

Wednesday, 6 May 2026

1
2 (2.00 pm)
3 **MS LANGDALE:** Thank you. Can we have NHFT0000168 page64,
4 please, on the screen. Dr Lloyd, this is 16 July 2020,
5 "72 hour review". And we see under "Patient comments",
6 page 64, third paragraph down:
7 "Dr Seedat observed there seems to be no insight or
8 remorse and ... the danger is that this will happen
9 again and perhaps [VC] will end up killing someone.
10 [VC] ... responds by saying 'it will not happen again'."
11 Did you see this in the notes?
12 **A.** Yes, I did.
13 **Q.** Do you agree with it, what he said?
14 **A.** So when I read this in the notes, having also read in
15 detail the events that had led up to both the first and
16 second admissions, I felt that his comment here had to
17 be put into context, and I understand that Dr Seedat
18 does go on and put it into context.
19 What he is saying is that VC's behaviour, ie,
20 attempting to kick down the door, the unintended
21 consequence of this was that the student jumped out of
22 the window and that, should he do it again, it could be
23 that she jumps out of a higher window or something else
24 happens and he ends up killing someone; not that he has
25 clear intent, planning, you know, any kind of

1

1 been going on in the community, shouldn't it?
2 **A.** It should, yes.
3 **Q.** Why wasn't it?
4 **A.** I'm not certain why it wasn't started immediately but
5 I do believe that Claudia Birtles did a good piece of
6 psychoeducation work and relapse prevention early
7 warning signals with VC in January 2021.
8 **Q.** Well, I don't mind us jumping to that, if you like, it's
9 NHFT0000168, page 145. And this is the Relapse
10 Prevention Plan, page 145. And so VC started to
11 complete card sorting exercises for the plan. Let's
12 have a look at the bottom of it.
13 "If [VC] were to become unwell again he would like
14 people not to be overly judgemental.
15 "He would like to avoid hospital, use least
16 restrictive practice (increase contact with care
17 team/[Crisis Team] ...) and speak with the family on his
18 behalf.
19 "[VC] would like to remain on Aripiprazole as he has
20 been on this since the start".
21 It's hardly a Relapse Prevention Plan that, is it?
22 Whatever he's been asked to do, that's simply
23 a "I just want to get on with my own thing", isn't it?
24 **A.** This looks like an advanced statement actually, rather
25 than an actual Relapse Prevention Plan, yes, I agree.

3

1 premeditated wish to kill someone --
2 **Q.** But his actions could result in killing someone.
3 **A.** That's right, yes, it could.
4 **Q.** So you agreed with that when you read it?
5 **A.** Absolutely.
6 **Q.** And if we see, if we go, please, to NHFT0000222, you see
7 the Discharge Summary. It repeats what's in the note
8 that's coming off the screen, the diagnosis -- primary
9 diagnosis of schizophrenia.
10 So if we go, please, to page 2: "Primary Diagnosis
11 Paranoid Schizophrenia" at this time.
12 Dr Burri was the one who conducted further
13 examinations, wasn't it, in respect of VC, rather than
14 yourself soon after?
15 **A.** That's right.
16 **Q.** But whether -- he described, he thought two consecutive
17 episodes of psychosis or a psychotic disorder. But the
18 treatment would have been the same, from what you were
19 saying before: antipsychotic medication in conjunction
20 with psychological therapies; is that right?
21 **A.** That's correct, yes.
22 **Q.** I don't want to get hung up on a diagnosis. The
23 treatment was the same at the time.
24 **A.** Yes.
25 **Q.** Psychoeducation and relapse prevention work should have

2

1 It looks as though these are VC's wishes in terms of
2 what he would like to see in event of a further relapse.
3 **Q.** And they look like very rehearsed in terms of Mental
4 Health Act language and terminology, "not to be overly
5 judgmental", "least restrictive practice"; do you agree?
6 **A.** Yes.
7 **Q.** Do many of your patients say: "I'd like you to use the
8 least restrictive practice"?
9 **A.** No, they don't.
10 **Q.** Have you ever heard that?
11 **A.** Not that I can recall, no.
12 **Q.** And you've had how many patients?
13 **A.** Over the years?
14 **Q.** Yes.
15 **A.** Gosh, thousands.
16 **Q.** Do many say: "I don't want you to be overly judgemental"?
17 **A.** That depends. It depends on the sort of education and
18 the eloquence of a patient. So yes, occasionally, that
19 has been said.
20 **Q.** Where criminal acts have been committed there's
21 a requirement to be judgemental, isn't it, even within
22 mental health services and developing a therapeutic
23 relationship with the patient, to recognise behaviour
24 that falls under criminal law. Do you agree or not?
25 **A.** I think we would do everything in our capacity to

4

1 prevent further criminal behaviour, yes. It's not
 2 something that we would endorse, no.
 3 **Q.** Can we have that down, please, and NHFT0000202, page 1.
 4 We're going back to 2020, 1 September. The Summary Care
 5 Plan sets out summary formulation at the beginning. The
 6 formulation doesn't actually, it's agreed, set out risk,
 7 risk management, anything of that kind.
 8 If we go to the bottom of the page it doesn't
 9 include the primary -- the schizophrenia diagnosis. And
 10 if we go to page 3, please, we see "Actions" listed:
 11 "Regular contact with Care Coordinator."
 12 How often VC has contact, et cetera.
 13 "Services to build therapeutic relationships ..."
 14 And under "Actions", further down:
 15 "Ongoing monitoring of mood, mental state and
 16 behaviours
 17 "Continue to explore and develop coping strategies
 18 that might prove effective ..."
 19 And the responsible people are named as yourself and
 20 Claudia Birtles.
 21 In terms of Claudia Birtles we're agreed, she wasn't
 22 doing detailed relapse prevention planning work with him
 23 or risk assessment management plans, was she, with you?
 24 **A.** Sorry, could you repeat the question?
 25 **Q.** She wasn't preparing risk assessment management plans

5

1 Our trainees, particularly our higher trainees, have
 2 to be able to work relatively independently and
 3 autonomously. We follow clear college guidelines on
 4 these issues, and they have certain competences that
 5 they must meet. The supervision level is indirect.
 6 **Q.** His name is not on the care plan though, is it,
 7 Dr Burri?
 8 **A.** I don't know why it's not on the care plan --
 9 **Q.** Are they sometimes -- are ST5s on the care plan named?
 10 **A.** Yes.
 11 **Q.** Why is your name -- you see, it's not clear what your
 12 role or responsibility was, listening to you. What were
 13 you expected to do?
 14 **A.** My role here is having oversight as the community
 15 consultant working in the team, it's having oversight.
 16 **Q.** So are you responsible, for example, for the review of
 17 his antipsychotic medication --
 18 **A.** No.
 19 **Q.** -- or discussion around that? Who is responsible for
 20 that in the community?
 21 **A.** Dr Burri would be at this stage because VC is on his
 22 caseload.
 23 **Q.** Did he ever discuss his medication with you, his
 24 treatment, what he needed, whether it needed to be
 25 adjusted or anything like that?

7

1 with you and she wasn't preparing either Relapse
 2 Prevention Plans or anything of that kind.
 3 **A.** Not with me, no. I wasn't directly involved in VC's
 4 care at this time. I think I've mentioned before that
 5 Dr Burri was the doctor that was working with him
 6 directly, and so my involvement was more indirect in
 7 terms of supervising him and providing expertise to the
 8 MDT.
 9 **Q.** Well, we see in the top box where it says:
 10 "Completing psychoeducation and relapse prevention
 11 planning ..."
 12 Neither is happening. Dr Burri goes and does one of
 13 the mental state examinations, and he is a trainee,
 14 isn't he? He's an ST5 or ST6.
 15 **A.** He was an ST5 at the time.
 16 **Q.** So he's an ST5. So he does his mental state examination
 17 in accordance with his level of skill. You aren't doing
 18 the mental state examinations at all, are you?
 19 **A.** Not at this stage, no.
 20 **Q.** Didn't you think in this patient that would be wise:
 21 that you should do one?
 22 **A.** VC at this stage is not really different to most of the
 23 patients on our caseload. So there is nothing
 24 particularly unusual or unique about VC's presentation
 25 at this stage.

6

1 **A.** Yes, he did in supervision sessions. Each time an
 2 adjustment was made, we did talk about that.
 3 **Q.** What about the elephant in the room, the one that you
 4 knew, that he wasn't taking it anyway?
 5 **A.** I didn't know this at this stage.
 6 **Q.** We discussed this morning how readily apparent, and went
 7 through a number of notes with Claudia Birtles referring
 8 to the fact he said he had 28 days, when she knew it was
 9 14 days medication and the like. He's constantly saying
 10 things that are very capable of disproof, if you look
 11 a few pages before or afterwards. Are you saying when
 12 you spoke to Dr Burri around this time you hadn't done
 13 that exercise to see --
 14 **A.** I hadn't specifically looked through the notes at this
 15 stage, no, because Dr Burri was essentially leading
 16 medically and was working alongside Claudia Birtles.
 17 So, no, I wouldn't have looked at the notes specifically
 18 at this stage.
 19 **Q.** When did you look at the notes and assess for yourself
 20 he was not taking medication as he should?
 21 **A.** So the only time that I knew that he hadn't was when
 22 Dr Burri handed VC's case directly over to me, which was
 23 at the end of his placement with us.
 24 **Q.** When was that?
 25 **A.** That would have been 31 July 2021. So this is all in

8

1 2020, I'm guessing. And that's when I would have had
2 the handover, I would have gone back and read in a bit
3 more detail about VC's presentation.

4 **Q.** So the care plan stays the same, very little update. So
5 in 2021, then, in accordance with this care plan, what
6 were you doing around Relapse Prevention Plans or
7 monitoring mood, mental state and behaviours of VC
8 because that's what it suggests you're doing, and it's
9 the same plan later on?

10 **A.** So the first time VC is booked in to see me is on
11 9 August 2021. There's a clinic appointment. That's --

12 **Q.** We know you don't have that. We've got all the did not
13 attends; we can deal with that. What did you actively
14 do? Can we just confine ourselves to that?

15 **A.** There was very little that I actively did because
16 I hadn't had the opportunity to --

17 **Q.** So it's nothing, just nothing.

18 **A.** -- to see him.

19 **Q.** No relapse prevention plan -- just to cut through this,
20 we've got a lot of documents to go, if we actually look
21 at what the care plan says you're doing, is the answer
22 "Didn't do any of that", either in 2020 because you
23 didn't expect yourself to do it, but 2021 likewise?

24 **A.** I didn't expect myself to be doing any of those actions
25 at this point and I don't know why my name is there.

9

1 **Q.** We've got the point of her role, thank you.

2 **A.** -- in this case.

3 **Q.** Annual Care Programme Approach, those reviews, were you
4 involved in those?

5 **A.** Yes.

6 **Q.** We understand the initial care plan is done by the care
7 coordinator in collaboration with the patient.

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

9 **Q.** What about the Care Programme Approach reviews? Did you
10 look at these?

11 **A.** Yes, so the CPA, the Care Programme Approach reviews are
12 done annually, and I understand in this occasion, in
13 2021, the review was done before I took
14 -- *(overspeaking)* --

15 **Q.** So you never did one of those reviews?

16 **A.** No.

17 **Q.** Just so we're clear. Okay.

18 **A.** No, so I wasn't involved because it happened the month
19 before. My first appointment with him was 9 August,
20 which he didn't attend.

21 **Q.** In terms of risk assessment, are you saying that was
22 delegated to the care coordinator?

23 **A.** No --

24 **Q.** -- the level of --

25 **A.** -- they carry out the formal risk assessment form which

11

1 **Q.** In 2021, when you'd taken over from Dr Burri, is it the
2 same: you didn't expect or believe you were responsible
3 for risk assessment on a regular basis, monitoring of
4 mood, mental state and behaviours?

5 **A.** Those actions, carrying out a level 2 risk assessment on
6 a regular basis, the fortnightly monitoring of mood,
7 mental state and behaviours and coping mechanisms, are
8 all roles that the care coordinator performs. So the
9 formal level 2 risk assessment forms are done by the
10 care coordinator; the fortnightly monitoring of mood,
11 mental state and behaviours is the role of the care
12 coordinator; and exploring and developing coping
13 strategies is also her role. If VC had agreed to have
14 CBTp, cognitive behavioural therapy for psychosis, then
15 the work around developing coping strategies would have
16 been done much more intensively by our team
17 psychologist.

18 **Q.** That places a lot of responsibility on the care
19 coordinator, doesn't it --

20 **A.** That's right.

21 **Q.** -- and none of yourself? There's nothing.

22 **A.** Absolutely, yes, and that's why they have a capped
23 caseload of 15 -- or they're supposed to -- because they
24 have an extremely broad, overarching role. They are the
25 lead clinician --

10

1 is in RiO but what we always do is we discuss risk in
2 a lot of detail in the MDT --

3 **Q.** Why aren't those meetings recorded? It's easy enough
4 these days, just record them, press a button, or got
5 your medical secretary to take a note -- *(overspeaking)*
6 --

7 **A.** I've already answered that question.

8 **Q.** But it's very convenient, isn't it, to say it was
9 discussed because we see no documentation between you
10 and Claudia Birtles about risk assessment or forms or
11 whatever you needed to complete?

12 **A.** I can't change that. It's something that wasn't just
13 done, it wasn't just our team, it was across the Local
14 Mental Health Teams. I can't really say much more.

15 **Q.** That's because it wasn't done, was it?

16 **A.** That --

17 **Q.** Risk assessment wasn't done in accordance with that care
18 plan at all?

19 **A.** Risk assessment was done regularly and there was a very
20 clear understanding of risk by Claudia Birtles, and
21 myself, but only based on the information that was
22 available to us.

23 **Q.** There was risk about -- risk to Claudia Birtles, wasn't
24 there? There was a risk management discussion between
25 you and her about her no longer being VC's carer and

12

1 people going in pairs. So there was risk assessment for
 2 her.
 3 **A.** No.
 4 **Q.** You didn't have that discussion with her?
 5 **A.** That wasn't done by me. That was a risk assessment done
 6 by Emma Robinson with Claudia Birtles at the time
 7 because Claudia was pregnant.
 8 **Q.** Did you know about that? Were you part of that risk
 9 assessment?
 10 **A.** I wasn't part of that risk assessment. They're usually
 11 done between a clinician and their line manager.
 12 **Q.** So that risk assessment took place -- we've seen notes
 13 of that -- but there wasn't a risk assessment of VC's
 14 risk to neighbours those around him or in the light of
 15 the events that had happened in 2020 or 2021 was there:
 16 the risk to the public and other people?
 17 **A.** I know that those risks are listed in the level 2 form,
 18 but I think unfortunately -- unfortunately, the detailed
 19 risk discussions that we had, no, because they were part
 20 of an MDT discussion. They were not recorded. It does
 21 not mean that they didn't happen. And we had an
 22 understanding of the risk to the public and I had
 23 a clear understanding of risk, as I knew it, and that's
 24 something that I've documented in my witness statement.
 25 **Q.** Let's move on now to the documents, NHFT0017810, page 2.

13

1 So Gary Carter doesn't email often, from what we've
 2 looked at, does he?
 3 **A.** No, he doesn't.
 4 **Q.** And he's emailed you querying medication, VC's
 5 medication, what's left, what's going on, against this
 6 backdrop. Did that make you ask further questions or
 7 wonder why he was doing that?
 8 **A.** I knew there had been a period where he hadn't engaged
 9 and I think I must have assumed that because they hadn't
 10 been able to see him for that period that the medication
 11 ... I'm not sure. Yes. I don't remember this email but
 12 yes, I can see that he said that.
 13 **Q.** So he's worried about medication at this time. And if
 14 we go -- (*overspeaking*) --
 15 **A.** He said that there's about ten left, yes.
 16 **Q.** If we go to NHFT0000168, page 138 please. This is
 17 10 November Bilal Burri note, and the plan, at the
 18 bottom:
 19 "Close monitoring in the community by [the care
 20 coordinator] ..."
 21 So what did you think was required for close
 22 monitoring?
 23 **A.** The most that we could offer was weekly at this stage.
 24 **Q.** So in your discussions about risks and generally, did
 25 you think you needed to escalate this or get a Mental

15

1 This is Dr Seedat emailing you. From what you said
 2 earlier, there's no conversations, you just email each
 3 other and he lets you know that he's surprised in
 4 November 2020 VC tries to contact him. So we see at
 5 page 2. His email at the bottom, and yours at the top.
 6 Four days later:

7 "... it looks like the team have been making a
 8 concerted effort to visit and follow [him] up
 9 patient has not been engaging ... CPN Gary Carter has
 10 now seen him. As you can imagine patients with
 11 psychosis can sometimes behave in quite erratic ways
 12 ..."

13 Were you interested to know why he was looking or
 14 wanted to speak to Dr Seedat?

15 **A.** Absolutely, and so as soon as I've sent this email,
 16 I make sure that VC's review is brought forward so that
 17 Dr Burri accesses him much sooner than he otherwise
 18 would have so that we can learn why it is that he wanted
 19 to see Dr Seedat.

20 **Q.** And if we look, please, at NHFT0017810, page 1, contrary
 21 to what you said a moment ago, Dr Lloyd from Gary
 22 Carter, 9 November:

23 "... 28 days of meds out ... said he had about 10
 24 left? Needless to say I kept the new meds and will
 25 liaise with Claudia about going out and again."

14

1 Health Act Assessment or do something to reflect that
 2 you couldn't possibly closely monitor according to what
 3 was -- (*overspeaking*) --

4 **A.** I don't think he would have met threshold for a Mental
 5 Health Act Assessment whatsoever at this stage. There
 6 is -- there is nothing to suggest here that there is an
 7 increase in risk to either himself or others or
 8 a deterioration in his self-care.

9 So no, he wouldn't meet threshold, and I think the
 10 other difficulty is that he's not in immediate crisis,
 11 he's come forward, he's been very open with the team,
 12 he's told us for the first time that he hasn't been
 13 completely honest with the inpatient team.

14 **Q.** "Very open with the team". With all you know now, let
 15 alone what you should have known then, are you actually
 16 suggesting he was being open with the team?

17 **A.** I think he was being more open than he had been.

18 **Q.** Well, that's not -- you asserted he was being open with
 19 the team; he wasn't, was he?

20 **A.** He was telling us that he's continuing to have symptoms,
 21 which is something that we didn't know.

22 **Q.** And he wanted to be more open, arguably, with Dr Burri
 23 or Dr Seedat, saying what in fact had happened: that
 24 he'd been hearing voices and --

25 **A.** Yes.

16

1 Q. -- just said he hadn't to get out of hospital. And when
 2 he tried to do that, I think he gets a response
 3 "Couldn't it have waited till a Thursday?" from
 4 Dr Burri, and Dr Seedat phones him and says "It's not my
 5 job, it's back to you."
 6 Do you think this lack of continuity of personal
 7 care impacted here?
 8 A. Possibly. I think often patients will form a strong
 9 relationship with a clinician very, very early on in
 10 their patient journey, and it looked to me that VC had
 11 quite a lot of rapport with Dr Seedat, because I know
 12 that this isn't the only time that he's gone and asked
 13 for Dr Seedat. I think it happens again consequently.
 14 So he keeps going back, wanting to talk to the
 15 doctor that he'd originally formed that relationship
 16 with. So yes, I think continuity of care can certainly
 17 be an issue, and I think we know that, particularly with
 18 all of the separate teams, it is very difficult.
 19 Q. Can we have CQCM0016518, page 33, please. In fact
 20 page 34. This is the CQC report page 34, third
 21 paragraph.
 22 "Despite the evidence that VC was symptomatic on the
 23 treatment prescribed and had been admitted to hospital
 24 on multiple occasions over a short period, there was no
 25 change in the approach to treatment. NICE guidelines

17

1 who book in appointments for doctors to see patients.
 2 That's how it works in all of the Early Intervention
 3 teams, and also in the LMHT, so I'm not sure --
 4 Q. -- (*overspeaking*) -- I'm beginning to wonder what the
 5 psychiatrist does, if you don't mind me asking,
 6 Dr Lloyd. So they're responsible for knowing when these
 7 doctors' assessments need to be conducted. They're the
 8 ones assessing for signs of psychosis, are they, as
 9 well, even though they're not doctors, when they go out
 10 to these visits -- (*overspeaking*) --
 11 A. They do the monitoring --
 12 Q. They're monitoring medication --
 13 A. -- yes.
 14 Q. Well, that's assessment, monitoring, telling you when it
 15 should happen?
 16 A. Yes, they do. They book in the medical appointments.
 17 It's not something that I necessarily agreed with, I'll
 18 be perfectly honest with you, and I did email both the
 19 administrative staff and also my line manager to say
 20 that I wasn't particularly happy that appointments were
 21 being booked in for the medical staff by care
 22 coordinators as often, you know --
 23 Q. As was required, by the sounds of it.
 24 A. But I --
 25 Q. But you didn't like that many?

19

1 are clear that people with schizophrenia whose illness
 2 has not responded adequately to treatment, should have
 3 their diagnosis and treatment reviewed to ensure it is
 4 at an adequate dosage and for the correct duration."
 5 We know that between 2 February 2021 and 13
 6 April 2021, he is not reviewed by a nurse or assessed by
 7 a doctor. Six weeks, 2 Feb to 15 March, six weeks he is
 8 not seen by anyone. What would you say about that?
 9 A. From the 2nd of February --
 10 Q. And 15 March 2021.
 11 A. That's six weeks.
 12 Q. Yeah. And he sees Dr Burri's on 15 March for a memory
 13 test and his next face-to-face review is on 13
 14 April 2021, four weeks after the memory test.
 15 A. I'm not certain in why over that six weeks he wasn't
 16 seen by anybody. The care plan would have suggested it
 17 should have been fortnightly at that stage.
 18 Q. But it wasn't, was it?
 19 A. No, but I don't know why.
 20 Q. So whose responsibility is that? If you can't do it
 21 yourself and you've delegated it to Dr Burri, whose
 22 responsibility is it to make sure it happens in
 23 appropriate times?
 24 A. Dr Burri would only see VC as and when required, and
 25 it's usually our nursing staff, the care coordinators,

18

1 A. But I got a response back saying that's what happens.
 2 That's the usual practice. And I have copies of those
 3 emails, if you need to see them.
 4 Q. May 2021. Were you aware that VC had gone to Thames
 5 House in London? You didn't hear anything about that.
 6 It would have been helpful to know what he was thinking
 7 about going down there and asking him about it.
 8 A. I didn't know about that, no.
 9 Q. Did you know in July that he had assaulted one of his
 10 flatmates that he subsequently became fixated on and
 11 tried to follow?
 12 A. No.
 13 Q. We've mentioned earlier stalking and being fixated on
 14 people; it's very troubling, isn't it, when those
 15 offences arise?
 16 A. That's right.
 17 Q. If we can have NHFT0000168 page 157, please. This is
 18 the appointment date, 9 August 2021, when he doesn't
 19 attend the appointment. See at the bottom of 157. "Did
 20 not attend ... at noon." The penultimate box:
 21 "... did not attend his clinic at noon today. ...
 22 CPN feels he might be relapsing so she will book ... for
 23 a home visit."
 24 With your ST6. Why was it that you wouldn't do
 25 a rearranged appointment as the consultant?

20

1 A. I was aware that I only had one home visit slot and,
 2 unfortunately, it was booked with another patient that
 3 needed to be seen just as urgently. However,
 4 Dr Sasidharan, Sasitha, had just started, had taken over
 5 from Dr Burri --

6 Q. So she was quite new in the role, was she, to
 7 psychiatry?

8 A. But she's an ST6 so she was six months away from
 9 becoming a consultant herself.

10 Q. Let's look at page 159, what she finds. So somebody
 11 again new to VC, meets him, and we get this report at
 12 paragraph 4, "he has been doing fine. "Reported ... he
 13 is compliant with his medications ... no side effects."
 14 The bottom paragraph, Mental state examination:
 15 "... voices ... become faint ... no longer
 16 distressed ... not ... responding to unseen stimuli.
 17 ... happy to follow medical advice. [And] Is willing to
 18 continue to take medication.
 19 "Impression: His mental health has remained stable."
 20 No challenging or probing there of medication when
 21 he says at the top, line 3, "Compliant with his
 22 medications and no side effects reported". At the very
 23 least it would require to have a look at where he keeps
 24 his medication, what he's got there, testing it out,
 25 having a conversation about that. There's no probe

21

1 A. No.

2 Q. So what do you rely on in understanding what happened at
 3 that event?

4 A. I rely on the medical notes and the description of
 5 what's happened. I rely on any further information
 6 brought to me by the care coordinator that she may have
 7 gleaned in her dealings with VC. And, usually, after
 8 a Mental Health Act Assessment like this, there's a long
 9 period of inpatient assessment and there are detailed
 10 notes about somebody's mental state, risk, all available
 11 in those notes. But, unfortunately in this case, he
 12 went into a private hospital and we weren't able to
 13 access those notes.

14 Q. But you could see he'd seriously assaulted a police
 15 officer?

16 A. Yes.

17 Q. You haven't seen it since, to see that there was
 18 a degree of planning when he takes his glasses off, puts
 19 them on the windowsill?

20 A. No.

21 Q. Indicates he doesn't want to hurt female police
 22 officers, but he'd like the male officer to take him out
 23 of the room. Yet you comment in your statement at
 24 paragraph 255:
 25 "... very likely [he] acted in self-defence: he

23

1 whatsoever, is there?

2 A. It doesn't look like she checked his medication, no.

3 Q. Would you have checked? Would you have asked more about
 4 that, given the background and your CPN thought he was
 5 relapsing?

6 A. Yes, probably.

7 Q. Probably or definitely? It's fundamental, isn't it?

8 A. Yes, I would have checked.

9 Q. So somebody, relatively inexperienced to you, does that
 10 assessment and all looks well at the conclusion of that,
 11 and that's not the case: it wasn't well, was it?

12 A. I don't think it was no. I can't remember specifically
 13 what the next appointment showed.

14 Q. The next appointment with you, page 163, the bottom box,
 15 you were due to be attending with a second doctor. If
 16 we go over the page, he didn't answer the door, no
 17 response. This was when events led to the Mental Health
 18 Act warrant and the assault on the police officer.

19 A. Right.

20 Q. So things weren't well. Moving forward at 167, please.
 21 If we can look under "Scene", third paragraph:
 22 "Officers went to restrain him and he seriously and
 23 repeatedly assaulted the male officer particularly."
 24 Have you ever watched the body-worn video footage of
 25 this event?

22

1 perceived himself to be under attack from the police and
 2 [needed] to fight for his life."

3 A. Yes, so the reason for that was that both Claudia
 4 Birtles and I had a conversation about this particular
 5 event, a detailed conversation. I'd also seen
 6 Ben Lomas' -- Dr Ben Lomas' entry in the notes and what
 7 we concluded from this, and certainly what Claudia said
 8 to me at the time, was that this was a man who was
 9 floridly psychotic. She had seen him, I think, just
 10 prior to this Mental Health Act Assessment with Gary
 11 Carter, and had felt that he was extremely unwell. He
 12 had a strong belief that there was a conspiracy against
 13 him, that a group of people, comprising MI5, the police,
 14 the Government and mental health services, were all
 15 conspiring against him and they were -- and that we were
 16 using some kind of technology --

17 Q. We've got that. So 31 August, that meeting --

18 A. Yes, so he was extremely frightened. And then a group
 19 of people, including the police, forced entry into his
 20 property, the very group of people that he is incredibly
 21 paranoid about, and, you know, I could see that that
 22 would feel really threatening and provoking.

23 Q. Dr Manzar was there, wasn't he? Dr Manzar who he
 24 already knew, Dr Lomas, Amie Staples, so mental health
 25 professionals, not just the police, and afterwards he

24

1 described it as poor judgement from himself, didn't he?
 2 Anyway, you've commented as to what you think likely
 3 happened in that moment.
 4 **A.** I, having spoken to his care coordinator, having had
 5 a detailed discussion with her, having thought about his
 6 kind of perceived thinking, how VC might have felt,
 7 given those fixed, strong delusional beliefs and having
 8 individuals who formed part of that belief walking into
 9 his property against his will. Now, obviously I wasn't
 10 there, I haven't seen the video footage so I made
 11 a comment based on the knowledge that I did have.
 12 **Q.** Might it have been better to view the best evidence
 13 before you did?
 14 **A.** I didn't even know video footage existed.
 15 **Q.** Can we have NHFT0018143, page 1, please. This is an
 16 email from Claudia Birtles to you. VC on this
 17 detention, is applying to a tribunal for his release.
 18 Ms Birtles says to you:
 19 "VC has a tribunal next Thursday. I'm going to
 20 suggest consideration of a depot, hope that's okay.
 21 This was a consideration after his last admission
 22 however Dr Seedat gave him the benefit of the doubt and
 23 agreed to continue with orals."
 24 Your ST6 responds:
 25 "I do agree with depot, especially him having no
 25

1 have CYGN0000056, page 3. We see there:
 2 "If discharged, we would be very concerned about
 3 [VC's] own safety and that of others: he hears voices,
 4 gains access to others' property and behaves in a way
 5 perceived as threatening to others. He has been violent
 6 towards others. When he's unwell the risk are serious."
 7 Did you agree with that?
 8 **A.** Yes, the risks could be significant when he's unwell.
 9 **Q.** "Could be" is not the same as when he's unwell the risks
 10 are serious. Not could be serious: are serious?
 11 **A.** The only time they have been serious, from what
 12 I believe, is the attack on the police, the two police
 13 officers. I've already told you about my views of him
 14 kicking the door down and what I believe the risks to
 15 have been at that time but I think, certainly on this
 16 occasion, just going to his third admission, yes, the
 17 attack sounded very serious.
 18 **Q.** If you go to page 5, please, (iii) at the top:
 19 "[VC's] delusions are sufficiently severe and
 20 distressing so as to cause him to seriously assault
 21 a police officer and require physical restraint. This
 22 is the second time his illness has resulted in someone
 23 else suffering a significant injury."
 24 So that's the same as the woman jumping out of the
 25 flat.

27

1 insight."
 2 Did you see the email?
 3 **A.** I saw -- I definitely saw Claudia's email.
 4 **Q.** Did you not respond to it, then?
 5 **A.** It was sent to me, VC, yeah. (*Read to self*).
 6 I probably had a conversation with her after it,
 7 rather than actually do an email response. I'm only in
 8 the office above, and Claudia often came in and spoke to
 9 me face-to-face.
 10 **Q.** But you agreed with it, you agreed with the depot?
 11 **A.** Absolutely, yes.
 12 **Q.** Indeed you do a report for the tribunal. If we can have
 13 CYGN0000011, page 3. Page 3 you set out a diagnosis.
 14 Sorry, that can come down. Different person, sorry.
 15 **A.** Oh, okay.
 16 **Q.** Don't worry.
 17 Did you read the tribunal ruling?
 18 **A.** I don't think I ever saw the tribunal ruling.
 19 **Q.** Were you interested to read the ruling, knowing he'd
 20 made an application?
 21 **A.** Yes.
 22 **Q.** So why didn't you read it?
 23 **A.** I don't think I ever received the ruling at all but
 24 I did receive verbal information back from Claudia.
 25 **Q.** What did you understand it had been? Perhaps we can
 25

26

1 Paragraph 13:
 2 "Unequivocal evidence [further down the page] the
 3 risks to others when [VC] is unwell are high, relapse
 4 occurs rapidly and is difficult to manage. These risks
 5 eventuated very recently and it is important that they
 6 are minimised so far as is reasonable before [VC] is
 7 discharged into the community."
 8 You should have read that, shouldn't you?
 9 **A.** I should have received it yes, and I don't know why
 10 I didn't. It may be because I wasn't involved in the
 11 particular tribunal and --
 12 **Q.** The findings are: when he is unwell, high relapse occurs
 13 rapidly and he is difficult to manage.
 14 **A.** That may be true for the second admission but we know
 15 now, don't we, that actually it's possibly not true for
 16 the lead-up to the third because he apparently stopped
 17 his medication in October but I guess the tribunal would
 18 not have known that.
 19 **Q.** Say that again.
 20 **A.** So in October 2020, when VC apparently stopped taking
 21 his medication --
 22 **Q.** So he tells Dr Blackwood, yes. So much earlier on in
 23 his illness.
 24 **A.** Yes, there's been a nine-month period leading up to
 25 September 2021 when he actually relapses. So there's
 25

28

1 a long period of him not taking medication, and not
 2 relapsing immediately.

3 **Q.** But you don't know, do you, about Sebastian --

4 **A.** I don't know that.

5 **Q.** -- the events with Sebastian in July 2021. He assaults
 6 him. You don't know about how he's following him; you
 7 don't know about why he goes to Thames House, why he's
 8 there. So what's your assumption that there's no
 9 difficulties or complications arising from his mental
 10 health at that time?

11 **A.** But my understanding is all of those events occur either
 12 mid or later in 2021, rather than early on. But yes, at
 13 the time I wouldn't have known that.

14 **Q.** It's guesswork for you, isn't it, because you never saw
 15 him and you only had the records, which we've got in
 16 front of us?

17 **A.** Yes, yeah.

18 **Q.** So can we have a look, please, 168, page 195. This is
 19 after his discharge. We see at the top of the page,
 20 195, 25 October, Claudia Birtles, underneath "Note":
 21 "[VC] wasn't sure of exactly how many tablets he was
 22 discharged with but believes it was possibly a 28-day
 23 supply [and Claudia Birtles] yet to receive the
 24 discharge summary."
 25 If we go to PAGR0000029, page 3. We know from
 29

1 statement you didn't have any concerns about him not
 2 attending this as he'd been seen by Claudia Birtles
 3 earlier.

4 It's not the same, is it, being seen by the care
 5 coordinator and being seen by you as the psychiatrist,
 6 the Consultant Psychiatrist?

7 **A.** I think it's unfortunate that he didn't attend but the
 8 reason that I make this comment is because the DNA
 9 policy for the Trust is really clear that, if a patient
 10 doesn't attend, you know, we need to try and assess or
 11 get some idea of the level of risk and, as part of that
 12 assessment of the level of risk, it's about whether
 13 a patient has been seen by somebody else, another
 14 clinician in the team; how they were at the time; was
 15 there any evidence of relapse; was there any evidence,
 16 signs and symptoms of psychosis? And whilst ideally
 17 I would have seen him because I wanted to have this
 18 conversation about depot, I felt at least he has been
 19 seen and there are no immediate risks to self or others
 20 highlighted.

21 **Q.** At page 199, please, at the top, 19 November, Claudia
 22 sees him, Claudia Birtles. 199, top box:
 23 "[VC] said he'd missed a couple of doses of
 24 aripiprazole, later failing to collect them last week.
 25 Been taking 10 milligrams since the admission. Aware he
 31

1 page 3 of the summary he was discharged to his new flat
 2 with 14 days' medication so very self-evidently and
 3 immediately telling a lie about the amount of medication
 4 he had to Claudia Birtles. Did you detect that at the
 5 time?

6 **A.** I don't think the Discharge Summary was available to us
 7 at that time.

8 **Q.** Well, it won't have been soon thereafter, will it? Soon
 9 enough if you wanted to see what he said. Did you
 10 detect that at any time?

11 **A.** I honestly don't remember seeing this Discharge Summary.

12 **Q.** You saw what Claudia Birtles had said about the
 13 medication. Did you suggest to her, "Well, look, given
 14 we wanted a depot, it hasn't happened, let's move on,
 15 double check, treble check this medication"?

16 **A.** My intention at this time was to try and see him and to
 17 have a very frank conversation with him about depot
 18 medication, and that was very much the plan at this
 19 stage: that there was a conversation with him where we
 20 made it really clear that we felt he needed to be on
 21 depot.

22 **Q.** If we look at 198, please, at the bottom, NHFT0000168
 23 page 198, 15 November, he doesn't attend the appointment
 24 with you. So NHFT0000168, page 198. Doesn't attend his
 25 appointment, at the bottom of the page. You say in your
 30

1 needs to take 20 milligrams."

2 So clear, not taking his medication as required, and
 3 we see if we have the rest of the page illuminated in
 4 one box, we see, please, that 29 November he didn't
 5 attend. 6 December, third missed appointment with you,
 6 and medication due on 14 December.

7 So you've had three missed appointments at this
 8 time, haven't you, in this period, when you say you want
 9 to speak to him about depot?

10 **A.** Yes.

11 **Q.** And you know he's not taking the medication, and you're
 12 sufficiently concerned to want to raise forcing
 13 medication through depot?

14 **A.** That's what I wanted to do at this stage, definitely.

15 **Q.** So what did you do at that point when he hadn't come for
 16 three times?

17 **A.** I was starting to feel this isn't good, however patients
 18 who are in the community, who are voluntary, cannot be
 19 compelled to attend appointments or indeed to take their
 20 medication, and that is unfortunately the position that
 21 we find ourselves in.

22 **Q.** So you thought there was nothing you could do at that
 23 point?

24 **A.** We didn't have powers at this point to do a lot more,
 25 until he actually met clear threshold for a Mental
 32

1 Health Act Assessment. They are essentially the only
2 powers that a Community Team has in the community unless
3 a patient is on a CTO.

4 **Q.** He wasn't taking the treatment that was necessary for
5 his mental disorder.

6 **A.** No.

7 **Q.** You knew that.

8 **A.** Yes.

9 **Q.** So why not trigger a Mental Health Act Assessment
10 -- (*overspeaking*) -- and detention under Section 3 for
11 treatment?

12 **A.** Because he would not meet threshold for a Mental Health
13 Act Assessment. It is very clear, you know, the Mental
14 Health Act has principles of least restriction, it has
15 Codes of Practice. Now, as far as VC is concerned what
16 we would have to show was clear evidence of
17 deteriorating mental health and a clear risk of harm to
18 self or others.

19 And whilst --

20 **Q.** You had the tribunal findings: rapid relapse, risk to
21 others. You had the evidence.

22 **A.** That is not enough evidence. That's historic evidence
23 of things that have happened historically. The evidence
24 that we'd need to be showing here is that there is
25 a current risk, at that time, of hallucinations,

33

1 neighbours and friends where appropriate.

2 "Consideration will be given to arranging a Mental
3 Health Act Assessment.

4 "The Police may be contacted to request a welfare
5 visit

6 "Other services such as the Crisis Team or the
7 Assertive Outreach Team may be asked to continue trying
8 to contact the patient out of hours."

9 So it continues. After the three successive DNAs,
10 did you trigger any of these responses?

11 **A.** This is not the policy that that we were using at the
12 time, the one that --

13 **Q.** It says "Policy Trustwide" on page 1, not that we need
14 to turn to it, but it doesn't suggest it's not for the
15 EIP.

16 **A.** No, no, it's not that it's not for EIP, but I think
17 there may have been another policy that we were using at
18 the time --

19 **Q.** Which was what?

20 **A.** -- I think unfortunately the policies get changed. If
21 you look in my -- the one I refer to repeatedly in my
22 statement, that's the policy that --

23 **Q.** Just tell me what you did -- (*overspeaking*) --

24 **A.** Essentially --

25 **Q.** Whatever the policy said, what did you do?

35

1 delusions, or thought disorder, that there is also some
2 kind of risk, some kind of escalation of risk to self or
3 others, and that could be thoughts or comments around
4 self-harm, thoughts or comments of harm to others,
5 escalating violence. That could even be a third-party
6 report.

7 So for example, if Mum had contacted us at that time
8 and said, "Look, I've had numerous phone calls with
9 him" -- which I know she had during this period.
10 Celeste Calocane had said, "I'm really worried, I think
11 VC's mental health is deteriorating for these reasons",
12 we could have taken that to the AMHP because there are
13 thresholds that need to be met, even in terms of calling
14 a Mental Health Act Assessment.

15 **Q.** Can we look at, please, at NHFT0000417, page 7, and this
16 is the relevant policy in place at the time around not
17 attending, DNAs. We see at the top:

18 "Actions to be taken by the clinical lead to
19 understand and mitigate risks may include the following:

20 "Where risks are identified".

21 If we go down to the third bullet point:

22 "Contact will be made with the patients GP on the
23 day of the missed appointment.

24 "Consideration will be given to an urgent home visit

25 "Making contact with known relatives/carers,

34

1 **A.** -- what we do as part of --

2 **Q.** No, what did you do after three DNAs by him? What did
3 you trigger or do?

4 **A.** After three DNAs, we then take it back to the
5 Multi-Disciplinary Team and we talk through what are the
6 options, what can we do to engage this man at this
7 stage? Are there --

8 **Q.** What did you do?

9 **A.** -- are there any options at this stage? And I think at
10 this point we decided that we would really try to enlist
11 the help of Celeste, with whom he had a good
12 relationship, with whom --

13 **Q.** So what did you do?

14 **A.** So there was a conversation. So Claudia spoke to
15 Celeste, and said, "We really need some help here, we
16 need to try to get VC to come to his appointments so
17 that Dr Lloyd can have a conversation with him", and she
18 does that on our behalf.

19 I think VC's response to that is that he's been
20 extremely busy with his university work. He's had a lot
21 of deadlines and he's really struggling at the moment.

22 **Q.** Let's just see what his response, let's stick to the
23 point you were making. NHFT0000168, page 201, please.
24 This is a note of 16 December 2021:

25 "[VC] was very confrontational and ... angry

36

1 throughout the call.
2 "... [asked] why had I tried to make contact with
3 him via his mum. [And] ... went on to say ... under no
4 circumstances could I have any contact with his mum as
5 it was 'stressing her out' ... totally unnecessary ...
6 he was contactable by his own number."

7 She went on to explain that there's a concern about
8 lack of contact from VC:

9 "[VC] has missed 3 appointments with Dr Lloyd, and
10 had not replied to ... text messages since November.
11 [VC] did not agree with this and told me that he was
12 'cutting his contact off completely' and I was never to
13 speak with her again."

14 So that response to go via his mother didn't work,
15 did it? He didn't want her having information and he
16 didn't want to speak to Claudia either.

17 So can we go to NHFT0000168, page 202, please.
18 10 January, we are into 2022 now, and another missed
19 appointment. Didn't attend your 12 noon appointment.

20 "... the 4th appointment he has missed ... One home
21 visit by me. He has also disengaged from his CPN
22 Claudia. We do not know if he is taking his medication.
23 We will discuss next steps at MDT ..."

24 So don't know if he's taking his medication, you
25 know there are attendant risks, he's not engaging with

37

1 has essentially disengaged and we have not been able to
2 monitor him."

3 This is your edit, isn't it? Above it says your
4 edit.

5 **A.** And that may be following an MDT discussion.

6 **Q.** "Perhaps a conversation with his mum and course tutors
7 to see if there are any concerns currently will be
8 prudent before considering discharge."

9 **A.** And what I'd hoped was that maybe if we'd spoken to Mum
10 and she'd had any new information, or the course tutor,
11 it might give us that sort of third-party information
12 that we need.

13 **Q.** You got some third-party information on 18 January?

14 **A.** Yes, we did unfortunately, yes.

15 **Q.** Yes, so in a completely different direction from the
16 University, concerning an assault by VC on his flatmate.

17 **A.** That's right.

18 **Q.** And the police were called out, yes?

19 **A.** Yes.

20 **Q.** If we can go, please, to NHFT0018114 page 1.

21 18 January. We also see Emma Robinson raising to you:

22 "Adele has just been to see me about the above
23 patient ... has raised concerns about going to see him
24 in terms of risk towards others, I think also in light
25 of the incident over the weekend locking students in his

39

1 Claudia or you. Can we have, please, NHFT0018181,
2 page 1. That's 10 January, the "Did not attend" for
3 you, and on 10 January Emma Robinson sends an email to
4 Claudia Birtles. So NHFT0018181, page 1.

5 "Hi Claudia ... please bring for discussion on
6 Thursday we may need to consider discharge, we know he
7 can become unwell and has had admissions but he is not
8 engaging at all. I don't know what more you can do ...
9 I know we discussed looking at a different CCO but
10 I don't think that will change engagement with services,
11 but happy to discuss."

12 "I don't know what more you can do"? Did you agree
13 with that? There was nothing more that Claudia Birtles
14 could do?

15 **A.** I think we went on to have further discussions at MDT
16 shortly around that time because both Emma Robinson felt
17 that we had become quite stuck at this stage. There
18 just didn't seem to be a way forward and obviously
19 Claudia had been trying. She just wasn't sure how much
20 longer she could keep trying so I think we did have
21 a further discussion --

22 **Q.** If we go to NHFT0000168, page 203, 17 January. Fourth
23 box down:

24 "Will discuss ... at MDT ... Thursday.

25 Consideration will need to be given to discharge as [VC]

38

1 accommodation. I know the last contact was a while ago
2 but I worried for the safety of the staff if they went
3 to see him, I have asked Adele to start have
4 conversations with the AMHPs with regards to a [Mental
5 Health Act] assessment ..."

6 So you -- I don't see a response there but did you
7 get that email?

8 **A.** I must have got it because I think a Mental Health Act
9 Assessment is immediately triggered.

10 **Q.** So after that incident, it looks as though discharge was
11 deflected by that incident and concerns for staff and
12 a Mental Health Act Assessment; is that right?

13 **A.** We had -- we clearly had definite grounds at that point
14 to call a Mental Health Act Assessment, yes.

15 **Q.** What had changed?

16 **A.** What had changed --

17 **Q.** Yes.

18 **A.** -- was that there had been an act of clear aggression
19 towards a student, which is very concerning, and
20 hence -- yes.

21 **Q.** We know an assessment was set up, 19 January. We'll be
22 hearing from Dr Mike Skelton about that. We know after
23 that assessment, 21 January, he was still in the
24 community and was missing medication and a further
25 assessment and detention arose, didn't it?

40

1 A. Yes.

2 Q. Had you followed that: that, in effect, on 19 January he
3 was discharged back into the community? Did you look at
4 that at the time?

5 A. I did.

6 Q. What did you make of that decision?

7 A. I could see it was a difficult decision because,
8 essentially, reading through the notes at that time, the
9 assessing team were not able to find any evidence of
10 psychosis and, without that, it becomes really tricky
11 to, again, have grounds for a Mental Health Act
12 Assessment and, secondly, you have to go for the least
13 restrictive option and I believe that VC was saying at
14 that time that he would be happy to take medication and
15 have follow-up from the Crisis Team. And so they used
16 that as a testing out period.

17 Now, whilst it wasn't ideal, you know, we are
18 limited by the constraints of the Mental Health Act,
19 which is law.

20 Q. NHFT0000168, page 225, please. The fourth admission,
21 3 February 2022. Claudia Birtles attends this ward
22 review -- Dr Thangavelu, Dr Gibson. If we go to
23 page 226, we see at paragraph 2:
24 "[VC] said his thoughts are normal. Denies people
25 interfering with them. Denies having thoughts that

41

1 isn't straightforward and he manages to conceal his
2 symptoms well, however his insight remains very poor
3 according to Claudia, we really need a robust plan at
4 the point of discharge."

5 So you were supporting a depot and a Community
6 Treatment Order.

7 A. Yes, and I had a conversation very shortly after this
8 with Dr Thangavelu over the phone.

9 Q. If we have, you'll tell us about that, please,
10 NHFT0019152, page 1. So when did you have the
11 conversation with him?

12 A. I can't give you the exact date but it would have been
13 very soon after I sent this email. It was followed up
14 with a phone call and a discussion about how challenging
15 it had become for the Community Team to see VC, to get
16 him to engage in any kind of treatment plan, whether
17 that be medication, CBT --

18 Q. How long was that conversation with him?

19 A. I don't think it was extremely, you know, it wasn't
20 a detailed conversation but it was a --

21 Q. You made your position clear that it --

22 A. Yes, absolutely and, you know, I made a plea that could
23 this really be given some serious consideration at this
24 point because, otherwise, I just didn't know the way
25 forward.

43

1 people are trying to harm him."

2 Three paragraphs down, he was asked about having
3 a depot. So four paragraphs down, please, from where
4 it's currently highlighted:
5 "He was then asked about having a depot form of
6 medication, and he would prefer not to have a depot. It
7 was explained that the Community Team thought it would
8 be beneficial to have one however he said that he didn't
9 like needles and would prefer to continue with tablets."
10 Did you know he'd said that?

11 A. Yes.

12 Q. Did you know whether he didn't like needles?

13 A. I didn't know that at that point, no.

14 Q. Did you know he'd had Covid vaccines, blood tests and
15 never been raised?

16 A. No, so I wouldn't have seen this at the time but I think
17 I did see it when I read the notes, just prior to my
18 next appointment.

19 Q. NHFT0018527, please, page 1, is an email from you,
20 Dr Lloyd, to Dr Thangavelu. You say:
21 "As you know, this will be his fourth admission. He
22 is essentially becoming a revolving door. Can we please
23 consider a depot for him and possibly a CTO so that we
24 don't end up back at square one with poor engagement and
25 concordance at discharge. I appreciate the situation

42

1 Q. If there had been a CTO, who would have been
2 administering the depot in the community: one of your
3 team?

4 A. It would have been one of my team.

5 Q. You or can the coordinator do it?

6 A. No --

7 Q. Can nurses do it?

8 A. -- it would have been one of the nursing staff.

9 Q. Is there a greater expense attached to depot medication,
10 compared with other medication? Are costs
11 a consideration here or not?

12 A. I don't think so.

13 Q. Not as far as you're aware?

14 A. No.

15 Q. It's not something that isn't authorised -- you've given
16 depots, have you, to other people?

17 A. Many a time.

18 Q. Many a time. So would you know now, for example, how
19 many people in the team are having -- patients under the
20 EIP team would be having depots?

21 A. I couldn't tell you off the top of my head but --

22 Q. We can probably get the information?

23 A. Yeah, we have a -- yeah, a -- (*overspeaking*) --

24 Q. So this wasn't a cultural outlier to suggest this, this
25 was a perfectly typical of patients that weren't taking

44

1 medication?

2 **A.** Typical of patients that are non-concordant, yes.

3 **Q.** If we go, please, to NHFT0000168, page 239. This is the
4 ward review, 10 February 2022, when Dr Thangavelu
5 discusses the depot option, paragraph 6:
6 "VC said no, said he was satisfied with the
7 medications as it is. He's been on it for a while.
8 When it's changed in the past he'd experienced side
9 effects."
10 Again, there doesn't seem to be, on that record,
11 does there, a challenge about anything and everything he
12 says about medication? He's not confronted at any time
13 with untruths he's told about them. Do you agree with
14 that: you don't see that anywhere?

15 **A.** I don't see that it's -- there's a sort of an assertive,
16 you know, kind of stance taken about VC needing to start
17 a depot.
18 I think there is a difficulty here which
19 Dr Thangavelu did explain to me on the phone, which is
20 that, during this admission, he had not really seen any
21 appreciable evidence of VC having psychotic symptoms
22 and, as such, it made it difficult for him to change the
23 Section 2 to a Section 3.

24 **Q.** I'm not going to argue about the capacity of the law.
25 Let me move on please to --

45

1 unwell."

2 Had you liaised at all with Crisis? You clearly had
3 the same views about this, did you liaise with them to
4 make a united position on that?

5 **A.** Not that I can remember.

6 **Q.** Because it looks as though Claudia Birtles is present at
7 some point, this in reach is happening at others, and if
8 both organisations were saying, "We can't manage it",
9 that was significant, wasn't it?

10 **A.** Yes.

11 **Q.** Can we go, please, to NHFT0000168, page 263. This is
12 your meeting. You finally meet VC on 14 March 2022.
13 And we see your notes in the bottom box. And VC told
14 you that he hadn't missed any medication. That's in the
15 first paragraph. In fact it was clear by that time that
16 he hadn't been taking medication, wasn't it, over time?

17 **A.** Yes.

18 **Q.** Did you probe or challenge him on that and say, "You
19 clearly haven't and this has caused your problems," or
20 anything like that?

21 **A.** I said to him that we had concerns that he had missed
22 medication, but I think what he said very specifically
23 was that in the lead-up to that fourth admission he had
24 been well, and he seemed really quite angry about that
25 fourth Mental Health Act Assessment. And he felt that

47

1 **A.** But there's an important point that I just want to make.
2 And without the Section 3, a CTO can't be put in place.

3 **Q.** No, I understand that but you could have put a Section 3
4 in place to get a treatment regime established. He
5 hadn't had consistent medication at this point for
6 a long while, had he? Understanding what worked well
7 was going to take time to find out and could have
8 justified an extensive detention to work out the
9 treatment?

10 **A.** He felt that he could not justify -- that there weren't
11 grounds to move to a Section 3. That's what he told
12 me --

13 **Q.** He'll give that evidence. We can hear from him, no
14 doubt.

15 **A.** Okay.

16 **Q.** But can we go, please, to NHFT0000168, page 250, please.
17 Is Mrs Sue Middleton one of the nurses in your team?

18 **A.** No.

19 **Q.** No. Because it looks as though, if we go to 250 and
20 251, "In-Reach to facilitate early discharge", she
21 attends VC's review, fourth admission. So we go to the
22 top, please, 251. So this is Crisis at the meeting:
23 "... 4th admission in the past 2 years and thoughts
24 of Community Team are he would be better placed on
25 a depot and CTO as risk to others increase when [he] is

46

1 it had been completely unnecessary because the
2 altercation that had taken place had not been driven
3 whatsoever by psychosis.

4 **Q.** And again, did you see independent evidence about that?
5 We know there was a video, a phone video of it.

6 **A.** I hadn't -- I didn't know there was a phone video of it
7 and I wouldn't have known. I guess you don't know what
8 you don't know. -- (*overspeaking*) --

9 **Q.** But you know you can't take what he says at face value
10 about --

11 **A.** I accept that it's very difficult but what I realised at
12 this stage was that we had absolutely no powers to get
13 him to come to appointments. We had no powers to get
14 him to take his treatment, that he had said to the
15 inpatient team he felt persecuted by us.

16 I was worried, because I know that Celeste Calocane
17 had also felt that that fourth admission had perhaps not
18 been necessary. I don't think she'd seen any evidence
19 in the lead-up to the fourth admission of any psychosis.

20 So it became really difficult to know how to manage
21 this situation where he could almost immediately
22 disengage again unless we at least tried to work on
23 his -- essentially he was telling us: "This is what I'm
24 prepared to do. I'm only, you know, willing to work
25 with you. These are my needs."

48

1 And I just didn't want that immediate disengagement.
 2 **Q.** At this meeting, you needed to dig deeper and consider
 3 other signs of relapse, didn't you? There had been
 4 numerous examples of him masking, concealing symptoms.
 5 You were getting straightforward exchange here.
 6 **A.** There was 20 minutes' follow-up here, and in that time
 7 you're not, you know, it's just not possible to start
 8 doing relapse signature work or start digging
 9 significantly deeper. What I concentrated on here was
 10 the events leading up to that fourth admission because
 11 that was something that would be informing risk, that
 12 future risk. So I needed to understand, you know, was
 13 that fourth admission, was it driven by psychosis or was
 14 it just an altercation like VC was saying?

15 Now I just wanted to try and under -- try and get
 16 his perspective on it. I'd already seen a conversation
 17 between the victim and Dr Gibson in the notes.
 18 **Q.** And you were aware of the screams in the night, in the
 19 middle of the night being heard from his room?
 20 **A.** So I'd heard about the screams in the night, but apart
 21 from that --
 22 **Q.** Just pausing there, that's significant, isn't it? His
 23 flatmates are saying screaming in the night.
 24 Interesting you see it in the same statement we went to
 25 before, shouting?

49

1 **Q.** It's a lot of missed appointments, isn't it?
 2 **A.** Mm-hm, it is.
 3 **Q.** Are some of those not recorded? I don't think they're
 4 all recorded in the notes.
 5 **A.** So there are five in between his third and fourth
 6 admission. There's two when I take over his care.
 7 There's a further one which I think, to be fair, he'd
 8 gone into hospital that time, that he'd missed the very,
 9 very first one. There's this one in June and there's
 10 another one in August. So I don't I - can't remember the
 11 exact number. I think I worked out that in total
 12 there'd been somewhere between ten and 11.
 13 **Q.** If we go, please, to NHFT0000168, page 270, 4 August,
 14 Gary Carter, who we've heard evidence from, knocks on
 15 the door. He's actually knocking at an address where
 16 he's told VC doesn't live. He says at the top:
 17 "... [he] will take [it] ... back to Dr Lloyd and
 18 Emma on Monday.
 19 "To consider
 20 "discharge to GP?
 21 "report as a missing person?"
 22 Then on 9 August:
 23 "[VC] has requested access to his notes."
 24 And then it's appreciated that the address for that
 25 is the Madison Court address.

51

1 **A.** Yes, so I'd read that, that there had been screams in
 2 the night, but beyond that, the discussion again didn't
 3 really highlight the seriousness at all of that
 4 particular incident.
 5 **Q.** Did you rely on Claudia Birtles to liaise with Ellie
 6 Turner from the University? You didn't speak to the
 7 University yourself about what was happening to the
 8 other students at the time while these assessments were
 9 going on or anything like that?
 10 **A.** I believe that Claudia was in touch with Ellie Turner,
 11 that that liaison was going on, yes.
 12 **Q.** Were you aware that he'd returned to the University and
 13 gave a false name when questioned who he was visiting?
 14 That's in the notes as well, isn't it, and emails?
 15 **A.** I can't remember. I possibly knew about that, yes.
 16 **Q.** Very troubling, isn't it, that he's gone back and given
 17 a false name?
 18 **A.** It's unusual behaviour, yes. And that was actually
 19 during his admission, if I remember correctly.
 20 **Q.** If we go, please, to NHFT0000168, page 267. Bottom of
 21 the page, doesn't attend an appointment with you. Yes?
 22 See 13 June.
 23 **A.** Yes.
 24 **Q.** So how many appointments has he missed with you by now?
 25 **A.** I think somewhere in the region of nine.

50

1 Were you aware at the time, as was apparent in the
 2 notes, that was the very property he'd had to leave in
 3 January so he couldn't possibly be living at
 4 Madison Court?
 5 **A.** No, I wasn't aware. I think because VC had had so many
 6 addresses at that stage, it was almost impossible to
 7 keep on top of it all. There were repeated changes of
 8 address from what I can understand, and on several
 9 occasions we had turned up to the wrong address purely
 10 because we just couldn't keep on top of this constant
 11 address change.
 12 **Q.** 18 August 2022, Gary Carter:
 13 "[VC] has applied for access to ... [the] notes.
 14 ... not contacted me after being sent an invite to do
 15 so."
 16 It goes without saying, if you don't know the
 17 address the invite is not going to be received and
 18 responded to, is it?
 19 **A.** No.
 20 **Q.** Telephone conversation with VC's mother. Hasn't seen
 21 him "for many months". "... attempted to go and see him
 22 but ... was not at the address."
 23 In these circumstances, the police should have been
 24 notified, shouldn't they? The police should have been
 25 asked to locate him. You knew he'd attacked, seriously

52

1 attacked, a police officer.
 2 **A.** So we had a conversation specifically about this in our
 3 MDT, and we talked about police involvement. And the
 4 options open to us at the time were two. One was
 5 missing person, to report him as a missing person, and
 6 the other one was to ask for a police welfare check.
 7 **Q.** What about the third one: using your initiative and
 8 saying: "This patient, we are concerned about. He's not
 9 taking his medication. He's had four admissions. He's
 10 attacked a police officer. We know he's caused harm to
 11 students. We want to know where he is. Can you help us
 12 find him?"

13 Do you think they'd say no, if you put it like that,
 14 as a Consultant Psychiatrist sufficiently concerned
 15 about where he was?
 16 **A.** We have had numerous conversations historically with the
 17 police, and asked for help in circumstances where quite
 18 risky patients have disappeared and we haven't been able
 19 to find them, and the response has been that it is not
 20 police duty to be finding patients with mental health
 21 issues, that this is the responsibility of Health and
 22 Social Care Services. That has been an issue over and
 23 over again. And I think, when you are faced with that
 24 repeatedly, you actually reach a stage where you think:
 25 you know what, is it even worth going down that line yet

53

1 It's the top box:
 2 "... for a period of time despite attempts to make
 3 contact and having done cold calls, decision made within
 4 the team to discharge back to the GP due to non
 5 engagement with view for GP to refer back to services in
 6 the future if needed."

7 Now it's understood neither care coordinator were
 8 present at that meeting. Can you --
 9 **A.** However, the actual decision to discharge, I have a very
 10 clear and distinct memory, took place well before this
 11 meeting and it took place when Gary Carter was present
 12 because, in fact, it was when he raises -- it was
 13 shortly after -- I don't think it was exactly at the
 14 time -- but he raises, "Bring to the MDT a discussion
 15 about discharge versus the police being missing".

16 I don't think it took place exactly when he said
 17 that but it was certainly some time in August.
 18 **Q.** He raised two options, then: discharge or contacting the
 19 police?
 20 **A.** That's what he raised. But we actually talked through
 21 much more than two options. We did talk about the two
 22 options. We mentioned -- you know, we had a discussion
 23 about missing person but we realised that, actually, VC
 24 wasn't missing. He'd had conversations with Mum,
 25 there'd been a conversation with his sister and no

55

1 again?
 2 So we'd been asking repeatedly for welfare checks,
 3 can we have help? And I think, you know, the police
 4 themselves are struggling resource-wise, and maybe they
 5 can't help.
 6 **Q.** The very next day of course, after your discharge,
 7 they'd issued a warrant, hadn't they, in relation to --
 8 **A.** Yes, well we didn't know about that.
 9 **Q.** Would you ordinarily know about that, if they'd issued
 10 warrants?
 11 **A.** No.
 12 **Q.** But in this case, even without knowing about the
 13 warrant, had you contacted first, at the time you were
 14 having the MDT. If we can have, please, NHFT0000168,
 15 page 271 on the screen, as I'd indicated before, he had
 16 committed this offence; they were interested in him,
 17 even if you had other experiences.
 18 **A.** We didn't know they were interested in him.
 19 **Q.** But if you didn't, you should have discharged your
 20 responsibility in asking them to find him, shouldn't
 21 you? And then it was a matter for them. You didn't
 22 discharge your responsibility; instead, you discharged
 23 him to the community, to a GP.
 24 So let's look at the discussion within the MDT.
 25 "... no contact has been made with [VC] ..."

54

1 concerns had been raised that he'd requested his notes.
 2 So we knew he wasn't actually missing --
 3 **Q.** They hadn't seen him. They hadn't seen him, so how
 4 could they raise concerns? The people living in and
 5 around him were the people who were likely to know if
 6 there were concerns, wherever he was.
 7 **A.** But his sister had had a conversation with him over the
 8 phone and in previous years --
 9 **Q.** So that you as a psychiatrist and you thought at this
 10 point there wasn't a problem?
 11 **A.** I hadn't seen him, no, at this point.
 12 **Q.** You'd seen him in March, hadn't you? You'd seen his
 13 records?
 14 **A.** I'd seen him in March. So in March he was well. He had
 15 just come out of hospital after a period of treatment
 16 where medication would have been administered to him and
 17 watched. So he was well at that point in March. I had
 18 no concerns immediately at that point about his mental
 19 health. Yes, there were historic concerns but,
 20 certainly at that point, there was nothing to suggest
 21 that he was psychotic or indeed -- (*overspeaking*) --
 22 **Q.** If you accepted everything he said to you. The only way
 23 you can conclude that is to accept everything you've
 24 written down in that box?
 25 **A.** But from a mental state examination there was nothing to

56

1 suggest that he was psychotic. He was not responding to
 2 hallucinations; he was not thought disordered. He'd
 3 just had a solid period of treatment, robust treatment,
 4 on the ward. I wouldn't have expected him to be unwell
 5 at that point.

6 **Q.** This meeting, this MDT -- I don't need any more
 7 information about it, thank you, just who was present.
 8 Who was present?

9 **A.** This MDT where I remember the discussion about
 10 discharge?

11 **Q.** Yes, the one that's recorded here.

12 **A.** Yes, so --

13 **Q.** 23 September.

14 **A.** I don't know who was present on the 23 September
 15 specifically.

16 **Q.** What's the minimum you'd have in an MDT?

17 **A.** I don't think there was a minimum number, specifically.
 18 Again, I think usually there would be someone that is
 19 a team leader or comes from a management background.
 20 There'd usually be some sort of medical representation.

21 **Q.** Is the pressure from a management background to
 22 discharge patients? We know that Gary Carter discharged
 23 quite number to the GP around this time. Is it an
 24 advantage to the service to just take people off the
 25 books, if you're not seeing them and doing very much?

57

1 coordinator, and I don't know why Sharon signed it in
 2 this case. I think the response -- the consultant
 3 responsible is an interesting word because, at the end
 4 of the day, I'm a community consultant working with
 5 a team. I'm not someone with ultimate or sole
 6 responsibility. It's not as though --

7 **Q.** The person with authority or power, if you choose to use
 8 it?

9 **A.** I have authority and power, so does the team leader, so
 10 does the clinical lead. The care coordinators have all
 11 of the knowledge. They do, as you can see, the vast
 12 majority of the work. The leadership across the team is
 13 shared and distributed. We have pharmacists that
 14 provide pharmacological leadership; we have
 15 psychologists that provide psychological leadership. So
 16 it's not as if I am the only one person here that has
 17 all of the responsibility.

18 **Q.** "Pooled GP list", what does that mean?

19 **A.** I don't know.

20 **Q.** Because there isn't a named GP, is there? There isn't
 21 a connection with a named human being out there?

22 **A.** No, that's --

23 **Q.** There's no description of why the decision's taken, no
 24 rationale --

25 **A.** No.

59

1 Is it better for you not to have had them on there at
 2 all?

3 **A.** No, I wouldn't have said so, no.

4 **Q.** Which is worse for the service: if a patient does
 5 something while they're actively being cared for within
 6 the service or when they've been discharged and sometime
 7 later? Which would you regard as a worse reflection?

8 **A.** It's not something that I've specifically reflected on.
 9 It's not something that I would even think about. As
 10 far as I'm concerned, in this situation here, we had
 11 tried over a nine-month period to engage VC, and we'd
 12 failed. We'd failed to engage him. We had not been
 13 able to see him as often as we'd wanted. I certainly
 14 hadn't been able to. We had not been able to get him to
 15 accept his treatment. We had no powers to compel him to
 16 come to appointments. We had no powers to enforce
 17 treatment without a CTO.

18 **Q.** So you felt redundant, you couldn't do anything else?

19 **A.** We felt absolutely redundant. Gary --

20 **Q.** Can I just remind you, we need to be mindful of the
 21 time, we have to break shortly. NHFT0000123, page 1,
 22 please, and this is the discharge letter to the GP and
 23 it's signed by Sharon Heath. Why doesn't it have your
 24 name as the Consultant Psychiatrist responsible?

25 **A.** Because discharge summaries usually come from the care

58

1 **Q.** -- no safety plan, no management plan?

2 **A.** No, it's not a good Discharge Summary at all.

3 **Q.** It's appalling. It's not a Discharge Summary at all,
 4 it's a "I've washed my hands away"?

5 **A.** No, it's not a discharge summary at all, I completely
 6 agree with that.

7 **Q.** It's not sent to the family?

8 **A.** No.

9 **Q.** It could have been sent to the family, couldn't it?

10 **A.** Yes.

11 **Q.** Even though you couldn't give, you thought, information
 12 directly from him about his health, you could have sent
 13 that to the family and should have done?

14 **A.** Yes, I think all of that information should have gone
 15 out. I spoke to Sharon Heath about it but this was much
 16 later on down the line because I hadn't seen it --
 17 hadn't seen this at the time, and I think her response
 18 was that all of that information should have been
 19 attached with this letter but, for some sort of --
 20 I think some kind of administrative failure, had led to
 21 just this covering letter going out. That was her
 22 response.

23 **Q.** Last question from me, please, NHFT0004820, page 3. You
 24 said this morning that you'd been instructed not to
 25 discuss events with colleagues.

60

1 A. That's right.

2 Q. This is an email 27 February 2025 to Claudia Birtles and
3 Sharon Heath:

4 "... I have been asked to answer a set of questions
5 in relation to a complaint made against the Trust by the
6 victims of VC's family. Given my very limited
7 involvement with him I would appreciate meeting up so we
8 can tackle some of these questions together and
9 formulate a response? Could we find a time fairly soon
10 to do this, please."

11 So it looked like you did have conversations
12 subsequent --

13 A. Yes.

14 Q. -- and had you forgotten that this morning when I asked
15 you about that?

16 A. This was at a point where everything was out in the
17 public domain. So we were then told "It is okay to now
18 have those discussions". So initially, in 2023 and
19 2024, before things were in the public domain, we could
20 not but then, afterwards, those conversations were
21 taking place.

22 Q. The Inquiry has a statement from Stephen McGowan --
23 Chair, the reference number WITN0319001, so we'll upload
24 that later -- In relation to audits of early
25 intervention psychosis programmes.

61

1 MR MOLONEY: Good afternoon, Dr Lloyd.

2 A. Good afternoon.

3 Q. The last document Ms Langdale took you to was a document
4 NHFT0004820, and I'd like to go to that, if I could. It
5 was an email from February that you explained the
6 significance of to Ms Langdale in your questions. And
7 if I could, please, I'd like to go to the last page of
8 that -- well, page 5 out of 6, please.

9 And to set the context for these emails, that this
10 is to you, and it's from a lady by the name of Anna
11 Hiley, and it's about the investigation. And we can see
12 halfway down the page:

13 "In preparing our response, I and an external
14 psychiatrist ... will be interviewing the staff who were
15 involved in specific aspects of [VC's] care."

16 Then in the next paragraph:

17 "We will provide in advance the questions pertinent
18 for yourself that I and Dr Read will be seeking to
19 respond to ..."

20 So this is essentially an email to you, saying that
21 they intended to interview you, and that they would send
22 the questions that were pertinent to you in advance so
23 you could consider them.

24 If we go up to page 4, you say that -- you say thank
25 you to Anna, and you say you'd:

63

1 You, I don't think, at Nottingham, have ever had
2 a peer review, have you, across the service?

3 A. An audit across the service?

4 Q. A peer review. Peer reviews: members of the review team
5 encouraged to share recommendations from their own
6 services and experience with others. Have you had that
7 within Nottingham?

8 A. I don't think so I've not come across a peer review
9 being done within our Trust.

10 Q. Do you think that would be helpful to have a review from
11 another Trust elsewhere --

12 A. Yes, yes of course.

13 Q. -- to share --

14 A. Absolutely, yes.

15 MS LANGDALE: Chair, those are my questions. It may be
16 a good time for the break before others ask the rest of
17 the questions.

18 THE CHAIR: I think we'll take a relatively short break so
19 if we take a break until -- if we start again at 3.45.
20 Thank you.

21 (3.28 pm)

22 (A short break)

23 (3.44 pm)

24 THE CHAIR: Mr Moloney.

25 Questioned by MR MOLONEY

62

1 "... really appreciate early access to the notes so
2 that [you] have ample time to ...read through all the
3 notes again and prepare for this interview. It has been
4 some time since I did this. ... I only work 2.5 days
5 ... so my [prep] ... time is very limited I look
6 forward to hearing from you ..."

7 We go up and we see that Theresa Dorey is sending
8 you the notes, and you say:

9 "Thank you for that," and then if we go up to page 3
10 Katie Crookes checks you have access to the notes, and
11 further up then you say -- and this is on page 3 and
12 this is from you to Claudia Birtles and Sharon Heath:

13 "Good morning Claudia/Sharon. I have been asked to
14 answer a set of questions in relation to a complaint
15 made against the Trust by the ... [family of VC's
16 victims', it should be]. Given my very limited
17 involvement with him I would appreciate meeting up so
18 that we can tackle some of these questions together and
19 formulate a response? Could we find a time fairly soon
20 to do this please. Many thanks, Tuhina".

21 Then we see that Sharon Heath says -- gives her
22 dates of availability: Tuesday 11th, Thursday 13th. You
23 say "unfortunately [you're] ... on leave that week.
24 Don't worry [you'll] ... meet Claudia and use the notes
25 to put a response together. Let me know if there's

64

1 anything you want to add with regard to the discharge
2 letter, process and contact with family?"

3 And then Sharon Heath says that she could meet the
4 following week, and then you organise the potential
5 Teams meeting.

6 Now isn't that just exactly what Gary Carter said,
7 that he wanted everybody to be on the same page?

8 **A.** It was really important here for me to get both Claudia
9 and Sharon's views, because many of the questions that
10 had been put to me were not things that I had been
11 directly involved with.

12 For example, the discharge letter question,
13 I wouldn't have written the discharge letter; it would
14 have come from Sharon Heath. So it was really important
15 to have her input with regard to that question.

16 And I must have read through all the questions and
17 realised that there were several questions where
18 Claudia, as lead clinician, would have had a lot more
19 understanding and knowledge than myself.

20 So yes, absolutely. I think we always work as
21 a team, and that's how Early Intervention in Psychosis
22 teams work. It's all about team working, team
23 decision-making, so everything we do is team oriented.
24 So in answering many of the questions which, when in
25 relation to the team, yes, of course I will ask for

65

1 an answer. And this happens quite a lot in complaints,
2 and various scenarios where questions are put to me by
3 a patient or a family, but actually, it's not pertinent
4 to me; it's what the family may think is pertinent to
5 me. There is a difference.

6 **Q.** So when you said, "Given my very limited involvement
7 with him I would appreciate meeting up so we can tackle
8 some of these questions together and formulate
9 a response", was that meaning that the response would
10 not be -- would simply be that they would feed in and
11 you would give any response that was from you?

12 **A.** Could you repeat that question?

13 **Q.** Was the response to come from you or from the collective
14 who met to discuss the questions?

15 **A.** The response would predominantly be from me, but I would
16 have used their knowledge, which for specific questions
17 it was really important for them to have an input.

18 **Q.** If you disagreed with them, would you have still
19 maintained your position?

20 **A.** Which is?

21 **Q.** Whatever position you were taking, that whatever you
22 thought.

23 **A.** Not if it wasn't something that I had enough knowledge
24 about. I would have to defer that knowledge to them.
25 That's why I'm asking them, because I wouldn't have

67

1 their opinion on many of the answers so that I make sure
2 I give the best and most accurate answer, and it's not
3 just based on what I think or believe.

4 **Q.** But these were questions directed to you that were
5 pertinent to you, as it said, and --

6 **A.** They were not pertinent to me. I read through them and
7 many of those questions, and I can't remember exactly
8 what they are off -- immediately, but I'm happy to, if
9 anyone has got a copy of those, we can look through them
10 and I can show you exactly how they're not specifically
11 pertinent to me; they're things that maybe the Trust
12 believed I should be able to fully answer myself but in
13 actual fact when I looked at the questions, there was
14 very clear evidence that both Claudia and Sharon would
15 be able to help immensely in terms of their involvement
16 in those questions.

17 **Q.** But the questions were to be asked of you. Surely your
18 answer, if these were -- if you weren't able to answer,
19 is to say, "Well, that question should be asked of
20 Sharon or it should be asked of Claudia", rather than
21 you giving an answer which was a collective answer?

22 **A.** I was told very clearly that these questions needed to
23 be answered by myself, that there was a recognition that
24 I may not have been the person leading specifically in
25 relation to this, but I was told that I needed to give

66

1 necessarily known the answer.

2 **Q.** And so is it your evidence that you did not say to Gary
3 Carter: "We need to all make sure we're on the same page
4 here"?

5 **A.** And when, apparently, did I say this to Gary Carter?

6 **Q.** In a car, I believe. He gave evidence that you were all
7 in a car after a meeting and you said, "We all need to
8 be on the same page here."

9 **A.** After a meeting where?

10 **Q.** Or car park --

11 **A.** In a car park?

12 **Q.** In a car park.

13 **A.** It was in a car park. Do we have any more information
14 beyond that? Do we have a date for the meeting or
15 minutes that I attended this meeting?

16 **Q.** Did you not remember if you had said that to Gary
17 Carter? Would you not remember if you'd said that to
18 Gary Carter, Dr Lloyd?

19 **A.** I don't recall saying that to Gary Carter, which is why
20 I'm asking for clarification.

21 **Q.** Right. If you'd said something like that to Gary Carter
22 in the early days, is it something you would remember or
23 not, ordinarily?

24 **A.** I would not have said anything to Gary Carter in the
25 early days because right at that initial stage,

68

1 particularly in 2023, we were told very clearly not to
 2 be talking about the case to anybody.
 3 **Q.** By 2023 --
 4 **A.** No, by 2020 -- it was in 20 --
 5 **Q.** No, I'm talking about -- I'm sorry, I'm moving on. I do
 6 apologise. That's my fault.
 7 **A.** Oh, sorry, I'm sorry.
 8 **Q.** By 2023, before discharge, Ms Robinson gave evidence
 9 that EIP had "lost VC yesterday". Did you see that
 10 evidence?
 11 **A.** I was travelling but I do believe I saw -- I briefly
 12 read a transcript. So yes, I saw -- I think I did see
 13 that, yes.
 14 **Q.** And you've answered questions by Ms Langdale today --
 15 **A.** Yes.
 16 **Q.** -- about how essentially you didn't know what to do with
 17 VC by the time it came to discharge.
 18 **A.** By the time it came to discharge, yes, we were
 19 struggling to find him. It had become incredibly
 20 difficult. He had become very skilled, by this stage,
 21 at avoiding services.
 22 **Q.** Given that, given that he was very skilled and it was
 23 very difficult to find him, why didn't you contact the
 24 police to see if they could find him?
 25 **A.** Because we knew from previous experience that every time

69

1 involved in the drug dealing.
 2 **Q.** Can we please look at the document WITN0163002. Now,
 3 this is -- do you remember VC asking for disclosure of
 4 his medical records after the fourth admission?
 5 **A.** This was shortly after the fourth admission?
 6 **Q.** Fourth admission, yes. Well, this document was in fact
 7 August 2022, but the date on it is actually
 8 21 February 2022 and it may be it's taken time. Gary --
 9 it's in the RiO as August but --
 10 **A.** Yes, I remember VC requesting his notes, yes.
 11 **Q.** Do you see the address, 15 Madison Court?
 12 **A.** I do see that, yes.
 13 **Q.** Did you see as well that he appears to have scrubbed out
 14 "209"?
 15 **A.** No, I can't -- I'm not sure what he's scrubbed out but
 16 I can see a scribbling.
 17 **Q.** I'd like to ask you about discharge, if I may, please.
 18 You were asked about the importance of the care
 19 coordinator's views by Ms Langdale.
 20 **A.** Yes, it is important.
 21 **Q.** Yes. But you accept that Gary Carter was not present at
 22 the meeting where he was discharged.
 23 **A.** As I've explained --
 24 **Q.** No, you said of course that you thought he'd had
 25 a meeting with Gary Carter before then, yes?

71

1 we have contacted the police asking for help, when there
 2 hasn't been clear and imminent risk to life or limb, and
 3 that's what we're quoted: there should be clear imminent
 4 risk to life or limb otherwise it is not their
 5 responsibility to be getting involved in cases relating
 6 to mental health issues; that it is the duty of the
 7 mental health team or social care.
 8 **Q.** Right.
 9 **A.** And that's been a repeated response from the police.
 10 **Q.** Now one of the addresses he gave was 209 Ilkeston Road,
 11 wasn't it? Do you remember that?
 12 **A.** I can't remember any of the addresses off the top of my
 13 head, but yes, if you say that was an address, I will
 14 accept that.
 15 **Q.** Have you ever been told that the police assessed that
 16 house as being linked to drug dealing?
 17 **A.** No, I didn't know that.
 18 **Q.** And that there were reports of a firearm, a black
 19 handgun being seen there on 26 July 2022?
 20 **A.** I didn't know that.
 21 **Q.** If you'd contacted the police when considering discharge
 22 when you couldn't find him, and you had been told that,
 23 would you have been very concerned about VC associating
 24 himself with that address?
 25 **A.** Possibly, yes. It depends whether he was directly

70

1 **A.** The discharge decision was taken before that final date.
 2 What I remember of that final meeting was that it was
 3 administrative. I can't remember any detail except it
 4 felt like a rubber stamping because, in an MDT meeting,
 5 it's the care coordinator that brings cases for
 6 discussion. Now, Gary Carter wasn't there, so I -- you
 7 know, I cannot understand who would have brought one of
 8 his cases for discussion. It doesn't quite compute with
 9 me. It's very odd.
 10 The decision to discharge, as far as I can remember,
 11 had been taken some time in August. Gary had come into
 12 the room and he had said, "I have done everything that
 13 I possibly can now. I've completely run out of all
 14 ideas". And I specifically have a clear and distinct
 15 memory of him saying that and having a discussion about
 16 the options: what else can we do? Should we think about
 17 Crisis? Mental Health Act admission? Should we think
 18 about police? And that's when there was the discussion
 19 about asking for either a welfare check or missing
 20 person, both of which we decided not to go for, for the
 21 reasons that I have put in my statement, and that at
 22 that point we felt that there was no other option,
 23 really, apart from discharge.
 24 I do not believe that the meeting on the 22nd was
 25 a decision-making meeting; I think it was

72

1 a rubber-stamping of discharge because I have no
2 recollection of any kind of decision being made on that
3 day.
4 **Q.** You'd previously agitated for VC to be given a depot,
5 hadn't you --
6 **A.** Yes.
7 **Q.** -- by an email to Dr Thangavelu. You discharged him
8 without any depot, didn't you?
9 **A.** Yes, because we had no choice but to do so. We had run
10 out of options. There was nothing else at that stage
11 that we felt we could do. We had lost him. We didn't
12 know where he was; his family didn't know where he was.
13 We had lost him, we had reached that position where,
14 after nine months of trying, we felt that there was
15 nothing else that our small team could do. We didn't
16 have the skillset of an Assertive Outreach Team, we
17 didn't have the ability to track and trace someone who
18 was changing addresses rapidly, who was potentially not
19 even in the county.
20 **Q.** So that was it.
21 **A.** So we had reached that position where we didn't know
22 what more we could do. And under those circumstances,
23 what are the options?
24 **Q.** Can I just ask you about annual job planning, very
25 quickly. Does annual job planning take place with the

73

1 **A.** That's correct.
2 **Q.** So you're saying that wasn't known within the Trust:
3 that there was no one taking notes of the MDTs?
4 **A.** So, as far as I was aware, the MDT meetings were not
5 being recorded across a number of teams across the
6 Trust. There was no administrative support to do that.
7 **Q.** That's what I understood your evidence to be but can
8 I just be clear then, because you referenced something
9 that was raised repeatedly by the consultants that was
10 being escalated within the Trust? Can I be clear what
11 you were speaking about then?
12 **A.** That wasn't the MDTs. I think that was to do with
13 caseload, I believe.
14 **Q.** All right.
15 **A.** Yes, so it was the fact that all of us had extremely
16 inflated caseloads for the amount of hours that we were
17 working and that's something that's been raised numerous
18 times in consultant meetings and forums.
19 **Q.** Now, you didn't detail that within your witness
20 statement to the Inquiry. Why not?
21 **A.** So what I mentioned in the witness statement was that
22 the three sessions that I had, the 12 hours that I had
23 allocated to EIP, didn't feel sufficient at all.
24 **Q.** Well, that's something quite different to you saying all
25 of the consultants were raising with the Trust the

75

1 Clinical Director?
2 **A.** Yes.
3 **Q.** Are hours and workload discussed?
4 **A.** Is what discussed.
5 **Q.** Are hours and workload discovered at the annual job
6 planning?
7 **A.** It is discussed, yes.
8 **Q.** It's a formal process that, isn't it, the annual job
9 planning?
10 **A.** It's a formal process.
11 **Q.** If you had an unsafe service, should it be escalated to
12 the Medical Director or the Chief Executive?
13 **A.** I didn't feel that service was unsafe?
14 **MR MOLONEY:** Thank you very much, Dr Lloyd.
15 **THE CHAIR:** Yes, Ms Cartwright.
16 **Questioned by MS CARTWRIGHT**
17 **MS CARTWRIGHT:** Good afternoon, Dr Lloyd. I ask questions
18 on behalf of the survivors.
19 Now, Dr Lloyd, you've told the Inquiry today that
20 there was a known issue regarding documenting the MDTs
21 and I think you've said that it had been raised
22 repeatedly through the consultant route?
23 **A.** No, I don't think I'd said that.
24 **Q.** All right, well, let me be clear. So we've got no
25 records of the MDTs?

74

1 workload. That's very different: that's an issue of
2 patient safety, it's an issue of clinical governance,
3 and you've given evidence as if this is a relevant
4 factor that was well known in the Trust. So why did you
5 not include it in your witness statement?
6 **A.** My witness statement was very much guided by the
7 questions that were put to me.
8 **Q.** So if you had relevant evidence that wasn't covered by
9 a question, you decided to leave it out of your
10 statement?
11 **A.** I don't believe that this is an issue just for our
12 Trust. I think that psychiatry is chronically
13 underfunded nationally. That's my understanding. So
14 I think this is a well-known fact across psychiatric
15 services and I wasn't specifically asked about my views
16 on services locally or nationally. I was purely asked
17 a series of questions to help the Inquiry to come to
18 their conclusions regarding this case. You know, I'm
19 not sure that what you're asking was necessarily
20 relevant, specifically to VC.
21 **Q.** All right, but you're essentially saying there's
22 a document trail that exists where the Trusts were being
23 notified about issue as to workload of the consultants
24 in this team?
25 **A.** It wasn't just this team; I'm talking about consultants

76

1 across adult mental health.

2 **Q.** All right, well, let's just deal with the MDT, then. So

3 you knew that the MDTs were not being recorded.

4 **A.** That's right.

5 **Q.** And so you essentially said to Ms Langdale, "Well,

6 there's nothing more to say on it," but actually, you do

7 have something more to say on it because you have your

8 own professional obligations in respect of recording;

9 would you agree?

10 **A.** So I raised it with the team --

11 **Q.** No, that's not the question.

12 **A.** So, okay --

13 **Q.** You had professional obligations, governed by the

14 General Medical Council, in respect of recording keeping

15 and ensuring that you record your relevant

16 decision-making and actions, and even more so when

17 you're attending MDTs, when you know they are not being

18 documented and you're party to them, even more so this

19 raises the obligation on you personally and

20 professionally to document your involvement in the MDT;

21 would you agree?

22 **A.** I think, if I'm expected to document every single

23 decision that's made in the MDT, that's all I would have

24 time to do. It just wouldn't be possible. There are

25 somewhere in the region of, you know, sort of 25-35, 40

77

1 And the guidance makes clear that you have to record

2 decisions made and actions agreed, and therefore, even

3 if other people weren't doing notes of the MDT, you

4 personally should have been making notes.

5 **A.** The decisions that were being made were not unilateral

6 decisions being made by me. They were team decisions.

7 And the team member that has clearly been identified as

8 being responsible for recording in the MDT notes is the

9 care coordinator; and so it is their role, primarily, as

10 lead clinician, to be recording in the notes, not mine.

11 I am one member of the team inputting and giving my

12 opinion at times when needed. There are many other

13 opinions coming from people --

14 **Q.** But a central member of the team --

15 **A.** I'm not a central member of the team --

16 **Q.** You are a consultant psychiatrist. There were no other

17 consultant psychiatrists contributing to those MDTs.

18 **A.** There wasn't, but I'm not necessarily the central

19 member; I'm not making unilateral decisions. These are

20 joint team decisions. The care coordinator is bringing

21 the case for discussion. It is their responsibility, as

22 far as I'm concerned, to be recording, and that's what

23 I've been told: that that is their role, it's their

24 duty, it was what I was told at the beginning. We

25 should have had administrative support, we didn't have

79

1 patients that are discussed. It's just -- it just would

2 not be possible for me to do that level of

3 documentation. It would be impossible. That's all

4 I would do in my 12 hours.

5 **Q.** Well, you are the responsible clinician, the community

6 consultant --

7 **A.** I'm not the responsible clinician, no. That is a legal

8 term.

9 **Q.** Well, you are VC's consultant --

10 **A.** I'm the community consultant, correct.

11 **Q.** But you were VC's consultant?

12 **A.** Yes, I am -- was.

13 **Q.** Well, you were supervising Dr Burri as your ST5.

14 **A.** Yes.

15 **Q.** And I'll come on to deal with that, but after he then

16 left and handed VC back over to you from July of 2021,

17 you were VC's community consultant, yes?

18 **A.** Yes.

19 **Q.** And so in terms of MDT where VC is being discussed and

20 decisions being made about him and his care and his

21 medical provision, you had an obligation to make formal

22 recordings of your work, that were accurate,

23 contemporaneous, and legible. They may have been brief

24 but you had a requirement yourself to make those notes;

25 would you agree?

78

1 it, but as consultant, I would not have the time or

2 ability in 12 hours to be making those detailed

3 recordings.

4 **Q.** So then when there were, as you've told us on a number

5 of occasions you reviewed VC's notes and noting that the

6 care coordinators were not documenting the MDTs, what

7 did you do to flag to them then, if you say it wasn't

8 your responsibility, "There are no notes of these

9 important MDTs"?

10 **A.** That's when I flagged it to the team leader and said,

11 "This isn't happening. We really need to have

12 administrative support," and she said, "No, that's just

13 something that we can't get. That resource is not

14 available to us. This is not just our team, this is

15 across many teams within the Trust."

16 And when I spoke to my peer group I found out

17 actually that was in fact the case.

18 And so it wasn't just me that wasn't, you know, sort

19 of flagging this up specifically; there were other

20 consultants in the Trust that were in exactly the same

21 position, and, you know, it's not -- it's a shared

22 responsibility, isn't it? It's not down to me to make

23 huge changes to what's going on across the Trust.

24 **Q.** I'm going to suggest to you, in fact what you're trying

25 to do is limit your responsibility and the leadership

80

1 you should have had as a consultant for VC's care, and
 2 for VC's decision to be discharged -- most aptly
 3 typified by the fact that you didn't even bother to
 4 draft the discharge letter handing over continuity of
 5 care to the GP when there was no care coordinator
 6 involved in that meeting; would you agree?

7 **A.** The decision to discharge VC was made well before that
 8 meeting when Gary Carter was present. It was made in
 9 August. He was present, and he should have drafted the
 10 letter, as all the other care coordinators do. Whenever
 11 there is a -- whenever there is a discharge meeting
 12 where a patient, family, GP are all invited to clinic,
 13 and I'm there and it's my clinic, I always draft the
 14 discharge letter on every occasion.

15 On this occasion there wasn't that meeting because
 16 VC was not present. It was an MDT discussion, and for
 17 that reason I didn't draft the letter, because it was an
 18 MDT discussion and it should have been the care
 19 coordinator who brought the case, and in any case, even
 20 when I do the discharge letter in clinic, there is also
 21 a second letter that goes out from the care coordinator.
 22 So there's usually two letters that the GP receives.

23 **Q.** Let's just look, because essentially, your evidence
 24 today that the decision to discharge was made before the
 25 September MDT is, I think, I'm going to suggest you've

81

1 you've realised there was no care coordinator in that
 2 MDT.
 3 **A.** That's not correct. I have written very clearly my
 4 recall, my memory of the meeting. The only thing that
 5 I have got wrong here is the date, and the reason for
 6 that is whilst I have clear memories of events and
 7 meetings, it's not always very easy to remember dates in
 8 detail. And what I'd done, I'd gone to the notes when
 9 I was writing my statement, and I'd looked at -- I'd
 10 used dates in the notes as anchors. And so when I'd
 11 seen that Sharon Heath had written in the notes that the
 12 discharge decision had been made on 22nd September, I'd
 13 attached my memory of what had happened to the
 14 22nd September, thinking that must have been the date
 15 when we had this conversation. And so essentially, yes,
 16 I'd made a mistake with the date here, but everything
 17 else I've written, including the fact that I was certain
 18 that Gary was present, which I was, was because he had
 19 been present.

20 **Q.** It's for the Chair to make of your evidence what she
 21 wishes to make.

22 **A.** Mm. That's absolutely fine.

23 **Q.** Now then we know Gary Carter wasn't there.

24 **A.** He wasn't.

25 **Q.** And we also know the previous care coordinator wasn't

83

1 changed it because you've now realised, in the
 2 correction you made, that Gary Carter wasn't in the MDT.
 3 So can we look at what you did say, please, in your
 4 witness statement, WITN0357001 at page 125.

5 So paragraph 347 on page 125. Thank you.

6 "I was present at this ..."

7 Sorry, 23 September you deal with the discharge, but
 8 you say:

9 "I was present at this MDT, from memory ..."

10 So this is the MDT of 22 November:

11 "... Emma Robinson ... Gary Carter (CCO), Abigail
 12 Parsonage ... Adele Pinder ... Frances Doughty ... and
 13 Paul Williams ... were all in attendance. There were
 14 other team members in attendance as well but I am unable
 15 to recall exactly who they were.

16 "It was decided to discharge VC from the service as
 17 a non-engaging patient. Despite a nine-month period of
 18 trying to engage him in the community from October 2021
 19 to September 2022 we reached a point where it became
 20 very clear that VC was actively and intentionally
 21 disengaging with services and his medication [and so
 22 on]."

23 You don't say in your witness statement there, "We
 24 made the decision before then in August," and I'm going
 25 to suggest that's the evidence you're now giving because

82

1 involved. So back to the question that you avoided
 2 before: why, therefore, did you not write the discharge
 3 letter providing the continuity of care back to the GP?
 4 You're discharging VC, as his consultant, from secondary
 5 mental health services back to the GP. Why did you not
 6 write it?

7 **A.** Because I assumed that it would be written by Gary
 8 Carter as soon as he returned, which was actually the
 9 week after, because that's what the care coordinators
 10 always do. And if that's their role and responsibility,
 11 I think it's --

12 **Q.** I'm going to suggest to you it's continuity of care
 13 again. Good medical practice makes clear as well you
 14 have your responsibilities again contained in good
 15 medical practice, that where continuity of care is being
 16 passed between teams, you have your responsibility to
 17 ensure that responsibility for safe patient transfer
 18 between teams. So you had a role, a significant role to
 19 play here, where you have a psychotic schizophrenia,
 20 a patient who was non-engaged, not complying with
 21 medication. If ever there was a discharge letter that
 22 needed to be carefully crafted, it was this one, and you
 23 should have written it, including your rationale for why
 24 you were discharging VC from secondary mental health?

25 **A.** If that's your view ...

84

1 **Q.** Well, then can we look at your notes, because I'm going
2 to suggest this again shows your poor note keeping and
3 recordkeeping. So let's just look at two examples of
4 when VC failed to attend and how your note keeping is
5 non-compliant with the policies that applied at the time
6 regarding do not attend. Can we look in the RIO,
7 please, NHFT0000168, and I'm going to suggest that these
8 entries really do show that, despite the complex picture
9 for VC, just the level of care and attention you were
10 giving to VC's case, page 267, please, your entry for
11 13th June.

12 Bottom of the page, we've got 13 June. Over the
13 page, please:

14 "Medication aripiprazole, [VC] did not attending his
15 10 am appointment, CPN to reschedule."

16 Now, in terms of the Trust's policy, perhaps we'll
17 just look at another example. 269, please, 1 August.
18 Again, your note for 1 August:

19 "Aripiprazole, [VC] did not attend his 11 am
20 appointment. Another will be arranged by his CPN."

21 Now, would you agree that this was an opportunity,
22 when you were making recordings, to actually do what you
23 should have done in accordance with the policy, which
24 would be to have documented calls to GP, calls to
25 family, your risk assessment at that time, in light of

85

1 **A.** I didn't but the CPN, the care coordinator who was with
2 me in the room, often she'll call immediately while --

3 **Q.** Well, again, the purpose of records and documenting it
4 is then it shows it's been done?

5 **A.** Yes, and she does document it. So if you look at the
6 next entry, "Phone call to [VC]", 3 August.

7 **Q.** That's not what the policy required on the day, that
8 a patient does not attend. It's "Contact the GP" and,
9 bearing in mind you've got a slot now in your busy
10 schedule where the patient has not turned up, the
11 policy --

12 **A.** We may have a slot but, actually, what we're doing in
13 that lots is me and the CPN are having a discussion,
14 we're looking through the notes, we're having
15 a discussion. That slot actually gets used up making
16 sure that all the actions from the DNA policy are
17 followed -- (*overspeaking*) --

18 **Q.** There is no evidence of that and, most significantly,
19 there is no evidence of what you were required to do
20 when VC did not attend, which is the risk assessment,
21 a documented risk assessment.

22 **A.** It's not a risk assessment, actually. It says "level of
23 risk" in the DNA policy that we follow, the one that you
24 will find that I have referenced. It says the level of
25 risk and I don't know which DNA policy you are looking

87

1 his non-attendance.

2 **A.** So as I've explained to you, we follow the Trust policy
3 with all of our DNAs, and in any one clinic there could
4 be a number of DNAs, you know, particularly with
5 psychotic patients. Sometimes it can be anything up to
6 50 per cent. And I think, if each time I'm almost
7 cutting and pasting, you know --

8 **Q.** Well, it's not cut and pasting.

9 **A.** Well, it almost is, isn't it? It's like discussion with
10 the CPN who is in the room, "Have you got any concerns?"
11 I have looked back at the notes and I have found that
12 there is nothing in the last few entries which are to of
13 concern, and then the next steps are that the CPN will
14 now contact the patient by phone, and that could be
15 immediately or a bit later in the week, if we've
16 identified no concerns. It would be -- you know, what
17 would be really helpful here is, if there had been DNAs,
18 there was almost like something that we could tick
19 really quickly to say, "These things are done", there's
20 essentially like a checklist for us. That would have
21 been helpful because, essentially, each time we would
22 just be saying the same thing in terms of repeating what
23 we're doing, as far as the Trust DNA policy is
24 concerned, and that's what we follow.

25 **Q.** So did you call VC's family?

86

1 at --

2 **Q.** I'm looking at the one that was in place from September
3 2021 --

4 **A.** I think there might have been two in place.

5 **Q.** There was one before but, again, that had requirements,
6 but the one you were required to follow, NHFT0004725,
7 please. So is it your evidence you were following an
8 earlier iteration of the policy and not following the
9 policy that was, in fact, the promulgated policy for the
10 Trust at the relevant time?

11 **A.** I was following the policy that I had --

12 **Q.** Well, let's look at this one. So this is the Trust
13 version, 7 September 2021. Is it your evidence to this
14 Inquiry that you were failing to follow the Trust's
15 relevant policy in 2021/2022?

16 **A.** So this was a new policy, wasn't it?

17 **Q.** No, this is the policy, version date September 2021.
18 It's the live policy for your relative involvement. So
19 is it your evidence you were failing to follow the Trust
20 policy?

21 **A.** No, I believe I was following the right policy and
22 I believe it's one that I have referenced in my ... in
23 my statement, so if we can put that up -- (*overspeaking*)
24 --

25 **Q.** Well, let's look at the other policy then NHFT0000417.

88

1 A. I'm happy to look at the one -- I'm happy to look at the
2 date on the one that we have in ...
3 Q. So this is the earlier policy, I think one you
4 reference. Is it this policy you are saying you were
5 following?
6 A. I can't tell you from looking at the front.
7 Q. Well, perhaps then let's just go to page 7, which would
8 show what you should be doing when a patient doesn't
9 turn up. Was it this policy you were following?
10 A. So actions will be taken by the clinical lead, which
11 wouldn't be me. I'm not the lead clinician. I mean,
12 I don't think it was this policy but I'm just looking at
13 it now. "The clinical lead must make repeated efforts
14 to contact the patient via telephone", yeah, "on the day
15 of the missed appointment", which they do, which is the
16 care coordinator.
17 Q. Let's just leave aside the content. I just want to try
18 and crystallise what you were following --
19 A. I can't -- I don't think it is this one. There is
20 another one which I have referenced.
21 Q. Then let's just look then, please, back to the September
22 2021, which is the 4725, please, NHFT0004725, and go to
23 page 7, please. So were you following this policy?
24 A. Yes, that's right, "Immediate assessment of the
25 patient's level of risk".

89

1 A. We always did that, for every patient.
2 Q. Well, there's no evidence of that whatsoever.
3 **THE CHAIR:** Ms Cartwright, ultimately I have to make
4 a decision about this and you're over time now by a long
5 way.
6 **MS CARTWRIGHT:** No. Well, I'll leave the other point.
7 **THE CHAIR:** Thank you.
8 Yes, Mr Straw.
9 **Questioned by MR STRAW**
10 **MR STRAW:** Dr Lloyd, I represent VC's family.
11 It's right, isn't it, that you quickly after the
12 June 2023 attacks realised that you'd made a serious
13 error by discharging VC into the community to his GP?
14 That's right, isn't it?
15 A. No, it's not right.
16 Q. And since then, your evidence has been aimed at covering
17 your back rather than telling the truth; that's right,
18 isn't it?
19 A. That's not correct.
20 Q. Well, let's look at a few examples. You said earlier on
21 that Celeste Calocane felt the fourth admission had not
22 been necessary; do you remember that?
23 A. That had been told to me by Claudia Birtles after the
24 fourth admission, and I had also read in the notes that
25 Celeste Calocane had felt that he hadn't been unwell,

91

1 Q. Yes, so --
2 A. So "level of risk" is not a risk assessment:
3 "In an outpatient clinic setting, an assessment of
4 the patient's level of risk may not necessarily require
5 the oversight of the full MDT and must be conducted by
6 a member of medical staff or another practitioner."
7 And that's what is conducted between myself and
8 Claudia Birtles:
9 "The requirement for either a full MDT risk
10 assessment ..."
11 So that's the full MDT risk:
12 "... or a risk assessment undertaken by an
13 individual member of staff will depend on ..."
14 So they're asking us to look at a level of risk --
15 Q. Yes, and that's what I'm asking you about.
16 A. And that's what we do and so --
17 Q. And that's what I'm suggesting to you. So it doesn't
18 have to be a formal document as in the risk assessments
19 that were -- but you needed to document, in your notes,
20 in your clinical entry, your assessment of risk, which
21 is a risk assessment, and that's what was needed and
22 required. And there's no evidence anywhere that you
23 would at any occasion consider that for VC and you've
24 certainly not documented it. And so I'm going to
25 suggest that you now say you did that.

90

1 and that that admission should not have taken place.
2 I specifically remember reading that at the time.
3 Q. Okay, well let's look at the notes, please, up on
4 screen: NOCC0000043. And we can see this is 28 January
5 2022 AMHP report by Fiona Parker. Can we go to page 4
6 of that, please.
7 We see at the top telephone call from Celeste:
8 "Unaware of situation and a little exasperated ..."
9 And then:
10 "... noted his belief in conspiracy theories. Does
11 not object to admission if we think he needs this."
12 A. Okay.
13 Q. That was her view, wasn't it? She didn't anywhere
14 suggest --
15 A. She didn't sound like she objected, no, but I certainly
16 got the impression from some of the excerpts in the
17 notes that she hadn't felt that he was unwell in the
18 lead-up to the admission or indeed after he'd been
19 admitted, when in the past she'd been really quite
20 assertive in coming forward whenever she had any
21 concerns. Even conversations on the phone, when his
22 voice had sounded a little bit unusual, she would ring
23 up and say, "He doesn't say sound right."
24 Whereas on this occasion she'd had a number of phone
25 calls with VC in the lead-up to the admission, and

92

1 hadn't really raised any concerns and had, in
 2 a telephone conversation and a ward round, suggested
 3 that she just hadn't felt that he'd been unwell this
 4 time.

5 **Q.** Hadn't raised any concerns. That's your evidence.
 6 **A.** Not -- certainly not as far as I'm aware in the lead-up
 7 to this admission.
 8 **Q.** Okay --
 9 **A.** I wasn't aware if she had.
 10 **Q.** Can we have RiOs, the NHFT0000168 document, page 223.
 11 There's an entry 2 February there in the middle of the
 12 page, telephone call to "mother (Celeste ...)":
 13 "She explained [VC] seemed normal to his parents,
 14 until they heard about [the] incident."
 15 Then she talked about talking to him on the phone,
 16 and I'll come back to that.
 17 "Celeste was worried about him. She thinks he is
 18 scared of mental health services and feels persecuted by
 19 them."
 20 So on the face of the RiO notes you had read she was
 21 expressing concerns, wasn't he?
 22 **A.** She's saying he's frightened of mental health services,
 23 he feels persecuted by them, which would explain why he
 24 had disengaged and why he had missed all the points with
 25 me, yes.

93

1 Mum and when you asked about sister, were any concerns
 2 raised?" And he said "No, she didn't raise any concerns
 3 on this occasion at all and in fact she seemed" -- and
 4 these are Gary's words -- "she'd seemed a little bit
 5 irritated by me contacting her."
 6 **Q.** You've mentioned couple of times there significant
 7 pieces of evidence about things you say Celeste said,
 8 which we don't see on the medical notes at all.
 9 **A.** Such as?
 10 **Q.** Well, the one you just mentioned?
 11 **A.** Just that one, yes.
 12 **Q.** Irritated, that's not on the notes, was it?
 13 **A.** That's not but that was communicated to me by Gary after
 14 because I specifically asked "Did Celeste express any
 15 concerns?" And the response was, "No". But there had
 16 been a conversation with sister, but no, no concerns had
 17 been expressed.
 18 **Q.** I suggest the reason it's not on the notes was because
 19 it wasn't ever said. That's right, isn't it?
 20 **A.** What was never said?
 21 **Q.** Your evidence just now about Gary Carter saying, well,
 22 Celeste was irritated, she didn't raise any concerns.
 23 That was never said, was it?
 24 **A.** That was said.
 25 **Q.** Okay, so I've just referred you to the point about

95

1 **Q.** Well, it was an indication that he was relapsing into
 2 paranoid delusions, wasn't it?
 3 **A.** She didn't suggest that at all. She was worried about
 4 him.
 5 **THE CHAIR:** She's not a psychiatrist.
 6 **A.** No, of course she's not, but I'm just saying that she's
 7 saying he's "scared of mental health services and feels
 8 persecuted by them." That doesn't suggest that she
 9 feels he's been particularly unwell.
 10 **MR STRAW:** Let's take another example. Earlier on you
 11 discussed your reasons for discharge, and you referred
 12 to the August 2022 phone calls referring to Celeste, the
 13 mum, and also the sister. And you said no concerns had
 14 been raised. Do you remember that?
 15 **A.** That's what I was told by the care coordinator, yes.
 16 **Q.** But that's misleading, isn't it. There was -- at no
 17 point did they say they weren't concerned about him.
 18 **A.** Right.
 19 **Q.** Rather, what they did say, and we've seen the note
 20 earlier, was that Celeste had had no face-to-face
 21 contact with VC for many months. Do you remember that
 22 note?
 23 **A.** I remember that note but I also recall that there'd been
 24 a conversation with -- with sister, and
 25 I said -- I specifically asked Gary: "When you spoke to

94

1 Celeste not having face-to-face contact for many months.
 2 It was obvious from an early stage, wasn't it, that
 3 face-to-face assessments of VC were important because he
 4 masked his symptoms?
 5 **A.** Yes, it was important, yes.
 6 **Q.** So it was significant, wasn't it, that Celeste hadn't
 7 had face-to-face contact with him for many months?
 8 **A.** That was significant. It was significant that we
 9 haven't been able to see VC for a number of months.
 10 **Q.** You were aware as well, weren't you, that VC had
 11 withdrawn consent for the medical team to share any
 12 information about him with Celeste towards the end of
 13 2021?
 14 **A.** That's correct.
 15 **Q.** So she really wasn't in a position to express a view
 16 about his mental state, was she, in those circumstances?
 17 **A.** Because she hadn't seen him.
 18 **Q.** She hadn't seen him, she wasn't being given any
 19 information from the medical services about him, she
 20 just didn't have a basis to properly understand what his
 21 mental state was?
 22 **A.** At that stage, unfortunately, we didn't either because
 23 we hadn't been able to see him.
 24 **Q.** But I'm asking about Celeste and you placing weight on,
 25 as you say, no concerns having been raised. I suggest,

96

1 in all of this contact, because of all of these reasons,
 2 you were just wrong to place any weight on the fact that
 3 she had been phoned up and she said, "I haven't had
 4 face-to-face contact with him for many months", and that
 5 was it?
 6 **A.** But there had been a telephone call with sister and
 7 also, on 31 August, I understand that Celeste had
 8 a conversation with VC. So I think there were two
 9 conversations with him on the phone and, whilst I accept
 10 they weren't face-to-face, I think because she knew --
 11 I got the sense that she knew him well because,
 12 previously when she'd had telephone conversations with
 13 him, even the tone of his voice she was able to pick up
 14 that there was something wrong because she called us and
 15 said, "He sounded really different on the phone, I'm
 16 very worried".
 17 So, you know, I'm not saying that it's easy to
 18 ascertain concern over the telephone but, if there had
 19 been something that she'd picked up, surely she would
 20 have told us.
 21 **Q.** Two other examples: in your witness statement you
 22 discuss the University, you discuss VC's university. So
 23 paragraph 143 you refer to your meeting with VC on
 24 14 March 2022, and you say:
 25 "I noted that VC was on track and coping well with
 97

1 **Q.** Can we have the RiO back on screen, please. It's
 2 NHFT0000168, page 210. The NHFT0000168 document, sorry.
 3 Page 210. So top of the screen here, 24 January 2022,
 4 an entry from Ms Birtles:
 5 "[VC] does appear to be struggling with his studies.
 6 Feedback from course leader indicates that [VC] has
 7 failed to complete a whole module and has been
 8 submitting exams too late."
 9 We saw a similar note from Dr Manzar's 28 January
 10 2022 assessment, which noted that VC was failing in his
 11 courses and the University is threatening to terminate
 12 his course. Now, when you say he was on track: again,
 13 that wasn't true, was it?
 14 **A.** When did I actually say that? What was the date?
 15 **Q.** Sorry, when did you say he's on track?
 16 **A.** Mm.
 17 **Q.** You just said it.
 18 **A.** No, as in you brought it up; it was in my statement. Do
 19 we have a date for that? Can we get that up?
 20 **Q.** Just a moment ago, when you were responding to me about
 21 his university course, you said you thought he was on
 22 track.
 23 **A.** It's what I had written in my statement, apparently.
 24 **Q.** That's what you said to me in oral evidence, in your
 25 sworn oral evidence a few moments ago.
 99

1 his degree."
 2 Do you remember that?
 3 **A.** He told me that.
 4 **Q.** Well, what you say in your witness statement is:
 5 "I noted VC was on track and coping well with his
 6 degree."
 7 That's what you say, isn't it?
 8 **A.** Yes, if that's what I've written, yes.
 9 **Q.** Again, it's not true, is it?
 10 **A.** I did later find out that he had decided not to pursue
 11 the Masters and had decided to go for a lesser degree.
 12 But he was on track with that and he achieved a good
 13 2:1, that's my understanding. So it wasn't that he
 14 wasn't on track. He didn't perhaps get the Masters that
 15 he'd wanted originally but he still gained a university
 16 degree, which is of -- you know, mechanical engineering
 17 is incredibly tough and he is a man with mental health
 18 issues who manages to gain a 2:1 in a really tough
 19 subject. I think that's --
 20 **Q.** Where did you get that information from?
 21 **A.** -- I think that's pretty impressive.
 22 **Q.** Yes, he got the 2:1 based on his marks up until early
 23 2020, didn't he? Not on what happened afterwards?
 24 That's right, isn't it?
 25 **A.** Yes, I guess it's up to 2020, yes.
 98

1 **MS LANGDALE:** It's March 2022.
 2 **A.** Okay, March 2022. Thank you. And was he back on track
 3 in March 2022? I'm not sure. Perhaps he was.
 4 Certainly that's probably what he told me.
 5 **MR STRAW:** Okay, and final --
 6 **A.** I'm not sure -- I'm really not sure what the question is
 7 here. At the time he told me he was back on track, and
 8 that's what I'd noted down, after my appointment. Is
 9 that the question?
 10 **Q.** Well, I think we've been through this in enough detail.
 11 **A.** I think we have, haven't we.
 12 **Q.** Last question, last area. You noted earlier that the
 13 decision to discharge had been made in August 2022 and
 14 the decision had been made on the basis that Mr Carter
 15 came up to you and indicated that --
 16 **A.** He didn't come up to me. He came to the team meeting
 17 and brought up with all of us that he had done
 18 everything that he possibly could, and we needed to
 19 consider either reporting VC as a missing person to the
 20 police or discharge, and we went on to have a discussion
 21 about a number of options.
 22 **Q.** So you had done all you could, there's nothing more you
 23 could do, and so the decision was made to discharge him.
 24 **A.** The decision was made to discharge because at that point
 25 in time we had no powers in the community. We didn't
 100

1 have any powers to compel him to attend appointments, we
2 didn't have any powers to compel him to take his
3 treatment. We'd tried for a nine-month period to do so.
4 It's a team that essentially was not capable or
5 resourced to manage someone like VC who was actively and
6 deliberately disengaging, changing addresses, telling us
7 he was abroad, us not being able to find him --

8 **Q.** You'd done all you could?

9 **A.** -- (*overspeaking*) -- Mum didn't know -- we felt that we
10 had done everything we could at that stage and we didn't
11 know what other options there were.

12 **Q.** Sure. Can we have the RiOs back on screen, please,
13 page 270. In the bottom of the page now, please.

14 So it's 31 August, the end of August, so after you'd
15 made the decision to discharge, on your evidence just
16 now, after you'd come to the point when you thought
17 you'd done all you could, you couldn't do anything else:

18 "Telephone conversation with Celeste ...

19 "[She'd] ... not seen [VC] face to face for many
20 months but she had a telephone conversation with him in
21 the last week. Celeste attempted to go and see [VC] but
22 he was not at the address she was familiar with.

23 "I feel [so this is Gary Carter] in the
24 circumstances I will arrange a visit with a colleague to
25 go out and see [VC] to determine his mental state and

101

1 **A.** At the end of the day, if Mr Carter comes along and says
2 to us "I've done everything that I can" then we have to
3 take him at his word. If he then decides that there's
4 more he feels he can do, it's -- it's -- yes, I don't
5 know. It's very odd. The timeline does not make sense
6 to me there.

7 **MR STRAW:** Thank you very much.

8 **THE CHAIR:** Thank you. Yes.

9 Yes, Ms Milligan.

10 **Questioned by MS MILLIGAN**

11 **MS MILLIGAN:** (*Unclear*) very brief lines of questioning, I'm
12 conscious of the time.

13 Dr Lloyd, I ask questions on behalf of Gary Carter.

14 Can I start with the issue of discharge that you've
15 just been discussing with Mr Straw.

16 **A.** Yes.

17 **Q.** If I could have please the RiO notes, the NHFT0000168
18 document. Just while they're loading, you gave evidence
19 that, at some time in August, there was a decision to
20 discharge that was subsequently rubber stamped. So the
21 first entry on this page is being entry by Mr Carter,
22 4 August, and I believe this is the one you were
23 referring to earlier, saying it was some time after this
24 entry that -- forgive me. You need the page number.
25 It's 270, it will come up in just one moment and it's

103

1 general wellbeing."

2 **A.** That should have happened as soon as we got the new
3 address, and in fact that was on the 9 August when we
4 got the new address, and so as soon as we got that,
5 there would have been a suggestion that Gary go and
6 visit VC at that new address. So I don't know why it's
7 taken another three weeks for Gary to decide at that
8 point that he will go and do a home visit, when we've
9 had the address for a significant length of time.

10 **Q.** This contradicts your evidence, doesn't it, you gave
11 just now?

12 **A.** Which evidence?

13 **Q.** Let me finish. This contradicts your evidence that you
14 gave just now --

15 **A.** Which is.

16 **Q.** -- that --

17 **A.** Gary had done everything that he can.

18 **THE CHAIR:** Just listen to the question.

19 **A.** Okay.

20 **MR STRAW:** This contradicts your evidence that you gave just
21 now which was that you decided to discharge him in
22 August 2022 because you as the team felt that you had
23 done all you could for him. And I suggest this
24 contradicts that because it shows that Mr Carter
25 considered there was more that could be done.

102

1 the first entry at the top of that screen. You say at
2 some point after this entry, that's when the decision
3 was made in MDT to discharge VC; is that right?

4 **A.** That's definitely what I believe because my recollection
5 is distinct and clear of Gary bringing the case to the
6 meeting for discussion and the discussion taking place
7 of discharge and I think versus reporting him to the
8 police. And, in fact, I think Gary says that it's
9 something that we need to consider and I don't think it
10 happened on the -- I don't think it happened around
11 4 August, I think it happened later, this --

12 **Q.** You say it was in August, sometime in August?

13 **A.** I think it was in August but I can't tell you exactly
14 when it was.

15 **Q.** All right, if we look down the page, just for your
16 reference, we heard that Gary went off unexpectedly on
17 carer's leave from 25 August 2022 but there's
18 a reference here on 31 August, at the bottom of the
19 page, to Gary nonetheless taking a telephone call from
20 Celeste -- you've just been through this with Mr Straw,
21 Celeste reporting:

22 "She has not seen [VC] face to face for many months
23 but she had a telephone conversation with him ...
24 attempted to go and see [VC] but he was not at the
25 address ..."

104

1 Then the final line:
2 "I feel in the circumstances I will arrange a visit
3 with a colleague to go out and see him to determine his
4 mental state and general wellbeing."

5 So my question is: even if -- and it's an if --
6 there had been a decision to discharge VC that was yet
7 to be "rubber stamped", in your words, this was
8 a material change that warranted consideration by the
9 team, wasn't it?

- 10 **A.** Say that again. What was a material change?
11 **Q.** VC's mother calling up and, in essence, expressing
12 concerns and VC's care coordinator saying, "In the
13 circumstances, I need to go out and visit him"? That
14 was a material change to whatever may have been
15 discussed earlier in August.
16 **A.** I think earlier in August, as soon as we got the new
17 address --
18 **Q.** Forgive me, I don't mean to be rude but we're tight on
19 time. That's not the question. I'm saying that if it
20 is the case that a decision has been made to discharge
21 VC, and it's an if, but let's proceed on that basis, by
22 31 August, there was a material change and it warranted
23 you and the other members of the EIP team to look again
24 and say, "Actually, before we rubber stamp this, is this
25 the right decision?" That's right, isn't it?

105

1 We see below the big redaction.
2 "VC ... gary has put this on rio 'I feel in the
3 circumstances I will arrange a visit with a colleague to
4 go out and see [VC] to determine his mental state and
5 general wellbeing.' Discuss MDT".

6 So the team, the broader team certainly didn't think
7 he'd been discharged, they're referring to VC as
8 a patient that needed to be discussed at MDT.

9 So he hadn't been discharged at this point, had he?

- 10 **A.** But as far as I'm concerned, the decision to discharge
11 had been taken. It's just he hadn't been discharged.
12 We had the conversation. But it doesn't look as though
13 the paperwork was done.

14 I honestly I don't know, but I can tell you for
15 a fact that I remember that meeting specifically, and it
16 may be that we had the discussion but then a decision
17 was taken after that not to discharge him. I haven't --
18 I really don't know but I know what I remember. And
19 I remember Gary specifically coming into the room and
20 saying, "I have done everything that I can," and us
21 talking -- the whole team talking about all the options.

22 And if you look at Gary's witness statement, again,
23 in there he states that he comes in to the MDT, and he
24 believes it's in August, and he says, "I have done
25 everything that I can."

107

1 **A.** I don't think I was aware of this particular entry from
2 the 31st.

3 **Q.** You didn't look at the RiO notes prior to the MDT --
4 (*overspeaking*) -- meeting to discharge VC.

5 **A.** No, because I thought the discharge had actually -- the
6 discharge decision had been taken. So no.

7 If I believed at that he's actually been discharged
8 already, it seems odd to then go back and look at the
9 notes.

10 **Q.** So even if it's yet to be rubber stamped, it's your
11 evidence that you don't need to look at the RiO notes?

12 **A.** If all we're doing is a process of administration, yes,
13 this person has been discharged, but Gary hasn't got
14 round doing the paperwork then yes, I wouldn't
15 necessarily go back and specifically look at the notes
16 because, as far as I'm concerned, that discharge
17 decision has taken place.

18 **Q.** Could I take you to another document, please,
19 NHFT0018512. And this is an email, you're not copied in
20 it, just to be clear.

21 **A.** Oh right.

22 **Q.** But this is from Ms Parsonage dated 8 September:

23 "Hi all,

24 "Looked at Gary's patients here's what we've got
25 over the next few weeks ..."

106

1 And it's at that point where we go through all the
2 options and discharge becomes something very prominent.
3 And it is there in his witness statement because I read
4 it, because I was questioning: this is odd, the timeline
5 doesn't look right. And when I looked at Gary's
6 statement and I actually saw those words.

7 **Q.** All right, one more document, please. Just building on
8 this. NHFT0018292. This is a week later,
9 16 September '22.

10 It's another cover email so there's been an MDT to
11 discuss what Gary had written on VC's RiO records. A
12 week later Ms Parsonage again emailing round:

13 "Here is the cover for next week."

14 If I could just pop down, later down that at page,
15 please. It may be on the next page, forgive me. There
16 we go, we see one of Gary's patients:

17 "VC -- discuss Tuesday discharge".

18 So there were discussions, weren't there, in MDT in
19 September about VC, and those culminated in the decision
20 on 23 September 2022 to discharge VC. That didn't take
21 place at an earlier date. You are simply wrong about
22 that.

23 **A.** "discuss Tuesday discharge". Well, we don't have MDTs
24 on a Tuesday.

25 **Q.** That's not the question I'm putting to you. I think

108

1 I've put it, and --

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

3 **A.** All right.

4 **THE CHAIR:** We've got the point.

5 **MS MILLIGAN:** Thank you.

6 **THE CHAIR:** Yes. Ms Patry, do you want to raise anything?

7 **Questioned by MS PATRY**

8 **MS PATRY:** Thank you, Dr Lloyd, I ask questions on behalf of

9 the University of Nottingham's.

10 **A.** Okay.

11 **Q.** Three very short topics.

12 **A.** Sure.

13 **Q.** At paragraph 160 of your statement which I can turn up

14 if it's helpful. WITN0357001, page 56. You seem to --

15 I'll give you a moment to look at it.

16 Can you just cast your eye over paragraph 160. You

17 appeared to suggest that you considered the incident at

18 the University on 15 January, the assault on the family,

19 had not been triggered by psychosis. Do you see that,

20 where you've written that?

21 **A.** Yes.

22 **Q.** Now, the University's position is that it was never told

23 that and the question I have for you is: did you at any

24 stage inform the University of that or instruct anyone

25 else, including Claudia Birtles, to tell the University

109

1 not been detained immediately. Would you like to see

2 that?

3 **A.** Sure.

4 **Q.** It's NGPF0003312, and we are looking at the bottom of

5 page 5 and top of page 6. Page 5, going over to 6.

6 Sorry, I can't see the page very clearly,

7 "Discussion with Ellie, [University] Mental Health":

8 "Ellie ... advised there was ambiguity re [VC]

9 residence at Raleigh Park, meaning that he may not be

10 allowed to go back through disciplinary procedures ...

11 Dr Skelton provided some input to Ellie, advising that

12 a community plan is the least restrictive option ..."

13 I'm not going to read it all but the very last part

14 of it:

15 "... it was emphasised [by Dr Skelton] that

16 stability for [VC] was important to the community plan

17 being successful."

18 So that's what the psychiatrist had advised and

19 that's what was contained in the AMHP report. The

20 question I have for you, Dr Lloyd, is: do you agree,

21 given your knowledge of VC at this relevant time -- this

22 is January 2022 -- do you agree that it was important

23 for VC to remain as stable as possible in order for the

24 community plan to be successful?

25 **A.** Yes.

111

1 that?

2 **A.** The reason why I have considered that it wasn't driven

3 by psychosis was because --

4 **Q.** Sorry, forgive me. I have five minutes. It's not about

5 why you reached that conclusion. Did you ever inform

6 the University of that conclusion or instruct anyone

7 else to inform the University of that conclusion?

8 **A.** That I didn't think it was driven by --

9 **Q.** Driven by psychosis.

10 **A.** I would have expected that the individuals that carried

11 out the Mental Health Act Assessment who have written

12 that down, the ward that couldn't find any psychosis

13 would have had liaison with the University --

14 **THE CHAIR:** You were asked a specific question as to whether

15 you didn't -- (*overspeaking*) --

16 **A.** No, I didn't because it wasn't something that I had any

17 first-hand knowledge of. It was just something that I'd

18 picked up from the notes.

19 **MS PATRY:** I am very grateful for that answer.

20 The second question I want to ask you is about, at

21 the time of the Mental Health Act Assessment that took

22 place around 19th January. The relevant AMHP report --

23 again, I can turn it up but I don't have much time --

24 reports that the advice from the psychiatrist was to

25 tell the University to keep VC stable, given that he had

110

1 **Q.** Thank you. Then finally, please, in a number of places

2 in your witness statement you seem to suggest that the

3 University mental health services didn't inform you of

4 any incidents during the relevant period. I'm going to

5 ask if you could please look at paragraph 283. That's

6 back at WITN0357001 at page 103.

7 So if I can situate you in time here, because it's

8 a very long statement, you're addressing the period

9 December 2021 here, and you can see that if you scroll

10 back up but in the interests of time please take it from

11 me that you're talking about a period December 2021

12 here.

13 **A.** Mm-hm.

14 **Q.** You appeared to be saying, right at the bottom of that

15 paragraph:

16 "The University Mental Health Advisory Service had

17 not shared any concerns regarding VC at this time."

18 If I can just ask you this question. The University

19 was wholly unaware that VC had committed an assault on

20 PC Pritchard; it was wholly unaware that he'd been

21 admitted to hospital after that assault; and in fact, we

22 can't see that there was any communication between

23 mental health services and the University at all until

24 January 2022.

25 So what I want to know is: what incident or concern

112

1 do you say should have been communicated by the Mental
 2 Health Advisory Service during that period?
 3 **A.** I think I was just suggesting that, if there had been
 4 an incident or anything untoward, that we perhaps might
 5 have heard from the University. It was no more than
 6 that.
 7 **Q.** All right so it's not a suggestion that we failed to do
 8 anything?
 9 **A.** Not at all, no.
 10 **Q.** Given that the NHS held the risk in relation to VC, do
 11 you accept that you or your team should have told the
 12 University, or arranged for the University to be told,
 13 about all the issues which took place between
 14 September 2021 and 15 January 2022? So that's the
 15 assault, that's the admission, and that's the -- we've
 16 heard extensive evidence on it today, that's all the
 17 failures that your team had in either engaging VC or
 18 treating him during the relevant period. Wasn't that
 19 something that you and your team needed to tell the
 20 University?
 21 **A.** I think, in retrospect, yes, that ought to have
 22 happened. We ought to have said at that point, when we
 23 found that he'd completely disengaged, I think he was
 24 seeing Claudia right up to sort of December, but yes,
 25 after that, there was a disengagement, and yes, there

113

1 assessment of the risk of something happening and they
 2 were saying there was serious risks. Do you disagree
 3 that there were serious risks rather than a serious
 4 incident?
 5 **A.** Now that you frame it in that way, I can see that, yes,
 6 there are risks that are serious.
 7 **THE CHAIR:** It's not how I'm framing it. I just want to
 8 know whether you were considering it in that way, about
 9 risks of things happening rather than incidents --
 10 **A.** Yes.
 11 **THE CHAIR:** -- which had happened.
 12 **A.** We recognised that there were definite risks with VC.
 13 **THE CHAIR:** Just finally in relation to what you've just
 14 gone through, in relation to your recollection that in
 15 fact VC was discharged in September, I think you told
 16 the Inquiry that it would be for the care coordinator to
 17 bring a case to the MDT; is that right?
 18 **A.** That's what normally happens. The care coordinators go
 19 through their caseload and they -- if there's
 20 individuals that they feel need to be discussed and,
 21 generally speaking, I think Gary Carter always
 22 discussed -- I think he pretty much discussed all of his
 23 cases, to be fair.
 24 **THE CHAIR:** The only care coordinator present that we know
 25 about on 22 September when there is this note of the

115

1 should have been better communication with the
 2 University -- (*overspeaking*) --
 3 **Q.** Were there any barriers to communication between your
 4 team in the University?
 5 **A.** I don't think so and I don't know why, you know. I also
 6 take responsibility. I don't know why there wasn't that
 7 communication. That should have happened.
 8 **MS PATRY:** I'm really very grateful for that answer. Thank
 9 you. Those are my questions.
 10 **Questioned by THE CHAIR**
 11 **THE CHAIR:** Yes, just one question, Dr Lloyd.
 12 **A.** Yes.
 13 **THE CHAIR:** You said at one stage when you were asked about
 14 risk, you said about the tribunal ruling. You said that
 15 you didn't think you ever saw the ruling and you were
 16 asked about it where it says that the risks were
 17 serious. I think you said the only time the risks had
 18 been serious was in relation to PC Pritchard. That's
 19 right?
 20 **A.** At that point, yes, I felt that that was a very serious
 21 incident.
 22 **THE CHAIR:** There's a difference, isn't there, between the
 23 risk of something happening and it actually happening?
 24 **A.** Yes.
 25 **THE CHAIR:** What you were being asked about there was the

114

1 discharge was Abi Parsonage, who says she was only there
 2 for about 15 minutes. So who brought that case to the
 3 MDT?
 4 **A.** That's what I don't know. That seems --
 5 **THE CHAIR:** Well, I'm going to ask whether it was you.
 6 **A.** No, absolutely not because I thought he'd already been
 7 discharged.
 8 **THE CHAIR:** I see. Thank you.
 9 Right, we'll finish there for today and start again
 10 tomorrow morning at 10.00.
 11 **(5.00 pm)**
 12 **(The hearing adjourned until 10.00 am the following day)**
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116

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22
23
24
25

INDEX

| | Page |
|-----------------------------------|------|
| Questioned by MR MOLONEY | 62 |
| Questioned by MS CARTWRIGHT | 74 |
| Questioned by MR STRAW | 91 |
| Questioned by MS MILLIGAN | 103 |
| Questioned by MS PATRY | 109 |
| Questioned by THE CHAIR | 114 |

| | | | | |
|--|--|---|--|--|
| <p>MR MOLONEY: [2] 63/1 74/14</p> <p>MR STRAW: [5] 91/10 94/10 100/5 102/20 103/7</p> <p>MS CARTWRIGHT: [2] 74/17 91/6</p> <p>MS LANGDALE: [3] 1/3 62/15 100/1</p> <p>MS MILLIGAN: [2] 103/11 109/5</p> <p>MS PATRY: [3] 109/8 110/19 114/8</p> <p>THE CHAIR: [22] 62/18 62/24 74/15 91/3 91/7 94/5 102/18 103/8 109/2 109/4 109/6 110/14 114/11 114/13 114/22 114/25 115/7 115/11 115/13 115/24 116/5 116/8</p> <hr/> <p>'22 [1] 108/9 'cutting [1] 37/12 'family [1] 64/15 'I [1] 107/2 'I feel [1] 107/2 'it [1] 1/10 'stressing [1] 37/5</p> <hr/> <p>...read [1] 64/2</p> <hr/> <p>1</p> <p>1 August [2] 85/17 85/18</p> <p>1 September [1] 5/4</p> <p>10 [1] 14/23</p> <p>10 am [1] 85/15</p> <p>10 February [1] 45/4</p> <p>10 January [3] 37/18 38/2 38/3</p> <p>10 milligrams [1] 31/25</p> <p>10 November [1] 15/17</p> <p>10.00 [2] 116/10 116/12</p> <p>103 [1] 112/6</p> <p>11 [1] 51/12</p> <p>11 am [1] 85/19</p> <p>11th [1] 64/22</p> <p>12 hours [3] 75/22 78/4 80/2</p> <p>12 noon [1] 37/19</p> <p>125 [2] 82/4 82/5</p> <p>13 [3] 18/5 18/13 28/1</p> <p>13 June [2] 50/22 85/12</p> <p>138 [1] 15/16</p> <p>13th [1] 64/22</p> <p>13th June [1] 85/11</p> <p>14 [4] 8/9 30/2 32/6</p> | <p>47/12</p> <p>14 March [1] 97/24</p> <p>143 [1] 97/23</p> <p>145 [2] 3/9 3/10</p> <p>15 [6] 10/23 18/10 18/12 71/11 109/18 116/2</p> <p>15 January 2022 [1] 113/14</p> <p>15 March [1] 18/7</p> <p>15 November [1] 30/23</p> <p>157 [2] 20/17 20/19</p> <p>159 [1] 21/10</p> <p>16 December 2021 [1] 36/24</p> <p>16 July 2020 [1] 1/4</p> <p>16 September '22 [1] 108/9</p> <p>160 [2] 109/13 109/16</p> <p>163 [1] 22/14</p> <p>167 [1] 22/20</p> <p>168 [1] 29/18</p> <p>17 January [1] 38/22</p> <p>18 August 2022 [1] 52/12</p> <p>18 January [2] 39/13 39/21</p> <p>19 January [2] 40/21 41/2</p> <p>19 November [1] 31/21</p> <p>195 [2] 29/18 29/20</p> <p>198 [3] 30/22 30/23 30/24</p> <p>199 [2] 31/21 31/22</p> <p>19th [1] 110/22</p> <hr/> <p>2</p> <p>2 years [1] 46/23</p> <p>2.00 [1] 1/2</p> <p>2.5 [1] 64/4</p> <p>20 [1] 69/4</p> <p>20 milligrams [1] 32/1</p> <p>20 minutes' [1] 49/6</p> <p>201 [1] 36/23</p> <p>202 [1] 37/17</p> <p>2020 [10] 1/4 5/4 9/1 9/22 13/15 14/4 28/20 69/4 98/23 98/25</p> <p>2021 [28] 3/7 8/25 9/5 9/11 9/23 10/1 11/13 13/15 18/5 18/6 18/10 18/14 20/4 20/18 28/25 29/5 29/12 36/24 78/16 82/18 88/3 88/13 88/17 89/22 96/13 112/9 112/11 113/14</p> <p>2021/2022 [1] 88/15</p> <p>2022 [25] 37/18 41/21 45/4 47/12 52/12 70/19 71/7 71/8 82/19 88/15 92/5</p> | <p>94/12 97/24 99/3 99/10 100/1 100/2 100/3 100/13 102/22 104/17 108/20 111/22 112/24 113/14</p> <p>2023 [5] 61/18 69/1 69/3 69/8 91/12</p> <p>2024 [1] 61/19</p> <p>2025 [1] 61/2</p> <p>2026 [1] 1/1</p> <p>203 [1] 38/22</p> <p>209 [2] 70/10 71/14</p> <p>21 February 2022 [1] 71/8</p> <p>21 January [1] 40/23</p> <p>210 [2] 99/2 99/3</p> <p>22 [1] 82/10</p> <p>22 September [1] 115/25</p> <p>223 [1] 93/10</p> <p>225 [1] 41/20</p> <p>226 [1] 41/23</p> <p>22nd [1] 72/24</p> <p>22nd September [2] 83/12 83/14</p> <p>23 [1] 82/7</p> <p>23 September [2] 57/13 57/14</p> <p>23 September 2022 [1] 108/20</p> <p>239 [1] 45/3</p> <p>24 January [1] 99/3</p> <p>25 August [1] 104/17</p> <p>25 October [1] 29/20</p> <p>25-35 [1] 77/25</p> <p>250 [2] 46/16 46/19</p> <p>251 [2] 46/20 46/22</p> <p>255 [1] 23/24</p> <p>26 July 2022 [1] 70/19</p> <p>263 [1] 47/11</p> <p>267 [2] 50/20 85/10</p> <p>269 [1] 85/17</p> <p>27 February [1] 61/2</p> <p>270 [3] 51/13 101/13 103/25</p> <p>271 [1] 54/15</p> <p>28 [3] 8/8 14/23 92/4</p> <p>28 January [1] 99/9</p> <p>283 [1] 112/5</p> <p>29 November [1] 32/4</p> <p>2:1 [3] 98/13 98/18 98/22</p> <p>2nd [1] 18/9</p> <hr/> <p>3</p> <p>3 August [1] 87/6</p> <p>3 February [1] 41/21</p> <p>3.28 [1] 62/21</p> <p>3.44 [1] 62/23</p> <p>3.45 [1] 62/19</p> <p>31 August [5] 24/17 97/7 101/14 104/18 105/22</p> <p>31 July [1] 8/25</p> | <p>31st [1] 106/2</p> <p>33 [1] 17/19</p> <p>34 [2] 17/20 17/20</p> <p>347 [1] 82/5</p> <p>35 [1] 77/25</p> <hr/> <p>4</p> <p>4 August [3] 51/13 103/22 104/11</p> <p>40 [1] 77/25</p> <p>4725 [1] 89/22</p> <p>4th [2] 37/20 46/23</p> <hr/> <p>5</p> <p>5.00 [1] 116/11</p> <p>50 per [1] 86/6</p> <p>56 [1] 109/14</p> <hr/> <p>6</p> <p>6 December [1] 32/5</p> <p>64 [1] 1/6</p> <hr/> <p>7</p> <p>7 September [1] 88/13</p> <p>72 [1] 1/5</p> <hr/> <p>8</p> <p>8 September [1] 106/22</p> <hr/> <p>9</p> <p>9 August [4] 9/11 11/19 51/22 102/3</p> <p>9 August 2021 [1] 20/18</p> <hr/> <p>A</p> <p>Abi [1] 116/1</p> <p>Abigail [1] 82/11</p> <p>ability [2] 73/17 80/2</p> <p>able [16] 7/2 15/10 23/12 39/1 41/9 53/18 58/13 58/14 58/14 66/12 66/15 66/18 96/9 96/23 97/13 101/7</p> <p>about [125]</p> <p>above [3] 26/8 39/3 39/22</p> <p>abroad [1] 101/7</p> <p>absolutely [11] 2/5 10/22 14/15 26/11 43/22 48/12 58/19 62/14 65/20 83/22 116/6</p> <p>accept [7] 48/11 56/23 58/15 70/14 71/21 97/9 113/11</p> <p>accepted [1] 56/22</p> <p>access [6] 23/13 27/4 51/23 52/13 64/1 64/10</p> <p>accesses [1] 14/17</p> <p>accommodation [1] 40/1</p> | <p>accordance [4] 6/17 9/5 12/17 85/23</p> <p>according [2] 16/2 43/3</p> <p>accurate [2] 66/2 78/22</p> <p>achieved [1] 98/12</p> <p>across [11] 12/13 59/12 62/2 62/3 62/8 75/5 75/5 76/14 77/1 80/15 80/23</p> <p>act [23] 4/4 16/1 16/5 22/18 23/8 24/10 33/1 33/9 33/13 33/14 34/14 35/3 40/5 40/8 40/12 40/14 40/18 41/11 41/18 47/25 72/17 110/11 110/21</p> <p>acted [1] 23/25</p> <p>actions [10] 2/2 5/10 5/14 9/24 10/5 34/18 77/16 79/2 87/16 89/10</p> <p>actively [5] 9/13 9/15 58/5 82/20 101/5</p> <p>acts [1] 4/20</p> <p>actual [3] 3/25 55/9 66/13</p> <p>actually [29] 3/24 5/6 9/20 16/15 26/7 28/15 28/25 32/25 50/18 51/15 53/24 55/20 55/23 56/2 67/3 71/7 77/6 80/17 84/8 85/22 87/12 87/15 87/22 99/14 105/24 106/5 106/7 108/6 114/23</p> <p>add [1] 65/1</p> <p>address [18] 51/15 51/24 51/25 52/8 52/9 52/11 52/17 52/22 70/13 70/24 71/11 101/22 102/3 102/4 102/6 102/9 104/25 105/17</p> <p>addresses [5] 52/6 70/10 70/12 73/18 101/6</p> <p>addressing [1] 112/8</p> <p>Adele [3] 39/22 40/3 82/12</p> <p>adequate [1] 18/4</p> <p>adequately [1] 18/2</p> <p>adjourned [1] 116/12</p> <p>adjusted [1] 7/25</p> <p>adjustment [1] 8/2</p> <p>administered [1] 56/16</p> <p>administering [1] 44/2</p> <p>administration [1] 106/12</p> <p>administrative [6] 19/19 60/20 72/3 75/6 79/25 80/12</p> <p>admission [28] 25/21</p> |
|--|--|---|--|--|

| | | | | |
|--|---|---|--|--|
| A | 81/6 85/21 111/20 111/22 | annually [1] 11/12 | 89/15 100/8 | 25/2 27/5 27/9 27/20 |
| admission... [27] | agreed [9] 2/4 5/6 5/21 10/13 19/17 25/23 26/10 26/10 79/2 | another [14] 21/2 31/13 35/17 37/18 51/10 62/11 85/17 85/20 89/20 90/6 94/10 102/7 106/18 108/10 | appointments [12] 19/1 19/16 19/20 32/7 32/19 36/16 37/9 48/13 50/24 51/1 58/16 101/1 | 27/24 28/6 31/2 31/5 31/11 32/2 33/15 33/15 35/6 36/1 37/4 38/25 40/10 41/16 42/21 44/13 44/13 45/7 45/22 46/19 46/25 47/6 50/14 51/21 52/1 53/5 53/14 54/15 56/9 58/7 58/9 58/10 58/13 58/13 58/24 59/6 59/11 59/16 65/18 65/20 66/5 70/16 71/9 71/13 71/23 72/10 72/10 75/4 75/4 76/3 76/23 78/13 79/7 79/9 79/21 79/22 80/1 80/4 81/1 81/10 82/14 82/16 83/10 84/4 84/8 84/8 84/13 86/2 86/23 86/23 90/18 93/6 93/6 95/9 96/10 96/25 99/18 100/19 102/2 102/2 102/4 102/4 102/22 105/16 105/16 106/16 106/16 107/7 107/10 107/10 107/12 110/14 111/23 111/23 |
| 27/16 28/14 31/25 41/20 42/21 45/20 46/21 46/23 47/23 48/17 48/19 49/10 49/13 50/19 51/6 71/4 71/5 71/6 72/17 91/21 91/24 92/1 92/11 92/18 92/25 93/7 113/15 | aimed [1] 91/16 | answered [3] 12/7 66/23 69/14 | appreciable [1] 45/21 | 81/10 82/14 82/16 83/10 84/4 84/8 84/8 84/13 86/2 86/23 86/23 90/18 93/6 93/6 95/9 96/10 96/25 99/18 100/19 102/2 102/2 102/4 102/4 102/22 105/16 105/16 106/16 106/16 107/7 107/10 107/10 107/12 110/14 111/23 111/23 |
| admissions [3] 1/16 38/7 53/9 | all [72] 6/18 8/25 9/12 10/8 12/18 16/14 17/18 19/2 22/10 23/10 24/14 26/23 29/11 38/8 47/2 50/3 51/4 52/7 58/2 59/10 59/17 60/2 60/3 60/5 60/14 60/18 64/2 65/16 65/22 68/3 68/6 68/7 72/13 74/24 75/14 75/15 75/23 75/24 76/21 77/2 77/23 78/3 81/10 81/12 82/13 86/3 87/16 93/24 94/3 95/3 95/8 97/1 97/1 100/17 100/22 101/8 101/17 102/23 104/15 106/12 106/23 107/21 108/1 108/7 109/3 111/13 112/23 113/7 113/9 113/13 113/16 115/22 | answers [1] 66/1 | appropriate [2] 18/23 35/1 | 81/10 82/14 82/16 83/10 84/4 84/8 84/8 84/13 86/2 86/23 86/23 90/18 93/6 93/6 95/9 96/10 96/25 99/18 100/19 102/2 102/2 102/4 102/4 102/22 105/16 105/16 106/16 106/16 107/7 107/10 107/10 107/12 110/14 111/23 111/23 |
| admitted [3] 17/23 92/19 112/21 | allocated [1] 75/23 | answering [1] 65/24 | April [2] 18/6 18/14 | ascertain [1] 97/18 |
| adult [1] 77/1 | allowed [1] 111/10 | answers [1] 66/1 | April 2021 [2] 18/6 18/14 | aside [1] 89/17 |
| advance [2] 63/17 63/22 | almost [5] 48/21 52/6 86/6 86/9 86/18 | antipsychotic [2] 2/19 7/17 | aptly [1] 81/2 | ask [13] 15/6 53/6 62/16 65/25 71/17 73/24 74/17 103/13 109/8 110/20 112/5 112/18 116/5 |
| advanced [1] 3/24 | alone [1] 16/15 | any [50] 1/25 9/22 9/24 23/5 30/10 31/1 31/15 31/15 35/10 36/9 37/4 39/7 39/10 41/9 43/16 45/12 45/20 47/14 48/18 48/19 57/6 67/11 68/13 70/12 72/3 73/2 73/8 81/19 86/3 86/10 90/23 92/20 93/1 93/5 95/1 95/2 95/14 95/22 96/11 96/18 97/2 101/1 101/2 109/23 110/12 110/16 112/4 112/17 112/22 114/3 | are [80] 4/1 5/19 6/18 7/9 7/9 7/16 8/10 8/11 10/7 10/9 10/24 11/11 11/21 13/17 16/15 18/1 19/8 23/9 27/6 27/10 27/10 27/19 28/3 28/6 28/12 31/19 32/18 32/18 33/1 34/12 34/20 36/5 36/7 36/9 37/18 37/25 39/7 41/17 41/24 42/1 44/10 44/19 45/2 46/24 48/25 49/23 51/3 51/5 53/8 53/23 54/4 62/15 66/8 67/2 73/23 74/3 74/5 77/17 77/24 78/1 78/5 78/9 79/12 79/16 79/19 80/8 81/12 86/12 86/13 86/19 87/13 87/16 87/25 89/4 95/4 108/21 111/4 114/9 115/6 115/6 | asked [26] 3/22 17/12 22/3 35/7 37/2 40/3 42/2 42/5 52/25 53/17 61/4 61/14 64/13 66/17 66/19 66/20 71/18 76/15 76/16 94/25 95/1 95/14 110/14 114/13 114/16 114/25 |
| advantage [1] 57/24 | along [1] 103/1 | anybody [2] 18/16 69/2 | area [1] 100/12 | asking [13] 19/5 20/7 54/2 54/20 67/25 68/20 70/1 71/3 72/19 76/19 90/14 90/15 96/24 |
| advice [2] 21/17 110/24 | alongside [1] 8/16 | anyone [4] 18/8 66/9 109/24 110/6 | aren't [2] 6/17 12/3 | aspects [1] 63/15 |
| advised [2] 111/8 111/18 | already [6] 12/7 24/24 27/13 49/16 106/8 116/6 | anything [15] 5/7 6/2 7/25 20/5 45/11 47/20 50/9 58/18 65/1 68/24 86/5 101/17 109/6 113/4 113/8 | arguably [1] 16/22 | assault [7] 22/18 27/20 39/16 109/18 112/19 112/21 113/15 |
| advising [1] 111/11 | also [17] 1/14 10/13 19/3 19/19 24/5 34/1 37/21 39/21 39/24 48/17 81/20 83/25 91/24 94/13 94/23 97/7 114/5 | anyway [2] 8/4 25/2 | argue [1] 45/24 | assaulted [3] 20/9 22/23 23/14 |
| Advisory [2] 112/16 113/2 | altercation [2] 48/2 49/14 | anywhere [3] 45/14 90/22 92/13 | aripiprazole [4] 3/19 31/24 85/14 85/19 | assaults [1] 29/5 |
| after [36] 2/14 18/14 23/7 25/21 26/6 29/19 35/9 36/2 36/4 40/10 40/22 43/7 43/13 52/14 54/6 55/13 56/15 68/7 68/9 71/4 71/5 73/14 78/15 84/9 91/11 91/23 92/18 95/13 100/8 101/14 101/16 103/23 104/2 107/17 112/21 113/25 | always [7] 12/1 65/20 81/13 83/7 84/10 91/1 115/21 | apart [2] 49/20 72/23 | arise [1] 20/15 | asserted [1] 16/18 |
| afternoon [3] 63/1 63/2 74/17 | am [8] 59/16 78/12 79/11 82/14 85/15 85/19 110/19 116/12 | apologise [1] 69/6 | arising [1] 29/9 | assertive [4] 35/7 45/15 73/16 92/20 |
| afterwards [4] 8/11 24/25 61/20 98/23 | ambiguity [1] 111/8 | appalling [1] 60/3 | arose [1] 40/25 | assess [2] 8/19 31/10 |
| again [32] 1/9 1/22 3/13 14/25 17/13 21/11 28/19 37/13 41/11 45/10 48/4 48/22 50/2 53/23 54/1 57/18 62/19 64/3 84/13 84/14 85/2 85/18 87/3 88/5 98/9 99/12 105/10 105/23 107/22 108/12 110/23 116/9 | AMHP [4] 34/12 92/5 110/22 111/19 | apparent [2] 8/6 52/1 | around [12] 7/19 8/12 9/6 10/15 13/14 34/3 34/16 38/16 56/5 57/23 104/10 110/22 | assessed [2] 18/6 70/15 |
| again' [1] 1/10 | AMHPs [1] 40/4 | apparently [4] 28/16 28/20 68/5 99/23 | arrange [3] 101/24 105/2 107/3 | assessing [2] 19/8 41/9 |
| against [6] 15/5 24/12 24/15 25/9 61/5 64/15 | Amie [1] 24/24 | appear [1] 99/5 | arranged [2] 85/20 113/12 | |
| aggression [1] 40/18 | amount [2] 30/3 75/16 | appeared [2] 109/17 112/14 | arranging [1] 35/2 | |
| agitated [1] 73/4 | ample [1] 64/2 | appears [1] 71/13 | as [114] 3/19 4/1 5/19 7/14 8/20 13/23 14/10 14/15 14/15 18/24 19/8 19/22 19/23 20/25 21/3 25/1 | |
| ago [4] 14/21 40/1 99/20 99/25 | anchors [1] 83/10 | application [1] 26/20 | | |
| agree [17] 1/13 3/25 4/5 4/24 25/25 27/7 37/11 38/12 45/13 60/6 77/9 77/21 78/25 | angry [2] 36/25 47/24 | applied [2] 52/13 85/5 | | |

| | | | | |
|---|---|--|---|--|
| <p>A</p> <p>assessment [53] 5/23 5/25 10/3 10/5 10/9 11/21 11/25 12/10 12/17 12/19 13/1 13/5 13/9 13/10 13/12 13/13 16/1 16/5 19/14 22/10 23/8 23/9 24/10 31/12 33/1 33/9 33/13 34/14 35/3 40/5 40/9 40/12 40/14 40/21 40/23 40/25 41/12 47/25 85/25 87/20 87/21 87/22 89/24 90/2 90/3 90/10 90/12 90/20 90/21 99/10 110/11 110/21 115/1</p> <p>assessments [4] 19/7 50/8 90/18 96/3</p> <p>associating [1] 70/23</p> <p>assumed [2] 15/9 84/7</p> <p>assumption [1] 29/8</p> <p>at [226]</p> <p>attached [3] 44/9 60/19 83/13</p> <p>attack [3] 24/1 27/12 27/17</p> <p>attacked [3] 52/25 53/1 53/10</p> <p>attacks [1] 91/12</p> <p>attempted [3] 52/21 101/21 104/24</p> <p>attempting [1] 1/20</p> <p>attempts [1] 55/2</p> <p>attend [19] 11/20 20/19 20/20 20/21 30/23 30/24 31/7 31/10 32/5 32/19 37/19 38/2 50/21 85/4 85/6 85/19 87/8 87/20 101/1</p> <p>attendance [3] 82/13 82/14 86/1</p> <p>attendant [1] 37/25</p> <p>attended [1] 68/15</p> <p>attending [5] 22/15 31/2 34/17 77/17 85/14</p> <p>attends [3] 9/13 41/21 46/21</p> <p>attention [1] 85/9</p> <p>audit [1] 62/3</p> <p>audits [1] 61/24</p> <p>August [36] 9/11 11/19 20/18 24/17 51/10 51/13 51/22 52/12 55/17 71/7 71/9 72/11 81/9 82/24 85/17 85/18 87/6 94/12 97/7 100/13 101/14 101/14 102/3 102/22 103/19 103/22 104/11 104/12 104/12</p> | <p>104/13 104/17 104/18 105/15 105/16 105/22 107/24</p> <p>August 2022 [4] 71/7 94/12 100/13 102/22</p> <p>authorised [1] 44/15</p> <p>authority [2] 59/7 59/9</p> <p>autonomously [1] 7/3</p> <p>availability [1] 64/22</p> <p>available [4] 12/22 23/10 30/6 80/14</p> <p>avoid [1] 3/15</p> <p>avoided [1] 84/1</p> <p>avoiding [1] 69/21</p> <p>aware [13] 20/4 21/1 31/25 44/13 49/18 50/12 52/1 52/5 75/4 93/6 93/9 96/10 106/1</p> <p>away [2] 21/8 60/4</p> | <p>108/4 110/3 110/16 112/7 116/6</p> <p>become [7] 3/13 21/15 38/7 38/17 43/15 69/19 69/20</p> <p>becomes [2] 41/10 108/2</p> <p>becoming [2] 21/9 42/22</p> <p>been [139]</p> <p>before [22] 2/19 6/4 8/11 11/13 11/19 25/13 28/6 39/8 49/25 54/15 55/10 61/19 62/16 69/8 71/25 72/1 81/7 81/24 82/24 84/2 88/5 105/24</p> <p>beginning [3] 5/5 19/4 79/24</p> <p>behalf [5] 3/18 36/18 74/18 103/13 109/8</p> <p>behave [1] 14/11</p> <p>behaves [1] 27/4</p> <p>behaviour [4] 1/19 4/23 5/1 50/18</p> <p>behavioural [1] 10/14</p> <p>behaviours [5] 5/16 9/7 10/4 10/7 10/11</p> <p>being [33] 12/25 16/16 16/17 16/18 19/21 20/13 31/4 31/5 49/19 52/14 55/15 58/5 59/21 62/9 70/16 70/19 73/2 75/5 75/10 76/22 77/3 77/17 78/19 78/20 79/5 79/6 79/8 84/15 96/18 101/7 103/21 111/17 114/25</p> <p>belief [3] 24/12 25/8 92/10</p> <p>beliefs [1] 25/7</p> <p>believe [16] 3/5 10/2 27/12 27/14 41/13 50/10 66/3 68/6 69/11 72/24 75/13 76/11 88/21 88/22 103/22 104/4</p> <p>believed [2] 66/12 106/7</p> <p>believes [2] 29/22 107/24</p> <p>below [1] 107/1</p> <p>Ben [2] 24/6 24/6</p> <p>Ben Lomas' [1] 24/6</p> <p>beneficial [1] 42/8</p> <p>benefit [1] 25/22</p> <p>best [2] 25/12 66/2</p> <p>better [4] 25/12 46/24 58/1 114/1 95/18 96/3 96/17 96/22 97/1 97/10 97/11 97/14 100/24 102/22 102/24 104/4 106/5 106/16 108/3</p> | <p>114/22</p> <p>beyond [2] 50/2 68/14</p> <p>big [1] 107/1</p> <p>Bilal [1] 15/17</p> <p>Birtles [29] 3/5 5/20 5/21 8/7 8/16 12/10 12/20 12/23 13/6 24/4 25/16 25/18 29/20 29/23 30/4 30/12 31/2 31/22 38/4 38/13 41/21 47/6 50/5 61/2 64/12 90/8 91/23 99/4 109/25</p> <p>bit [4] 9/2 86/15 92/22 95/4</p> <p>black [1] 70/18</p> <p>Blackwood [1] 28/22</p> <p>blood [1] 42/14</p> <p>body [1] 22/24</p> <p>body-worn [1] 22/24</p> <p>book [3] 19/1 19/16 20/22</p> <p>booked [3] 9/10 19/21 21/2</p> <p>books [1] 57/25</p> <p>both [8] 1/15 19/18 24/3 38/16 47/8 65/8 66/14 72/20</p> <p>bother [1] 81/3</p> <p>bottom [16] 3/12 5/8 14/5 15/18 20/19 21/14 22/14 30/22 30/25 47/13 50/20 85/12 101/13 104/18 111/4 112/14</p> <p>box [9] 6/9 20/20 22/14 31/22 32/4 38/23 47/13 55/1 56/24</p> <p>break [5] 58/21 62/16 62/18 62/19 62/22</p> <p>brief [2] 78/23 103/11</p> <p>briefly [1] 69/11</p> <p>bring [3] 38/5 55/14 115/17</p> <p>bringing [2] 79/20 104/5</p> <p>brings [1] 72/5</p> <p>broad [1] 10/24</p> <p>broader [1] 107/6</p> <p>brought [7] 14/16 23/6 72/7 81/19 99/18 100/17 116/2</p> <p>build [1] 5/13</p> <p>building [1] 108/7</p> <p>bullet [1] 34/21</p> <p>Burri [17] 2/12 6/5 6/12 7/7 7/21 8/12 8/15 8/22 10/1 14/17 15/17 16/22 17/4 18/21 18/24 21/5 78/13</p> <p>Burri's [1] 18/12</p> <p>busy [2] 36/20 87/9</p> <p>but [125]</p> | <p>button [1] 12/4</p> |
| | <p>B</p> <p>back [30] 5/4 9/2 17/5 17/14 20/1 26/24 36/4 41/3 42/24 50/16 51/17 55/4 55/5 78/16 84/1 84/3 84/5 86/11 89/21 91/17 93/16 99/1 100/2 100/7 101/12 106/8 106/15 111/10 112/6 112/10</p> <p>backdrop [1] 15/6</p> <p>background [3] 22/4 57/19 57/21</p> <p>barriers [1] 114/3</p> <p>based [4] 12/21 25/11 66/3 98/22</p> <p>basis [5] 10/3 10/6 96/20 100/14 105/21</p> <p>be [125]</p> <p>bearing [1] 87/9</p> <p>became [3] 20/10 48/20 82/19</p> <p>because [76] 7/21 8/15 9/8 9/15 9/22 10/23 11/18 12/9 12/15 13/7 13/19 15/9 17/11 28/10 28/16 29/14 31/8 31/17 33/12 34/12 38/16 40/8 41/7 43/24 46/19 47/6 48/1 48/16 49/10 52/5 52/10 55/12 58/25 59/3 59/20 60/16 65/9 67/25 68/25 69/25 72/4 73/1 73/9 75/8 77/7 81/15 81/17 81/23 82/1 82/25 83/18 84/7 84/9 85/1 86/21 95/14 95/18 96/3 96/17 96/22 97/1 97/10 97/11 97/14 100/24 102/22 102/24 104/4 106/5 106/16 108/3</p> | <p>108/4 110/3 110/16 112/7 116/6</p> <p>become [7] 3/13 21/15 38/7 38/17 43/15 69/19 69/20</p> <p>becomes [2] 41/10 108/2</p> <p>becoming [2] 21/9 42/22</p> <p>been [139]</p> <p>before [22] 2/19 6/4 8/11 11/13 11/19 25/13 28/6 39/8 49/25 54/15 55/10 61/19 62/16 69/8 71/25 72/1 81/7 81/24 82/24 84/2 88/5 105/24</p> <p>beginning [3] 5/5 19/4 79/24</p> <p>behalf [5] 3/18 36/18 74/18 103/13 109/8</p> <p>behave [1] 14/11</p> <p>behaves [1] 27/4</p> <p>behaviour [4] 1/19 4/23 5/1 50/18</p> <p>behavioural [1] 10/14</p> <p>behaviours [5] 5/16 9/7 10/4 10/7 10/11</p> <p>being [33] 12/25 16/16 16/17 16/18 19/21 20/13 31/4 31/5 49/19 52/14 55/15 58/5 59/21 62/9 70/16 70/19 73/2 75/5 75/10 76/22 77/3 77/17 78/19 78/20 79/5 79/6 79/8 84/15 96/18 101/7 103/21 111/17 114/25</p> <p>belief [3] 24/12 25/8 92/10</p> <p>beliefs [1] 25/7</p> <p>believe [16] 3/5 10/2 27/12 27/14 41/13 50/10 66/3 68/6 69/11 72/24 75/13 76/11 88/21 88/22 103/22 104/4</p> <p>believed [2] 66/12 106/7</p> <p>believes [2] 29/22 107/24</p> <p>below [1] 107/1</p> <p>Ben [2] 24/6 24/6</p> <p>Ben Lomas' [1] 24/6</p> <p>beneficial [1] 42/8</p> <p>benefit [1] 25/22</p> <p>best [2] 25/12 66/2</p> <p>better [4] 25/12 46/24 58/1 114/1 95/18 96/3 96/17 96/22 97/1 97/10 97/11 97/14 100/24 102/22 102/24 104/4 106/5 106/16 108/3</p> | <p>114/22</p> <p>beyond [2] 50/2 68/14</p> <p>big [1] 107/1</p> <p>Bilal [1] 15/17</p> <p>Birtles [29] 3/5 5/20 5/21 8/7 8/16 12/10 12/20 12/23 13/6 24/4 25/16 25/18 29/20 29/23 30/4 30/12 31/2 31/22 38/4 38/13 41/21 47/6 50/5 61/2 64/12 90/8 91/23 99/4 109/25</p> <p>bit [4] 9/2 86/15 92/22 95/4</p> <p>black [1] 70/18</p> <p>Blackwood [1] 28/22</p> <p>blood [1] 42/14</p> <p>body [1] 22/24</p> <p>body-worn [1] 22/24</p> <p>book [3] 19/1 19/16 20/22</p> <p>booked [3] 9/10 19/21 21/2</p> <p>books [1] 57/25</p> <p>both [8] 1/15 19/18 24/3 38/16 47/8 65/8 66/14 72/20</p> <p>bother [1] 81/3</p> <p>bottom [16] 3/12 5/8 14/5 15/18 20/19 21/14 22/14 30/22 30/25 47/13 50/20 85/12 101/13 104/18 111/4 112/14</p> <p>box [9] 6/9 20/20 22/14 31/22 32/4 38/23 47/13 55/1 56/24</p> <p>break [5] 58/21 62/16 62/18 62/19 62/22</p> <p>brief [2] 78/23 103/11</p> <p>briefly [1] 69/11</p> <p>bring [3] 38/5 55/14 115/17</p> <p>bringing [2] 79/20 104/5</p> <p>brings [1] 72/5</p> <p>broad [1] 10/24</p> <p>broader [1] 107/6</p> <p>brought [7] 14/16 23/6 72/7 81/19 99/18 100/17 116/2</p> <p>build [1] 5/13</p> <p>building [1] 108/7</p> <p>bullet [1] 34/21</p> <p>Burri [17] 2/12 6/5 6/12 7/7 7/21 8/12 8/15 8/22 10/1 14/17 15/17 16/22 17/4 18/21 18/24 21/5 78/13</p> <p>Burri's [1] 18/12</p> <p>busy [2] 36/20 87/9</p> <p>but [125]</p> | <p>C</p> <p>call [10] 37/1 40/14 43/14 86/25 87/2 87/6 92/7 93/12 97/6 104/19</p> <p>called [2] 39/18 97/14</p> <p>calling [2] 34/13 105/11</p> <p>calls [6] 34/8 55/3 85/24 85/24 92/25 94/12</p> <p>Calocene [4] 34/10 48/16 91/21 91/25</p> <p>came [5] 26/8 69/17 69/18 100/15 100/16</p> <p>can [82] 1/3 4/11 5/3 9/13 9/14 14/10 14/11 14/18 15/12 17/16 17/19 20/17 22/21 25/15 26/12 26/14 26/25 29/18 34/15 36/6 36/17 37/17 38/1 38/7 38/8 38/12 39/20 42/22 44/5 44/7 44/22 46/13 46/16 47/5 47/11 52/8 53/11 54/3 54/14 55/8 56/23 58/20 59/11 61/8 63/11 64/18 66/9 66/10 67/7 71/2 71/16 72/10 72/13 72/16 73/24 75/7 75/10 82/3 85/1 85/6 86/5 88/23 92/4 92/5 93/10 99/1 99/19 101/12 102/17 103/2 103/4 103/14 107/14 107/20 107/25 109/13 109/16 110/23 112/7 112/9 112/18 115/5</p> <p>can't [21] 12/12 12/14 18/20 22/12 43/12 46/2 47/8 48/9 50/15 51/10 54/5 66/7 70/12 71/15 72/3 80/13 89/6 89/19 104/13 111/6 112/22</p> <p>cannot [2] 32/18 72/7</p> <p>capable [2] 8/10 101/4</p> <p>capacity [2] 4/25 45/24</p> <p>capped [1] 10/22</p> <p>car [6] 68/6 68/7 68/10 68/11 68/12 68/13</p> <p>card [1] 3/11</p> <p>care [64] 3/16 5/4 5/11 6/4 7/6 7/8 7/9 9/4 9/5 9/21 10/8 10/10 10/11 10/18 11/3 11/6 11/6 11/9 11/11 11/22 12/17</p> |

| | | | | |
|---|--|---|--|--|
| <p>C</p> <p>care... [43] 15/19 16/8 17/7 17/16 18/16 18/25 19/21 23/6 25/4 31/4 51/6 53/22 55/7 58/25 59/10 63/15 70/7 71/18 72/5 78/20 79/9 79/20 80/6 81/1 81/5 81/5 81/10 81/18 81/21 83/1 83/25 84/3 84/9 84/12 84/15 85/9 87/1 89/16 94/15 105/12 115/16 115/18 115/24</p> <p>cared [1] 58/5</p> <p>carefully [1] 84/22</p> <p>carer [1] 12/25</p> <p>carer's [1] 104/17</p> <p>carers [1] 34/25</p> <p>carried [1] 110/10</p> <p>carry [1] 11/25</p> <p>carrying [1] 10/5</p> <p>Carter [32] 14/9 14/22 15/1 24/11 51/14 52/12 55/11 57/22 65/6 68/3 68/5 68/17 68/18 68/19 68/21 68/24 71/21 71/25 72/6 81/8 82/2 82/11 83/23 84/8 95/21 100/14 101/23 102/24 103/1 103/13 103/21 115/21</p> <p>Cartwright [4] 74/15 74/16 91/3 117/4</p> <p>case [17] 8/22 11/2 22/11 23/11 54/12 59/2 69/2 76/18 79/21 80/17 81/19 81/19 85/10 104/5 105/20 115/17 116/2</p> <p>caseload [5] 6/23 7/22 10/23 75/13 115/19</p> <p>caseloads [1] 75/16</p> <p>cases [4] 70/5 72/5 72/8 115/23</p> <p>cast [1] 109/16</p> <p>cause [1] 27/20</p> <p>caused [2] 47/19 53/10</p> <p>CBT [1] 43/17</p> <p>CBTp [1] 10/14</p> <p>CCO [2] 38/9 82/11</p> <p>Celeste [23] 34/10 36/11 36/15 48/16 91/21 91/25 92/7 93/12 93/17 94/12 94/20 95/7 95/14 95/22 96/1 96/6 96/12 96/24 97/7 101/18 101/21 104/20 104/21</p> <p>cent [1] 86/6</p> <p>central [3] 79/14 79/15 79/18</p> | <p>certain [4] 3/4 7/4 18/15 83/17</p> <p>certainly [11] 17/16 24/7 27/15 55/17 56/20 58/13 90/24 92/15 93/6 100/4 107/6</p> <p>cetera [1] 5/12</p> <p>Chair [5] 61/23 62/15 83/20 114/10 117/8</p> <p>challenge [2] 45/11 47/18</p> <p>challenging [2] 21/20 43/14</p> <p>change [9] 12/12 17/25 38/10 45/22 52/11 105/8 105/10 105/14 105/22</p> <p>changed [5] 35/20 40/15 40/16 45/8 82/1</p> <p>changes [2] 52/7 80/23</p> <p>changing [2] 73/18 101/6</p> <p>check [4] 30/15 30/15 53/6 72/19</p> <p>checked [3] 22/2 22/3 22/8</p> <p>checklist [1] 86/20</p> <p>checks [2] 54/2 64/10</p> <p>Chief [1] 74/12</p> <p>choice [1] 73/9</p> <p>choose [1] 59/7</p> <p>chronically [1] 76/12</p> <p>circumstances [9] 37/4 52/23 53/17 73/22 96/16 101/24 105/2 105/13 107/3</p> <p>clarification [1] 68/20</p> <p>Claudia [48] 3/5 5/20 5/21 8/7 8/16 12/10 12/20 12/23 13/6 13/7 14/25 24/3 24/7 25/16 26/8 26/24 29/20 29/23 30/4 30/12 31/2 31/21 31/22 36/14 37/16 37/22 38/1 38/4 38/5 38/13 38/19 41/21 43/3 47/6 50/5 50/10 61/2 64/12 64/13 64/24 65/8 65/18 66/14 66/20 90/8 91/23 109/25 113/24</p> <p>Claudia's [1] 26/3</p> <p>Claudia/Sharon [1] 64/13</p> <p>clear [31] 1/25 7/3 7/11 11/17 12/20 13/23 18/1 30/20 31/9 32/2 32/25 33/13 33/16 33/17 40/18 43/21 47/15 55/10 66/14 70/2 70/3 72/14</p> | <p>74/24 75/8 75/10 79/1 82/20 83/6 84/13 104/5 106/20</p> <p>clearly [8] 40/13 47/2 47/19 66/22 69/1 79/7 83/3 111/6</p> <p>clinic [7] 9/11 20/21 81/12 81/13 81/20 86/3 90/3</p> <p>clinical [7] 34/18 59/10 74/1 76/2 89/10 89/13 90/20</p> <p>clinician [9] 10/25 13/11 17/9 31/14 65/18 78/5 78/7 79/10 89/11</p> <p>close [2] 15/19 15/21</p> <p>closely [1] 16/2</p> <p>co [1] 46/16</p> <p>Codes [1] 33/15</p> <p>cognitive [1] 10/14</p> <p>cold [1] 55/3</p> <p>collaboration [1] 11/7</p> <p>colleague [3] 101/24 105/3 107/3</p> <p>colleagues [1] 60/25</p> <p>collect [1] 31/24</p> <p>collective [2] 66/21 67/13</p> <p>college [1] 7/3</p> <p>come [18] 16/11 26/14 32/15 36/16 48/13 56/15 58/16 58/25 62/8 65/14 67/13 72/11 76/17 78/15 93/16 100/16 101/16 103/25</p> <p>comes [3] 57/19 103/1 107/23</p> <p>coming [4] 2/8 79/13 92/20 107/19</p> <p>comment [4] 1/16 23/23 25/11 31/8</p> <p>commented [1] 25/2</p> <p>comments [3] 1/5 34/3 34/4</p> <p>committed [3] 4/20 54/16 112/19</p> <p>communicated [2] 95/13 113/1</p> <p>communication [4] 112/22 114/1 114/3 114/7</p> <p>community [26] 3/1 7/14 7/20 15/19 28/7 32/18 33/2 33/2 40/24 41/3 42/7 43/5 43/15 44/2 46/24 54/23 59/4 78/5 78/10 78/17 82/18 91/13 100/25 111/12 111/16 111/24</p> <p>compared [1] 44/10</p> <p>compel [3] 58/15 101/1 101/2</p> <p>compelled [1] 32/19</p> | <p>competences [1] 7/4</p> <p>complaint [2] 61/5 64/14</p> <p>complaints [1] 67/1</p> <p>complete [3] 3/11 12/11 99/7</p> <p>completely [6] 16/13 39/15 48/1 60/5 72/13 113/23</p> <p>completely' [1] 37/12</p> <p>Completing [1] 6/10</p> <p>complex [1] 85/8</p> <p>compliant [3] 21/13 21/21 85/5</p> <p>complications [1] 29/9</p> <p>complying [1] 84/20</p> <p>comprising [1] 24/13</p> <p>compute [1] 72/8</p> <p>conceal [1] 43/1</p> <p>concealing [1] 49/4</p> <p>concentrated [1] 49/9</p> <p>concern [4] 37/7 86/13 97/18 112/25</p> <p>concerned [12] 27/2 32/12 33/15 53/8 53/14 58/10 70/23 79/22 86/24 94/17 106/16 107/10</p> <p>concerning [2] 39/16 40/19</p> <p>concerns [25] 31/1 39/7 39/23 40/11 47/21 56/1 56/4 56/6 56/18 56/19 86/10 86/16 92/21 93/1 93/5 93/21 94/13 95/1 95/2 95/15 95/16 95/22 96/25 105/12 112/17</p> <p>concerted [1] 14/8</p> <p>conclude [1] 56/23</p> <p>concluded [1] 24/7</p> <p>conclusion [4] 22/10 110/5 110/6 110/7</p> <p>conclusions [1] 76/18</p> <p>concordance [1] 42/25</p> <p>concordant [1] 45/2</p> <p>conducted [4] 2/12 19/7 90/5 90/7</p> <p>confine [1] 9/14</p> <p>confrontational [1] 36/25</p> <p>confronted [1] 45/12</p> <p>conjunction [1] 2/19</p> <p>connection [1] 59/21</p> <p>conscious [1] 103/12</p> <p>consecutive [1] 2/16</p> <p>consent [1] 96/11</p> <p>consequence [1] 1/21</p> <p>consequently [1] 17/13</p> <p>consider [8] 38/6</p> | <p>42/23 49/2 51/19 63/23 90/23 100/19 104/9</p> <p>consideration [8] 25/20 25/21 34/24 35/2 38/25 43/23 44/11 105/8</p> <p>considered [3] 102/25 109/17 110/2</p> <p>considering [3] 39/8 70/21 115/8</p> <p>consistent [1] 46/5</p> <p>conspiracy [2] 24/12 92/10</p> <p>conspiring [1] 24/15</p> <p>constant [1] 52/10</p> <p>constantly [1] 8/9</p> <p>constraints [1] 41/18</p> <p>consultant [20] 7/15 20/25 21/9 31/6 53/14 58/24 59/2 59/4 74/22 75/18 78/6 78/9 78/10 78/11 78/17 79/16 79/17 80/1 81/1 84/4</p> <p>consultants [5] 75/9 75/25 76/23 76/25 80/20</p> <p>contact [24] 3/16 5/11 5/12 14/4 34/22 34/25 35/8 37/2 37/4 37/8 37/12 40/1 54/25 55/3 65/2 69/23 86/14 87/8 89/14 94/21 96/1 96/7 97/1 97/4</p> <p>contactable [1] 37/6</p> <p>contacted [6] 34/7 35/4 52/14 54/13 70/1 70/21</p> <p>contacting [2] 55/18 95/5</p> <p>contained [2] 84/14 111/19</p> <p>contemporaneous [1] 78/23</p> <p>content [1] 89/17</p> <p>context [3] 1/17 1/18 63/9</p> <p>continue [5] 5/17 21/18 25/23 35/7 42/9</p> <p>continues [1] 35/9</p> <p>continuing [1] 16/20</p> <p>continuity [6] 17/6 17/16 81/4 84/3 84/12 84/15</p> <p>contradicts [4] 102/10 102/13 102/20 102/24</p> <p>contrary [1] 14/20</p> <p>contributing [1] 79/17</p> <p>convenient [1] 12/8</p> <p>conversation [28] 21/25 24/4 24/5 26/6 30/17 30/19 31/18 36/14 36/17 39/6 43/7 43/11 43/18 43/20</p> |
|---|--|---|--|--|

| | | | | |
|--|---|--|--|--|
| <p>C</p> <p>conversation... [14] 49/16 52/20 53/2 55/25 56/7 83/15 93/2 94/24 95/16 97/8 101/18 101/20 104/23 107/12</p> <p>conversations [9] 14/2 40/4 53/16 55/24 61/11 61/20 92/21 97/9 97/12</p> <p>coordinator [28] 5/11 10/8 10/10 10/12 10/19 11/7 11/22 15/20 23/6 25/4 31/5 44/5 55/7 59/1 72/5 79/9 79/20 81/5 81/19 81/21 83/1 83/25 87/1 89/16 94/15 105/12 115/16 115/24</p> <p>coordinator's [1] 71/19</p> <p>coordinators [7] 18/25 19/22 59/10 80/6 81/10 84/9 115/18</p> <p>copied [1] 106/19</p> <p>copies [1] 20/2</p> <p>coping [6] 5/17 10/7 10/12 10/15 97/25 98/5</p> <p>copy [1] 66/9</p> <p>correct [7] 2/21 18/4 75/1 78/10 83/3 91/19 96/14</p> <p>correction [1] 82/2</p> <p>correctly [1] 50/19</p> <p>costs [1] 44/10</p> <p>could [53] 1/22 2/2 2/3 5/24 15/23 23/14 24/21 27/8 27/9 27/10 32/22 34/3 34/5 34/12 37/4 38/14 38/20 41/7 43/22 46/3 46/7 46/10 48/21 56/4 60/9 60/12 61/9 61/19 63/4 63/7 63/23 64/19 65/3 67/12 69/24 73/11 73/15 73/22 86/3 86/14 86/18 100/18 100/22 100/23 101/8 101/10 101/17 102/23 102/25 103/17 106/18 108/14 112/5</p> <p>couldn't [11] 16/2 17/3 44/21 52/3 52/10 58/18 60/9 60/11 70/22 101/17 110/12</p> <p>Council [1] 77/14</p> <p>county [1] 73/19</p> <p>couple [2] 31/23 95/6</p> <p>course [10] 39/6 39/10 54/6 62/12 65/25 71/24 94/6 99/6 99/12 99/21</p> | <p>courses [1] 99/11</p> <p>Court [3] 51/25 52/4 71/11</p> <p>cover [2] 108/10 108/13</p> <p>covered [1] 76/8</p> <p>covering [2] 60/21 91/16</p> <p>Covid [1] 42/14</p> <p>CPA [1] 11/11</p> <p>CPN [10] 14/9 20/22 22/4 37/21 85/15 85/20 86/10 86/13 87/1 87/13</p> <p>CQC [1] 17/20</p> <p>CQCM0016518 [1] 17/19</p> <p>crafted [1] 84/22</p> <p>criminal [3] 4/20 4/24 5/1</p> <p>crisis [7] 3/17 16/10 35/6 41/15 46/22 47/2 72/17</p> <p>Crookes [1] 64/10</p> <p>crystallise [1] 89/18</p> <p>CTO [6] 33/3 42/23 44/1 46/2 46/25 58/17</p> <p>culminated [1] 108/19</p> <p>cultural [1] 44/24</p> <p>current [1] 33/25</p> <p>currently [2] 39/7 42/4</p> <p>cut [2] 9/19 86/8</p> <p>cutting [1] 86/7</p> <p>CYGN0000011 [1] 26/13</p> <p>CYGN0000056 [1] 27/1</p> | <p>December 2021 [2] 112/9 112/11</p> <p>decide [1] 102/7</p> <p>decided [7] 36/10 72/20 76/9 82/16 98/10 98/11 102/21</p> <p>decides [1] 103/3</p> <p>decision [32] 41/6 41/7 55/3 55/9 65/23 72/1 72/10 72/25 73/2 77/16 77/23 81/2 81/7 81/24 82/24 83/12 91/4 100/13 100/14 100/23 100/24 101/15 103/19 104/2 105/6 105/20 105/25 106/6 106/17 107/10 107/16 108/19</p> <p>decision's [1] 59/23</p> <p>decision-making [2] 65/23 77/16</p> <p>decisions [7] 78/20 79/2 79/5 79/6 79/6 79/19 79/20</p> <p>deeper [2] 49/2 49/9</p> <p>defence [1] 23/25</p> <p>defer [1] 67/24</p> <p>definite [2] 40/13 115/12</p> <p>definitely [4] 22/7 26/3 32/14 104/4</p> <p>deflected [1] 40/11</p> <p>degree [5] 23/18 98/1 98/6 98/11 98/16</p> <p>delegated [2] 11/22 18/21</p> <p>deliberately [1] 101/6</p> <p>delusional [1] 25/7</p> <p>delusions [3] 27/19 34/1 94/2</p> <p>Denies [2] 41/24 41/25</p> <p>depend [1] 90/13</p> <p>depends [3] 4/17 4/17 70/25</p> <p>depot [21] 25/20 25/25 26/10 30/14 30/17 30/21 31/18 32/9 32/13 42/3 42/5 42/6 42/23 43/5 44/2 44/9 45/5 45/17 46/25 73/4 73/8</p> <p>depots [2] 44/16 44/20</p> <p>described [2] 2/16 25/1</p> <p>description [2] 23/4 59/23</p> <p>despite [4] 17/22 55/2 82/17 85/8</p> <p>detail [7] 1/15 9/3 12/2 72/3 75/19 83/8 100/10</p> <p>detailed [7] 5/22 13/18 23/9 24/5 25/5 43/20 80/2</p> | <p>detrained [1] 111/1</p> <p>detect [2] 30/4 30/10</p> <p>detention [4] 25/17 33/10 40/25 46/8</p> <p>deteriorating [2] 33/17 34/11</p> <p>deterioration [1] 16/8</p> <p>determine [3] 101/25 105/3 107/4</p> <p>develop [1] 5/17</p> <p>developing [3] 4/22 10/12 10/15</p> <p>diagnosis [7] 2/8 2/9 2/10 2/22 5/9 18/3 26/13</p> <p>did [88] 1/11 1/12 3/5 7/23 8/1 8/2 8/19 9/12 9/13 9/15 11/9 11/15 13/8 15/6 15/21 15/24 19/18 20/9 20/19 20/21 25/11 25/13 26/2 26/4 26/17 26/24 26/25 27/7 30/4 30/9 30/13 32/15 35/10 35/23 35/25 36/2 36/2 36/8 36/13 37/11 37/15 38/2 38/12 38/20 39/14 40/6 41/3 41/5 41/6 42/10 42/12 42/14 42/17 43/10 45/19 47/3 47/18 48/4 50/5 55/21 61/11 64/4 68/2 68/5 68/16 69/9 69/12 71/13 76/4 80/7 82/3 84/2 84/5 85/14 85/19 86/25 87/20 90/25 91/1 94/17 94/19 95/14 98/10 98/20 99/14 99/15 109/23 110/5</p> <p>didn't [80] 6/20 8/5 9/22 9/23 9/24 10/2 11/20 13/4 13/21 16/21 19/25 20/5 20/8 22/16 25/1 25/14 26/22 28/10 31/1 31/7 32/4 32/24 37/14 37/15 37/16 37/19 38/18 40/25 42/8 42/12 42/13 43/24 48/6 49/1 49/3 50/2 50/6 54/8 54/18 54/19 54/21 69/16 69/23 70/17 70/20 73/8 73/11 73/12 73/15 73/17 73/21 74/13 75/19 75/23 79/25 81/3 81/17 87/1 92/13 92/15 94/3 95/2 95/22 96/20 96/22 98/14 98/23 100/16 100/25 101/2 101/9 101/10 106/3 107/6 108/20 110/8 110/15 110/16 112/3 114/15</p> <p>difference [2] 67/5</p> | <p>114/22</p> <p>different [7] 6/22 26/14 38/9 39/15 75/24 76/1 97/15</p> <p>difficult [9] 17/18 28/4 28/13 41/7 45/22 48/11 48/20 69/20 69/23</p> <p>difficulties [1] 29/9</p> <p>difficulty [2] 16/10 45/18</p> <p>dig [1] 49/2</p> <p>digging [1] 49/8</p> <p>directed [1] 66/4</p> <p>direction [1] 39/15</p> <p>directly [6] 6/3 6/6 8/22 60/12 65/11 70/25</p> <p>Director [2] 74/1 74/12</p> <p>disagree [1] 115/2</p> <p>disagreed [1] 67/18</p> <p>disappeared [1] 53/18</p> <p>discharge [73] 2/7 29/19 29/24 30/6 30/11 38/6 38/25 39/8 40/10 42/25 43/4 46/20 51/20 54/6 54/22 55/4 55/9 55/15 55/18 57/10 57/22 58/22 58/25 60/2 60/3 60/5 65/1 65/12 65/13 69/8 69/17 69/18 70/21 71/17 72/1 72/10 72/23 73/1 81/4 81/7 81/11 81/14 81/20 81/24 82/7 82/16 83/12 84/2 84/21 94/11 100/13 100/20 100/23 100/24 101/15 102/21 103/14 103/20 104/3 104/7 105/6 105/20 106/4 106/5 106/6 106/16 107/10 107/17 108/2 108/17 108/20 108/23 116/1</p> <p>discharged [19] 27/2 28/7 29/22 30/1 41/3 54/19 54/22 57/22 58/6 71/22 73/7 81/2 106/7 106/13 107/7 107/9 107/11 115/15 116/7</p> <p>discharging [3] 84/4 84/24 91/13</p> <p>disciplinary [2] 36/5 111/10</p> <p>disclosure [1] 71/3</p> <p>discovered [1] 74/5</p> <p>discuss [13] 7/23 12/1 37/23 38/11 38/24 60/25 67/14 97/22 97/22 107/5 108/11 108/17 108/23</p> |
|--|---|--|--|--|

| | | | | |
|---|--|--|--|--|
| <p>D</p> <p>discussed [14] 8/6 12/9 38/9 74/3 74/4 74/7 78/1 78/19 94/11 105/15 107/8 115/20 115/22 115/22</p> <p>discusses [1] 45/5</p> <p>discussing [1] 103/15</p> <p>discussion [29] 7/19 12/24 13/4 13/20 25/5 38/5 38/21 39/5 43/14 50/2 54/24 55/14 55/22 57/9 72/6 72/8 72/15 72/18 79/21 81/16 81/18 86/9 87/13 87/15 100/20 104/6 104/6 107/16 111/7</p> <p>discussions [5] 13/19 15/24 38/15 61/18 108/18</p> <p>disengage [1] 48/22</p> <p>disengaged [4] 37/21 39/1 93/24 113/23</p> <p>disengagement [2] 49/1 113/25</p> <p>disengaging [2] 82/21 101/6</p> <p>disorder [3] 2/17 33/5 34/1</p> <p>disordered [1] 57/2</p> <p>disproof [1] 8/10</p> <p>distinct [3] 55/10 72/14 104/5</p> <p>distressed [1] 21/16</p> <p>distressing [1] 27/20</p> <p>distributed [1] 59/13</p> <p>DNA [5] 31/8 86/23 87/16 87/23 87/25</p> <p>DNAs [7] 34/17 35/9 36/2 36/4 86/3 86/4 86/17</p> <p>do [104] 1/13 1/22 3/5 3/22 4/5 4/7 4/16 4/24 4/25 6/21 7/13 9/14 9/22 9/23 12/1 16/1 17/2 17/6 18/20 19/11 19/16 20/24 23/2 25/25 26/7 26/12 29/3 32/14 32/15 32/22 32/24 35/25 36/1 36/2 36/3 36/6 36/8 36/13 37/22 38/8 38/12 38/14 44/5 44/7 45/13 48/24 52/14 53/13 58/18 59/11 61/10 62/10 64/20 65/23 68/13 68/14 69/5 69/11 69/16 70/11 71/3 71/11 71/12 72/16 72/24 73/9 73/11 73/15 73/22 75/6 75/12 77/6 77/24 78/2 78/4 80/7</p> | <p>80/25 81/10 81/20 84/10 85/6 85/8 85/22 87/19 89/15 90/16 91/22 94/14 94/21 98/2 99/18 100/23 101/3 101/17 102/8 103/4 109/6 109/19 111/20 111/22 113/1 113/7 113/10 115/2</p> <p>doctor [4] 6/5 17/15 18/7 22/15</p> <p>doctors [2] 19/1 19/9</p> <p>doctors' [1] 19/7</p> <p>document [15] 63/3 63/3 71/2 71/6 76/22 77/20 77/22 87/5 90/18 90/19 93/10 99/2 103/18 106/18 108/7</p> <p>documentation [2] 12/9 78/3</p> <p>documented [5] 13/24 77/18 85/24 87/21 90/24</p> <p>documenting [3] 74/20 80/6 87/3</p> <p>documents [2] 9/20 13/25</p> <p>does [19] 1/18 6/12 6/16 13/20 15/2 19/5 22/9 36/18 45/11 58/4 59/9 59/10 59/18 73/25 87/5 87/8 92/10 99/5 103/5</p> <p>doesn't [24] 5/6 5/8 10/19 15/1 15/3 20/18 22/2 23/21 30/23 30/24 31/10 35/14 45/10 50/21 51/16 58/23 72/8 89/8 90/17 92/23 94/8 102/10 107/12 108/5</p> <p>doing [16] 5/22 6/17 9/6 9/8 9/21 9/24 15/7 21/12 49/8 57/25 79/3 86/23 87/12 89/8 106/12 106/14</p> <p>domain [2] 61/17 61/19</p> <p>don't [72] 2/22 3/8 4/9 4/16 7/8 9/12 9/25 15/11 16/4 18/19 19/5 22/12 26/16 26/18 26/23 28/9 28/15 29/3 29/4 29/6 29/7 30/6 30/11 37/24 38/8 38/10 38/12 40/6 42/24 43/19 44/12 45/14 45/15 48/7 48/8 48/18 51/3 51/10 52/16 55/13 55/16 57/6 57/14 57/17 59/1 59/19 62/1 62/8 64/24 68/19 74/23 76/11 82/23 87/25 89/12 89/19 95/8 102/6</p> | <p>103/4 104/9 104/10 105/18 106/1 106/11 107/14 107/18 108/23 110/23 114/5 114/5 114/6 116/4</p> <p>done [33] 8/12 10/9 10/16 11/6 11/12 11/13 12/13 12/15 12/17 12/19 13/5 13/5 13/11 55/3 60/13 62/9 72/12 83/8 85/23 86/19 87/4 100/17 100/22 101/8 101/10 101/17 102/17 102/23 102/25 103/2 107/13 107/20 107/24</p> <p>door [5] 1/20 22/16 27/14 42/22 51/15</p> <p>Dorey [1] 64/7</p> <p>dosage [1] 18/4</p> <p>doses [1] 31/23</p> <p>double [1] 30/15</p> <p>doubt [2] 25/22 46/14</p> <p>Doughty [1] 82/12</p> <p>down [22] 1/6 1/20 5/3 5/14 20/7 26/14 27/14 28/2 34/21 38/23 42/2 42/3 53/25 56/24 60/16 63/12 80/22 100/8 104/15 108/14 108/14 110/12</p> <p>Dr [63] 1/4 1/7 1/17 2/12 6/5 6/12 7/7 7/21 8/12 8/15 8/22 10/1 14/1 14/14 14/17 14/19 14/21 16/22 16/23 17/4 17/4 17/11 17/13 18/12 18/21 18/24 19/6 21/4 21/5 24/6 24/23 24/23 24/24 25/22 28/22 36/17 37/9 40/22 41/22 41/22 42/20 42/20 43/8 45/4 45/19 49/17 51/17 63/1 63/18 68/18 73/7 74/14 74/17 74/19 78/13 91/10 99/9 103/13 109/8 111/11 111/15 111/20 114/11</p> <p>Dr Ben [1] 24/6</p> <p>Dr Blackwood [1] 28/22</p> <p>Dr Burri [16] 2/12 6/5 6/12 7/7 7/21 8/12 8/15 8/22 10/1 14/17 16/22 17/4 18/21 18/24 21/5 78/13</p> <p>Dr Burri's [1] 18/12</p> <p>Dr Gibson [2] 41/22 49/17</p> <p>Dr Lloyd [15] 1/4 19/6 36/17 37/9 42/20 63/1 68/18 74/14 74/17 74/19 91/10 103/13 109/8 111/20</p> | <p>114/11</p> <p>Dr Lomas [1] 24/24</p> <p>Dr Manzar [2] 24/23 24/23</p> <p>Dr Manzar's [1] 99/9</p> <p>Dr Mike [1] 40/22</p> <p>Dr Read [1] 63/18</p> <p>Dr Sasidharan [1] 21/4</p> <p>Dr Seedat [10] 1/7 1/17 14/1 14/14 14/19 16/23 17/4 17/11 17/13 25/22</p> <p>Dr Skelton [2] 111/11 111/15</p> <p>Dr Thangavelu [6] 41/22 42/20 43/8 45/4 45/19 73/7</p> <p>draft [3] 81/4 81/13 81/17</p> <p>drafted [1] 81/9</p> <p>driven [5] 48/2 49/13 110/2 110/8 110/9</p> <p>drug [2] 70/16 71/1</p> <p>due [3] 22/15 32/6 55/4</p> <p>duration [1] 18/4</p> <p>during [6] 34/9 45/20 50/19 112/4 113/2 113/18</p> <p>duty [3] 53/20 70/6 79/24</p> <hr/> <p>E</p> <p>each [4] 8/1 14/2 86/6 86/21</p> <p>earlier [14] 14/2 20/13 28/22 31/3 88/8 89/3 91/20 94/10 94/20 100/12 103/23 105/15 105/16 108/21</p> <p>early [12] 3/6 17/9 19/2 29/12 46/20 61/24 64/1 65/21 68/22 68/25 96/2 98/22</p> <p>easy [3] 12/3 83/7 97/17</p> <p>edit [2] 39/3 39/4</p> <p>education [1] 4/17</p> <p>effect [1] 41/2</p> <p>effective [1] 5/18</p> <p>effects [3] 21/13 21/22 45/9</p> <p>effort [1] 14/8</p> <p>efforts [1] 89/13</p> <p>EIP [6] 35/15 35/16 44/20 69/9 75/23 105/23</p> <p>either [10] 6/1 9/22 16/7 29/11 37/16 72/19 90/9 96/22 100/19 113/17</p> <p>elephant [1] 8/3</p> <p>Ellie [5] 50/5 50/10 111/7 111/8 111/11</p> | <p>eloquence [1] 4/18</p> <p>else [11] 1/23 27/23 31/13 58/18 72/16 73/10 73/15 83/17 101/17 109/25 110/7</p> <p>elsewhere [1] 62/11</p> <p>email [20] 14/2 14/5 14/15 15/1 15/11 19/18 25/16 26/2 26/3 26/7 38/3 40/7 42/19 43/13 61/2 63/5 63/20 73/7 106/19 108/10</p> <p>emailed [1] 15/4</p> <p>emailing [2] 14/1 108/12</p> <p>emails [3] 20/3 50/14 63/9</p> <p>Emma [6] 13/6 38/3 38/16 39/21 51/18 82/11</p> <p>emphasised [1] 111/15</p> <p>encouraged [1] 62/5</p> <p>end [7] 1/9 8/23 42/24 59/3 96/12 101/14 103/1</p> <p>endorse [1] 5/2</p> <p>ends [1] 1/24</p> <p>enforce [1] 58/16</p> <p>engage [5] 36/6 43/16 58/11 58/12 82/18</p> <p>engaged [2] 15/8 84/20</p> <p>engagement [3] 38/10 42/24 55/5</p> <p>engaging [5] 14/9 37/25 38/8 82/17 113/17</p> <p>engineering [1] 98/16</p> <p>enlist [1] 36/10</p> <p>enough [5] 12/3 30/9 33/22 67/23 100/10</p> <p>ensure [2] 18/3 84/17</p> <p>ensuring [1] 77/15</p> <p>entries [2] 85/8 86/12</p> <p>entry [13] 24/6 24/19 85/10 87/6 90/20 93/11 99/4 103/21 103/21 103/24 104/1 104/2 106/1</p> <p>episodes [1] 2/17</p> <p>erratic [1] 14/11</p> <p>error [1] 91/13</p> <p>escalate [1] 15/25</p> <p>escalated [2] 74/11 75/10</p> <p>escalating [1] 34/5</p> <p>escalation [1] 34/2</p> <p>especially [1] 25/25</p> <p>essence [1] 105/11</p> <p>essentially [16] 8/15 33/1 35/24 39/1 41/8 42/22 48/23 63/20 69/16 76/21 77/5</p> |
|---|--|--|--|--|

| | | | | |
|---|--|---|--|--|
| <p>E</p> <p>essentially... [5] 81/23 83/15 86/20 86/21 101/4</p> <p>established [1] 46/4</p> <p>et [1] 5/12</p> <p>et cetera [1] 5/12</p> <p>even [20] 4/21 19/9 25/14 34/5 34/13 53/25 54/12 54/17 58/9 60/11 73/19 77/16 77/18 79/2 81/3 81/19 92/21 97/13 105/5 106/10</p> <p>event [4] 4/2 22/25 23/3 24/5</p> <p>events [8] 1/15 13/15 22/17 29/5 29/11 49/10 60/25 83/6</p> <p>eventuated [1] 28/5</p> <p>ever [11] 4/10 7/23 22/24 26/18 26/23 62/1 70/15 84/21 95/19 110/5 114/15</p> <p>every [4] 69/25 77/22 81/14 91/1</p> <p>everybody [1] 65/7</p> <p>everything [14] 4/25 45/11 56/22 56/23 61/16 65/23 72/12 83/16 100/18 101/10 102/17 103/2 107/20 107/25</p> <p>evidence [48] 17/22 25/12 28/2 31/15 31/15 33/16 33/21 33/22 33/22 33/23 41/9 45/21 46/13 48/4 48/18 51/14 66/14 68/2 68/6 69/8 69/10 75/7 76/3 76/8 81/23 82/25 83/20 87/18 87/19 88/7 88/13 88/19 90/22 91/2 91/16 93/5 95/7 95/21 99/24 99/25 101/15 102/10 102/12 102/13 102/20 103/18 106/11 113/16</p> <p>evidently [1] 30/2</p> <p>exact [2] 43/12 51/11</p> <p>exactly [9] 29/21 55/13 55/16 65/6 66/7 66/10 80/20 82/15 104/13</p> <p>examination [3] 6/16 21/14 56/25</p> <p>examinations [3] 2/13 6/13 6/18</p> <p>example [6] 7/16 34/7 44/18 65/12 85/17 94/10</p> <p>examples [4] 49/4 85/3 91/20 97/21</p> <p>exams [1] 99/8</p> | <p>exasperated [1] 92/8</p> <p>except [1] 72/3</p> <p>excerpts [1] 92/16</p> <p>exchange [1] 49/5</p> <p>Executive [1] 74/12</p> <p>exercise [1] 8/13</p> <p>exercises [1] 3/11</p> <p>existed [1] 25/14</p> <p>exists [1] 76/22</p> <p>expect [3] 9/23 9/24 10/2</p> <p>expected [4] 7/13 57/4 77/22 110/10</p> <p>expense [1] 44/9</p> <p>experience [2] 62/6 69/25</p> <p>experienced [1] 45/8</p> <p>experiences [1] 54/17</p> <p>expertise [1] 6/7</p> <p>explain [3] 37/7 45/19 93/23</p> <p>explained [5] 42/7 63/5 71/23 86/2 93/13</p> <p>explore [1] 5/17</p> <p>exploring [1] 10/12</p> <p>express [2] 95/14 96/15</p> <p>expressed [1] 95/17</p> <p>expressing [2] 93/21 105/11</p> <p>extensive [2] 46/8 113/16</p> <p>external [1] 63/13</p> <p>extremely [6] 10/24 24/11 24/18 36/20 43/19 75/15</p> <p>eye [1] 109/16</p> <p>F</p> <p>face [22] 18/13 18/13 26/9 26/9 48/9 93/20 94/20 94/20 96/1 96/1 96/3 96/3 96/7 96/7 97/4 97/4 97/10 97/10 101/19 101/19 104/22 104/22</p> <p>faced [1] 53/23</p> <p>facilitate [1] 46/20</p> <p>fact [21] 8/8 16/23 17/19 47/15 55/12 66/13 71/6 75/15 76/14 80/17 80/24 81/3 83/17 88/9 95/3 97/2 102/3 104/8 107/15 112/21 115/15</p> <p>factor [1] 76/4</p> <p>failed [5] 58/12 58/12 85/4 99/7 113/7</p> <p>failing [4] 31/24 88/14 88/19 99/10</p> <p>failure [1] 60/20</p> <p>failures [1] 113/17</p> <p>faint [1] 21/15</p> <p>fair [2] 51/7 115/23</p> <p>fairly [2] 61/9 64/19</p> | <p>falls [1] 4/24</p> <p>false [2] 50/13 50/17</p> <p>familiar [1] 101/22</p> <p>family [14] 3/17 60/7 60/9 60/13 61/6 65/2 67/3 67/4 73/12 81/12 85/25 86/25 91/10 109/18</p> <p>far [11] 28/6 33/15 44/13 58/10 72/10 75/4 79/22 86/23 93/6 106/16 107/10</p> <p>fault [1] 69/6</p> <p>Feb [1] 18/7</p> <p>February [8] 18/5 18/9 41/21 45/4 61/2 63/5 71/8 93/11</p> <p>February 2021 [1] 18/5</p> <p>feed [1] 67/10</p> <p>Feedback [1] 99/6</p> <p>feel [8] 24/22 32/17 74/13 75/23 101/23 105/2 107/2 115/20</p> <p>feels [6] 20/22 93/18 93/23 94/7 94/9 103/4</p> <p>felt [23] 1/16 24/11 25/6 30/20 31/18 38/16 46/10 47/25 48/15 48/17 58/18 58/19 72/4 72/22 73/11 73/14 91/21 91/25 92/17 93/3 101/9 102/22 114/20</p> <p>female [1] 23/21</p> <p>few [5] 8/11 86/12 91/20 99/25 106/25</p> <p>fight [1] 24/2</p> <p>final [4] 72/1 72/2 100/5 105/1</p> <p>finally [3] 47/12 112/1 115/13</p> <p>find [16] 32/21 41/9 46/7 53/12 53/19 54/20 61/9 64/19 69/19 69/23 69/24 70/22 87/24 98/10 101/7 110/12</p> <p>finding [1] 53/20</p> <p>findings [2] 28/12 33/20</p> <p>finds [1] 21/10</p> <p>fine [2] 21/12 83/22</p> <p>finish [2] 102/13 116/9</p> <p>Fiona [1] 92/5</p> <p>firearm [1] 70/18</p> <p>first [10] 1/15 9/10 11/19 16/12 47/15 51/9 54/13 103/21 104/1 110/17</p> <p>first-hand [1] 110/17</p> <p>five [2] 51/5 110/4</p> <p>fixated [2] 20/10 20/13</p> <p>fixed [1] 25/7</p> | <p>flag [1] 80/7</p> <p>flagged [1] 80/10</p> <p>flagging [1] 80/19</p> <p>flat [2] 27/25 30/1</p> <p>flatmate [1] 39/16</p> <p>flatmates [2] 20/10 49/23</p> <p>floridly [1] 24/9</p> <p>follow [12] 7/3 14/8 20/11 21/17 41/15 49/6 86/2 86/24 87/23 88/6 88/14 88/19</p> <p>follow-up [2] 41/15 49/6</p> <p>followed [3] 41/2 43/13 87/17</p> <p>following [13] 29/6 34/19 39/5 65/4 88/7 88/8 88/11 88/21 89/5 89/9 89/18 89/23 116/12</p> <p>footage [3] 22/24 25/10 25/14</p> <p>forced [1] 24/19</p> <p>forcing [1] 32/12</p> <p>forgive [4] 103/24 105/18 108/15 110/4</p> <p>forgotten [1] 61/14</p> <p>form [4] 11/25 13/17 17/8 42/5</p> <p>formal [6] 10/9 11/25 74/8 74/10 78/21 90/18</p> <p>formed [2] 17/15 25/8</p> <p>forms [2] 10/9 12/10</p> <p>formulate [3] 61/9 64/19 67/8</p> <p>formulation [2] 5/5 5/6</p> <p>fortnightly [3] 10/6 10/10 18/17</p> <p>forums [1] 75/18</p> <p>forward [7] 14/16 16/11 22/20 38/18 43/25 64/6 92/20</p> <p>found [3] 80/16 86/11 113/23</p> <p>four [4] 14/6 18/14 42/3 53/9</p> <p>fourth [16] 38/22 41/20 42/21 46/21 47/23 47/25 48/17 48/19 49/10 49/13 51/5 71/4 71/5 71/6 91/21 91/24</p> <p>frame [1] 115/5</p> <p>framing [1] 115/7</p> <p>Frances [1] 82/12</p> <p>frank [1] 30/17</p> <p>friends [1] 35/1</p> <p>frightened [2] 24/18 93/22</p> <p>front [2] 29/16 89/6</p> <p>full [3] 90/5 90/9 90/11</p> | <p>fully [1] 66/12</p> <p>fundamental [1] 22/7</p> <p>further [12] 2/12 4/2 5/1 5/14 15/6 23/5 28/2 38/15 38/21 40/24 51/7 64/11</p> <p>future [2] 49/12 55/6</p> <p>G</p> <p>gain [1] 98/18</p> <p>gained [1] 98/15</p> <p>gains [1] 27/4</p> <p>gary [45] 14/9 14/21 15/1 24/10 51/14 52/12 55/11 57/22 58/19 65/6 68/2 68/5 68/16 68/18 68/19 68/21 68/24 71/8 71/21 71/25 72/6 72/11 81/8 82/2 82/11 83/18 83/23 84/7 94/25 95/13 95/21 101/23 102/5 102/7 102/17 103/13 104/5 104/8 104/16 104/19 106/13 107/2 107/19 108/11 115/21</p> <p>Gary's [5] 95/4 106/24 107/22 108/5 108/16</p> <p>gave [9] 25/22 50/13 68/6 69/8 70/10 102/10 102/14 102/20 103/18</p> <p>general [4] 77/14 102/1 105/4 107/5</p> <p>generally [2] 15/24 115/21</p> <p>get [21] 2/22 3/23 15/25 17/1 21/11 31/11 35/20 36/16 40/7 43/15 44/22 46/4 48/12 48/13 49/15 58/14 65/8 80/13 98/14 98/20 99/19</p> <p>gets [2] 17/2 87/15</p> <p>getting [2] 49/5 70/5</p> <p>Gibson [2] 41/22 49/17</p> <p>give [8] 39/11 43/12 46/13 60/11 66/2 66/25 67/11 109/15</p> <p>given [20] 22/4 25/7 30/13 34/24 35/2 38/25 43/23 44/15 50/16 61/6 64/16 67/6 69/22 69/22 73/4 76/3 96/18 110/25 111/21 113/10</p> <p>gives [1] 64/21</p> <p>giving [4] 66/21 79/11 82/25 85/10</p> <p>glasses [1] 23/18</p> <p>gleaned [1] 23/7</p> <p>go [50] 1/18 2/6 2/10 5/8 5/10 9/20 15/14</p> |
|---|--|---|--|--|

| | | | | |
|--|--|---|---|---|
| <p>G</p> <p>go... [43] 15/16 19/9 22/16 27/18 29/25 34/21 37/14 37/17 38/22 39/20 41/12 41/22 45/3 46/19 46/21 47/11 50/20 51/13 52/21 63/4 63/7 63/24 64/7 64/9 72/20 89/7 89/22 92/5 98/11 101/21 101/25 102/5 102/8 104/24 105/3 105/13 106/8 106/15 107/4 108/1 108/16 111/10 115/18</p> <p>goes [4] 6/12 29/7 52/16 81/21</p> <p>going [29] 3/1 5/4 13/1 14/25 15/5 17/14 20/7 25/19 27/16 39/23 45/24 46/7 50/9 50/11 52/17 53/25 60/21 80/23 80/24 81/25 82/24 84/12 85/1 85/7 90/24 111/5 111/13 112/4 116/5</p> <p>gone [8] 9/2 17/12 20/4 50/16 51/8 60/14 83/8 115/14</p> <p>good [12] 3/5 32/17 36/11 60/2 62/16 63/1 63/2 64/13 74/17 84/13 84/14 98/12</p> <p>Gosh [1] 4/15</p> <p>got [26] 9/12 9/20 11/1 12/4 20/1 21/24 24/17 29/15 39/13 40/8 66/9 74/24 83/5 85/12 86/10 87/9 92/16 97/11 98/22 102/2 102/4 102/4 105/16 106/13 106/24 109/4</p> <p>governance [1] 76/2</p> <p>governed [1] 77/13</p> <p>Government [1] 24/14</p> <p>GP [17] 34/22 51/20 54/23 55/4 55/5 57/23 58/22 59/18 59/20 81/5 81/12 81/22 84/3 84/5 85/24 87/8 91/13</p> <p>grateful [2] 110/19 114/8</p> <p>greater [1] 44/9</p> <p>grounds [3] 40/13 41/11 46/11</p> <p>group [4] 24/13 24/18 24/20 80/16</p> <p>guess [3] 28/17 48/7 98/25</p> <p>guessing [1] 9/1</p> <p>guesswork [1] 29/14</p> <p>guidance [1] 79/1</p> <p>guided [1] 76/6</p> | <p>guidelines [2] 7/3 17/25</p> <p>H</p> <p>had [200]</p> <p>hadn't [32] 8/12 8/14 8/21 9/16 15/8 15/9 17/1 32/15 46/5 47/14 47/16 48/6 54/7 56/3 56/3 56/11 56/12 58/14 60/16 60/17 73/5 91/25 92/17 93/1 93/3 93/5 96/6 96/17 96/18 96/23 107/9 107/11</p> <p>halfway [1] 63/12</p> <p>hallucinations [2] 33/25 57/2</p> <p>hand [1] 110/17</p> <p>handed [2] 8/22 78/16</p> <p>handgun [1] 70/19</p> <p>handing [1] 81/4</p> <p>handover [1] 9/2</p> <p>hands [1] 60/4</p> <p>happen [4] 1/8 1/10 13/21 19/15</p> <p>happened [17] 11/18 13/15 16/23 23/2 23/5 25/3 30/14 33/23 83/13 98/23 102/2 104/10 104/10 104/11 113/22 114/7 115/11</p> <p>happening [8] 6/12 47/7 50/7 80/11 114/23 114/23 115/1 115/9</p> <p>happens [6] 1/24 17/13 18/22 20/1 67/1 115/18</p> <p>happy [7] 19/20 21/17 38/11 41/14 66/8 89/1 89/1</p> <p>hardly [1] 3/21</p> <p>harm [5] 33/17 34/4 34/4 42/1 53/10</p> <p>has [45] 1/24 3/19 4/19 5/12 14/9 14/9 18/2 21/12 21/19 25/19 27/5 27/22 31/13 31/18 33/2 33/14 33/14 37/9 37/20 37/21 38/7 39/1 39/22 39/23 47/19 50/24 51/23 52/13 53/19 53/22 54/25 59/16 61/22 64/3 66/9 79/7 87/10 91/16 99/6 99/7 104/22 105/20 106/13 106/17 107/2</p> <p>hasn't [5] 16/12 30/14 52/20 70/2 106/13</p> <p>have [217]</p> <p>haven't [9] 23/17 25/10 32/8 47/19</p> | <p>53/18 96/9 97/3 100/11 107/17</p> <p>having [23] 1/14 7/14 7/15 21/25 25/4 25/4 25/5 25/7 25/25 37/15 41/25 42/2 42/5 44/19 44/20 45/21 54/14 55/3 72/15 87/13 87/14 96/1 96/25</p> <p>he [239]</p> <p>he'd [26] 16/24 17/15 23/14 23/22 26/19 31/2 31/23 42/10 42/14 45/8 50/12 51/7 51/8 52/2 52/25 55/24 56/1 57/2 71/24 92/18 93/3 98/15 107/7 112/20 113/23 116/6</p> <p>He'll [1] 46/13</p> <p>he's [41] 3/22 6/14 6/16 8/9 14/3 15/4 15/13 16/10 16/11 16/11 16/12 16/20 17/12 21/24 27/6 27/8 27/9 29/6 29/7 32/11 36/19 36/20 36/21 37/24 37/25 45/7 45/12 45/13 50/16 51/15 51/16 53/8 53/9 53/9 53/10 71/15 93/22 94/7 94/9 99/15 106/7</p> <p>head [2] 44/21 70/13</p> <p>health [48] 4/4 4/22 12/14 16/1 16/5 21/19 22/17 23/8 24/10 24/14 24/24 29/10 33/1 33/9 33/12 33/14 33/17 34/11 34/14 35/3 40/5 40/8 40/12 40/14 41/11 41/18 47/25 53/20 53/21 56/19 60/12 70/6 70/7 72/17 77/1 84/5 84/24 93/18 93/22 94/7 98/17 110/11 110/21 111/7 112/3 112/16 112/23 113/2</p> <p>hear [2] 20/5 46/13</p> <p>heard [8] 4/10 49/19 49/20 51/14 93/14 104/16 113/5 113/16</p> <p>hearing [4] 16/24 40/22 64/6 116/12</p> <p>hears [1] 27/3</p> <p>Heath [8] 58/23 60/15 61/3 64/12 64/21 65/3 65/14 83/11</p> <p>held [1] 113/10</p> <p>help [9] 36/11 36/15 53/11 53/17 54/3 54/5 66/15 70/1 76/17</p> <p>helpful [5] 20/6 62/10 86/17 86/21 109/14</p> <p>hence [1] 40/20</p> | <p>her [19] 10/13 11/1 12/25 12/25 13/2 13/4 23/7 25/5 26/6 30/13 37/5 37/13 37/15 60/17 60/21 64/21 65/15 92/13 95/5</p> <p>here [28] 1/16 7/14 16/6 17/7 33/24 36/15 44/11 45/18 49/5 49/6 49/9 57/11 58/10 59/16 65/8 68/4 68/8 83/5 83/16 84/19 86/17 99/3 100/7 104/18 108/13 112/7 112/9 112/12</p> <p>here's [1] 106/24</p> <p>herself [1] 21/9</p> <p>Hi [2] 38/5 106/23</p> <p>high [2] 28/3 28/12</p> <p>higher [2] 1/23 7/1</p> <p>highlight [1] 50/3</p> <p>highlighted [2] 31/20 42/4</p> <p>Hiley [1] 63/11</p> <p>him [117] 5/22 6/5 6/7 9/18 11/19 13/14 14/4 14/8 14/10 14/17 15/10 17/4 20/7 21/11 22/22 23/22 24/9 24/13 24/15 25/22 25/25 27/13 27/20 29/1 29/6 29/6 29/15 30/16 30/17 30/19 31/1 31/17 31/22 32/9 34/9 36/2 36/17 37/3 39/2 39/23 40/3 42/1 42/23 43/11 43/16 43/18 45/22 46/13 47/18 47/21 48/13 48/14 49/4 52/21 52/21 52/25 53/5 53/12 54/16 54/18 54/20 54/23 56/3 56/3 56/5 56/7 56/11 56/12 56/14 56/16 57/4 58/12 58/13 58/14 58/15 60/12 61/7 64/17 67/7 69/19 69/23 69/24 70/22 72/15 73/7 73/11 73/13 78/20 82/18 93/15 93/17 94/4 94/17 96/7 96/12 96/17 96/18 96/19 96/23 97/4 97/9 97/11 97/13 100/23 101/1 101/2 101/7 101/20 102/21 102/23 103/3 104/7 104/23 105/3 105/13 107/17 113/18</p> <p>himself [4] 16/7 24/1 25/1 70/24</p> <p>his [110] 1/16 2/2 3/17 6/16 6/17 7/6 7/17 7/21 7/23 7/23 8/23 14/5 16/8 18/13</p> | <p>20/9 20/21 21/13 21/19 21/21 21/24 22/2 23/18 24/2 24/19 25/4 25/5 25/9 25/9 25/17 25/21 27/16 27/22 28/17 28/21 28/23 29/9 29/19 30/1 30/24 32/2 33/5 36/16 36/20 36/22 37/3 37/4 37/6 37/12 37/14 37/21 37/22 37/24 39/6 39/16 39/25 41/24 42/21 43/1 43/2 48/14 48/23 49/16 49/19 49/22 50/19 51/5 51/6 51/23 53/9 55/25 56/1 56/7 56/12 56/18 58/15 60/12 71/4 71/10 72/8 73/12 78/20 78/20 82/21 84/4 85/14 85/19 85/20 86/1 91/13 92/10 92/21 93/13 96/4 96/16 96/20 97/13 98/1 98/5 98/22 99/5 99/10 99/12 99/21 101/2 101/25 103/3 105/3 107/4 108/3 115/22</p> <p>historic [2] 33/22 56/19</p> <p>historically [2] 33/23 53/16</p> <p>hm [2] 51/2 112/13</p> <p>home [5] 20/23 21/1 34/24 37/20 102/8</p> <p>honest [2] 16/13 19/18</p> <p>honestly [2] 30/11 107/14</p> <p>hope [1] 25/20</p> <p>hoped [1] 39/9</p> <p>hospital [7] 3/15 17/1 17/23 23/12 51/8 56/15 112/21</p> <p>hour [1] 1/5</p> <p>hours [7] 35/8 74/3 74/5 75/16 75/22 78/4 80/2</p> <p>house [3] 20/5 29/7 70/16</p> <p>how [20] 4/12 5/12 8/6 19/2 25/6 29/6 29/21 31/14 38/19 43/14 43/18 44/18 48/20 50/24 56/3 65/21 66/10 69/16 85/4 115/7</p> <p>however [6] 21/3 25/22 32/17 42/8 43/2 55/9</p> <p>huge [1] 80/23</p> <p>human [1] 59/21</p> <p>hung [1] 2/22</p> <p>hurt [1] 23/21</p> |
|--|--|---|---|---|

| | | | | |
|--|--|---|--|---|
| <p>I</p> <p>I actively [1] 9/15</p> <p>I actually [2] 99/14 108/6</p> <p>I agree [1] 3/25</p> <p>I also [2] 94/23 114/5</p> <p>I always [1] 81/13</p> <p>I am [4] 59/16 79/11 82/14 110/19</p> <p>I and [1] 63/13</p> <p>I appreciate [1] 42/25</p> <p>I ask [3] 74/17 103/13 109/8</p> <p>I asked [1] 61/14</p> <p>I assumed [1] 84/7</p> <p>I be [1] 75/10</p> <p>I believe [8] 27/12 27/14 41/13 75/13 88/21 88/22 103/22 104/4</p> <p>I believed [1] 106/7</p> <p>I briefly [1] 69/11</p> <p>I can [15] 4/11 47/5 52/8 66/10 71/16 72/10 103/2 107/14 107/20 107/25 109/13 110/23 112/7 112/18 115/5</p> <p>I can't [11] 12/12 12/14 22/12 43/12 70/12 71/15 72/3 89/6 89/19 104/13 111/6</p> <p>I cannot [1] 72/7</p> <p>I certainly [2] 58/13 92/15</p> <p>I completely [1] 60/5</p> <p>I could [6] 24/21 41/7 63/4 63/7 103/17 108/14</p> <p>I couldn't [1] 44/21</p> <p>I definitely [1] 26/3</p> <p>I did [7] 19/18 25/11 26/24 41/5 42/17 69/12 98/10</p> <p>I didn't [14] 8/5 9/24 20/8 25/14 28/10 42/13 48/6 70/17 70/20 74/13 81/17 87/1 110/8 110/16</p> <p>I do [6] 3/5 25/25 69/5 71/12 72/24 81/20</p> <p>I don't [49] 2/22 3/8 4/16 7/8 9/25 15/11 16/4 18/19 22/12 26/18 26/23 28/9 29/4 30/6 38/8 38/10 38/12 40/6 43/19 44/12 45/15 48/18 51/3 55/13 55/16 57/6 57/14 57/17 59/1 59/19 62/1 62/8 74/23 76/11 87/25 89/12 89/19 102/6 103/4</p> | <p>104/9 104/10 105/18 106/1 107/14 110/23 114/5 114/5 114/6 116/4</p> <p>I ever [2] 26/18 26/23</p> <p>I feel [2] 101/23 105/2</p> <p>I felt [3] 1/16 31/18 114/20</p> <p>I flagged [1] 80/10</p> <p>I found [1] 80/16</p> <p>I give [1] 66/2</p> <p>I got [2] 20/1 97/11</p> <p>I guess [3] 28/17 48/7 98/25</p> <p>I had [10] 13/22 24/4 43/7 56/17 75/22 75/22 88/11 91/24 99/23 110/16</p> <p>I hadn't [5] 8/14 9/16 48/6 56/11 60/16</p> <p>I have [23] 20/2 37/4 55/9 59/9 61/4 72/12 72/21 73/1 83/3 83/5 83/6 86/11 86/11 87/24 88/22 89/20 91/3 107/20 107/24 109/23 110/2 110/4 111/20</p> <p>I haven't [3] 25/10 97/3 107/17</p> <p>I honestly [1] 30/11</p> <p>I just [10] 3/23 43/24 46/1 49/1 49/15 58/20 73/24 75/8 89/17 115/7</p> <p>I kept [1] 14/24</p> <p>I knew [3] 8/21 13/23 15/8</p> <p>I know [7] 13/17 17/11 34/9 38/9 40/1 48/16 107/18</p> <p>I looked [2] 66/13 108/5</p> <p>I made [2] 25/10 43/22</p> <p>I make [2] 14/16 31/8</p> <p>I may [2] 66/24 71/17</p> <p>I mean [1] 89/11</p> <p>I mentioned [1] 75/21</p> <p>I must [3] 15/9 40/8 65/16</p> <p>I need [1] 105/13</p> <p>I needed [1] 49/12</p> <p>I noted [2] 97/25 98/5</p> <p>I possibly [2] 50/15 72/13</p> <p>I probably [1] 26/6</p> <p>I raised [1] 77/10</p> <p>I read [4] 1/14 42/17 66/6 108/3</p> <p>I realised [1] 48/11</p> <p>I refer [1] 35/21</p> <p>I rely [2] 23/4 23/5</p> <p>I remember [7] 50/19</p> | <p>57/9 71/10 72/2 94/23 107/18 107/19</p> <p>I represent [1] 91/10</p> <p>I said [1] 47/21</p> <p>I said -- I specifically [1] 94/25</p> <p>I saw [3] 26/3 69/11 69/12</p> <p>I say [1] 68/5</p> <p>I see [1] 116/8</p> <p>I sent [1] 43/13</p> <p>I should [2] 28/9 66/12</p> <p>I specifically [3] 72/14 92/2 95/14</p> <p>I spoke [2] 60/15 80/16</p> <p>I start [1] 103/14</p> <p>I suggest [3] 95/18 96/25 102/23</p> <p>I take [2] 51/6 106/18</p> <p>I think [67] 4/25 6/4 13/18 15/9 16/17 17/8 17/13 17/16 17/17 24/9 27/15 31/7 34/10 35/16 35/20 36/9 36/19 38/15 38/20 39/24 40/8 42/16 45/18 47/22 50/25 51/7 51/11 52/5 53/23 54/3 57/18 59/2 60/14 60/17 60/20 62/18 65/20 66/3 69/12 72/25 74/21 75/12 76/12 76/14 77/22 86/6 88/4 89/3 97/8 97/10 98/19 98/21 100/10 100/11 104/7 104/8 104/11 104/13 105/16 108/25 113/3 113/21 113/23 114/17 115/15 115/21 115/22</p> <p>I thought [2] 106/5 116/6</p> <p>I took [1] 11/13</p> <p>I understand [4] 1/17 11/12 46/3 97/7</p> <p>I understood [1] 75/7</p> <p>I want [2] 110/20 112/25</p> <p>I wanted [2] 31/17 32/14</p> <p>I was [21] 21/1 32/17 37/12 48/16 66/22 66/25 69/11 75/4 76/16 79/24 82/6 82/9 83/9 83/17 83/18 88/11 88/21 94/15 106/1 108/4 113/3</p> <p>I wasn't [9] 6/3 11/18 13/10 19/20 25/9 28/10 52/5 76/15 93/9</p> <p>I will [4] 65/25 70/13 105/2 107/3</p> <p>I worked [1] 51/11</p> <p>I worried [1] 40/2</p> | <p>I would [12] 9/1 9/2 22/8 31/17 64/17 67/7 67/15 67/24 68/24 77/23 78/4 110/10</p> <p>I wouldn't [9] 8/17 29/13 42/16 48/7 57/4 58/3 65/13 67/25 106/14</p> <p>I'd [21] 4/7 24/5 39/9 49/16 49/20 50/1 54/15 56/14 63/4 63/7 71/17 74/23 83/8 83/8 83/9 83/9 83/10 83/12 83/16 100/8 110/17</p> <p>I'll [5] 19/17 78/15 91/6 93/16 109/15</p> <p>I'm [66] 3/4 9/1 15/11 18/15 19/3 19/4 25/19 26/7 34/10 45/24 48/23 48/24 58/10 59/4 59/5 66/8 67/25 68/20 69/5 69/5 69/5 69/7 71/15 76/18 76/25 77/22 78/7 78/10 79/15 79/18 79/19 79/22 80/24 81/13 81/25 82/24 84/12 85/1 85/7 86/6 88/2 89/1 89/1 89/11 89/12 90/15 90/17 90/24 93/6 94/6 96/24 97/15 97/17 100/3 100/6 100/6 103/11 105/19 106/16 107/10 108/25 111/13 112/4 114/8 115/7 116/5</p> <p>I've [18] 6/4 12/7 13/24 14/15 27/13 34/8 58/8 60/4 62/8 71/23 72/13 79/23 83/17 86/2 95/25 98/8 103/2 109/1</p> <p>I, [1] 25/4</p> <p>I, having [1] 25/4</p> <p>idea [1] 31/11</p> <p>ideal [1] 41/17</p> <p>ideally [1] 31/16</p> <p>ideas [1] 72/14</p> <p>identified [3] 34/20 79/7 86/16</p> <p>ie [1] 1/19</p> <p>if [116] 2/6 2/6 2/10 3/8 3/13 5/8 5/10 8/10 9/20 10/13 14/20 15/13 15/16 18/20 19/5 20/3 20/17 22/15 22/21 26/12 27/2 27/18 29/25 30/9 30/22 31/9 32/3 34/7 34/21 35/20 37/22 37/24 38/22 39/7 39/9 39/20 40/2 41/22 43/9 44/1 45/3 46/19 47/7 50/19 50/20 51/13 52/16 53/13 54/9 54/14 54/17 54/19</p> | <p>55/6 56/5 56/22 57/25 58/4 59/7 59/16 62/19 62/19 63/4 63/7 63/24 64/9 64/25 66/8 66/18 66/18 67/18 67/23 68/16 68/17 68/21 69/24 70/13 70/21 71/17 74/11 76/3 76/8 77/22 79/3 80/7 84/10 84/21 84/25 86/6 86/15 86/17 87/5 88/23 92/11 93/9 97/18 98/8 103/1 103/3 103/17 104/15 105/5 105/5 105/19 105/21 106/7 106/10 106/12 107/22 108/14 109/14 112/5 112/7 112/9 112/18 113/3 115/19</p> <p>iii [1] 27/18</p> <p>Ilkeston [1] 70/10</p> <p>Ilkeston Road [1] 70/10</p> <p>illness [3] 18/1 27/22 28/23</p> <p>illuminated [1] 32/3</p> <p>imagine [1] 14/10</p> <p>immediate [4] 16/10 31/19 49/1 89/24</p> <p>immediately [10] 3/4 29/2 30/3 40/9 48/21 56/18 66/8 86/15 87/2 111/1</p> <p>immensely [1] 66/15</p> <p>imminent [2] 70/2 70/3</p> <p>impacted [1] 17/7</p> <p>importance [1] 71/18</p> <p>important [11] 28/5 46/1 65/8 65/14 67/17 71/20 80/9 96/3 96/5 111/16 111/22</p> <p>impossible [2] 52/6 78/3</p> <p>impression [2] 21/19 92/16</p> <p>impressive [1] 98/21</p> <p>incident [10] 39/25 40/10 40/11 50/4 93/14 109/17 112/25 113/4 114/21 115/4</p> <p>incidents [2] 112/4 115/9</p> <p>include [3] 5/9 34/19 76/5</p> <p>including [4] 24/19 83/17 84/23 109/25</p> <p>increase [3] 3/16 16/7 46/25</p> <p>incredibly [3] 24/20 69/19 98/17</p> <p>indeed [4] 26/12 32/19 56/21 92/18</p> <p>independent [1] 48/4</p> <p>independently [1]</p> |
|--|--|---|--|---|

| | | | | |
|--|---|--|--|--|
| <p>I</p> <p>independently... [1] 7/2</p> <p>indicated [2] 54/15 100/15</p> <p>indicates [2] 23/21 99/6</p> <p>indication [1] 94/1</p> <p>indirect [2] 6/6 7/5</p> <p>individual [1] 90/13</p> <p>individuals [3] 25/8 110/10 115/20</p> <p>inexperienced [1] 22/9</p> <p>inflated [1] 75/16</p> <p>inform [4] 109/24 110/5 110/7 112/3</p> <p>information [16] 12/21 23/5 26/24 37/15 39/10 39/11 39/13 44/22 57/7 60/11 60/14 60/18 68/13 96/12 96/19 98/20</p> <p>informing [1] 49/11</p> <p>initial [2] 11/6 68/25</p> <p>initially [1] 61/18</p> <p>initiative [1] 53/7</p> <p>injury [1] 27/23</p> <p>inpatient [3] 16/13 23/9 48/15</p> <p>input [3] 65/15 67/17 111/11</p> <p>inputting [1] 79/11</p> <p>Inquiry [6] 61/22 74/19 75/20 76/17 88/14 115/16</p> <p>insight [3] 1/7 26/1 43/2</p> <p>instead [1] 54/22</p> <p>instruct [2] 109/24 110/6</p> <p>instructed [1] 60/24</p> <p>intended [1] 63/21</p> <p>intensively [1] 10/16</p> <p>intent [1] 1/25</p> <p>intention [1] 30/16</p> <p>intentionally [1] 82/20</p> <p>interested [4] 14/13 26/19 54/16 54/18</p> <p>interesting [2] 49/24 59/3</p> <p>interests [1] 112/10</p> <p>interfering [1] 41/25</p> <p>intervention [3] 19/2 61/25 65/21</p> <p>interview [2] 63/21 64/3</p> <p>interviewing [1] 63/14</p> <p>into [13] 1/17 1/18 23/12 24/19 25/8 28/7 37/18 41/3 51/8 72/11 91/13 94/1 107/19</p> | <p>investigation [1] 63/11</p> <p>invite [2] 52/14 52/17</p> <p>invited [1] 81/12</p> <p>involved [10] 6/3 11/4 11/18 28/10 63/15 65/11 70/5 71/1 81/6 84/1</p> <p>involvement [8] 6/6 53/3 61/7 64/17 66/15 67/6 77/20 88/18</p> <p>irritated [3] 95/5 95/12 95/22</p> <p>is [225]</p> <p>is: [1] 112/25</p> <p>is: what [1] 112/25</p> <p>isn't [32] 3/23 4/21 6/14 12/8 17/12 20/14 22/7 29/14 32/17 39/3 43/1 44/15 49/22 50/14 50/16 51/1 59/20 59/20 65/6 74/8 80/11 80/22 86/9 91/11 91/14 91/18 94/16 95/19 98/7 98/24 105/25 114/22</p> <p>issue [8] 17/17 53/22 74/20 76/1 76/2 76/11 76/23 103/14</p> <p>issued [2] 54/7 54/9</p> <p>issues [5] 7/4 53/21 70/6 98/18 113/13</p> <p>it [322]</p> <p>it's [110] 3/8 3/21 5/1 5/6 7/8 7/11 7/15 9/8 9/17 12/3 12/8 12/12 17/4 17/5 18/25 19/17 20/14 22/7 28/15 29/14 31/4 31/7 31/12 35/14 35/16 35/16 42/4 44/15 45/8 45/15 48/11 49/7 50/18 51/1 51/24 55/1 55/7 58/8 58/9 58/23 59/6 59/16 60/2 60/3 60/3 60/4 60/5 60/7 63/10 63/11 65/22 66/2 67/3 67/4 71/8 71/9 72/5 72/9 74/8 74/10 76/2 78/1 79/23 80/21 80/21 80/22 81/13 83/7 83/20 84/11 84/12 86/8 86/9 87/4 87/8 87/22 88/18 88/22 91/11 91/15 95/18 97/17 98/9 98/25 99/1 99/23 100/1 101/4 101/14 102/6 103/4 103/4 103/5 103/25 103/25 104/8 105/5 105/21 106/10 106/10 107/11 107/24 108/1 108/10 109/14 110/4 111/4 112/7 113/7 115/7</p> <p>iteration [1] 88/8</p> | <p>J</p> <p>January [19] 3/7 37/18 38/2 38/3 38/22 39/13 39/21 40/21 40/23 41/2 52/3 92/4 99/3 99/9 109/18 110/22 111/22 112/24 113/14</p> <p>January 2021 [1] 3/7</p> <p>January 2022 [1] 112/24</p> <p>job [5] 17/5 73/24 73/25 74/5 74/8</p> <p>joint [1] 79/20</p> <p>journey [1] 17/10</p> <p>judgement [1] 25/1</p> <p>judgemental [2] 3/14 4/21</p> <p>judgmental [2] 4/5 4/16</p> <p>July [6] 1/4 8/25 20/9 29/5 70/19 78/16</p> <p>July 2021 [1] 29/5</p> <p>jumped [1] 1/21</p> <p>jumping [2] 3/8 27/24</p> <p>jumps [1] 1/23</p> <p>June [5] 50/22 51/9 85/11 85/12 91/12</p> <p>June 2023 [1] 91/12</p> <p>just [90] 3/23 9/14 9/17 9/19 11/17 12/4 12/12 12/13 14/2 17/1 21/3 21/4 24/9 24/25 27/16 35/23 36/22 38/18 38/19 39/22 42/17 43/24 46/1 49/1 49/7 49/14 49/15 49/22 52/10 56/15 57/3 57/7 57/24 58/20 60/21 65/6 66/3 73/24 75/8 76/11 76/25 77/2 77/24 78/1 78/1 80/12 80/14 80/18 81/23 85/3 85/9 85/17 86/22 89/7 89/12 89/17 89/17 89/21 93/3 94/6 95/10 95/11 95/21 95/25 96/20 97/2 99/17 99/20 101/15 102/11 102/14 102/18 102/20 103/15 103/18 103/25 104/15 104/20 106/20 107/11 108/7 108/14 109/16 110/17 112/18 113/3 114/11 115/7 115/13 115/13</p> <p>justified [1] 46/8</p> <p>justify [1] 46/10</p> | <p>keeps [2] 17/14 21/23</p> <p>kept [1] 14/24</p> <p>kick [1] 1/20</p> <p>kicking [1] 27/14</p> <p>kill [1] 2/1</p> <p>killing [3] 1/9 1/24 2/2</p> <p>kind [11] 1/25 5/7 6/2 24/16 25/6 34/2 34/2 43/16 45/16 60/20 73/2</p> <p>knew [14] 8/4 8/8 8/21 13/23 15/8 24/24 33/7 50/15 52/25 56/2 69/25 77/3 97/10 97/11</p> <p>knocking [1] 51/15</p> <p>knocks [1] 51/14</p> <p>know [112] 1/25 7/8 8/5 9/12 9/25 13/8 13/17 14/3 14/13 16/14 16/21 17/11 17/17 18/5 18/19 19/22 20/6 20/8 20/9 24/21 25/14 28/9 28/14 29/3 29/4 29/6 29/7 29/25 31/10 32/11 33/13 34/9 37/22 37/24 37/25 38/6 38/8 38/9 38/12 40/1 40/21 40/22 41/17 42/10 42/12 42/13 42/14 42/21 43/19 43/22 43/24 44/18 45/16 48/5 48/6 48/7 48/8 48/9 48/16 48/20 48/24 49/7 49/12 52/16 53/10 53/11 53/25 54/3 54/8 54/9 54/18 55/22 56/5 57/14 57/22 59/1 59/19 64/25 69/16 70/17 70/20 72/7 73/12 73/12 73/21 76/18 77/17 77/25 80/18 80/21 83/23 83/25 86/4 86/7 86/16 87/25 97/17 98/16 101/9 101/11 102/6 103/5 107/14 107/18 107/18 112/25 114/5 114/5 114/6 115/8 115/24 116/4</p> <p>knowing [3] 19/6 26/19 54/12</p> <p>knowledge [8] 25/11 59/11 65/19 67/16 67/23 67/24 110/17 111/21</p> <p>known [10] 16/15 28/18 29/13 34/25 48/7 68/1 74/20 75/2 76/4 76/14</p> | <p>L</p> <p>lack [2] 17/6 37/8</p> <p>lady [1] 63/10</p> <p>Langdale [5] 63/3 63/6 69/14 71/19 77/5</p> <p>language [1] 4/4</p> <p>last [11] 25/21 31/24 40/1 60/23 63/3 63/7 86/12 100/12 100/12 101/21 111/13</p> <p>late [1] 99/8</p> <p>later [13] 9/9 14/6 29/12 31/24 58/7 60/16 61/24 86/15 98/10 104/11 108/8 108/12 108/14</p> <p>law [3] 4/24 41/19 45/24</p> <p>lead [14] 10/25 28/16 34/18 47/23 48/19 59/10 65/18 79/10 89/10 89/11 89/13 92/18 92/25 93/6</p> <p>lead-up [6] 28/16 47/23 48/19 92/18 92/25 93/6</p> <p>leader [4] 57/19 59/9 80/10 99/6</p> <p>leadership [4] 59/12 59/14 59/15 80/25</p> <p>leading [4] 8/15 28/24 49/10 66/24</p> <p>learn [1] 14/18</p> <p>least [9] 3/15 4/5 4/8 21/23 31/18 33/14 41/12 48/22 111/12</p> <p>leave [6] 52/2 64/23 76/9 89/17 91/6 104/17</p> <p>led [3] 1/15 22/17 60/20</p> <p>left [4] 14/24 15/5 15/15 78/16</p> <p>legal [1] 78/7</p> <p>legible [1] 78/23</p> <p>length [1] 102/9</p> <p>lesser [1] 98/11</p> <p>let [5] 16/14 45/25 64/25 74/24 102/13</p> <p>let's [19] 3/11 13/25 21/10 30/14 36/22 36/22 54/24 77/2 81/23 85/3 88/12 88/25 89/7 89/17 89/21 91/20 92/3 94/10 105/21</p> <p>lets [1] 14/3</p> <p>letter [14] 58/22 60/19 60/21 65/2 65/12 65/13 81/4 81/10 81/14 81/17 81/20 81/21 84/3 84/21</p> <p>letters [1] 81/22</p> <p>level [16] 6/17 7/5</p> |
|--|---|--|--|--|

| | | | | |
|---|--|--|--|---|
| L | 8/10 8/19 9/20 11/10 14/20 21/10 21/23 22/2 22/21 29/18 30/13 30/22 34/8 34/15 35/21 41/3 54/24 64/5 66/9 71/2 81/23 82/3 85/1 85/3 85/6 85/17 87/5 88/12 88/25 89/1 89/1 89/21 90/14 91/20 92/3 104/15 105/23 106/3 106/8 106/11 106/15 107/12 107/22 108/5 109/15 112/5 looked [10] 8/14 8/17 15/2 17/10 61/11 66/13 83/9 86/11 106/24 108/5 looking [8] 14/13 38/9 87/14 87/25 88/2 89/6 89/12 111/4 looks [7] 3/24 4/1 14/7 22/10 40/10 46/19 47/6 lost [3] 69/9 73/11 73/13 lot [9] 9/20 10/18 12/2 17/11 32/24 36/20 51/1 65/18 67/1 lots [1] 87/13 | 101/5 management [7] 5/7 5/23 5/25 12/24 57/19 57/21 60/1 manager [2] 13/11 19/19 manages [2] 43/1 98/18 many [24] 4/7 4/12 4/16 19/25 29/21 44/17 44/18 44/19 50/24 52/5 52/21 64/20 65/9 65/24 66/1 66/7 79/12 80/15 94/21 96/1 96/7 97/4 101/19 104/22 Manzar [2] 24/23 24/23 Manzar's [1] 99/9 March [12] 18/7 18/10 18/12 47/12 56/12 56/14 56/14 56/17 97/24 100/1 100/2 100/3 March 2021 [1] 18/10 March 2022 [4] 47/12 100/1 100/2 100/3 marks [1] 98/22 masked [1] 96/4 masking [1] 49/4 Masters [2] 98/11 98/14 material [4] 105/8 105/10 105/14 105/22 matter [1] 54/21 may [23] 1/1 20/4 23/6 28/10 28/14 34/19 35/4 35/7 35/17 38/6 39/5 62/15 66/24 67/4 71/8 71/17 78/23 87/12 90/4 105/14 107/16 108/15 111/9 maybe [3] 39/9 54/4 66/11 McGowan [1] 61/22 MDT [41] 6/8 12/2 13/20 37/23 38/15 38/24 39/5 53/3 54/14 54/24 55/14 57/6 57/9 57/16 72/4 75/4 77/2 77/20 77/23 78/19 79/3 79/8 81/16 81/18 81/25 82/2 82/9 82/10 83/2 90/5 90/9 90/11 104/3 106/3 107/5 107/8 107/23 108/10 108/18 115/17 116/3 MDTs [10] 74/20 74/25 75/3 75/12 77/3 77/17 79/17 80/6 80/9 108/23 me [55] 6/3 8/22 9/10 13/5 17/10 19/5 23/6 24/8 26/5 26/9 35/23 37/11 37/21 39/22 45/19 45/25 46/12 | 52/14 60/23 64/25 65/8 65/10 66/6 66/11 67/2 67/4 67/5 67/15 72/9 74/24 76/7 78/2 79/6 80/18 80/22 87/2 87/13 89/11 91/23 93/25 95/5 95/13 98/3 99/20 99/24 100/4 100/7 100/16 102/13 103/6 103/24 105/18 108/15 110/4 112/11 mean [4] 13/21 59/18 89/11 105/18 meaning [2] 67/9 111/9 mechanical [1] 98/16 mechanisms [1] 10/7 medical [16] 12/5 19/16 19/21 21/17 23/4 57/20 71/4 74/12 77/14 78/21 84/13 84/15 90/6 95/8 96/11 96/19 medically [1] 8/16 medication [46] 2/19 7/17 7/23 8/9 8/20 15/4 15/5 15/10 15/13 19/12 21/18 21/20 21/24 22/2 28/17 28/21 29/1 30/2 30/3 30/13 30/15 30/18 32/2 32/6 32/11 32/13 32/20 37/22 37/24 40/24 41/14 42/6 43/17 44/9 44/10 45/1 45/12 46/5 47/14 47/16 47/22 53/9 56/16 82/21 84/21 85/14 medications [3] 21/13 21/22 45/7 meds [2] 14/23 14/24 meet [6] 7/5 16/9 33/12 47/12 64/24 65/3 meeting [31] 24/17 46/22 47/12 49/2 55/8 55/11 57/6 61/7 64/17 65/5 67/7 68/7 68/9 68/14 68/15 71/22 71/25 72/2 72/4 72/24 72/25 81/6 81/8 81/11 81/15 83/4 97/23 100/16 104/6 106/4 107/15 meetings [4] 12/3 75/4 75/18 83/7 meets [1] 21/11 member [7] 79/7 79/11 79/14 79/15 79/19 90/6 90/13 members [3] 62/4 82/14 105/23 memories [1] 83/6 memory [7] 18/12 18/14 55/10 72/15 | 82/9 83/4 83/13 mental [63] 4/3 4/22 5/15 6/13 6/16 6/18 9/7 10/4 10/7 10/11 12/14 15/25 16/4 21/14 21/19 22/17 23/8 23/10 24/10 24/14 24/24 29/9 32/25 33/5 33/9 33/12 33/13 33/17 34/11 34/14 35/2 40/4 40/8 40/12 40/14 41/11 41/18 47/25 53/20 56/18 56/25 70/6 70/7 72/17 77/1 84/5 84/24 93/18 93/22 94/7 96/16 96/21 98/17 101/25 105/4 107/4 110/11 110/21 111/7 112/3 112/16 112/23 113/1 mentioned [6] 6/4 20/13 55/22 75/21 95/6 95/10 messages [1] 37/10 met [4] 16/4 32/25 34/13 67/14 MI5 [1] 24/13 mid [1] 29/12 middle [2] 49/19 93/11 Middleton [1] 46/17 might [7] 5/18 20/22 25/6 25/12 39/11 88/4 113/4 Mike [1] 40/22 Milligan [3] 103/9 103/10 117/6 milligrams [2] 31/25 32/1 mind [3] 3/8 19/5 87/9 mindful [1] 58/20 mine [1] 79/10 minimised [1] 28/6 minimum [2] 57/16 57/17 minutes [3] 68/15 110/4 116/2 minutes' [1] 49/6 misleading [1] 94/16 missed [14] 31/23 32/5 32/7 34/23 37/9 37/18 37/20 47/14 47/21 50/24 51/1 51/8 89/15 93/24 missing [10] 40/24 51/21 53/5 53/5 55/15 55/23 55/24 56/2 72/19 100/19 mistake [1] 83/16 mitigate [1] 34/19 Mm [4] 51/2 83/22 99/16 112/13 Mm-hm [2] 51/2 112/13 |
| level... [14] 10/5 10/9 11/24 13/17 31/11 31/12 78/2 85/9 87/22 87/24 89/25 90/2 90/4 90/14 liaise [3] 14/25 47/3 50/5 liaised [1] 47/2 liaison [2] 50/11 110/13 lie [1] 30/3 life [3] 24/2 70/2 70/4 light [3] 13/14 39/24 85/25 like [33] 3/8 3/13 3/15 3/19 3/24 4/2 4/3 4/7 7/25 8/9 14/7 19/25 22/2 23/8 23/22 42/9 42/12 47/20 49/14 50/9 53/13 61/11 63/4 63/7 68/21 71/17 72/4 86/9 86/18 86/20 92/15 101/5 111/1 likely [3] 23/25 25/2 56/5 likewise [1] 9/23 limb [2] 70/2 70/4 limit [1] 80/25 limited [5] 41/18 61/6 64/5 64/16 67/6 line [6] 13/11 19/19 21/21 53/25 60/16 105/1 lines [1] 103/11 linked [1] 70/16 list [1] 59/18 listed [2] 5/10 13/17 listen [1] 102/18 listening [1] 7/12 little [5] 9/4 9/15 92/8 92/22 95/4 live [2] 51/16 88/18 living [2] 52/3 56/4 Lloyd [17] 1/4 14/21 19/6 36/17 37/9 42/20 51/17 63/1 68/18 74/14 74/17 74/19 91/10 103/13 109/8 111/20 114/11 LMHT [1] 19/3 loading [1] 103/18 Local [1] 12/13 locally [1] 76/16 locate [1] 52/25 locking [1] 39/25 Lomas [1] 24/24 Lomas' [2] 24/6 24/6 London [1] 20/5 long [6] 23/8 29/1 43/18 46/6 91/4 112/8 longer [3] 12/25 21/15 38/20 look [48] 3/12 4/3 | M made [33] 8/2 25/10 26/20 30/20 34/22 43/21 43/22 45/22 54/25 55/3 61/5 64/15 73/2 77/23 78/20 79/2 79/5 79/6 81/7 81/8 81/24 82/2 82/24 83/12 83/16 91/12 100/13 100/14 100/23 100/24 101/15 104/3 105/20 Madison [3] 51/25 52/4 71/11 Madison Court [3] 51/25 52/4 71/11 maintained [1] 67/19 majority [1] 59/12 make [19] 14/16 15/6 18/22 31/8 37/2 41/6 46/1 47/4 55/2 66/1 68/3 78/21 78/24 80/22 83/20 83/21 89/13 91/3 103/5 makes [2] 79/1 84/13 making [11] 14/7 34/25 36/23 65/23 72/25 77/16 79/4 79/19 80/2 85/22 87/15 male [2] 22/23 23/22 man [3] 24/8 36/6 98/17 manage [5] 28/4 28/13 47/8 48/20 | ment [4] 13/21 59/18 89/11 105/18 meaning [2] 67/9 111/9 mechanical [1] 98/16 mechanisms [1] 10/7 medical [16] 12/5 19/16 19/21 21/17 23/4 57/20 71/4 74/12 77/14 78/21 84/13 84/15 90/6 95/8 96/11 96/19 medically [1] 8/16 medication [46] 2/19 7/17 7/23 8/9 8/20 15/4 15/5 15/10 15/13 19/12 21/18 21/20 21/24 22/2 28/17 28/21 29/1 30/2 30/3 30/13 30/15 30/18 32/2 32/6 32/11 32/13 32/20 37/22 37/24 40/24 41/14 42/6 43/17 44/9 44/10 45/1 45/12 46/5 47/14 47/16 47/22 53/9 56/16 82/21 84/21 85/14 medications [3] 21/13 21/22 45/7 meds [2] 14/23 14/24 meet [6] 7/5 16/9 33/12 47/12 64/24 65/3 meeting [31] 24/17 46/22 47/12 49/2 55/8 55/11 57/6 61/7 64/17 65/5 67/7 68/7 68/9 68/14 68/15 71/22 71/25 72/2 72/4 72/24 72/25 81/6 81/8 81/11 81/15 83/4 97/23 100/16 104/6 106/4 107/15 meetings [4] 12/3 75/4 75/18 83/7 meets [1] 21/11 member [7] 79/7 79/11 79/14 79/15 79/19 90/6 90/13 members [3] 62/4 82/14 105/23 memories [1] 83/6 memory [7] 18/12 18/14 55/10 72/15 | | |

| | | | | |
|--|---|---|---|--|
| <p>M</p> <p>module [1] 99/7</p> <p>Moloney [3] 62/24 62/25 117/3</p> <p>moment [6] 14/21 25/3 36/21 99/20 103/25 109/15</p> <p>moments [1] 99/25</p> <p>Monday [1] 51/18</p> <p>monitor [2] 16/2 39/2</p> <p>monitoring [10] 5/15 9/7 10/3 10/6 10/10 15/19 15/22 19/11 19/12 19/14</p> <p>month [5] 11/18 28/24 58/11 82/17 101/3</p> <p>months [10] 21/8 52/21 73/14 94/21 96/1 96/7 96/9 97/4 101/20 104/22</p> <p>mood [5] 5/15 9/7 10/4 10/6 10/10</p> <p>more [25] 6/6 9/3 10/16 12/14 16/17 16/22 22/3 32/24 38/8 38/12 38/13 55/21 57/6 65/18 68/13 73/22 77/6 77/7 77/16 77/18 100/22 102/25 103/4 108/7 113/5</p> <p>morning [5] 8/6 60/24 61/14 64/13 116/10</p> <p>most [5] 6/22 15/23 66/2 81/2 87/18</p> <p>mother [4] 37/14 52/20 93/12 105/11</p> <p>move [4] 13/25 30/14 45/25 46/11</p> <p>moving [2] 22/20 69/5</p> <p>Mr [12] 62/24 62/25 91/8 91/9 100/14 102/24 103/1 103/15 103/21 104/20 117/3 117/5</p> <p>Mr Carter [4] 100/14 102/24 103/1 103/21</p> <p>Mr Moloney [3] 62/24 62/25 117/3</p> <p>Mr Straw [5] 91/8 91/9 103/15 104/20 117/5</p> <p>Mrs [1] 46/17</p> <p>Mrs Sue [1] 46/17</p> <p>Ms [20] 25/18 63/3 63/6 69/8 69/14 71/19 74/15 74/16 77/5 91/3 99/4 103/9 103/10 106/22 108/12 109/6 109/7 117/4 117/6 117/7</p> <p>Ms Birtles [2] 25/18 99/4</p> | <p>Ms Cartwright [4] 74/15 74/16 91/3 117/4</p> <p>Ms Langdale [5] 63/3 63/6 69/14 71/19 77/5</p> <p>Ms Milligan [3] 103/9 103/10 117/6</p> <p>Ms Parsonage [2] 106/22 108/12</p> <p>Ms Robinson [1] 69/8</p> <p>much [14] 10/16 12/14 14/17 28/22 30/18 38/19 55/21 57/25 60/15 74/14 76/6 103/7 110/23 115/22</p> <p>Multi [1] 36/5</p> <p>Multi-Disciplinary [1] 36/5</p> <p>multiple [1] 17/24</p> <p>mum [9] 34/7 37/3 37/4 39/6 39/9 55/24 94/13 95/1 101/9</p> <p>must [7] 7/5 15/9 40/8 65/16 83/14 89/13 90/5</p> <p>my [46] 3/23 6/6 7/14 9/25 11/19 13/24 17/4 19/19 27/13 29/11 30/16 35/21 35/21 42/17 44/4 44/21 48/25 60/4 61/6 62/15 64/5 64/16 67/6 69/6 70/12 72/21 76/6 76/13 76/15 78/4 79/11 80/16 81/13 83/3 83/4 83/9 83/13 88/22 88/23 98/13 99/18 99/23 100/8 104/4 105/5 114/9</p> <p>myself [6] 9/24 12/21 65/19 66/12 66/23 90/7</p> | <p>7/24 12/11 15/25 21/3 24/2 30/20 49/2 49/12 55/6 66/22 66/25 79/12 84/22 90/19 90/21 100/18 107/8 113/19</p> <p>needing [1] 45/16</p> <p>needles [2] 42/9 42/12</p> <p>Needless [1] 14/24</p> <p>needs [3] 32/1 48/25 92/11</p> <p>neighbours [2] 13/14 35/1</p> <p>neither [2] 6/12 55/7</p> <p>never [7] 11/15 29/14 37/12 42/15 95/20 95/23 109/22</p> <p>new [10] 14/24 21/6 21/11 30/1 39/10 88/16 102/2 102/4 102/6 105/16</p> <p>next [13] 18/13 22/13 22/14 25/19 37/23 42/18 54/6 63/16 86/13 87/6 106/25 108/13 108/15</p> <p>NGPF0003312 [1] 111/4</p> <p>NHFT0000123 [1] 58/21</p> <p>NHFT0000168 [21] 1/3 3/9 15/16 20/17 30/22 30/24 36/23 37/17 38/22 41/20 45/3 46/16 47/11 50/20 51/13 54/14 85/7 93/10 99/2 99/2 103/17</p> <p>NHFT0000202 [1] 5/3</p> <p>NHFT0000222 [1] 2/6</p> <p>NHFT0000417 [2] 34/15 88/25</p> <p>NHFT0004725 [2] 88/6 89/22</p> <p>NHFT0004820 [2] 60/23 63/4</p> <p>NHFT0017810 [2] 13/25 14/20</p> <p>NHFT0018114 [1] 39/20</p> <p>NHFT0018143 [1] 25/15</p> <p>NHFT0018181 [2] 38/1 38/4</p> <p>NHFT0018292 [1] 108/8</p> <p>NHFT0018512 [1] 106/19</p> <p>NHFT0018527 [1] 42/19</p> <p>NHFT0019152 [1] 43/10</p> <p>NHS [1] 113/10</p> <p>NICE [1] 17/25</p> <p>night [5] 49/18 49/19</p> | <p>49/20 49/23 50/2</p> <p>nine [6] 28/24 50/25 58/11 73/14 82/17 101/3</p> <p>nine-month [1] 82/17</p> <p>no [120]</p> <p>NOCC0000043 [1] 92/4</p> <p>nodded [1] 11/8</p> <p>non [6] 45/2 55/4 82/17 84/20 85/5 86/1</p> <p>non-attendance [1] 86/1</p> <p>non-compliant [1] 85/5</p> <p>non-concordant [1] 45/2</p> <p>non-engaged [1] 84/20</p> <p>non-engaging [1] 82/17</p> <p>none [1] 10/21</p> <p>nonetheless [1] 104/19</p> <p>noon [3] 20/20 20/21 37/19</p> <p>normal [2] 41/24 93/13</p> <p>normally [1] 115/18</p> <p>not [201]</p> <p>note [13] 2/7 12/5 15/17 29/20 36/24 85/2 85/4 85/18 94/19 94/22 94/23 99/9 115/25</p> <p>noted [6] 92/10 97/25 98/5 99/10 100/8 100/12</p> <p>notes [56] 1/11 1/14 8/7 8/14 8/17 8/19 13/12 23/4 23/10 23/11 23/13 24/6 41/8 42/17 47/13 49/17 50/14 51/4 51/23 52/2 52/13 56/1 64/1 64/3 64/8 64/10 64/24 71/10 75/3 78/24 79/3 79/4 79/8 79/10 80/5 80/8 83/8 83/10 83/11 85/1 86/11 87/14 90/19 91/24 92/3 92/17 93/20 95/8 95/12 95/18 103/17 106/3 106/9 106/11 106/15 110/18</p> <p>nothing [14] 6/23 9/17 9/17 10/21 16/6 32/22 38/13 56/20 56/25 73/10 73/15 77/6 86/12 100/22</p> <p>notified [2] 52/24 76/23</p> <p>noting [1] 80/5</p> <p>Nottingham [2] 62/1 62/7</p> <p>Nottingham's [1]</p> | <p>109/9</p> <p>November [8] 14/4 14/22 15/17 30/23 31/21 32/4 37/10 82/10</p> <p>now [39] 13/25 14/10 16/14 25/9 28/15 33/15 37/18 41/17 44/18 49/15 50/24 55/7 61/17 65/6 70/10 71/2 72/6 72/13 74/19 75/19 82/1 82/25 83/23 85/16 85/21 86/14 87/9 89/13 90/25 91/4 95/21 99/12 101/13 101/16 102/11 102/14 102/21 109/22 115/5</p> <p>number [14] 8/7 37/6 51/11 57/17 57/23 61/23 75/5 80/4 86/4 92/24 96/9 100/21 103/24 112/1</p> <p>numerous [4] 34/8 49/4 53/16 75/17</p> <p>nurse [1] 18/6</p> <p>nurses [2] 44/7 46/17</p> <p>nursing [2] 18/25 44/8</p> |
| O | | | | |
| <p>object [1] 92/11</p> <p>objected [1] 92/15</p> <p>obligation [2] 77/19 78/21</p> <p>obligations [2] 77/8 77/13</p> <p>observed [1] 1/7</p> <p>obvious [1] 96/2</p> <p>obviously [2] 25/9 38/18</p> <p>occasion [7] 11/12 27/16 81/14 81/15 90/23 92/24 95/3</p> <p>occasionally [1] 4/18</p> <p>occasions [3] 17/24 52/9 80/5</p> <p>occur [1] 29/11</p> <p>occurs [2] 28/4 28/12</p> <p>October [4] 28/17 28/20 29/20 82/18</p> <p>October 2021 [1] 82/18</p> <p>odd [4] 72/9 103/5 106/8 108/4</p> <p>off [8] 2/8 23/18 37/12 44/21 57/24 66/8 70/12 104/16</p> <p>offence [1] 54/16</p> <p>offences [1] 20/15</p> <p>offer [1] 15/23</p> <p>office [1] 26/8</p> <p>officer [7] 22/18 22/23 23/15 23/22 27/21 53/1 53/10</p> <p>officers [3] 22/22</p> | | | | |

| | | | | |
|--|--|---|---|--|
| <p>O</p> <p>officers... [2] 23/22 27/13</p> <p>often [7] 5/12 15/1 17/8 19/22 26/8 58/13 87/2</p> <p>Oh [3] 26/15 69/7 106/21</p> <p>okay [14] 11/17 25/20 26/15 46/15 61/17 77/12 92/3 92/12 93/8 95/25 100/2 100/5 102/19 109/10</p> <p>on [164]</p> <p>one [51] 2/12 6/12 6/21 8/3 11/15 20/9 21/1 32/4 35/12 35/21 37/20 42/8 42/24 44/2 44/4 44/8 46/17 51/7 51/9 51/9 51/10 53/4 53/6 53/7 57/11 59/16 70/10 72/7 75/3 79/11 84/22 86/3 87/23 88/2 88/5 88/6 88/12 88/22 89/1 89/2 89/3 89/19 89/20 95/10 95/11 103/22 103/25 108/7 108/16 114/11 114/13</p> <p>ones [1] 19/8</p> <p>Ongoing [1] 5/15</p> <p>only [17] 8/21 12/21 17/12 18/24 21/1 26/7 27/11 29/15 33/1 48/24 56/22 59/16 64/4 83/4 114/17 115/24 116/1</p> <p>open [7] 16/11 16/14 16/16 16/17 16/18 16/22 53/4</p> <p>opinion [2] 66/1 79/12</p> <p>opinions [1] 79/13</p> <p>opportunity [2] 9/16 85/21</p> <p>option [4] 41/13 45/5 72/22 111/12</p> <p>options [13] 36/6 36/9 53/4 55/18 55/21 55/22 72/16 73/10 73/23 100/21 101/11 107/21 108/2</p> <p>or [84] 1/7 1/23 2/17 4/24 5/23 6/2 6/14 6/24 7/12 7/19 7/25 8/11 9/6 10/2 10/23 12/4 12/10 12/10 13/14 13/15 14/13 15/6 15/25 16/1 16/7 16/7 16/23 18/6 21/20 22/7 29/9 29/12 31/10 31/19 32/19 33/18 34/1 34/2 34/3 34/4 35/6 36/3 38/1 39/10 44/5 44/11 47/18</p> | <p>47/19 49/8 49/13 50/9 55/18 56/21 57/19 58/6 59/5 59/7 66/3 66/20 67/3 67/13 68/10 68/14 68/22 70/2 70/4 70/7 72/19 74/12 76/16 80/1 86/15 90/6 90/12 92/18 100/20 101/4 109/24 110/6 112/25 113/4 113/11 113/12 113/17</p> <p>oral [2] 99/24 99/25</p> <p>orals [1] 25/23</p> <p>order [2] 43/6 111/23</p> <p>ordinarily [2] 54/9 68/23</p> <p>organisations [1] 47/8</p> <p>organise [1] 65/4</p> <p>oriented [1] 65/23</p> <p>originally [2] 17/15 98/15</p> <p>other [22] 13/16 14/3 16/10 35/6 44/10 44/16 49/3 50/8 53/6 54/17 72/22 79/3 79/12 79/16 80/19 81/10 82/14 88/25 91/6 97/21 101/11 105/23</p> <p>others [15] 16/7 27/3 27/5 27/6 28/3 31/19 33/18 33/21 34/3 34/4 39/24 46/25 47/7 62/6 62/16</p> <p>others' [1] 27/4</p> <p>otherwise [3] 14/17 43/24 70/4</p> <p>ought [2] 113/21 113/22</p> <p>our [15] 4/25 6/23 7/1 7/1 10/16 12/13 18/25 36/18 53/2 62/9 63/13 73/15 76/11 80/14 86/3</p> <p>ourselves [2] 9/14 32/21</p> <p>out [39] 1/21 1/23 5/5 5/6 10/5 11/25 14/23 14/25 17/1 19/9 21/24 23/22 26/13 27/24 35/8 39/18 41/16 46/7 46/8 51/11 56/15 59/21 60/15 60/21 61/16 63/8 71/13 71/15 72/13 73/10 76/9 80/16 81/21 98/10 101/25 105/3 105/13 107/4 110/11</p> <p>out' [1] 37/5</p> <p>outlier [1] 44/24</p> <p>outpatient [1] 90/3</p> <p>Outreach [2] 35/7 73/16</p> <p>over [23] 4/13 8/22</p> | <p>10/1 17/24 18/15 21/4 22/16 39/25 43/8 47/16 51/6 53/22 53/23 56/7 58/11 78/16 81/4 85/12 91/4 97/18 106/25 109/16 111/5</p> <p>overarching [1] 10/24</p> <p>overly [3] 3/14 4/4 4/16</p> <p>oversight [3] 7/14 7/15 90/5</p> <p>overspeaking [17] 11/14 12/5 15/14 16/3 19/4 19/10 33/10 35/23 44/23 48/8 56/21 87/17 88/23 101/9 106/4 110/15 114/2</p> <p>own [5] 3/23 27/3 37/6 62/5 77/8</p> | <p>30/24</p> <p>page 199 [1] 31/21</p> <p>page 2 [3] 2/10 13/25 14/5</p> <p>page 201 [1] 36/23</p> <p>page 202 [1] 37/17</p> <p>page 203 [1] 38/22</p> <p>page 210 [2] 99/2 99/3</p> <p>page 223 [1] 93/10</p> <p>page 225 [1] 41/20</p> <p>page 226 [1] 41/23</p> <p>page 239 [1] 45/3</p> <p>page 250 [1] 46/16</p> <p>page 263 [1] 47/11</p> <p>page 267 [2] 50/20 85/10</p> <p>page 270 [2] 51/13 101/13</p> <p>page 271 [1] 54/15</p> <p>page 3 [9] 5/10 26/13 26/13 27/1 29/25 30/1 60/23 64/9 64/11</p> <p>page 33 [1] 17/19</p> <p>page 34 [2] 17/20 17/20</p> <p>page 4 [2] 63/24 92/5</p> <p>page 5 [4] 27/18 63/8 111/5 111/5</p> <p>page 56 [1] 109/14</p> <p>page 6 [1] 111/5</p> <p>page 64 [1] 1/6</p> <p>page 7 [3] 34/15 89/7 89/23</p> <p>page64 [1] 1/3</p> <p>pages [1] 8/11</p> <p>PAGR0000029 [1] 29/25</p> <p>pairs [1] 13/1</p> <p>paperwork [2] 106/14 107/13</p> <p>paragraph [17] 1/6 17/21 21/12 21/14 22/21 23/24 28/1 41/23 45/5 47/15 63/16 82/5 97/23 109/13 109/16 112/5 112/15</p> <p>Paragraph 13 [1] 28/1</p> <p>paragraph 143 [1] 97/23</p> <p>paragraph 160 [2] 109/13 109/16</p> <p>paragraph 255 [1] 23/24</p> <p>paragraph 283 [1] 112/5</p> <p>paragraph 347 [1] 82/5</p> <p>paragraph 4 [1] 21/12</p> <p>paragraph 6 [1] 45/5</p> <p>paragraphs [2] 42/2 42/3</p> <p>paranoid [3] 2/11</p> | <p>24/21 94/2</p> <p>parents [1] 93/13</p> <p>park [5] 68/10 68/11 68/12 68/13 111/9</p> <p>Parker [1] 92/5</p> <p>Parsonage [4] 82/12 106/22 108/12 116/1</p> <p>part [7] 13/8 13/10 13/19 25/8 31/11 36/1 111/13</p> <p>particular [4] 24/4 28/11 50/4 106/1</p> <p>particularly [8] 6/24 7/1 17/17 19/20 22/23 69/1 86/4 94/9</p> <p>party [4] 34/5 39/11 39/13 77/18</p> <p>passed [1] 84/16</p> <p>past [3] 45/8 46/23 92/19</p> <p>pasting [2] 86/7 86/8</p> <p>patient [28] 1/5 4/18 4/23 6/20 11/7 14/9 17/10 21/2 31/9 31/13 33/3 35/8 39/23 53/8 58/4 67/3 76/2 81/12 82/17 84/17 84/20 86/14 87/8 87/10 89/8 89/14 91/1 107/8</p> <p>patient's [2] 89/25 90/4</p> <p>patients [18] 4/7 4/12 6/23 14/10 17/8 19/1 32/17 34/22 44/19 44/25 45/2 53/18 53/20 57/22 78/1 86/5 106/24 108/16</p> <p>Patry [3] 109/6 109/7 117/7</p> <p>Paul [1] 82/13</p> <p>pausing [1] 49/22</p> <p>PC [2] 112/20 114/18</p> <p>PC Pritchard [2] 112/20 114/18</p> <p>peer [5] 62/2 62/4 62/4 62/8 80/16</p> <p>penultimate [1] 20/20</p> <p>people [18] 3/14 5/19 13/1 13/16 18/1 20/14 24/13 24/19 24/20 41/24 42/1 44/16 44/19 56/4 56/5 57/24 79/3 79/13</p> <p>per [1] 86/6</p> <p>perceived [3] 24/1 25/6 27/5</p> <p>perfectly [2] 19/18 44/25</p> <p>performs [1] 10/8</p> <p>perhaps [9] 1/9 26/25 39/6 48/17 85/16 89/7 98/14 100/3 113/4</p> <p>period [20] 15/8 15/10 17/24 23/9</p> |
|--|--|---|---|--|

| | | | | |
|---|--|--|---|--|
| <p>P</p> <p>period... [16] 28/24 29/1 32/8 34/9 41/16 55/2 56/15 57/3 58/11 82/17 101/3 112/4 112/8 112/11 113/2 113/18</p> <p>persecuted [4] 48/15 93/18 93/23 94/8</p> <p>person [11] 26/14 51/21 53/5 53/5 55/23 59/7 59/16 66/24 72/20 100/19 106/13</p> <p>personal [1] 17/6</p> <p>personally [2] 77/19 79/4</p> <p>perspective [1] 49/16</p> <p>pertinent [7] 63/17 63/22 66/5 66/6 66/11 67/3 67/4</p> <p>pharmacists [1] 59/13</p> <p>pharmacological [1] 59/14</p> <p>phone [15] 34/8 43/8 43/14 45/19 48/5 48/6 56/8 86/14 87/6 92/21 92/24 93/15 94/12 97/9 97/15</p> <p>phoned [1] 97/3</p> <p>phones [1] 17/4</p> <p>physical [1] 27/21</p> <p>pick [1] 97/13</p> <p>picked [2] 97/19 110/18</p> <p>picture [1] 85/8</p> <p>piece [1] 3/5</p> <p>pieces [1] 95/7</p> <p>Pinder [1] 82/12</p> <p>place [19] 13/12 34/16 46/2 46/4 48/2 55/10 55/11 55/16 61/21 73/25 88/2 88/4 92/1 97/2 104/6 106/17 108/21 110/22 113/13</p> <p>placed [1] 46/24</p> <p>placement [1] 8/23</p> <p>places [2] 10/18 112/1</p> <p>placing [1] 96/24</p> <p>plan [25] 3/10 3/11 3/21 3/25 5/5 7/6 7/8 7/9 9/4 9/5 9/9 9/19 9/21 11/6 12/18 15/17 18/16 30/18 43/3 43/16 60/1 60/1 111/12 111/16 111/24</p> <p>planning [8] 1/25 5/22 6/11 23/18 73/24 73/25 74/6 74/9</p> <p>plans [4] 5/23 5/25 6/2 9/6</p> <p>play [1] 84/19</p> | <p>plea [1] 43/22</p> <p>please [65] 1/4 2/6 2/10 5/3 5/10 14/20 15/16 17/19 20/17 22/20 25/15 27/18 29/18 30/22 31/21 32/4 34/15 36/23 37/17 38/1 38/5 39/20 41/20 42/3 42/19 42/22 43/9 45/3 45/25 46/16 46/16 46/22 47/11 50/20 51/13 54/14 58/22 60/23 61/10 63/7 63/8 64/20 71/2 71/17 82/3 85/7 85/10 85/13 85/17 88/7 89/21 89/22 89/23 92/3 92/6 99/1 101/12 101/13 103/17 106/18 108/7 108/15 112/1 112/5 112/10</p> <p>pm [4] 1/2 62/21 62/23 116/11</p> <p>point [36] 9/25 11/1 32/15 32/23 32/24 34/21 36/10 36/23 40/13 42/13 43/4 43/24 46/1 46/5 47/7 56/10 56/11 56/17 56/18 56/20 57/5 61/16 72/22 82/19 91/6 94/17 95/25 100/24 101/16 102/8 104/2 107/9 108/1 109/4 113/22 114/20</p> <p>points [1] 93/24</p> <p>police [31] 22/18 23/14 23/21 24/1 24/13 24/19 24/25 27/12 27/12 27/21 35/4 39/18 52/23 52/24 53/1 53/3 53/6 53/10 53/17 53/20 54/3 55/15 55/19 69/24 70/1 70/9 70/15 70/21 72/18 100/20 104/8</p> <p>policies [2] 35/20 85/5</p> <p>policy [32] 31/9 34/16 35/11 35/13 35/17 35/22 35/25 85/16 85/23 86/2 86/23 87/7 87/11 87/16 87/23 87/25 88/8 88/9 88/9 88/11 88/15 88/16 88/17 88/18 88/20 88/21 88/25 89/3 89/4 89/9 89/12 89/23</p> <p>Pooled [1] 59/18</p> <p>poor [4] 25/1 42/24 43/2 85/2</p> <p>pop [1] 108/14</p> <p>position [10] 32/20 43/21 47/4 67/19</p> | <p>67/21 73/13 73/21 80/21 96/15 109/22</p> <p>possible [4] 49/7 77/24 78/2 111/23</p> <p>possibly [10] 16/2 17/8 28/15 29/22 42/23 50/15 52/3 70/25 72/13 100/18</p> <p>potential [1] 65/4</p> <p>potentially [1] 73/18</p> <p>power [2] 59/7 59/9</p> <p>powers [9] 32/24 33/2 48/12 48/13 58/15 58/16 100/25 101/1 101/2</p> <p>practice [7] 3/16 4/5 4/8 20/2 33/15 84/13 84/15</p> <p>practitioner [1] 90/6</p> <p>predominantly [1] 67/15</p> <p>prefer [2] 42/6 42/9</p> <p>pregnant [1] 13/7</p> <p>premeditated [1] 2/1</p> <p>prep [1] 64/5</p> <p>prepare [1] 64/3</p> <p>prepared [1] 48/24</p> <p>preparing [3] 5/25 6/1 63/13</p> <p>prescribed [1] 17/23</p> <p>present [15] 47/6 55/8 55/11 57/7 57/8 57/14 71/21 81/8 81/9 81/16 82/6 82/9 83/18 83/19 115/24</p> <p>presentation [2] 6/24 9/3</p> <p>press [1] 12/4</p> <p>pressure [1] 57/21</p> <p>pretty [2] 98/21 115/22</p> <p>prevent [1] 5/1</p> <p>prevention [10] 2/25 3/6 3/10 3/21 3/25 5/22 6/2 6/10 9/6 9/19</p> <p>previous [3] 56/8 69/25 83/25</p> <p>previously [2] 73/4 97/12</p> <p>primarily [1] 79/9</p> <p>primary [3] 2/8 2/10 5/9</p> <p>principles [1] 33/14</p> <p>prior [3] 24/10 42/17 106/3</p> <p>Pritchard [2] 112/20 114/18</p> <p>private [1] 23/12</p> <p>probably [5] 22/6 22/7 26/6 44/22 100/4</p> <p>probe [2] 21/25 47/18</p> <p>probing [1] 21/20</p> <p>problem [1] 56/10</p> <p>problems [1] 47/19</p> <p>procedures [1]</p> | <p>111/10</p> <p>proceed [1] 105/21</p> <p>process [4] 65/2 74/8 74/10 106/12</p> <p>professional [2] 77/8 77/13</p> <p>professionally [1] 77/20</p> <p>professionals [1] 24/25</p> <p>Programme [3] 11/3 11/9 11/11</p> <p>programmes [1] 61/25</p> <p>prominent [1] 108/2</p> <p>promulgated [1] 88/9</p> <p>properly [1] 96/20</p> <p>property [4] 24/20 25/9 27/4 52/2</p> <p>prove [1] 5/18</p> <p>provide [3] 59/14 59/15 63/17</p> <p>provided [1] 111/11</p> <p>providing [2] 6/7 84/3</p> <p>provision [1] 78/21</p> <p>provoking [1] 24/22</p> <p>prudent [1] 39/8</p> <p>psychiatric [1] 76/14</p> <p>psychiatrist [11] 19/5 31/5 31/6 53/14 56/9 58/24 63/14 79/16 94/5 110/24 111/18</p> <p>psychiatrists [1] 79/17</p> <p>psychiatry [2] 21/7 76/12</p> <p>psychoeducation [3] 2/25 3/6 6/10</p> <p>psychological [2] 2/20 59/15</p> <p>psychologist [1] 10/17</p> <p>psychologists [1] 59/15</p> <p>psychosis [15] 2/17 10/14 14/11 19/8 31/16 41/10 48/3 48/19 49/13 61/25 65/21 109/19 110/3 110/9 110/12</p> <p>psychotic [7] 2/17 24/9 45/21 56/21 57/1 84/19 86/5</p> <p>public [4] 13/16 13/22 61/17 61/19</p> <p>purely [2] 52/9 76/16</p> <p>purpose [1] 87/3</p> <p>pursue [1] 98/10</p> <p>put [13] 1/17 1/18 46/2 46/3 53/13 64/25 65/10 67/2 72/21 76/7 88/23 107/2 109/1</p> <p>puts [1] 23/18</p> <p>putting [1] 108/25</p> | <p>Q</p> <p>querying [1] 15/4</p> <p>question [23] 5/24 12/7 60/23 65/12 65/15 66/19 67/12 76/9 77/11 84/1 100/6 100/9 100/12 102/18 105/5 105/19 108/25 109/23 110/14 110/20 111/20 112/18 114/11</p> <p>questioned [13] 50/13 62/25 74/16 91/9 103/10 109/7 114/10 117/3 117/4 117/5 117/6 117/7 117/8</p> <p>questioning [2] 103/11 108/4</p> <p>questions [31] 15/6 61/4 61/8 62/15 62/17 63/6 63/17 63/22 64/14 64/18 65/9 65/16 65/17 65/24 66/4 66/7 66/13 66/16 66/17 66/22 67/2 67/8 67/14 67/16 69/14 74/17 76/7 76/17 103/13 109/8 114/9</p> <p>quickly [3] 73/25 86/19 91/11</p> <p>quite [11] 14/11 17/11 21/6 38/17 47/24 53/17 57/23 67/1 72/8 75/24 92/19</p> <p>quoted [1] 70/3</p> <hr/> <p>R</p> <p>raise [5] 32/12 56/4 95/2 95/22 109/6</p> <p>raised [14] 39/23 42/15 55/18 55/20 56/1 74/21 75/9 75/17 77/10 93/1 93/5 94/14 95/2 96/25</p> <p>raises [3] 55/12 55/14 77/19</p> <p>raising [2] 39/21 75/25</p> <p>Raleigh [1] 111/9</p> <p>rapid [1] 33/20</p> <p>rapidly [3] 28/4 28/13 73/18</p> <p>rapport [1] 17/11</p> <p>rather [9] 2/13 3/24 26/7 29/12 66/20 91/17 94/19 115/3 115/9</p> <p>rationale [2] 59/24 84/23</p> <p>re [1] 111/8</p> <p>reach [3] 46/20 47/7 53/24</p> <p>reached [4] 73/13 73/21 82/19 110/5</p> <p>read [19] 1/14 1/14</p> |
|---|--|--|---|--|

| | | | | |
|--|--|--|---|---|
| <p>R</p> <p>read... [17] 2/4 9/2 26/5 26/17 26/19 26/22 28/8 42/17 50/1 63/18 65/16 66/6 69/12 91/24 93/20 108/3 111/13</p> <p>readily [1] 8/6</p> <p>reading [2] 41/8 92/2</p> <p>realised [6] 48/11 55/23 65/17 82/1 83/1 91/12</p> <p>really [33] 6/22 12/14 24/22 30/20 31/9 34/10 36/10 36/15 36/21 41/10 43/3 43/23 45/20 47/24 48/20 50/3 64/1 65/8 65/14 67/17 72/23 80/11 85/8 86/17 86/19 92/19 93/1 96/15 97/15 98/18 100/6 107/18 114/8</p> <p>rearranged [1] 20/25</p> <p>reason [6] 24/3 31/8 81/17 83/5 95/18 110/2</p> <p>reasonable [1] 28/6</p> <p>reasons [4] 34/11 72/21 94/11 97/1</p> <p>recall [5] 4/11 68/19 82/15 83/4 94/23</p> <p>receive [2] 26/24 29/23</p> <p>received [3] 26/23 28/9 52/17</p> <p>receives [1] 81/22</p> <p>recently [1] 28/5</p> <p>recognise [1] 4/23</p> <p>recognised [1] 115/12</p> <p>recognition [1] 66/23</p> <p>recollection [3] 73/2 104/4 115/14</p> <p>recommendations [1] 62/5</p> <p>record [4] 12/4 45/10 77/15 79/1</p> <p>recorded [7] 12/3 13/20 51/3 51/4 57/11 75/5 77/3</p> <p>recording [5] 77/8 77/14 79/8 79/10 79/22</p> <p>recordings [3] 78/22 80/3 85/22</p> <p>recordkeeping [1] 85/3</p> <p>records [6] 29/15 56/13 71/4 74/25 87/3 108/11</p> <p>redaction [1] 107/1</p> <p>redundant [2] 58/18 58/19</p> <p>refer [3] 35/21 55/5</p> | <p>97/23</p> <p>reference [4] 61/23 89/4 104/16 104/18</p> <p>referenced [4] 75/8 87/24 88/22 89/20</p> <p>referred [2] 94/11 95/25</p> <p>referring [4] 8/7 94/12 103/23 107/7</p> <p>reflect [1] 16/1</p> <p>reflected [1] 58/8</p> <p>reflection [1] 58/7</p> <p>regard [3] 58/7 65/1 65/15</p> <p>regarding [4] 74/20 76/18 85/6 112/17</p> <p>regards [1] 40/4</p> <p>regime [1] 46/4</p> <p>region [2] 50/25 77/25</p> <p>regular [3] 5/11 10/3 10/6</p> <p>regularly [1] 12/19</p> <p>rehearsed [1] 4/3</p> <p>relapse [17] 2/25 3/6 3/9 3/21 3/25 4/2 5/22 6/1 6/10 9/6 9/19 28/3 28/12 31/15 33/20 49/3 49/8</p> <p>relapses [1] 28/25</p> <p>relapsing [4] 20/22 22/5 29/2 94/1</p> <p>relating [1] 70/5</p> <p>relation [10] 54/7 61/5 61/24 64/14 65/25 66/25 113/10 114/18 115/13 115/14</p> <p>relationship [4] 4/23 17/9 17/15 36/12</p> <p>relationships [1] 5/13</p> <p>relative [1] 88/18</p> <p>relatively [3] 7/2 22/9 62/18</p> <p>relatives [1] 34/25</p> <p>relatives/carers [1] 34/25</p> <p>release [1] 25/17</p> <p>relevant [11] 34/16 76/3 76/8 76/20 77/15 88/10 88/15 110/22 111/21 112/4 113/18</p> <p>rely [4] 23/2 23/4 23/5 50/5</p> <p>remain [2] 3/19 111/23</p> <p>remained [1] 21/19</p> <p>remains [1] 43/2</p> <p>remember [29] 15/11 22/12 30/11 47/5 50/15 50/19 51/10 57/9 66/7 68/16 68/17 68/22 70/11 70/12 71/3 71/10 72/2 72/3 72/10 83/7 91/22 92/2 94/14 94/21 94/23</p> | <p>98/2 107/15 107/18 107/19</p> <p>remind [1] 58/20</p> <p>remorse [1] 1/8</p> <p>repeat [2] 5/24 67/12</p> <p>repeated [3] 52/7 70/9 89/13</p> <p>repeatedly [6] 22/23 35/21 53/24 54/2 74/22 75/9</p> <p>repeating [1] 86/22</p> <p>repeats [1] 2/7</p> <p>replied [1] 37/10</p> <p>report [9] 17/20 21/11 26/12 34/6 51/21 53/5 92/5 110/22 111/19</p> <p>reported [2] 21/12 21/22</p> <p>reporting [3] 100/19 104/7 104/21</p> <p>reports [2] 70/18 110/24</p> <p>represent [1] 91/10</p> <p>representation [1] 57/20</p> <p>request [1] 35/4</p> <p>requested [2] 51/23 56/1</p> <p>requesting [1] 71/10</p> <p>require [3] 21/23 27/21 90/4</p> <p>required [8] 15/21 18/24 19/23 32/2 87/7 87/19 88/6 90/22</p> <p>requirement [3] 4/21 78/24 90/9</p> <p>requirements [1] 88/5</p> <p>reschedule [1] 85/15</p> <p>residence [1] 111/9</p> <p>resource [2] 54/4 80/13</p> <p>resource-wise [1] 54/4</p> <p>resourced [1] 101/5</p> <p>respect [3] 2/13 77/8 77/14</p> <p>respond [2] 26/4 63/19</p> <p>responded [2] 18/2 52/18</p> <p>responding [3] 21/16 57/1 99/20</p> <p>responds [2] 1/10 25/24</p> <p>response [23] 17/2 20/1 22/17 26/7 36/19 36/22 37/14 40/6 53/19 59/2 60/17 60/22 61/9 63/13 64/19 64/25 67/9 67/9 67/11 67/13 67/15 70/9 95/15</p> <p>responses [1] 35/10</p> <p>responsibilities [1]</p> | <p>84/14</p> <p>responsibility [18] 7/12 10/18 18/20 18/22 53/21 54/20 54/22 59/6 59/17 70/5 79/21 80/8 80/22 80/25 84/10 84/16 84/17 114/6</p> <p>responsible [10] 5/19 7/16 7/19 10/2 19/6 58/24 59/3 78/5 78/7 79/8</p> <p>rest [2] 32/3 62/16</p> <p>restrain [1] 22/22</p> <p>restraint [1] 27/21</p> <p>restriction [1] 33/14</p> <p>restrictive [5] 3/16 4/5 4/8 41/13 111/12</p> <p>result [1] 2/2</p> <p>resulted [1] 27/22</p> <p>retrospect [1] 113/21</p> <p>returned [2] 50/12 84/8</p> <p>review [13] 1/5 7/16 11/13 14/16 18/13 41/22 45/4 46/21 62/2 62/4 62/4 62/8 62/10</p> <p>reviewed [3] 18/3 18/6 80/5</p> <p>reviews [5] 11/3 11/9 11/11 11/15 62/4</p> <p>revolving [1] 42/22</p> <p>right [41] 2/3 2/15 2/20 10/20 20/16 22/19 39/17 40/12 61/1 68/21 68/25 70/8 74/24 75/14 76/21 77/2 77/4 88/21 89/24 91/11 91/14 91/15 91/17 92/23 94/18 95/19 98/24 104/3 104/15 105/25 105/25 106/21 108/5 108/7 109/3 112/14 113/7 113/24 114/19 115/17 116/9</p> <p>ring [1] 92/22</p> <p>rio [10] 12/1 71/9 85/6 93/20 99/1 103/17 106/3 106/11 107/2 108/11</p> <p>RIOs [2] 93/10 101/12</p> <p>risk [65] 5/6 5/7 5/23 5/25 10/3 10/5 10/9 11/21 11/25 12/1 12/10 12/17 12/19 12/20 12/23 12/23 12/24 13/1 13/5 13/8 13/10 13/12 13/13 13/14 13/16 13/19 13/22 13/23 16/7 23/10 27/6 31/11 31/12 33/17 33/20 33/25 34/2 34/2 39/24 46/25 49/11 49/12</p> | <p>70/2 70/4 85/25 87/20 87/21 87/22 87/23 87/25 89/25 90/2 90/2 90/4 90/9 90/11 90/12 90/14 90/18 90/20 90/21 113/10 114/14 114/23 115/1</p> <p>risks [18] 13/17 15/24 27/8 27/9 27/14 28/3 28/4 31/19 34/19 34/20 37/25 114/16 114/17 115/2 115/3 115/6 115/9 115/12</p> <p>risky [1] 53/18</p> <p>Road [1] 70/10</p> <p>Robinson [6] 13/6 38/3 38/16 39/21 69/8 82/11</p> <p>robust [2] 43/3 57/3</p> <p>role [12] 7/12 7/14 10/11 10/13 10/24 11/1 21/6 79/9 79/23 84/10 84/18 84/18</p> <p>roles [1] 10/8</p> <p>room [7] 8/3 23/23 49/19 72/12 86/10 87/2 107/19</p> <p>round [3] 93/2 106/14 108/12</p> <p>route [1] 74/22</p> <p>rubber [6] 72/4 73/1 103/20 105/7 105/24 106/10</p> <p>rude [1] 105/18</p> <p>ruled [6] 26/17 26/18 26/19 26/23 114/14 114/15</p> <p>run [2] 72/13 73/9</p> <hr/> <p>S</p> <p>safe [1] 84/17</p> <p>safety [4] 27/3 40/2 60/1 76/2</p> <p>said [63] 1/13 4/19 8/8 14/1 14/21 14/23 15/12 15/15 17/1 24/7 30/9 30/12 31/23 34/8 34/10 35/25 36/15 41/24 42/8 42/10 45/6 45/6 47/21 47/22 48/14 55/16 56/22 58/3 60/24 65/6 66/5 67/6 68/7 68/16 68/17 68/21 68/24 71/24 72/12 74/21 74/23 77/5 80/10 80/12 91/20 94/13 94/25 95/2 95/7 95/19 95/20 95/23 95/24 97/3 97/15 99/17 99/21 99/24 113/22 114/13 114/14 114/14 114/17</p> <p>same [15] 2/18 2/23 9/4 9/9 10/2 27/9 27/24 31/4 47/3 49/24 65/7 68/3 68/8 80/20</p> |
|--|--|--|---|---|

| | | | | |
|-------------------------------|------------------------------|-----------------------------|-------------------------------|------------------------------|
| S | 84/24 | self-harm [1] 34/4 | 38/20 46/20 65/3 | 94/13 94/24 95/1 |
| same... [1] 86/22 | secondly [1] 41/12 | send [1] 63/21 | 80/12 83/20 87/5 | 95/16 97/6 |
| Sasidharan [1] 21/4 | secretary [1] 12/5 | sending [1] 64/7 | 92/13 92/15 92/15 | situate [1] 112/7 |
| Sasitha [1] 21/4 | Section [6] 33/10 | sends [1] 38/3 | 92/17 92/20 92/22 | situation [4] 42/25 |
| satisfied [1] 45/6 | 45/23 45/23 46/2 46/3 | sense [2] 97/11 | 93/3 93/9 93/13 93/15 | 48/21 58/10 92/8 |
| saw [10] 26/3 26/3 | 46/11 | 103/5 | 93/17 93/20 94/3 94/3 | six [5] 18/7 18/7 |
| 26/18 29/14 30/12 | Section 2 [1] 45/23 | sent [7] 14/15 26/5 | 94/8 95/2 95/3 95/22 | 18/11 18/15 21/8 |
| 69/11 69/12 99/9 | Section 3 [2] 33/10 | 43/13 52/14 60/7 60/9 | 96/15 96/16 96/17 | six months [1] 21/8 |
| 108/6 114/15 | 46/2 | 60/12 | 96/18 96/18 96/19 | six weeks [4] 18/7 |
| say [49] 4/7 4/16 12/8 | see [80] 1/5 1/11 2/6 | separate [1] 17/18 | 97/3 97/3 97/10 97/11 | 18/7 18/11 18/15 |
| 12/14 14/24 18/8 | 2/6 4/2 5/10 6/9 7/11 | September [20] 5/4 | 97/13 97/14 97/19 | Skelton [3] 40/22 |
| 19/19 28/19 30/25 | 8/13 9/10 9/18 12/9 | 28/25 57/13 57/14 | 101/20 101/22 104/22 | 111/11 111/15 |
| 32/8 37/3 42/20 47/18 | 14/4 14/19 15/10 | 81/25 82/7 82/19 | 104/23 116/1 | skill [1] 6/17 |
| 53/13 63/24 63/24 | 15/12 18/24 19/1 20/3 | 83/12 83/14 88/2 | she'd [8] 39/10 48/18 | skilled [2] 69/20 |
| 63/25 64/8 64/11 | 20/19 23/14 23/17 | 88/13 88/17 89/21 | 92/19 92/24 95/4 | 69/22 |
| 64/23 66/19 68/2 68/5 | 24/21 26/2 27/1 29/19 | 106/22 108/9 108/19 | 97/12 97/19 101/19 | skillset [1] 73/16 |
| 70/13 77/6 77/7 80/7 | 30/9 30/16 32/3 32/4 | 108/20 113/14 115/15 | she'll [1] 87/2 | slot [4] 21/1 87/9 |
| 82/3 82/8 82/23 86/19 | 34/17 36/22 39/7 | 115/25 | she's [5] 21/8 93/22 | 87/12 87/15 |
| 90/25 92/23 92/23 | 39/21 39/22 39/23 | September 2021 [1] | 94/5 94/6 94/6 | small [1] 73/15 |
| 94/17 94/19 95/7 | 40/3 40/6 41/7 41/23 | 113/14 | short [4] 17/24 62/18 | so [218] |
| 96/25 97/24 98/4 98/7 | 42/17 43/15 45/14 | September 2022 [1] | 62/22 109/11 | social [2] 53/22 70/7 |
| 99/12 99/14 99/15 | 45/15 47/13 48/4 | 82/19 | shortly [5] 38/16 43/7 | sole [1] 59/5 |
| 104/1 104/12 105/10 | 49/24 50/22 52/21 | series [1] 76/17 | 55/13 58/21 71/5 | solid [1] 57/3 |
| 105/24 113/1 | 58/13 59/11 63/11 | serious [15] 27/6 | should [39] 1/22 2/25 | some [23] 24/16 |
| saying [33] 1/10 1/19 | 64/7 64/21 69/9 69/12 | 27/10 27/10 27/10 | 3/2 6/21 8/20 16/15 | 31/11 34/1 34/2 36/15 |
| 2/19 8/9 8/11 11/21 | 69/24 71/11 71/12 | 27/11 27/17 43/23 | 18/2 18/17 19/15 28/8 | 39/13 43/23 47/7 51/3 |
| 16/23 20/1 41/13 47/8 | 71/13 71/16 92/4 92/7 | 91/12 114/17 114/18 | 28/9 52/23 52/24 | 55/17 57/20 60/19 |
| 49/14 49/23 52/16 | 95/8 96/9 96/23 | 114/20 115/2 115/3 | 54/19 60/13 60/14 | 60/20 61/8 64/4 64/18 |
| 53/8 63/20 68/19 | 101/21 101/25 104/24 | 115/3 115/6 | 60/18 64/16 66/12 | 67/8 72/11 92/16 |
| 72/15 75/2 75/24 | 105/3 107/1 107/4 | seriously [4] 22/22 | 66/19 66/20 70/3 | 103/19 103/23 104/2 |
| 76/21 86/22 89/4 | 108/16 109/19 111/1 | 23/14 27/20 52/25 | 72/16 72/17 74/11 | 111/11 |
| 93/22 94/6 94/7 95/21 | 111/6 112/9 112/22 | seriousness [1] 50/3 | 79/4 79/25 81/1 81/9 | somebody [3] 21/10 |
| 97/17 103/23 105/12 | 115/5 116/8 | service [10] 57/24 | 81/18 84/23 85/23 | 22/9 31/13 |
| 105/19 107/20 112/14 | Seedat [10] 1/7 1/17 | 58/4 58/6 62/2 62/3 | 89/8 92/1 102/2 113/1 | somebody's [1] |
| 115/2 | 14/1 14/14 14/19 | 74/11 74/13 82/16 | 113/11 114/1 114/7 | 23/10 |
| says [19] 6/9 9/21 | 16/23 17/4 17/11 | 112/16 113/2 | shouldn't [4] 3/1 28/8 | someone [9] 1/9 1/24 |
| 17/4 21/21 25/18 | 17/13 25/22 | services [19] 4/22 | 52/24 54/20 | 2/1 2/2 27/22 57/18 |
| 35/13 39/3 45/12 48/9 | seeing [3] 30/11 | 5/13 24/14 35/6 38/10 | shouting [1] 49/25 | 59/5 73/17 101/5 |
| 51/16 64/21 65/3 | 57/25 113/24 | 53/22 55/5 62/6 69/21 | show [4] 33/16 66/10 | something [30] 1/23 |
| 87/22 87/24 103/1 | seeking [1] 63/18 | 76/15 76/16 82/21 | 85/8 89/8 | 5/2 12/12 13/24 16/1 |
| 104/8 107/24 114/16 | seem [4] 38/18 45/10 | 84/5 93/18 93/22 94/7 | showed [1] 22/13 | 16/21 19/17 44/15 |
| 116/1 | 109/14 112/2 | 96/19 112/3 112/23 | showing [1] 33/24 | 49/11 58/5 58/8 58/9 |
| scared [2] 93/18 94/7 | seemed [4] 47/24 | sessions [2] 8/1 | shows [3] 85/2 87/4 | 67/23 68/21 68/22 |
| scenarios [1] 67/2 | 93/13 95/3 95/4 | 75/22 | 102/24 | 75/8 75/17 75/24 77/7 |
| Scene [1] 22/21 | seems [3] 1/7 106/8 | set [6] 5/6 26/13 | side [3] 21/13 21/22 | 80/13 86/18 97/14 |
| schedule [1] 87/10 | 116/4 | 40/21 61/4 63/9 64/14 | 45/8 | 97/19 104/9 108/2 |
| schizophrenia [5] | seen [35] 13/12 | sets [1] 5/5 | signals [1] 3/7 | 110/16 110/17 113/19 |
| 2/9 2/11 5/9 18/1 | 14/10 18/8 18/16 21/3 | setting [1] 90/3 | signature [1] 49/8 | 114/23 115/1 |
| 84/19 | 23/17 24/5 24/9 25/10 | several [2] 52/8 | signed [2] 58/23 59/1 | sometime [2] 58/6 |
| screaming [1] 49/23 | 31/2 31/4 31/5 31/13 | 65/17 | significance [1] 63/6 | 104/12 |
| screams [3] 49/18 | 31/17 31/19 42/16 | severe [1] 27/19 | significant [10] 27/8 | sometimes [3] 7/9 |
| 49/20 50/1 | 45/20 48/18 49/16 | share [3] 62/5 62/13 | 27/23 47/9 49/22 | 14/11 86/5 |
| screen [8] 1/4 2/8 | 52/20 56/3 56/3 56/11 | 96/11 | 84/18 95/6 96/6 96/8 | somewhere [3] 50/25 |
| 54/15 92/4 99/1 99/3 | 56/12 56/12 56/14 | shared [3] 59/13 | 96/8 102/9 | 51/12 77/25 |
| 101/12 104/1 | 60/16 60/17 70/19 | 80/21 112/17 | significantly [2] 49/9 | soon [11] 2/14 14/15 |
| scribbling [1] 71/16 | 83/11 94/19 96/17 | Sharon [12] 58/23 | 87/18 | 30/8 30/8 43/13 61/9 |
| scroll [1] 112/9 | 96/18 101/19 104/22 | 59/1 60/15 61/3 64/12 | signs [3] 19/8 31/16 | 64/19 84/8 102/2 |
| scrubbed [2] 71/13 | sees [2] 18/12 31/22 | 64/13 64/21 65/3 | 49/3 | 102/4 105/16 |
| 71/15 | self [8] 16/8 23/25 | 65/14 66/14 66/20 | similar [1] 99/9 | sooner [1] 14/17 |
| Sebastian [2] 29/3 | 26/5 30/2 31/19 33/18 | 83/11 | simply [3] 3/22 67/10 | sorry [11] 5/24 26/14 |
| 29/5 | 34/2 34/4 | Sharon's [1] 65/9 | 108/21 | 26/14 69/5 69/7 69/7 |
| second [6] 1/16 | self-care [1] 16/8 | she [60] 1/23 5/21 | since [6] 3/20 23/17 | 82/7 99/2 99/15 110/4 |
| 22/15 27/22 28/14 | self-defence [1] | 5/23 5/25 6/1 8/8 | 31/25 37/10 64/4 | 111/6 |
| 81/21 110/20 | 23/25 | 20/22 21/6 21/6 21/8 | 91/16 | sort [8] 4/17 39/11 |
| secondary [2] 84/4 | self-evidently [1] | 21/10 22/2 23/6 24/9 | single [1] 77/22 | 45/15 57/20 60/19 |
| | 30/2 | 34/9 36/17 37/7 38/19 | sister [7] 55/25 56/7 | 77/25 80/18 113/24 |

| | | | | |
|--|--|--|--|---|
| <p>S</p> <p>sorting [1] 3/11</p> <p>sound [2] 92/15 92/23</p> <p>sounded [3] 27/17 92/22 97/15</p> <p>sounds [1] 19/23</p> <p>speak [6] 3/17 14/14 32/9 37/13 37/16 50/6</p> <p>speaking [2] 75/11 115/21</p> <p>specific [3] 63/15 67/16 110/14</p> <p>specifically [20] 8/14 8/17 22/12 47/22 53/2 57/15 57/17 58/8 66/10 66/24 72/14 76/15 76/20 80/19 92/2 94/25 95/14 106/15 107/15 107/19</p> <p>spoke [6] 8/12 26/8 36/14 60/15 80/16 94/25</p> <p>spoken [2] 25/4 39/9</p> <p>square [1] 42/24</p> <p>ST5 [4] 6/14 6/15 6/16 78/13</p> <p>ST5s [1] 7/9</p> <p>ST6 [4] 6/14 20/24 21/8 25/24</p> <p>stability [1] 111/16</p> <p>stable [3] 21/19 110/25 111/23</p> <p>staff [9] 18/25 19/19 19/21 40/2 40/11 44/8 63/14 90/6 90/13</p> <p>stage [26] 6/19 6/22 6/25 7/21 8/5 8/15 8/18 15/23 16/5 18/17 30/19 32/14 36/7 36/9 38/17 48/12 52/6 53/24 68/25 69/20 73/10 96/2 96/22 101/10 109/24 114/13</p> <p>stalking [1] 20/13</p> <p>stamp [1] 105/24</p> <p>stamped [3] 103/20 105/7 106/10</p> <p>stamping [2] 72/4 73/1</p> <p>stance [1] 45/16</p> <p>Staples [1] 24/24</p> <p>start [8] 3/20 40/3 45/16 49/7 49/8 62/19 103/14 116/9</p> <p>started [3] 3/4 3/10 21/4</p> <p>starting [1] 32/17</p> <p>state [16] 5/15 6/13 6/16 6/18 9/7 10/4 10/7 10/11 21/14 23/10 56/25 96/16 96/21 101/25 105/4 107/4</p> <p>statement [27] 3/24</p> | <p>13/24 23/23 31/1 35/22 49/24 61/22 72/21 75/20 75/21 76/5 76/6 76/10 82/4 82/23 83/9 88/23 97/21 98/4 99/18 99/23 107/22 108/3 108/6 109/13 112/2 112/8</p> <p>states [1] 107/23</p> <p>stays [1] 9/4</p> <p>Stephen [1] 61/22</p> <p>steps [2] 37/23 86/13</p> <p>stick [1] 36/22</p> <p>still [3] 40/23 67/18 98/15</p> <p>stimuli [1] 21/16</p> <p>stopped [2] 28/16 28/20</p> <p>straightforward [2] 43/1 49/5</p> <p>strategies [3] 5/17 10/13 10/15</p> <p>Straw [5] 91/8 91/9 103/15 104/20 117/5</p> <p>strong [3] 17/8 24/12 25/7</p> <p>struggling [4] 36/21 54/4 69/19 99/5</p> <p>stuck [1] 38/17</p> <p>student [2] 1/21 40/19</p> <p>students [3] 39/25 50/8 53/11</p> <p>studies [1] 99/5</p> <p>subject [1] 98/19</p> <p>submitting [1] 99/8</p> <p>subsequent [1] 61/12</p> <p>subsequently [2] 20/10 103/20</p> <p>successful [2] 111/17 111/24</p> <p>successive [1] 35/9</p> <p>such [3] 35/6 45/22 95/9</p> <p>Sue [1] 46/17</p> <p>suffering [1] 27/23</p> <p>sufficient [1] 75/23</p> <p>sufficiently [3] 27/19 32/12 53/14</p> <p>suggest [22] 16/6 25/20 30/13 35/14 44/24 56/20 57/1 80/24 81/25 82/25 84/12 85/2 85/7 90/25 92/14 94/3 94/8 95/18 96/25 102/23 109/17 112/2</p> <p>suggested [2] 18/16 93/2</p> <p>suggesting [3] 16/16 90/17 113/3</p> <p>suggestion [2] 102/5 113/7</p> <p>suggests [1] 9/8</p> | <p>summaries [1] 58/25</p> <p>summary [10] 2/7 5/4 5/5 29/24 30/1 30/6 30/11 60/2 60/3 60/5</p> <p>supervising [2] 6/7 78/13</p> <p>supervision [2] 7/5 8/1</p> <p>supply [1] 29/23</p> <p>support [3] 75/6 79/25 80/12</p> <p>supporting [1] 43/5</p> <p>supposed [1] 10/23</p> <p>sure [17] 14/16 15/11 18/22 19/3 29/21 38/19 66/1 68/3 71/15 76/19 87/16 100/3 100/6 100/6 101/12 109/12 111/3</p> <p>surely [2] 66/17 97/19</p> <p>surprised [1] 14/3</p> <p>survivors [1] 74/18</p> <p>sworn [1] 99/25</p> <p>symptomatic [1] 17/22</p> <p>symptoms [6] 16/20 31/16 43/2 45/21 49/4 96/4</p> <hr/> <p>T</p> <p>tablets [2] 29/21 42/9</p> <p>tackle [3] 61/8 64/18 67/7</p> <p>take [23] 12/5 21/18 23/22 32/1 32/19 36/4 41/14 46/7 48/9 48/14 51/6 51/17 57/24 62/18 62/19 73/25 94/10 101/2 103/3 106/18 108/20 112/10 114/6</p> <p>taken [17] 10/1 21/4 34/12 34/18 45/16 48/2 59/23 71/8 72/1 72/11 89/10 92/1 102/7 106/6 106/17 107/11 107/17</p> <p>takes [1] 23/18</p> <p>taking [18] 8/4 8/20 28/20 29/1 31/25 32/2 32/11 33/4 37/22 37/24 44/25 47/16 53/9 61/21 67/21 75/3 104/6 104/19</p> <p>talk [4] 8/2 17/14 36/5 55/21</p> <p>talked [3] 53/3 55/20 93/15</p> <p>talking [7] 69/2 69/5 76/25 93/15 107/21 107/21 112/11</p> <p>team [66] 3/17 3/17 7/15 10/16 12/13 14/7 16/11 16/13 16/14 16/16 16/19 31/14</p> | <p>33/2 35/6 35/7 36/5 41/9 41/15 42/7 43/15 44/3 44/4 44/19 44/20 46/17 46/24 48/15 55/4 57/19 59/5 59/9 59/12 62/4 65/21 65/22 65/22 65/23 65/25 70/7 73/15 73/16 76/24 76/25 77/10 79/6 79/7 79/11 79/14 79/15 79/20 80/10 80/14 82/14 96/11 100/16 101/4 102/22 105/9 105/23 107/6 107/6 107/21 113/11 113/17 113/19 114/4</p> <p>teams [9] 12/14 17/18 19/3 65/5 65/22 75/5 80/15 84/16 84/18</p> <p>technology [1] 24/16</p> <p>telephone [12] 52/20 89/14 92/7 93/2 93/12 97/6 97/12 97/18 101/18 101/20 104/19 104/23</p> <p>tell [9] 35/23 43/9 44/21 89/6 104/13 107/14 109/25 110/25 113/19</p> <p>telling [6] 16/20 19/14 30/3 48/23 91/17 101/6</p> <p>tells [1] 28/22</p> <p>ten [2] 15/15 51/12</p> <p>term [1] 78/8</p> <p>terminate [1] 99/11</p> <p>terminology [1] 4/4</p> <p>terms [11] 4/1 4/3 5/21 6/7 11/21 34/13 39/24 66/15 78/19 85/16 86/22</p> <p>test [2] 18/13 18/14</p> <p>testing [2] 21/24 41/16</p> <p>tests [1] 42/14</p> <p>text [1] 37/10</p> <p>Thames [2] 20/4 29/7</p> <p>than [13] 2/13 3/25 14/17 16/17 26/7 29/12 55/21 65/19 66/20 91/17 113/5 115/3 115/9</p> <p>Thangavelu [6] 41/22 42/20 43/8 45/4 45/19 73/7</p> <p>thank [18] 1/3 11/1 57/7 62/20 63/24 64/9 74/14 82/5 91/7 100/2 103/7 103/8 109/2 109/5 109/8 112/1 114/8 116/8</p> <p>thanks [1] 64/20</p> <p>that [713]</p> <p>that's [106] 2/3 2/8</p> | <p>2/15 2/21 3/22 9/1 9/8 9/11 10/20 10/22 12/15 13/23 16/18 18/11 19/2 19/14 20/1 20/2 20/16 22/11 25/20 27/24 32/14 33/22 35/22 38/2 39/17 46/11 47/14 49/22 50/14 55/20 57/11 59/22 61/1 65/21 67/25 69/6 70/3 70/9 72/18 75/1 75/7 75/17 75/17 75/24 76/1 76/1 76/13 77/4 77/11 77/23 77/23 78/3 79/22 80/10 80/12 82/25 83/3 83/22 84/9 84/10 84/25 86/24 87/7 89/24 90/7 90/11 90/15 90/16 90/17 90/21 91/14 91/17 91/19 93/5 94/15 94/16 95/12 95/13 95/19 96/14 98/7 98/8 98/13 98/19 98/21 98/24 99/24 100/4 100/8 104/2 104/4 105/19 105/25 108/25 111/18 111/19 112/5 113/14 113/15 113/15 113/16 114/18 115/18 116/4</p> <p>their [16] 13/11 17/10 18/3 32/19 62/5 66/1 66/15 67/16 70/4 76/18 79/9 79/21 79/23 79/23 84/10 115/19</p> <p>them [24] 12/4 20/3 23/19 31/24 41/25 45/13 47/3 53/19 54/20 54/21 57/25 58/1 63/23 66/6 66/9 67/17 67/18 67/24 67/25 77/18 80/7 93/19 93/23 94/8</p> <p>themselves [1] 54/4</p> <p>then [45] 9/5 10/14 16/15 24/18 26/4 36/4 42/5 51/22 51/24 54/21 55/18 61/17 61/20 63/16 64/9 64/11 64/21 65/3 65/4 71/25 75/8 75/11 77/2 78/15 80/4 80/7 82/24 83/23 85/1 86/13 87/4 88/25 89/7 89/21 89/21 91/16 92/9 93/15 103/2 103/3 105/1 106/8 106/14 107/16 112/1</p> <p>theories [1] 92/10</p> <p>therapeutic [2] 4/22 5/13</p> <p>therapies [1] 2/20</p> |
|--|--|--|--|---|

| | | | | |
|---|---|--|--|--|
| <p>T</p> <p>therapy [1] 10/14</p> <p>there [150]</p> <p>there'd [4] 51/12 55/25 57/20 94/23</p> <p>there's [32] 4/20 9/11 10/21 14/2 15/15 21/25 23/8 28/24 28/25 29/8 37/7 45/15 46/1 51/6 51/7 51/9 51/9 59/23 64/25 76/21 77/6 81/22 86/19 90/22 91/2 93/11 100/22 103/3 104/17 108/10 114/22 115/19</p> <p>thereafter [1] 30/8</p> <p>therefore [2] 79/2 84/2</p> <p>Theresa [1] 64/7</p> <p>these [25] 4/1 7/4 11/10 12/4 19/6 19/10 28/4 34/11 35/10 48/25 50/8 52/23 61/8 63/9 64/18 66/4 66/18 66/22 67/8 79/19 80/8 85/7 86/19 95/4 97/1</p> <p>they [53] 4/3 4/9 7/4 7/5 7/9 10/22 10/23 10/24 11/25 13/19 13/20 13/21 15/9 19/8 19/9 19/11 19/16 19/16 24/15 27/11 28/5 31/14 33/1 40/2 41/15 52/24 54/4 54/7 54/16 54/18 56/3 56/3 56/4 59/11 63/21 63/21 66/6 66/8 67/10 69/24 77/17 78/23 79/6 82/15 89/15 93/14 94/17 94/17 94/19 97/10 115/1 115/19 115/20</p> <p>they'd [3] 53/13 54/7 54/9</p> <p>they're [13] 10/23 13/10 19/6 19/7 19/9 19/12 51/3 58/5 66/10 66/11 90/14 103/18 107/7</p> <p>they've [1] 58/6</p> <p>thing [3] 3/23 83/4 86/22</p> <p>things [9] 8/10 22/20 33/23 61/19 65/10 66/11 86/19 95/7 115/9</p> <p>think [109] 4/25 6/4 6/20 13/18 15/9 15/21 15/25 16/4 16/9 16/17 17/2 17/6 17/8 17/13 17/16 17/17 22/12 24/9 25/2 26/18 26/23 27/15 30/6 31/7 34/10 35/16 35/20 36/9</p> | <p>36/19 38/10 38/15 38/20 39/24 40/8 42/16 43/19 44/12 45/18 47/22 48/18 50/25 51/3 51/7 51/11 52/5 53/13 53/23 53/24 54/3 55/13 55/16 57/17 57/18 58/9 59/2 60/14 60/17 60/20 62/1 62/8 62/10 62/18 65/20 66/3 67/4 69/12 72/16 72/17 72/25 74/21 74/23 75/12 76/12 76/14 77/22 81/25 84/11 86/6 88/4 89/3 89/12 89/19 92/11 97/8 97/10 98/19 98/21 100/10 100/11 104/7 104/8 104/9 104/10 104/11 104/13 105/16 106/1 107/6 108/25 110/8 113/3 113/21 113/23 114/5 114/15 114/17 115/15 115/21 115/22</p> <p>thinking [3] 20/6 25/6 83/14</p> <p>thinks [1] 93/17</p> <p>third [12] 1/6 17/20 22/21 27/16 28/16 32/5 34/5 34/21 39/11 39/13 51/5 53/7</p> <p>third-party [2] 39/11 39/13</p> <p>this [208]</p> <p>those [29] 9/24 10/5 11/3 11/4 11/15 12/3 13/14 13/17 20/2 20/14 23/11 23/13 25/7 29/11 51/3 61/18 61/20 62/15 66/7 66/9 66/16 73/22 78/24 79/17 80/2 96/16 108/6 108/19 114/9</p> <p>though [9] 4/1 7/6 19/9 40/10 46/19 47/6 59/6 60/11 107/12</p> <p>thought [15] 2/16 22/4 25/5 32/22 34/1 42/7 56/9 57/2 60/11 67/22 71/24 99/21 101/16 106/5 116/6</p> <p>thoughts [5] 34/3 34/4 41/24 41/25 46/23</p> <p>thousands [1] 4/15</p> <p>threatening [3] 24/22 27/5 99/11</p> <p>three [9] 32/7 32/16 35/9 36/2 36/4 42/2 75/22 102/7 109/11</p> <p>three weeks [1] 102/7</p> <p>threshold [4] 16/4 16/9 32/25 33/12</p> | <p>thresholds [1] 34/13</p> <p>through [19] 8/7 8/14 9/19 32/13 36/5 41/8 55/20 64/2 65/16 66/6 66/9 74/22 87/14 100/10 104/20 108/1 111/10 115/14 115/19</p> <p>throughout [1] 37/1</p> <p>Thursday [5] 17/3 25/19 38/6 38/24 64/22</p> <p>tick [1] 86/18</p> <p>tight [1] 105/18</p> <p>till [1] 17/3</p> <p>time [87] 2/11 2/23 6/4 6/15 8/1 8/12 8/21 9/10 13/6 15/13 16/12 17/12 24/8 27/11 27/15 27/22 29/10 29/13 30/5 30/7 30/10 30/16 31/14 32/8 33/25 34/7 34/16 35/12 35/18 38/16 41/4 41/8 41/14 42/16 44/17 44/18 45/12 46/7 47/15 47/16 49/6 50/8 51/8 52/1 53/4 54/13 55/2 55/14 55/17 57/23 58/21 60/17 61/9 62/16 64/2 64/4 64/5 64/19 69/17 69/18 69/25 71/8 72/11 77/24 80/1 85/5 85/25 86/6 86/21 88/10 91/4 92/2 93/4 100/7 100/25 102/9 103/12 103/19 103/23 105/19 110/21 110/23 111/21 112/7 112/10 112/17 114/17</p> <p>timeline [2] 103/5 108/4</p> <p>times [5] 18/23 32/16 75/18 79/12 95/6</p> <p>today [6] 20/21 69/14 74/19 81/24 113/16 116/9</p> <p>together [4] 61/8 64/18 64/25 67/8</p> <p>told [27] 16/12 27/13 37/11 45/13 46/11 47/13 51/16 61/17 66/22 66/25 69/1 70/15 70/22 74/19 79/23 79/24 80/4 91/23 94/15 97/20 98/3 100/4 100/7 109/22 113/11 113/12 115/15</p> <p>tomorrow [1] 116/10</p> <p>tone [1] 97/13</p> <p>too [1] 99/8</p> <p>took [8] 11/13 13/12 55/10 55/11 55/16 63/3 110/21 113/13</p> <p>top [19] 6/9 14/5</p> | <p>21/21 27/18 29/19 31/21 31/22 34/17 44/21 46/22 51/16 52/7 52/10 55/1 70/12 92/7 99/3 104/1 111/5</p> <p>topics [1] 109/11</p> <p>total [1] 51/11</p> <p>totally [1] 37/5</p> <p>touch [1] 50/10</p> <p>tough [2] 98/17 98/18</p> <p>towards [4] 27/6 39/24 40/19 96/12</p> <p>trace [1] 73/17</p> <p>track [10] 73/17 97/25 98/5 98/12 98/14 99/12 99/15 99/22 100/2 100/7</p> <p>trail [1] 76/22</p> <p>trainee [1] 6/13</p> <p>trainees [2] 7/1 7/1</p> <p>transcript [1] 69/12</p> <p>transfer [1] 84/17</p> <p>travelling [1] 69/11</p> <p>treating [1] 113/18</p> <p>treatment [20] 2/18 2/23 7/24 17/23 17/25 18/2 18/3 33/4 33/11 43/6 43/16 46/4 46/9 48/14 56/15 57/3 57/3 58/15 58/17 101/3</p> <p>treble [1] 30/15</p> <p>tribunal [9] 25/17 25/19 26/12 26/17 26/18 28/11 28/17 33/20 114/14</p> <p>tricky [1] 41/10</p> <p>tried [6] 17/2 20/11 37/2 48/22 58/11 101/3</p> <p>tries [1] 14/4</p> <p>trigger [3] 33/9 35/10 36/3</p> <p>triggered [2] 40/9 109/19</p> <p>troubling [2] 20/14 50/16</p> <p>true [4] 28/14 28/15 98/9 99/13</p> <p>Trust [20] 31/9 61/5 62/9 62/11 64/15 66/11 75/2 75/6 75/10 75/25 76/4 76/12 80/15 80/20 80/23 86/2 86/23 88/10 88/12 88/19</p> <p>Trust's [2] 85/16 88/14</p> <p>Trusts [1] 76/22</p> <p>Trustwide [1] 35/13</p> <p>truth [1] 91/17</p> <p>try [7] 30/16 31/10 36/10 36/16 49/15 49/15 89/17</p> <p>trying [7] 35/7 38/19 38/20 42/1 73/14 80/24 82/18</p> | <p>Tuesday [4] 64/22 108/17 108/23 108/24</p> <p>Tuhina [1] 64/20</p> <p>turn [4] 35/14 89/9 109/13 110/23</p> <p>turned [2] 52/9 87/10</p> <p>Turner [2] 50/6 50/10</p> <p>tutor [1] 39/10</p> <p>tutors [1] 39/6</p> <p>two [12] 2/16 27/12 51/6 53/4 55/18 55/21 55/21 81/22 85/3 88/4 97/8 97/21</p> <p>typical [2] 44/25 45/2</p> <p>typified [1] 81/3</p> <hr/> <p>U</p> <p>ultimate [1] 59/5</p> <p>ultimately [1] 91/3</p> <p>unable [1] 82/14</p> <p>unaware [3] 92/8 112/19 112/20</p> <p>Unclear [1] 103/11</p> <p>under [10] 1/5 4/24 5/14 22/21 24/1 33/10 37/3 44/19 49/15 73/22</p> <p>underfunded [1] 76/13</p> <p>underneath [1] 29/20</p> <p>understand [11] 1/17 11/6 11/12 26/25 34/19 46/3 49/12 52/8 72/7 96/20 97/7</p> <p>understanding [9] 12/20 13/22 13/23 23/2 29/11 46/6 65/19 76/13 98/13</p> <p>understood [2] 55/7 75/7</p> <p>undertaken [1] 90/12</p> <p>Unequivocal [1] 28/2</p> <p>unexpectedly [1] 104/16</p> <p>unfortunate [1] 31/7</p> <p>unfortunately [9] 13/18 13/18 21/2 23/11 32/20 35/20 39/14 64/23 96/22</p> <p>unilateral [2] 79/5 79/19</p> <p>unintended [1] 1/20</p> <p>unique [1] 6/24</p> <p>united [1] 47/4</p> <p>university [29] 36/20 39/16 50/6 50/7 50/12 97/22 97/22 98/15 99/11 99/21 109/9 109/18 109/24 109/25 110/6 110/7 110/13 110/25 111/7 112/3 112/16 112/18 112/23 113/5 113/12 113/12 113/20 114/2 114/4</p> <p>University's [1] 109/22</p> |
|---|---|--|--|--|

| | | | | |
|--|---|--|---|---|
| <p>U</p> <p>unless [2] 33/2 48/22</p> <p>unnecessary [2] 37/5 48/1</p> <p>unsafe [2] 74/11 74/13</p> <p>unseen [1] 21/16</p> <p>until [6] 32/25 62/19 93/14 98/22 112/23 116/12</p> <p>untoward [1] 113/4</p> <p>untruths [1] 45/13</p> <p>unusual [3] 6/24 50/18 92/22</p> <p>unwell [14] 3/13 24/11 27/6 27/8 27/9 28/3 28/12 38/7 47/1 57/4 91/25 92/17 93/3 94/9</p> <p>up [51] 1/9 1/15 1/24 2/22 14/8 28/16 28/24 40/21 41/15 42/24 43/13 47/23 48/19 49/6 49/10 52/9 61/7 63/24 64/7 64/9 64/11 64/17 67/7 80/19 86/5 87/10 87/15 88/23 89/9 92/3 92/18 92/23 92/25 93/6 97/3 97/13 97/19 98/22 98/25 99/18 99/19 100/15 100/16 100/17 103/25 105/11 109/13 110/18 110/23 112/10 113/24</p> <p>update [1] 9/4</p> <p>upload [1] 61/23</p> <p>urgent [1] 34/24</p> <p>urgently [1] 21/3</p> <p>us [26] 3/8 8/23 12/22 16/12 16/20 29/16 30/6 34/7 39/11 43/9 48/15 48/23 53/4 53/11 75/15 80/4 80/14 86/20 90/14 97/14 97/20 100/17 101/6 101/7 103/2 107/20</p> <p>use [4] 3/15 4/7 59/7 64/24</p> <p>used [4] 41/15 67/16 83/10 87/15</p> <p>using [4] 24/16 35/11 35/17 53/7</p> <p>usual [1] 20/2</p> <p>usually [7] 13/10 18/25 23/7 57/18 57/20 58/25 81/22</p> | <p>6/24 8/22 9/3 12/25 13/13 14/16 15/4 27/3 27/19 34/11 36/19 46/21 52/20 61/6 63/15 64/15 78/9 78/11 78/17 80/5 81/1 81/2 85/10 86/25 91/10 97/22 105/11 105/12 108/11</p> <p>verbal [1] 26/24</p> <p>version [2] 88/13 88/17</p> <p>versus [2] 55/15 104/7</p> <p>very [67] 4/3 8/10 9/4 9/15 12/8 12/19 16/11 16/14 17/9 17/9 17/18 20/14 21/22 23/25 24/20 27/2 27/17 28/5 30/2 30/17 30/18 33/13 36/25 40/19 43/2 43/7 43/13 47/22 48/11 50/16 51/8 51/9 52/2 54/6 55/9 57/25 61/6 64/5 64/16 66/14 66/22 67/6 69/1 69/20 69/22 69/23 70/23 72/9 73/24 74/14 76/1 76/6 82/20 83/3 83/7 97/16 103/5 103/7 103/11 108/2 109/11 110/19 111/6 111/13 112/8 114/8 114/20</p> <p>via [3] 37/3 37/14 89/14</p> <p>victim [1] 49/17</p> <p>victims [1] 61/6</p> <p>victims' [1] 64/16</p> <p>video [6] 22/24 25/10 25/14 48/5 48/5 48/6</p> <p>view [5] 25/12 55/5 84/25 92/13 96/15</p> <p>views [5] 27/13 47/3 65/9 71/19 76/15</p> <p>violence [1] 34/5</p> <p>violent [1] 27/5</p> <p>visit [12] 14/8 20/23 21/1 34/24 35/5 37/21 101/24 102/6 102/8 105/2 105/13 107/3</p> <p>visiting [1] 50/13</p> <p>visits [1] 19/10</p> <p>voice [2] 92/22 97/13</p> <p>voices [3] 16/24 21/15 27/3</p> <p>voluntary [1] 32/18</p> | <p>wanted [11] 14/14 14/18 16/22 30/9 30/14 31/17 32/14 49/15 58/13 65/7 98/15</p> <p>wanting [1] 17/14</p> <p>ward [5] 41/21 45/4 57/4 93/2 110/12</p> <p>warning [1] 3/7</p> <p>warrant [3] 22/18 54/7 54/13</p> <p>warranted [2] 105/8 105/22</p> <p>warrants [1] 54/10</p> <p>was [346]</p> <p>washed [1] 60/4</p> <p>wasn't [72] 2/13 3/3 3/4 5/21 5/25 6/1 6/3 8/4 11/18 12/12 12/13 12/15 12/17 12/23 13/5 13/10 13/13 16/19 18/15 18/18 19/20 22/11 24/23 25/9 28/10 29/21 33/4 38/19 41/17 43/19 44/24 47/9 47/16 52/5 55/24 56/2 56/10 67/23 70/11 72/6 75/2 75/12 76/8 76/15 76/25 79/18 80/7 80/18 80/18 81/15 82/2 83/23 83/24 83/25 88/16 92/13 93/9 93/21 94/2 95/19 96/2 96/6 96/15 96/18 98/13 98/14 99/13 105/9 110/2 110/16 113/18 114/6</p> <p>watched [2] 22/24 56/17</p> <p>way [7] 27/4 38/18 43/24 56/22 91/5 115/5 115/8</p> <p>ways [1] 14/11</p> <p>we [274]</p> <p>we'd [7] 33/24 39/9 54/2 58/11 58/12 58/13 101/3</p> <p>we'll [5] 40/21 61/23 62/18 85/16 116/9</p> <p>we're [11] 5/4 5/21 11/17 68/3 70/3 86/23 87/12 87/14 87/14 105/18 106/12</p> <p>we've [18] 9/12 9/20 11/1 13/12 15/1 20/13 24/17 29/15 51/14 74/24 85/12 86/15 94/19 100/10 102/8 106/24 109/4 113/15</p> <p>Wednesday [1] 1/1</p> <p>week [9] 31/24 64/23 65/4 84/9 86/15 101/21 108/8 108/12 108/13</p> <p>weekend [1] 39/25</p> | <p>weekly [1] 15/23</p> <p>weeks [7] 18/7 18/7 18/11 18/14 18/15 102/7 106/25</p> <p>weight [2] 96/24 97/2</p> <p>welfare [4] 35/4 53/6 54/2 72/19</p> <p>well [56] 3/8 6/9 16/18 19/9 19/14 22/10 22/11 22/20 30/8 30/13 43/2 46/6 47/24 50/14 54/8 55/10 56/14 56/17 63/8 66/19 71/6 71/13 74/24 75/24 76/4 76/14 77/2 77/5 78/5 78/9 78/13 81/7 82/14 84/13 85/1 86/8 86/9 87/3 88/12 88/25 89/7 91/2 91/6 91/20 92/3 94/1 95/10 95/21 96/10 97/11 97/25 98/4 98/5 100/10 108/23 116/5</p> <p>wellbeing [2] 102/1 105/4</p> <p>wellbeing.' [1] 107/5</p> <p>went [10] 8/6 22/22 23/12 37/3 37/7 38/15 40/2 49/24 100/20 104/16</p> <p>were [112] 2/18 3/13 7/12 9/6 10/2 11/3 13/8 13/19 13/20 14/13 19/20 20/4 22/15 24/14 24/15 24/15 26/19 31/14 35/11 35/17 36/23 39/18 41/9 43/5 47/8 49/5 49/18 50/8 50/12 52/1 52/7 53/4 54/13 54/16 54/18 55/7 56/5 56/5 56/6 56/19 61/17 61/19 61/20 63/14 63/22 65/10 65/17 66/4 66/4 66/6 66/17 66/18 67/21 68/6 69/1 69/18 70/18 71/18 75/4 75/11 75/16 75/25 76/7 76/22 77/3 78/11 78/13 78/17 78/22 79/5 79/5 79/6 79/16 80/4 80/6 80/19 80/20 82/13 82/13 82/15 84/24 85/9 88/14 88/19 89/4 89/9 89/18 89/23 90/19 95/1 96/3 96/10 97/2 97/8 99/20 101/11 103/22 108/18 110/14 114/3 114/13 114/15 114/16 114/25 115/2 115/3 115/8 115/12</p> <p>weren't [10] 22/20 23/12 44/25 46/10</p> | <p>66/18 79/3 94/17 96/10 97/10 108/18</p> <p>what [139]</p> <p>what's [7] 2/7 15/5 15/5 23/5 29/8 57/16 80/23</p> <p>whatever [6] 3/22 12/11 35/25 67/21 67/21 105/14</p> <p>whatsoever [4] 16/5 22/1 48/3 91/2</p> <p>when [83] 1/14 2/4 8/8 8/11 8/19 8/21 8/24 9/1 10/1 17/1 18/24 19/6 19/9 19/14 20/14 20/18 21/20 22/17 23/18 27/6 27/8 27/9 28/3 28/12 28/20 28/25 32/8 32/15 42/17 43/10 45/4 45/8 46/25 50/13 51/6 53/23 55/11 55/12 55/16 58/6 61/14 65/24 66/13 67/6 68/5 70/1 70/21 70/22 72/18 77/16 77/17 79/12 80/4 80/10 80/16 81/5 81/8 81/20 83/8 83/10 83/15 85/4 85/22 87/20 89/8 92/19 92/21 94/25 95/1 97/12 99/12 99/14 99/15 99/20 101/16 102/3 102/8 104/2 104/14 108/5 113/22 114/13 115/25</p> <p>whenever [3] 81/10 81/11 92/20</p> <p>where [36] 4/20 6/9 15/8 21/23 30/19 34/20 35/1 42/3 48/21 51/15 53/11 53/15 53/17 53/24 56/16 57/9 61/16 65/17 67/2 68/9 71/22 73/12 73/12 73/13 73/21 76/22 78/19 81/12 82/19 84/15 84/19 87/10 98/20 108/1 109/20 114/16</p> <p>Whereas [1] 92/24</p> <p>wherever [1] 56/6</p> <p>whether [9] 2/16 7/24 31/12 42/12 43/16 70/25 110/14 115/8 116/5</p> <p>which [43] 8/22 11/20 11/25 16/21 29/15 34/9 35/19 40/19 41/19 45/18 45/19 51/7 58/4 58/7 65/24 66/21 67/16 67/20 68/19 72/20 83/18 84/8 85/23 86/12 87/20 87/25 89/7 89/10 89/15</p> |
| <p>V</p> <p>vaccines [1] 42/14</p> <p>value [1] 48/9</p> <p>various [1] 67/2</p> <p>vast [1] 59/11</p> <p>VC [118]</p> <p>VC's [32] 1/19 4/1 6/3</p> | <p>waited [1] 17/3</p> <p>walking [1] 25/8</p> <p>want [17] 2/22 3/23 4/16 23/21 32/8 32/12 37/15 37/16 46/1 49/1 53/11 65/1 89/17 109/6 110/20 112/25 115/7</p> | | | |

| | | | | |
|--|---|--|--|--|
| <p>W</p> <p>which... [14] 89/15 89/20 89/22 90/20 93/23 95/8 98/16 99/10 102/12 102/15 102/21 109/13 113/13 115/11</p> <p>while [7] 40/1 45/7 46/6 50/8 58/5 87/2 103/18</p> <p>whilst [5] 31/16 33/19 41/17 83/6 97/9</p> <p>who [30] 2/12 7/19 19/1 24/8 24/23 25/8 32/18 32/18 44/1 50/13 51/14 56/5 57/7 57/8 57/14 63/14 67/14 72/7 73/17 73/18 81/19 82/15 84/20 86/10 87/1 98/18 101/5 110/11 116/1 116/2</p> <p>whole [2] 99/7 107/21</p> <p>wholly [2] 112/19 112/20</p> <p>whom [2] 36/11 36/12</p> <p>whose [3] 18/1 18/20 18/21</p> <p>why [37] 3/3 3/4 7/8 7/11 9/25 10/22 12/3 14/13 14/18 15/7 18/15 18/19 20/24 26/22 28/9 29/7 29/7 33/9 37/2 58/23 59/1 59/23 67/25 68/19 69/23 75/20 76/4 84/2 84/5 84/23 93/23 93/24 102/6 110/2 110/5 114/5 114/6</p> <p>will [33] 1/8 1/9 1/10 14/24 17/8 20/22 25/9 30/8 34/22 34/24 35/2 37/23 38/10 38/24 38/25 39/7 42/21 51/17 63/14 63/17 63/18 65/25 70/13 85/20 86/13 87/24 89/10 90/13 101/24 102/8 103/25 105/2 107/3</p> <p>Williams [1] 82/13</p> <p>willing [2] 21/17 48/24</p> <p>window [2] 1/22 1/23</p> <p>windowsill [1] 23/19</p> <p>wise [2] 6/20 54/4</p> <p>wish [1] 2/1</p> <p>wishes [2] 4/1 83/21</p> <p>withdrawn [1] 96/11</p> <p>within [10] 4/21 54/24 55/3 58/5 62/7 62/9 75/2 75/10 75/19 80/15</p> | <p>without [6] 41/10 46/2 52/16 54/12 58/17 73/8</p> <p>WITN0163002 [1] 71/2</p> <p>WITN0319001 [1] 61/23</p> <p>WITN0357001 [3] 82/4 109/14 112/6</p> <p>witness [13] 11/8 13/24 75/19 75/21 76/5 76/6 82/4 82/23 97/21 98/4 107/22 108/3 112/2</p> <p>woman [1] 27/24</p> <p>won't [1] 30/8</p> <p>wonder [2] 15/7 19/4</p> <p>word [2] 59/3 103/3</p> <p>words [3] 95/4 105/7 108/6</p> <p>work [16] 2/25 3/6 5/22 7/2 10/15 36/20 37/14 46/8 48/22 48/24 49/8 59/12 64/4 65/20 65/22 78/22</p> <p>worked [2] 46/6 51/11</p> <p>working [6] 6/5 7/15 8/16 59/4 65/22 75/17</p> <p>workload [4] 74/3 74/5 76/1 76/23</p> <p>works [1] 19/2</p> <p>worn [1] 22/24</p> <p>worried [7] 15/13 34/10 40/2 48/16 93/17 94/3 97/16</p> <p>worry [2] 26/16 64/24</p> <p>worse [2] 58/4 58/7</p> <p>worth [1] 53/25</p> <p>would [94] 2/18 3/13 3/15 3/19 4/2 4/25 5/2 6/20 7/21 8/25 9/1 9/2 10/15 14/18 16/4 18/8 18/16 18/24 20/6 21/23 22/3 22/3 22/8 24/22 27/2 28/17 31/17 33/12 33/16 36/10 41/14 42/6 42/7 42/9 43/12 44/1 44/4 44/8 44/18 44/20 46/24 49/11 54/9 56/16 57/18 58/7 58/9 61/7 62/10 63/21 64/17 65/13 65/18 66/14 67/7 67/9 67/10 67/10 67/11 67/15 67/15 67/18 67/24 68/17 68/22 68/24 70/23 72/7 77/9 77/21 77/23 78/1 78/3 78/4 78/25 80/1 81/6 84/7 85/21 85/24 86/16 86/17 86/20 86/21 89/7 90/23 92/22 93/23 97/19 102/5 110/10 110/13 111/1</p> | <p>115/16</p> <p>wouldn't [13] 8/17 16/9 20/24 29/13 42/16 48/7 57/4 58/3 65/13 67/25 77/24 89/11 106/14</p> <p>write [2] 84/2 84/6</p> <p>writing [1] 83/9</p> <p>written [12] 56/24 65/13 83/3 83/11 83/17 84/7 84/23 98/8 99/23 108/11 109/20 110/11</p> <p>wrong [5] 52/9 83/5 97/2 97/14 108/21</p> <hr/> <p>Y</p> <p>yeah [6] 18/12 26/5 29/17 44/23 44/23 89/14</p> <p>years [3] 4/13 46/23 56/8</p> <p>yes [129]</p> <p>yesterday [1] 69/9</p> <p>yet [5] 23/23 29/23 53/25 105/6 106/10</p> <p>you [535]</p> <p>you'd [15] 10/1 56/12 56/12 57/16 60/24 63/25 68/17 68/21 70/21 73/4 91/12 101/8 101/14 101/16 101/17</p> <p>you'll [2] 43/9 64/24</p> <p>you're [19] 9/8 9/21 32/11 44/13 49/7 57/25 64/23 75/2 76/19 76/21 77/17 77/18 80/24 82/25 84/4 91/4 106/19 112/8 112/11</p> <p>you've [21] 4/12 18/21 25/2 32/7 44/15 56/23 69/14 74/19 74/21 76/3 80/4 81/25 82/1 83/1 87/9 90/23 95/6 103/14 104/20 109/20 115/13</p> <p>your [87] 4/7 7/11 7/11 12/5 15/24 20/24 22/4 23/23 25/24 29/8 30/25 37/19 39/3 39/3 43/21 44/2 46/17 47/12 47/13 47/19 53/7 54/6 54/19 54/22 58/23 63/6 66/17 67/19 68/2 75/7 75/19 76/5 76/9 77/7 77/15 77/20 78/13 78/22 80/8 80/25 81/23 82/3 82/23 83/20 84/14 84/16 84/23 84/25 85/1 85/2 85/4 85/10 85/18 85/25 87/9 88/7 88/13 88/18 88/19 90/19 90/20 90/20</p> | <p>91/16 91/17 93/5 94/11 95/21 97/21 97/23 98/4 99/24 101/15 102/10 102/13 102/20 104/15 105/7 106/10 109/13 109/16 111/21 112/2 113/11 113/17 113/19 114/3 115/14</p> <p>yours [1] 14/5</p> <p>yourself [9] 2/14 5/19 8/19 9/23 10/21 18/21 50/7 63/18 78/24</p> | |
|--|---|--|--|--|