 63/14 64/21 65/3 65/4 76/12 78/13 78/23 79/24</p> <p>planned [2] 36/9 41/21</p> <p>planning [30] 6/24 7/2 34/5 47/2 53/20 53/22 54/16 54/20 55/3 55/19 56/7 60/23 61/9 62/16 62/22 63/5 63/11 63/16 63/19 64/2 64/15 65/2 65/20 66/19 74/14 74/17 76/19 77/1 78/21 79/5</p> <p>plans [8] 54/23 54/23 56/14 63/25 74/10 74/22 77/24 78/6</p> <p>plead [1] 67/16</p> <p>pleas [1] 50/20</p> <p>please [4] 15/5 18/23 20/24 27/17</p> <p>pm [1] 80/24</p> <p>point [10] 7/12 21/17 28/11 32/12 63/3 63/20 65/12 66/21 77/9 79/3</p> <p>pointing [1] 76/20</p> <p>points [3] 6/9 20/23 31/19</p> <p>police [26] 18/22 19/2 20/2 20/7 20/7 20/10 20/13 21/11 21/13 22/25 23/4 23/7 24/13 26/16 26/17 27/12 31/22 32/6 41/8 43/8 48/12 49/18 50/16 52/10 52/13 57/25</p>	<p>policies [3] 53/19 55/14 75/4</p> <p>policy [4] 76/21 77/6 78/10 78/24</p> <p>population [1] 3/11</p> <p>posed [6] 29/5 45/23 46/6 49/11 49/23 52/12</p> <p>posing [1] 50/17</p> <p>positive [2] 8/13 26/5</p> <p>positively [1] 7/11</p> <p>possess [1] 54/2</p> <p>possibility [1] 33/4</p> <p>possible [2] 12/13 31/11</p> <p>post [3] 21/4 61/3 77/5</p> <p>post-discharge [1] 77/5</p> <p>post-incident [1] 61/3</p> <p>post-the [1] 21/4</p> <p>potential [9] 10/24 17/8 23/13 25/1 39/1 39/14 44/5 46/18 48/21</p> <p>powers [5] 21/12 21/25 30/11 32/6 62/14</p> <p>practical [1] 53/6</p> <p>practice [10] 8/8 8/8 31/14 33/19 38/22 43/21 54/24 55/8 56/12 78/2</p> <p>practice-based [1] 31/14</p> <p>practitioner [2] 39/10 65/10</p> <p>pre [2] 10/12 13/20</p> <p>preceded [2] 27/7 72/3</p> <p>preceding [4] 18/8 22/13 22/16 30/4</p> <p>precise [3] 35/23 67/25 68/15</p> <p>prefix [1] 12/1</p> <p>premises [1] 17/20</p> <p>preparation [1] 4/16</p> <p>prepared [7] 2/12 4/1 8/5 8/9 9/20 14/19 28/18</p> <p>preparing [1] 5/24</p> <p>prescribed [17] 18/4 25/3 28/14 30/1 34/25 35/2 35/15 35/17 36/7 37/9 40/5 41/3 41/12 52/5 57/16 79/9 79/14</p> <p>prescribing [1] 38/15</p> <p>prescription [1] 79/11</p> <p>presence [2] 7/11 19/16</p> <p>present [6] 2/15 7/14 7/20 8/14 15/16 19/20</p> <p>presentation [17] 1/4 1/14 17/5 27/20 29/4</p>	<p>39/17 39/22 41/7 51/5 56/19 59/16 60/21 62/12 78/19 78/25 81/3 81/5</p> <p>presented [4] 15/25 16/7 21/9 31/25</p> <p>presents [1] 59/13</p> <p>presumed [1] 11/5</p> <p>prevented [1] 23/7</p> <p>previous [24] 6/15 11/9 18/22 18/22 19/1 19/3 19/16 19/20 19/25 20/13 20/17 27/11 27/25 28/2 28/4 28/16 28/24 28/25 29/3 29/7 41/20 48/7 49/21 71/4</p> <p>previously [20] 4/1 17/13 18/24 24/20 28/13 28/19 28/22 29/4 32/3 33/1 34/25 48/24 49/1 53/12 59/5 61/8 63/3 63/8 65/18 70/23</p> <p>primarily [2] 66/12 73/18</p> <p>primary [5] 39/7 39/12 64/1 65/7 65/9</p> <p>principal [1] 53/15</p> <p>principally [1] 9/23</p> <p>principles [1] 77/11</p> <p>prior [22] 1/16 9/17 15/9 20/8 22/7 23/6 25/20 26/22 28/11 28/14 30/20 32/25 36/9 39/5 39/15 47/23 48/2 50/12 51/2 58/16 66/24 67/5</p> <p>prison [2] 68/19 69/6</p> <p>problems [1] 50/6</p> <p>proceed [1] 67/9</p> <p>process [14] 1/9 3/1 4/23 4/24 10/19 11/17 51/23 52/23 57/7 64/20 65/25 67/24 70/12 76/24</p> <p>processes [6] 7/2 34/12 43/5 43/10 55/15 70/19</p> <p>professional [1] 75/6</p> <p>professionally [1] 29/6</p> <p>professionals [6] 14/2 30/24 42/16 55/7 56/9 60/12</p> <p>Professor [4] 19/23 76/3 76/17 80/19</p> <p>Professor Appleby [2] 76/3 76/17</p> <p>Professor Fazel [1] 19/23</p> <p>Professor Spiegelhalter [1] 80/19</p> <p>profile [1] 46/19</p> <p>Programme [3]</p>
--	---	--	---	---

<p>P</p> <p>Programme... [3] 64/23 74/15 75/16</p> <p>programmes [3] 24/4 35/7 36/4</p> <p>progression [1] 70/7</p> <p>prolonged [4] 29/14 41/2 57/9 61/21</p> <p>prominence [2] 27/11 75/15</p> <p>prominent [3] 10/5 74/7 75/13</p> <p>promote [1] 75/8</p> <p>properly [4] 8/1 42/21 46/1 71/16</p> <p>property [3] 19/13 24/18 50/15</p> <p>proportion [3] 2/22 28/21 35/16</p> <p>proportions [1] 13/24</p> <p>prosecute [1] 1/18</p> <p>prosecuted [1] 20/2</p> <p>prosecution [2] 20/6 20/11</p> <p>protect [1] 16/9</p> <p>protection [1] 70/10</p> <p>protective [1] 62/8</p> <p>protocols [3] 38/1 74/23 75/17</p> <p>provide [10] 2/18 11/21 30/13 31/13 34/19 43/20 47/21 54/23 55/24 79/6</p> <p>provided [22] 3/2 5/10 5/16 8/18 10/18 10/20 11/3 11/10 19/8 27/14 27/15 33/9 45/12 45/19 48/15 51/22 57/6 60/18 61/7 65/3 70/11 80/17</p> <p>providers [1] 32/25</p> <p>provides [3] 31/17 53/11 57/20</p> <p>providing [5] 13/25 44/19 52/10 60/12 80/14</p> <p>provision [3] 5/19 68/19 74/21</p> <p>psychiatric [2] 15/15 46/9</p> <p>psychiatrists [1] 15/10</p> <p>psychological [2] 38/18 47/4</p> <p>psychosis [5] 6/16 15/25 17/11 24/20 39/14</p> <p>psychotic [12] 15/12 15/20 16/5 17/1 17/25 18/7 18/13 18/20 25/1 25/22 52/20 53/8</p> <p>public [12] 10/3 14/17 17/17 17/19 17/19 21/15 25/16</p>	<p>29/10 29/21 32/9 46/12 70/10</p> <p>publication [1] 4/12</p> <p>publicly [10] 2/2 2/6 2/25 3/23 4/25 9/25 10/2 10/15 14/21 80/15</p> <p>published [7] 1/5 2/13 3/21 6/10 9/22 14/22 80/6</p> <p>purpose [2] 32/10 34/3</p> <p>purposes [3] 7/21 20/16 21/15</p> <p>pursuant [3] 5/4 9/21 14/18</p> <p>pursued [1] 59/20</p> <p>put [3] 35/15 39/3 76/22</p>	<p>R20 [2] 61/17 70/1</p> <p>R21 [4] 44/25 44/25 65/18 65/18</p> <p>R22 [5] 39/25 53/11 53/12 71/10 73/12</p> <p>R23 [1] 70/4</p> <p>R24 [3] 17/15 72/24 73/12</p> <p>R25 [2] 47/24 70/1</p> <p>R26 [6] 29/8 40/22 77/15 78/8 79/6 79/16</p> <p>R27 [1] 72/24</p> <p>R28 [1] 70/4</p> <p>R29 [2] 24/7 73/2</p> <p>R3 [3] 72/23 76/23 77/4</p> <p>R30 [5] 22/9 48/24 59/3 77/15 77/16</p> <p>R31 [1] 50/21</p> <p>R32 [1] 70/1</p> <p>R33 [4] 59/21 73/3 77/15 77/25</p> <p>R34 [3] 66/16 79/6 79/6</p> <p>R35 [2] 72/24 73/13</p> <p>R36 [3] 27/4 70/1 72/24</p> <p>R37 [1] 73/17</p> <p>R38 [1] 16/3</p> <p>R39 [1] 71/10</p> <p>R4 [3] 25/14 70/1 72/24</p> <p>R40 [1] 71/11</p> <p>R41 [1] 46/8</p> <p>R42 [1] 50/13</p> <p>R43 [1] 73/9</p> <p>R44 [1] 53/4</p> <p>R5 [2] 30/12 30/14</p> <p>R6 [1] 70/4</p> <p>R7 [6] 20/24 30/12 31/17 31/17 70/22 73/8</p> <p>R8 [1] 25/25</p> <p>R9 [2] 43/24 58/9</p> <p>raised [6] 32/22 34/6 49/18 53/4 64/4 70/17</p> <p>raising [1] 6/9</p> <p>random [1] 2/23</p> <p>range [7] 8/22 9/2 19/9 43/21 55/18 55/21 66/23</p> <p>ranged [1] 14/11</p> <p>rapidly [1] 53/7</p> <p>rarely [3] 32/16 61/1 61/2</p> <p>rate [2] 9/5 19/24</p> <p>rather [8] 3/9 7/24 10/9 14/7 64/9 67/19 68/24 76/21</p> <p>re [1] 71/21</p> <p>re-traumatising [1] 71/21</p> <p>reached [3] 15/8 15/10 21/23</p> <p>readily [1] 3/10</p> <p>readmission [1]</p>	<p>57/10</p> <p>reasonable [2] 9/2 11/5</p> <p>reasonably [3] 21/24 30/22 36/22</p> <p>reasons [1] 55/21</p> <p>reassess [1] 39/21</p> <p>reassessment [2] 39/17 58/22</p> <p>reassurance [2] 47/5 70/10</p> <p>recall [1] 34/12</p> <p>recalling [1] 34/9</p> <p>receipt [1] 36/9</p> <p>receive [2] 56/1 79/22</p> <p>received [5] 1/25 5/13 5/22 6/11 25/21</p> <p>receiving [6] 38/13 43/25 44/6 58/11 58/17 62/21</p> <p>recent [10] 14/22 18/12 46/22 48/1 52/4 76/19 77/7 77/21 79/2 79/13</p> <p>recently [1] 66/17</p> <p>recognise [2] 37/1 56/24</p> <p>recognised [4] 46/25 53/25 59/2 66/11</p> <p>recollection [1] 26/23</p> <p>recommend [2] 43/4 75/7</p> <p>recommendation [8] 7/23 74/6 76/24 77/4 77/16 77/25 78/8 79/16</p> <p>recommendations [20] 2/21 7/21 8/8 32/19 43/1 74/3 74/5 75/1 75/12 75/15 75/19 75/24 76/8 76/13 76/19 77/7 77/10 79/2 79/7 80/18</p> <p>recommended [1] 31/13</p> <p>reconciliation [1] 79/20</p> <p>reconfiguration [2] 58/14 58/18</p> <p>record [4] 12/12 12/19 42/9 46/3</p> <p>record-keeping [1] 42/9</p> <p>recorded [19] 7/20 13/11 13/16 15/7 15/18 16/6 17/24 22/12 22/17 24/12 25/2 25/19 26/11 29/12 30/2 49/5 50/6 63/14 64/23</p> <p>recording [3] 42/9 42/24 46/14</p> <p>records [8] 11/17 18/11 23/1 42/16</p>	<p>52/15 52/21 57/12 72/13</p> <p>recovery [1] 60/11</p> <p>recurring [2] 2/19 63/23</p> <p>reduced [4] 34/15 39/7 58/20 72/6</p> <p>reductions [1] 40/4</p> <p>refer [1] 58/7</p> <p>reference [1] 12/20</p> <p>referenced [1] 53/12</p> <p>referrals [2] 13/7 23/11</p> <p>referred [3] 31/18 61/8 76/5</p> <p>reflect [5] 40/25 45/8 59/17 67/19 76/25</p> <p>reflected [2] 37/10 62/10</p> <p>reflecting [1] 47/19</p> <p>reflective [1] 55/8</p> <p>reflects [3] 8/1 51/8 68/23</p> <p>regarding [31] 23/6 29/25 31/15 34/6 34/22 35/6 35/9 38/21 40/16 42/6 43/11 44/3 45/3 45/10 45/12 49/14 49/24 50/8 51/4 52/11 53/17 54/3 55/7 55/14 58/13 59/9 60/2 63/11 65/24 66/20 70/17</p> <p>regards [3] 53/9 75/4 76/19</p> <p>regime [3] 6/20 25/9 39/5</p> <p>regimes [2] 37/6 40/13</p> <p>regular [2] 41/11 43/6</p> <p>regularly [1] 72/5</p> <p>rehabilitative [1] 66/6</p> <p>reintroduction [1] 53/2</p> <p>relapse [13] 16/25 17/6 17/11 40/18 43/14 52/4 54/4 56/20 57/10 57/21 57/23 61/12 63/5</p> <p>related [9] 2/12 2/22 3/11 15/4 23/2 28/13 35/11 54/17 63/16</p> <p>relates [1] 74/3</p> <p>relating [10] 4/5 5/14 6/10 6/21 37/24 42/23 43/2 51/6 51/19 80/2</p> <p>relation [10] 5/1 14/4 36/16 36/17 51/24 61/17 62/5 65/8 66/1 75/1</p> <p>relationship [8] 12/15 12/19 12/21 13/13 13/16 13/20 16/23 60/22</p>
	<p>Q</p> <p>qualitative [2] 2/8 2/18</p> <p>quality [7] 8/22 27/14 43/9 72/5 74/13 75/25 78/5</p> <p>quantity [1] 25/23</p> <p>question [2] 40/19 51/9</p> <p>questioned [2] 33/3 39/4</p> <p>questionnaire [48] 1/4 1/6 1/9 1/12 1/19 1/23 2/1 2/5 3/1 4/22 5/7 5/16 10/8 10/19 10/21 10/23 11/25 12/2 15/23 20/4 20/8 20/19 20/22 24/7 25/10 27/20 37/10 38/8 43/19 47/21 50/13 51/23 57/7 57/18 58/6 64/13 69/21 69/25 70/12 71/6 72/16 72/17 73/4 76/18 77/15 80/12 81/3 81/5</p> <p>quickly [1] 29/23</p> <p>quote [1] 37/12</p>			
	<p>R</p> <p>R1 [1] 37/10</p> <p>R10 [3] 38/11 71/19 73/16</p> <p>R11 [4] 22/3 71/10 71/13 72/24</p> <p>R12 [1] 70/1</p> <p>R13 [2] 33/13 72/24</p> <p>R14 [1] 71/9</p> <p>R15 [4] 64/16 71/10 76/23 76/23</p> <p>R16 [1] 32/23</p> <p>R17 [1] 70/1</p> <p>R18 [2] 26/8 73/9</p> <p>R19 [2] 70/1 71/9</p> <p>R2 [3] 69/25 71/10 71/13</p>			

<p>R</p> <p>relationships [1] 14/5</p> <p>relative [5] 24/11 51/7 51/15 51/18 52/3</p> <p>relatively [1] 58/17</p> <p>relatives [1] 12/25</p> <p>release [2] 70/8 71/17</p> <p>released [4] 21/3 26/17 69/16 70/21</p> <p>relevance [1] 7/16</p> <p>relevant [36] 1/24 3/6 5/6 5/16 5/19 6/20 8/15 10/13 11/20 11/23 14/8 16/1 27/10 31/20 36/9 36/13 38/19 40/23 42/18 43/7 44/14 45/2 46/3 48/20 50/2 53/13 57/20 59/21 61/16 62/24 65/11 65/19 72/20 72/22 72/25 73/8</p> <p>reliable [3] 11/6 11/12 12/14</p> <p>reliance [1] 61/13</p> <p>relied [2] 10/15 41/13</p> <p>relies [1] 2/24</p> <p>reluctance [1] 37/8</p> <p>reluctant [1] 77/8</p> <p>rely [2] 46/17 46/20</p> <p>remained [3] 18/19 22/1 52/17</p> <p>remaining [1] 10/16</p> <p>remarks [1] 4/10</p> <p>remove [2] 21/13 32/8</p> <p>rendered [2] 67/23 69/2</p> <p>reoccurring [1] 43/2</p> <p>reorganisation [1] 58/16</p> <p>repeat [1] 31/19</p> <p>repeated [12] 17/22 22/20 23/13 40/3 40/18 48/6 49/3 50/16 52/1 57/10 59/6 76/13</p> <p>repeatedly [4] 26/1 51/3 56/22 57/14</p> <p>replaced [1] 51/10</p> <p>report [83]</p> <p>reported [17] 6/15 14/13 18/10 20/2 20/6 22/25 24/14 26/19 48/14 49/18 52/9 71/11 71/13 72/23 73/9 73/12 73/16</p> <p>reporting [1] 72/21</p> <p>reports [60] 2/2 2/6 3/21 3/25 4/4 4/8 4/9 4/16 4/25 5/2 5/5 5/6 6/5 6/6 6/10 8/5 8/9 8/17 8/22 9/19 9/20 9/23 9/25 10/2 10/7</p>	<p>10/16 10/23 13/15 14/6 14/17 14/19 14/20 14/24 14/25 15/3 20/7 27/15 32/20 36/20 37/1 37/14 37/23 43/1 43/3 43/11 51/12 55/18 55/20 56/13 56/23 57/3 58/2 63/24 72/3 72/10 73/19 73/20 74/4 75/7 76/11</p> <p>repository [1] 15/2</p> <p>representation [1] 19/16</p> <p>representative [1] 3/7</p> <p>represented [1] 28/1</p> <p>representing [11] 15/19 28/7 28/9 28/12 35/1 42/8 42/10 47/17 50/10 55/2 55/16</p> <p>represents [2] 62/19 63/3</p> <p>request [3] 5/4 40/4 51/16</p> <p>require [1] 53/8</p> <p>required [10] 7/8 8/24 16/8 16/13 24/23 38/23 60/11 62/8 64/24 78/7</p> <p>requirement [1] 19/7</p> <p>requirements [1] 79/24</p> <p>requires [2] 62/22 67/17</p> <p>requiring [2] 22/22 29/16</p> <p>research [2] 76/5 76/7</p> <p>resided [1] 22/5</p> <p>residence [1] 17/12</p> <p>resident [8] 13/3 22/4 22/10 22/11 48/25 49/1 59/4 59/4</p> <p>residential [2] 26/2 49/25</p> <p>residents [1] 13/25</p> <p>resistant [1] 37/12</p> <p>Resolution [1] 75/21</p> <p>resources [1] 7/1</p> <p>Resourcing [1] 55/13</p> <p>respect [7] 1/13 3/15 5/1 11/13 67/10 71/24 72/16</p> <p>respond [5] 36/18 37/2 41/25 53/7 64/4</p> <p>responded [1] 33/10</p> <p>respondent [5] 37/11 50/14 50/19 53/5 71/19</p> <p>respondents [15] 5/11 10/21 11/10 12/2 69/22 70/1 70/4 71/5 71/10 71/13 72/16 72/18 72/20 73/9 73/14</p>	<p>responding [3] 38/2 56/5 56/18</p> <p>response [9] 7/7 34/5 40/14 43/17 45/6 52/17 66/14 67/22 78/25</p> <p>responses [3] 1/19 10/9 10/23</p> <p>responsibility [7] 21/1 67/14 68/2 70/24 71/8 73/16 74/20</p> <p>responsible [2] 42/21 56/4</p> <p>restriction [5] 21/2 23/12 68/10 70/25 71/3</p> <p>restrictions [1] 68/12</p> <p>result [14] 8/25 12/13 23/4 23/10 25/23 33/23 41/24 45/17 48/21 49/22 52/17 58/25 59/18 67/1</p> <p>resulted [3] 1/19 2/6 31/7</p> <p>resulting [4] 24/10 30/16 59/24 61/19</p> <p>resume [1] 54/15</p> <p>retains [1] 14/23</p> <p>return [3] 8/13 65/16 66/2</p> <p>returned [1] 26/17</p> <p>returning [1] 65/6</p> <p>returns [1] 2/5</p> <p>revealed [1] 72/8</p> <p>review [27] 1/24 2/2 2/8 2/11 2/16 2/17 2/21 3/17 3/17 4/7 5/9 5/25 6/4 9/15 10/1 11/21 14/16 14/21 30/20 31/2 32/23 75/11 78/11 79/10 79/20 79/25 80/9</p> <p>reviewed [31] 2/1 3/9 4/11 5/23 9/10 10/6 12/17 14/7 15/22 15/23 28/4 32/19 35/1 35/9 36/15 37/17 42/6 42/8 42/11 42/22 43/2 51/12 55/17 56/10 56/15 63/2 63/24 67/12 67/15 74/4 76/25</p> <p>reviewers [4] 8/25 9/4 11/16 72/4</p> <p>reviewing [1] 56/5</p> <p>reviews [6] 4/2 4/3 4/4 4/4 7/5 78/24</p> <p>revisit [1] 43/16</p> <p>right [1] 51/16</p> <p>rights [1] 51/16</p> <p>rise [1] 9/18</p> <p>risk [79] 6/23 17/10 20/16 25/9 29/5 37/24 42/2 42/5 42/7 42/12 42/21 42/24 43/3 43/4 43/5 43/9 43/12 43/16</p>	<p>44/17 45/3 45/6 45/11 45/16 45/18 46/2 46/14 46/19 47/2 47/7 47/8 47/10 47/12 47/23 48/5 48/18 48/21 49/12 50/2 50/12 50/17 53/10 54/18 54/20 54/22 57/21 61/15 63/1 63/18 65/19 66/9 74/9 74/9 74/12 74/13 75/17 75/20 75/21 77/1 77/7 77/8 77/11 77/12 77/17 77/22 77/22 77/23 77/24 78/1 78/1 78/5 78/5 78/9 78/11 78/12 78/13 78/18 78/19 78/21 78/23</p> <p>risks [21] 17/6 24/25 44/5 44/18 45/23 46/6 46/16 49/11 49/23 52/12 54/7 54/24 56/20 60/15 62/11 63/3 65/16 66/3 66/11 78/13 78/14</p> <p>Ritchie [4] 2/4 42/13 42/20 42/25</p> <p>robust [1] 78/6</p> <p>role [4] 27/10 44/13 51/6 51/10</p> <p>roles [2] 56/8 60/11</p> <p>rounds [1] 79/15</p> <p>routes [1] 74/20</p> <p>routine [1] 79/13</p> <p>Rule [1] 5/4</p> <p>Rule 9 [1] 5/4</p> <p>Rules [1] 5/4</p>	<p>67/11 68/7</p> <p>scrutinised [1] 35/13</p> <p>scrutiny [1] 55/20</p> <p>second [4] 4/21 31/17 74/14 75/18</p> <p>secondary [1] 39/7</p> <p>Section [12] 16/13 21/12 21/19 21/25 26/3 32/7 52/24 68/8 68/11 68/13 68/16 74/15</p> <p>Section 117 [1] 74/15</p> <p>Section 135 [1] 52/24</p> <p>Section 136 [4] 21/12 21/19 21/25 32/7</p> <p>Section 2 [2] 16/13 26/3</p> <p>Section 37 [2] 68/8 68/13</p> <p>Section 41 [1] 68/11</p> <p>Section 45A [1] 68/16</p> <p>secure [2] 70/7 70/14</p> <p>secured [1] 52/22</p> <p>see [7] 12/18 50/7 68/13 68/20 69/10 76/18 80/16</p> <p>seeking [1] 78/15</p> <p>seen [8] 13/18 23/18 24/6 27/5 27/24 34/24 50/13 75/24</p> <p>selecting [1] 9/11</p> <p>selection [2] 3/4 38/9</p> <p>self [2] 9/11 19/14</p> <p>self-harm [1] 19/14</p> <p>sensory [1] 27/2</p> <p>sent [1] 80/12</p> <p>sentence [3] 69/23 70/2 70/6</p> <p>sentenced [1] 70/13</p> <p>sentencing [5] 4/10 69/14 70/15 71/15 71/20</p> <p>September [1] 22/16</p> <p>series [3] 17/16 31/22 32/25</p> <p>serious [4] 4/3 17/8 32/2 48/21</p> <p>seriously [2] 16/4 50/20</p> <p>seriousness [1] 22/24</p> <p>serum [1] 79/13</p> <p>served [1] 23/9</p> <p>serves [1] 60/8</p> <p>service [4] 14/18 22/6 30/15 78/22</p> <p>services [51] 4/6 6/17 6/19 6/22 9/17 9/21 14/1 16/17 18/11 24/21 28/1 28/17 28/20 29/14 30/2 31/23 33/9 34/18 36/8</p>
---	---	--	--	--

<p>S</p> <p>services... [32] 36/18 38/14 39/8 39/18 40/12 40/25 44/7 45/5 48/2 51/2 51/4 53/6 56/16 56/18 57/1 57/11 57/20 58/4 58/14 58/18 58/25 59/15 61/23 62/2 62/7 62/24 63/9 64/7 65/14 66/5 78/9 78/20</p> <p>set [5] 4/8 10/12 11/21 15/17 24/9</p> <p>setting [8] 11/23 17/9 17/17 17/19 25/16 49/2 49/25 59/6</p> <p>settings [5] 13/5 13/10 26/16 62/19 70/7</p> <p>several [5] 59/25 71/5 73/1 73/7 74/6</p> <p>severe [3] 17/25 38/20 70/3</p> <p>severity [1] 48/13</p> <p>shall [1] 30/13</p> <p>share [1] 1/7</p> <p>shared [6] 18/16 42/18 44/14 45/2 72/19 77/2</p> <p>sharing [6] 44/16 47/11 47/13 47/16 47/22 76/1</p> <p>she [6] 17/20 18/1 18/4 18/10 21/6 32/1</p> <p>shelters [1] 13/5</p> <p>shop [2] 21/7 25/17</p> <p>short [2] 54/12 80/25</p> <p>shortcoming [1] 8/1</p> <p>shortcomings [5] 33/20 45/25 62/9 63/18 64/19</p> <p>shortly [8] 18/18 21/10 24/12 26/2 30/2 31/25 38/16 64/17</p> <p>should [17] 3/8 9/20 14/6 14/19 21/11 29/5 30/19 32/6 32/21 35/13 56/7 71/7 77/17 77/23 78/2 78/17 80/1</p> <p>show [1] 55/18</p> <p>shown [1] 68/6</p> <p>sic [2] 4/14 4/15</p> <p>side [4] 18/5 37/7 40/6 40/16</p> <p>sight [1] 73/2</p> <p>significance [1] 41/18</p> <p>significant [8] 22/14 32/2 33/19 36/3 40/20 44/12 46/13 77/3</p> <p>significantly [2] 58/19 66/23</p> <p>signs [3] 43/18 54/4 66/8</p> <p>silent [1] 11/4</p>	<p>similar [2] 13/6 53/4</p> <p>similarly [3] 15/12 68/23 70/22</p> <p>simply [2] 7/14 11/4</p> <p>since [4] 2/3 4/15 14/20 42/25</p> <p>single [1] 46/15</p> <p>sits [1] 19/21</p> <p>situation [2] 24/15 44/24</p> <p>six [1] 29/16</p> <p>size [1] 3/19</p> <p>skewed [1] 10/3</p> <p>skills [1] 78/17</p> <p>slit [1] 18/4</p> <p>small [4] 5/14 35/16 68/3 69/4</p> <p>smaller [4] 13/24 20/4 25/10 69/21</p> <p>smashed [1] 26/14</p> <p>so [6] 5/19 8/3 11/5 20/9 42/22 75/24</p> <p>social [1] 74/19</p> <p>some [23] 5/2 5/3 7/7 8/20 9/24 14/21 15/10 20/1 25/14 27/13 27/25 31/19 35/14 37/16 38/1 43/22 49/16 56/16 64/8 64/13 64/14 75/12 77/14</p> <p>son [2] 24/15 65/22</p> <p>son's [1] 61/10</p> <p>sought [6] 1/12 1/15 11/21 18/11 45/20 48/11</p> <p>source [6] 3/16 12/11 20/17 46/15 50/1 53/15</p> <p>sources [2] 43/16 45/10</p> <p>span [1] 4/11</p> <p>spanning [2] 4/23 14/10</p> <p>special [1] 68/12</p> <p>specialist [3] 39/18 47/6 58/18</p> <p>specific [2] 7/24 76/22</p> <p>specifically [3] 35/4 36/5 71/13</p> <p>specificity [1] 76/8</p> <p>specified [1] 68/1</p> <p>specify [1] 77/8</p> <p>speed [2] 70/6 71/17</p> <p>Spiegelhalter [1] 80/19</p> <p>spoken [1] 73/18</p> <p>spouses [1] 12/22</p> <p>stabbed [5] 17/20 21/7 22/3 26/1 46/11</p> <p>stabbing [1] 25/17</p> <p>stabilising [1] 29/23</p> <p>stability [2] 16/19 57/23</p> <p>staff [13] 6/25 18/14</p>	<p>22/18 22/21 29/24 31/14 46/17 46/20 49/4 60/19 78/12 78/18 80/2</p> <p>stage [3] 35/15 39/24 62/20</p> <p>stages [4] 38/25 45/7 45/9 60/7</p> <p>stairs [1] 24/17</p> <p>stakeholders [1] 62/25</p> <p>standardisation [1] 74/10</p> <p>standards [1] 78/7</p> <p>standing [1] 51/25</p> <p>start [4] 20/24 39/6 54/9 80/23</p> <p>started [1] 37/8</p> <p>state [14] 1/16 8/6 10/4 20/20 31/4 31/11 33/17 40/12 49/15 52/7 52/20 57/15 58/24 60/5</p> <p>stated [2] 26/22 69/9</p> <p>statement [12] 51/23 52/4 52/15 52/21 57/6 57/17 57/22 70/11 70/17 76/5 77/11 77/12</p> <p>statements [6] 1/21 5/19 5/22 10/9 51/22 61/7</p> <p>states [2] 77/4 77/16</p> <p>statistical [1] 80/21</p> <p>status [1] 76/25</p> <p>statutory [7] 21/18 31/4 32/12 51/8 51/15 62/7 62/10</p> <p>stepfamily [1] 12/25</p> <p>steps [7] 1/17 7/3 36/23 36/25 49/20 75/7 76/20</p> <p>still [2] 4/17 73/5</p> <p>stop [1] 40/10</p> <p>stopped [1] 57/24</p> <p>strategies [1] 37/22</p> <p>strategy [1] 56/18</p> <p>street [1] 25/18</p> <p>strengthening [2] 43/4 74/9</p> <p>stress [1] 44/13</p> <p>stressors [1] 16/22</p> <p>strictly [1] 1/22</p> <p>struck [1] 17/18</p> <p>structure [1] 8/17</p> <p>structured [29] 2/8 5/8 5/25 6/7 6/12 7/6 8/13 9/1 9/3 9/15 10/14 10/22 11/7 12/4 13/8 34/19 37/3 39/20 41/16 43/5 49/12 55/23 58/23 59/19 60/2 62/4 63/21 64/11 75/19</p> <p>structures [1] 76/22</p> <p>struggle [2] 56/24</p>	<p>72/21</p> <p>studies [3] 11/23 11/24 16/2</p> <p>subject [13] 2/24 3/17 6/7 9/14 17/22 24/22 28/8 28/10 28/23 29/3 29/18 33/14 64/22</p> <p>subjected [1] 2/7</p> <p>subsequent [3] 53/1 57/24 69/5</p> <p>subsequently [2] 24/17 25/17</p> <p>subset [1] 69/21</p> <p>substance [6] 16/21 17/11 24/19 25/6 45/14 66/9</p> <p>substance-induced [1] 24/19</p> <p>substances [1] 26/6</p> <p>substantial [2] 2/21 25/23</p> <p>such [26] 2/23 3/7 5/22 6/6 6/16 7/8 7/16 9/20 11/4 14/1 22/19 23/14 31/9 39/3 45/7 53/11 54/17 56/1 57/3 60/19 68/4 69/5 72/2 73/10 74/25 77/20</p> <p>suffering [3] 17/24 21/14 32/8</p> <p>sufficient [2] 46/3 80/1</p> <p>sufficiently [1] 70/3</p> <p>suggested [1] 33/8</p> <p>suggesting [1] 76/14</p> <p>suggests [1] 63/2</p> <p>suicide [7] 12/8 14/14 23/22 36/2 67/23 69/2 76/4</p> <p>summaries [5] 2/9 3/2 4/5 5/9 6/1</p> <p>superficial [1] 29/23</p> <p>supervised [1] 63/21</p> <p>supervision [7] 6/25 13/7 34/20 40/11 42/1 55/5 64/12</p> <p>supplement [1] 5/5</p> <p>supplementary [1] 11/6</p> <p>support [10] 13/7 16/17 39/12 53/15 58/3 58/17 58/19 59/19 60/11 65/14</p> <p>supported [4] 13/4 22/4 44/8 66/18</p> <p>supporting [1] 56/9</p> <p>supports [2] 20/14 69/9</p> <p>surrounding [1] 70/18</p> <p>sustained [4] 17/16 22/14 40/24 47/25</p> <p>sustaining [1] 57/1</p> <p>symptomology [6] 15/6 15/12 15/20 24/3</p>	<p>24/6 79/15</p> <p>symptoms [2] 6/16 18/14</p> <p>Syndrome [1] 59/11</p> <p>synthesis [1] 46/14</p> <p>synthesise [1] 49/13</p> <p>synthesised [1] 46/5</p> <p>system [5] 33/22 49/22 64/24 76/15 79/12</p> <p>systematic [1] 41/23</p> <p>systemic [1] 7/24</p> <p>systems [3] 7/1 55/15 78/3</p> <hr/> <p>T</p> <p>tablets [1] 41/9</p> <p>take [3] 50/19 52/14 80/11</p> <p>taken [21] 1/17 7/4 11/1 11/24 12/19 16/25 23/4 26/15 26/19 35/24 36/23 36/25 39/24 41/10 41/17 42/1 49/20 50/18 68/18 73/2 80/22</p> <p>taking [7] 18/4 20/15 33/11 33/24 40/10 41/11 52/5</p> <p>team [36] 1/21 2/1 2/11 2/17 4/7 5/12 5/13 5/24 6/6 7/10 8/21 8/25 9/6 10/13 11/19 19/19 27/13 29/12 30/9 34/13 36/15 41/4 42/23 44/9 46/25 47/5 56/11 60/14 64/22 67/6 74/4 79/17 79/21 79/23 80/9 80/21</p> <p>Team's [3] 27/22 55/20 75/11</p> <p>teams [5] 44/4 44/15 62/19 74/21 75/21</p> <p>telling [1] 18/3</p> <p>ten [1] 29/15</p> <p>tend [1] 76/20</p> <p>term [1] 51/8</p> <p>terminology [1] 51/13</p> <p>terms [2] 34/17 70/9</p> <p>test [3] 43/14 66/25 79/10</p> <p>than [13] 3/10 7/24 10/9 14/7 14/12 19/25 20/15 52/2 64/10 68/24 69/17 70/25 76/21</p> <p>thank [11] 4/20 27/19 54/9 54/10 74/1 76/17 80/7 80/11 80/19 80/22 80/23</p> <p>that [237]</p> <p>that's [4] 19/2 25/13 69/20 69/22</p>
--	--	--	--	---

<p>T</p> <p>their [19] 1/7 1/15 6/15 11/11 21/12 21/23 29/3 30/15 32/6 36/8 36/13 48/25 56/24 57/2 71/6 71/11 73/15 79/23 80/13</p> <p>them [2] 71/16 72/19</p> <p>thematic [1] 11/19</p> <p>theme [3] 12/3 15/5 72/20</p> <p>themes [5] 2/19 38/7 43/2 58/5 63/23</p> <p>themselves [2] 12/4 78/3</p> <p>then [3] 21/6 26/14 70/14</p> <p>therapeutic [1] 60/22</p> <p>therapy [1] 38/18</p> <p>there [47] 4/15 7/3 7/12 7/14 10/24 11/8 11/13 18/8 19/1 21/17 22/17 23/11 29/20 29/25 31/3 32/12 33/6 33/22 34/3 38/1 38/3 39/6 39/16 40/12 41/21 44/13 46/15 46/25 48/3 48/10 49/6 53/21 55/21 59/6 60/5 61/11 62/3 63/13 64/20 65/9 65/13 66/4 66/13 67/25 75/12 75/14 80/5</p> <p>there's [2] 63/5 75/19</p> <p>thereafter [2] 18/18 71/18</p> <p>therefore [14] 3/2 4/9 6/4 7/13 9/6 9/23 10/4 10/6 14/6 19/15 24/23 28/25 36/8 55/18</p> <p>these [24] 3/4 5/8 5/23 15/13 16/24 22/19 22/24 28/23 29/21 34/9 40/14 43/20 43/22 45/15 45/25 49/9 49/17 56/11 56/23 62/9 63/7 63/16 63/24 70/9</p> <p>they [23] 3/14 8/9 20/2 22/4 23/24 29/5 32/16 36/5 36/6 36/11 45/1 48/6 68/19 69/23 71/16 72/18 72/21 72/21 73/5 73/7 73/10 77/12 77/20</p> <p>think [1] 4/18</p> <p>thinking [1] 30/6</p> <p>third [4] 5/13 48/20 74/17 75/23</p> <p>third-party [1] 48/20</p> <p>this [92]</p> <p>those [26] 1/22 2/7 4/16 5/18 6/5 6/7 8/3 8/11 9/12 10/20 10/23 13/21 13/25 20/9</p>	<p>27/18 37/20 38/9 38/22 42/21 45/9 54/17 55/1 55/20 80/4 80/8 80/11</p> <p>threat [1] 16/10</p> <p>threatened [1] 17/13</p> <p>threatening [4] 23/9 49/3 49/8 59/7</p> <p>threats [3] 17/5 22/18 22/20</p> <p>three [8] 1/20 3/18 5/22 10/9 58/7 70/25 73/4 73/23</p> <p>three years [3] 70/25 73/4 73/23</p> <p>threw [1] 26/12</p> <p>throat [1] 18/4</p> <p>through [13] 2/25 3/23 4/24 13/4 31/4 33/9 41/25 43/5 54/23 55/24 60/9 60/15 70/7</p> <p>Thursday [1] 1/1</p> <p>time [26] 12/21 14/21 15/11 15/16 16/11 17/25 22/6 24/21 25/12 25/21 28/9 29/10 29/15 30/12 32/1 36/19 42/17 44/1 47/5 51/9 58/10 60/18 65/11 73/3 73/21 80/16</p> <p>times [4] 8/18 8/23 52/3 55/11</p> <p>today [2] 58/8 80/4</p> <p>together [4] 16/25 44/4 46/16 78/18</p> <p>tolerate [1] 38/5</p> <p>tomorrow [1] 76/17</p> <p>tools [3] 43/6 74/11 75/20</p> <p>topic [1] 27/22</p> <p>tormented [1] 18/7</p> <p>total [6] 3/5 3/11 4/23 5/22 6/3 69/22</p> <p>touch [2] 3/16 32/14</p> <p>touched [2] 1/6 40/22</p> <p>touching [1] 1/19</p> <p>towards [6] 17/5 22/18 29/21 49/4 76/20 79/3</p> <p>trained [1] 42/22</p> <p>training [5] 31/14 55/8 78/11 78/14 78/17</p> <p>transfer [2] 69/6 70/18</p> <p>transferred [2] 68/19 70/14</p> <p>transition [2] 58/25 63/21</p> <p>trauma [1] 17/23</p> <p>traumatising [1] 71/21</p> <p>trays [1] 22/20</p> <p>treated [2] 53/1 68/18</p>	<p>treating [3] 15/9 15/14 64/22</p> <p>treatment [58] 4/13 6/10 6/24 16/13 16/15 16/16 24/4 24/24 25/7 25/8 27/23 28/8 28/11 29/18 31/8 31/20 32/14 33/4 33/5 34/4 34/22 34/23 35/7 35/11 36/4 36/9 36/12 36/19 36/25 37/6 37/16 37/18 38/4 38/17 39/1 40/17 41/1 41/25 44/6 53/20 54/3 54/15 54/25 55/11 55/19 56/5 56/25 57/5 58/3 59/19 60/23 61/8 61/13 61/14 62/21 63/13 65/22 68/18</p> <p>treatment-related [1] 35/11</p> <p>triangulation [1] 78/15</p> <p>trigger [2] 25/1 64/10</p> <p>trust [27] 4/1 5/3 7/4 10/17 31/13 44/1 44/22 58/12 58/15 71/24 72/4 72/9 72/20 72/25 73/5 73/8 73/18 75/4 75/6 77/17 78/2 78/9 78/11 78/24 79/5 79/22 80/1</p> <p>Trust's [5] 22/5 29/11 45/22 53/19 78/4</p> <p>Trust-level [2] 72/9 73/18</p> <p>Trusts [3] 73/15 76/9 76/20</p> <p>turn [11] 15/5 16/1 30/13 43/22 50/4 50/21 60/24 62/15 64/13 68/5 71/23</p> <p>two [5] 26/13 29/17 29/19 70/16 73/2</p> <p>two months [1] 70/16</p> <p>two years [1] 73/2</p> <p>two-year [1] 29/19</p> <p>type [2] 7/7 77/8</p> <p>types [3] 74/6 74/7 75/12</p> <p>typically [2] 9/18 56/2</p>	<p>51/7 51/9 52/1 52/23 57/13 61/5 61/23 65/23 68/8 68/11 68/13 68/14 68/16 68/17 70/8 74/4</p> <p>under-representation [1] 19/16</p> <p>underlying [5] 36/24 37/19 39/22 59/10 59/17</p> <p>undermine [1] 61/14</p> <p>underpinning [1] 8/20</p> <p>underrepresented [1] 35/22</p> <p>understand [4] 1/16 48/12 49/11 67/7</p> <p>understanding [7] 1/10 5/6 11/22 45/23 46/19 59/10 60/21</p> <p>understood [6] 3/8 14/6 25/11 48/23 49/24 64/22</p> <p>undertake [1] 12/14</p> <p>undertaken [9] 3/25 44/17 45/4 48/5 49/13 62/5 66/25 76/5 78/25</p> <p>unfit [1] 67/16</p> <p>unit [3] 12/24 13/21 46/10</p> <p>Unknown [1] 13/17</p> <p>unlawful [2] 19/6 19/12</p> <p>unlikely [1] 28/18</p> <p>unmanaged [1] 47/23</p> <p>unmarried [1] 12/23</p> <p>unnecessary [1] 69/3</p> <p>unprovoked [2] 17/16 25/16</p> <p>unsurprising [1] 28/17</p> <p>until [2] 39/11 70/16</p> <p>untreated [2] 18/20 52/18</p> <p>unusual [1] 27/1</p> <p>unwilling [1] 38/5</p> <p>up [8] 18/6 29/19 30/8 30/22 47/10 50/18 74/22 75/18</p> <p>update [1] 43/16</p> <p>updated [1] 45/8</p> <p>updating [2] 43/6 74/12</p> <p>upon [13] 2/24 3/18 3/19 11/3 14/17 15/8 19/6 32/14 33/25 40/22 41/14 47/9 67/1</p> <p>ups [1] 77/5</p> <p>urgent [1] 53/8</p> <p>us [2] 72/23 73/16</p> <p>use [20] 6/18 19/8 19/25 21/25 22/19 24/2 24/25 26/24 27/8 31/15 32/22 37/2 37/21 43/5 46/1 49/17</p>	<p>51/12 62/14 69/10 74/11</p> <p>used [8] 4/10 5/5 32/16 45/11 68/14 68/21 71/12 77/23</p> <p>user [1] 30/15</p> <p>users [1] 78/22</p> <p>using [4] 2/8 17/17 26/21 77/17</p> <p>usually [1] 3/25</p>
		<p>U</p> <p>ultimately [1] 52/22</p> <p>unable [2] 23/5 38/5</p> <p>unclear [1] 8/19</p> <p>under [41] 5/4 5/17 13/11 16/13 16/15 18/14 19/16 21/2 21/12 21/18 22/5 24/17 24/20 24/22 25/11 26/3 28/4 28/19 29/11 29/17 30/11 30/19 31/2 32/6 32/24</p>	<p>V</p> <p>vague [2] 8/19 76/8</p> <p>valuable [1] 54/2</p> <p>variability [1] 64/2</p> <p>varied [2] 72/11 74/6</p> <p>varies [1] 14/5</p> <p>variety [1] 19/10</p> <p>various [1] 19/11</p> <p>vary [1] 8/17</p> <p>vast [4] 19/20 28/24 42/6 69/16</p> <p>VC [2] 1/12 6/11</p> <p>vehicle [1] 61/18</p> <p>verification [1] 48/16</p> <p>verify [3] 41/16 43/14 45/20</p> <p>verifying [1] 37/3</p> <p>very [2] 32/16 70/15</p> <p>via [2] 1/25 10/19</p> <p>victim [6] 14/4 17/21 25/17 26/1 44/7 48/11</p> <p>victim's [1] 59/25</p> <p>victim-perpetrator [1] 14/4</p> <p>victims [4] 3/12 12/5 12/16 13/23</p> <p>view [2] 8/7 18/15</p> <p>views [2] 75/6 78/16</p> <p>violence [20] 11/9 17/8 18/22 18/25 19/3 19/5 19/13 19/17 19/18 19/20 19/25 20/1 20/1 20/5 20/17 20/20 22/18 27/11 48/21 50/12</p> <p>violent [8] 20/7 22/14 29/5 29/20 47/25 49/4 49/8 59/7</p> <p>violently [1] 59/23</p> <p>visits [1] 66/15</p> <p>visual [1] 27/2</p> <p>vodka [1] 27/6</p> <p>voices [2] 18/3 18/7</p> <p>volunteered [1] 2/25</p> <p>vulnerable [1] 65/17</p>	
			<p>W</p> <p>wait [1] 73/10</p> <p>waiting [3] 30/25 55/11 73/5</p> <p>Wales [1] 3/22</p> <p>want [1] 51/21</p> <p>ward [6] 46/23 59/24 60/3 64/18 78/4 79/15</p> <p>warning [3] 23/9</p>	

<p>W</p> <p>warning... [2] 43/18 66/8</p> <p>warrant [2] 52/23 52/25</p> <p>warranted [2] 18/15 67/3</p> <p>was [174]</p> <p>way [5] 35/15 36/17 38/9 45/3 77/20</p> <p>we [15] 3/21 32/17 32/17 32/18 47/17 65/18 68/13 68/20 69/19 74/7 76/18 79/19 80/10 80/22 80/23</p> <p>We'll [1] 54/9</p> <p>we're [2] 69/18 76/16</p> <p>we've [2] 27/9 27/9</p> <p>weapons [4] 17/18 22/20 23/13 49/17</p> <p>website [4] 2/13 3/24 3/24 80/6</p> <p>weekly [3] 38/25 41/3 79/19</p> <p>weeks [2] 22/13 52/19</p> <p>weight [1] 40/7</p> <p>welfare [1] 13/6</p> <p>welfare-based [1] 13/6</p> <p>well [6] 10/17 35/22 61/11 68/2 74/24 75/21</p> <p>went [1] 46/10</p> <p>were [119]</p> <p>Wernicke [1] 59/11</p> <p>Wernicke-Korsakoff s [1] 59/11</p> <p>Weston [4] 1/3 1/4 31/18 81/4</p> <p>what [1] 26/12</p> <p>when [22] 2/20 8/21 20/6 20/15 25/4 30/14 33/10 33/14 39/6 42/14 43/7 44/25 49/24 54/6 56/15 57/5 59/21 61/8 65/18 69/14 78/13 78/14</p> <p>where [35] 3/14 7/19 7/23 10/4 10/24 11/5 11/8 11/13 11/20 13/10 13/15 15/7 15/13 17/20 22/4 30/4 32/22 33/15 34/20 35/18 36/23 36/24 37/6 38/4 43/8 49/2 50/22 56/23 56/25 59/6 61/10 63/4 63/20 73/22 74/25</p> <p>whereby [1] 28/13</p> <p>wherein [1] 69/16</p> <p>whether [8] 8/1 21/11 30/18 32/5 41/17 49/20 59/16 62/7</p>	<p>which [90]</p> <p>while [4] 22/15 44/7 52/19 54/23</p> <p>whilst [4] 3/2 16/5 35/20 46/10</p> <p>who [19] 9/16 17/21 18/16 20/12 24/11 27/17 38/12 48/1 49/1 51/24 53/8 53/14 59/4 65/6 66/17 78/16 79/8 79/22 80/12</p> <p>whom [1] 43/25</p> <p>why [2] 33/4 77/20</p> <p>wide [1] 19/9</p> <p>wider [5] 1/10 13/1 13/21 19/17 55/15</p> <p>will [19] 2/13 2/15 3/6 3/14 3/18 27/17 27/21 27/24 34/24 42/2 60/24 62/15 68/5 68/6 73/19 80/5 80/14 80/17 80/23</p> <p>window [1] 26/14</p> <p>wish [1] 33/11</p> <p>within [21] 5/15 5/15 11/11 13/10 13/13 13/21 17/8 34/12 36/5 43/1 48/22 56/22 57/17 58/15 61/2 66/10 68/21 68/22 70/17 79/21 80/5</p> <p>without [6] 19/12 33/24 40/10 41/15 46/10 48/16</p> <p>witness [11] 1/20 5/19 10/9 51/21 52/2 52/10 52/22 57/6 58/2 70/11 76/5</p> <p>witnessed [1] 26/14</p> <p>woman [4] 17/15 21/5 43/25 58/10</p> <p>word [1] 73/19</p> <p>workforce [1] 75/25</p> <p>working [1] 76/2</p> <p>worsen [1] 24/2</p> <p>worsening [1] 24/6</p> <p>worst [1] 77/12</p> <p>worth [1] 35/20</p> <p>would [15] 11/16 23/3 28/18 31/7 34/21 39/7 40/4 40/10 54/8 65/14 66/14 69/9 74/2 74/5 80/11</p> <hr/> <p>Y</p> <p>year [7] 14/11 14/13 22/10 22/16 29/15 29/19 50/25</p> <p>years [14] 2/23 21/4 42/25 52/2 57/11 58/4 69/17 70/25 71/3 73/2 73/4 73/23 73/25 77/7</p> <p>yes [13] 1/3 7/7 7/10 15/13 27/19 42/4 54/9 54/14 62/17 71/22 74/1 80/7 80/10</p>	<p>Yes/No [1] 7/7</p> <p>yet [2] 14/22 68/20</p> <p>you [20] 2/20 3/13 3/19 4/20 11/18 11/22 12/18 27/18 27/19 27/21 54/9 54/10 74/1 74/3 76/17 80/7 80/15 80/15 80/22 80/23</p> <p>you'll [3] 28/15 50/7 80/16</p> <p>young [2] 21/5 38/12</p> <p>your [2] 3/15 80/16</p>		
---	---	--	--	--