1 **Wednesday, 25 September 2024**
2 **(10.02 am)**
3 **LADY JUSTICE THIRLWALL:** Good morning.
4 **MR SCORER:** Good morning, my Lady.
5 **LADY JUSTICE THIRLWALL:** I understand we have
6 Father O&P&R online?
7 **MR SCORER:** That's right, my Lady.
8 **LADY JUSTICE THIRLWALL:** I understand you are going
9 to read both statements, starting with Mother O&P&R?
10 **MR SCORER:** That's correct.
11 **LADY JUSTICE THIRLWALL:** Thank you very much. When
12 you're ready.
13 **MOTHER O&P&R statement read**
14 **MR SCORER:** This is the witness statement of the
15 Mother of Children O&P&R.
16 "I, Mother O&P&R will say as follows:
17 "I make this statement in response to the Inquiry's
18 Rule 9 request. This statement should be read in
19 conjunction with my police and Victim Impact statements.
20 "Experience at the Countess of Chester Hospital.
21 "My first child was born at the Countess of Chester
22 Hospital. This was a normal pregnancy, there were no
23 complications, and the care was good.
24 "Initially I did not realise that I was pregnant
25 with triplets. When I went to a booking appointment at

1 the Countess of Chester Hospital I thought that my
2 stomach was bigger than in my previous pregnancy but
3 I didn't think anything of it.
4 "My first ultrasound scan took place at about
5 12 weeks gestation. It was then that we were told that
6 I was having triplets. Father O&P&R and I were both
7 quite worried about how we would cope but our family was
8 very supportive and we knew we would get through it
9 together.
10 "The Consultant at the Countess of Chester Hospital
11 referred me to the Liverpool Women's Hospital for
12 a second scan. However, he told us that he was happy to
13 care for me at the Countess of Chester Hospital and they
14 could refer back to Liverpool Women’s Hospital if there
15 were any problems along the way.
16 "The Countess of Chester Hospital was more
17 convenient for us so I was happy with this plan.
18 "At Liverpool Women’s Hospital I was told that one
19 of the triplets was a little smaller than the other two,
20 and as all three triplets were sharing one placenta,
21 I was given the option of having the smaller triplet's
22 heartbeat stopped to give the two others a better chance
23 of survival. We decided against this and to let things
24 be.
25 "At the Countess of Chester Hospital I had scans

1 every two weeks initially, but this increased to weekly
2 as the pregnancy progressed.
3 "At around 23 weeks I was given steroids so that if
4 the babies arrived early their lungs would develop more
5 quickly. We desperately wanted the babies to get as
6 close to 34 weeks as possible. Every scan was fine, and
7 we were told that the babies were growing well.
8 "We decided to find out the sex of the babies and
9 we also named them early on.
10 "At around 30 weeks I had some tightening. I was
11 very large and I went into the the Countess of Chester
12 Hospital as a precaution. They did a swab and said that
13 everything was fine, and that they did not expect the
14 babies to arrive early.
15 "I did not actually expect our babies to be born at
16 the Countess of Chester Hospital, I was explicitly told
17 throughout my pregnancy that they would be born there
18 only if there was a nurse and a bed for each baby.
19 I was told that for this reason, it was very unlikely
20 that I would actually have them at the Countess of
21 Chester Hospital. I was warned by Consultants that it
22 was likely that we would have to travel to another
23 hospital. We were told that this could be Birmingham or
24 London but we had to be ready to go anywhere.
25 "It was only when I went into labour that I was

1 told I was going to be giving birth at the Countess of
2 Chester Hospital. I was told that there were enough
3 nurses and beds to deliver the babies there.
4 "Going into hospital to have the triplets was
5 a different experience from having my first child.
6 Ahead of giving birth, I was told by Jim McCormack that
7 we would be able to look around the Neonatal Unit at the
8 Countess of Chester Hospital. In the event, this was
9 put off and I was not given the opportunity to look
10 around and see the Unit. We were told that the
11 probability of us being there would be low. That said,
12 we had not experienced a Neonatal Unit before so we had
13 nothing to compare it with anyway.
14 "I was given to understand throughout my pregnancy
15 that on delivery the babies would need to go to the
16 Neonatal Unit as a precaution due to the risk factors
17 that come with a triplet pregnancy and them having to be
18 born at 34 weeks.
19 "On an evening in June 2016, I was at home.
20 I started to get contractions at around 2300 hours.
21 I called the Countess of Chester Hospital to let them
22 know and they told me to come in straight away. I was
23 in a lot of pain.
24 "When I arrived, the contractions were strong but
25 they said that my cervix was not dilating so they didn't

1 consider me to be in active labour. A nurse from the
2 Fetal medicine unit popped in to see me and expressed
3 surprise that I hadn't been moved towards a caesarean
4 section, given my state.
5 "The next day, they reviewed me and decided to do
6 the section.
7 "I had diamorphine injected into my leg. I cannot
8 remember how long it was before this wore off.
9 "On a date in June at approximately 1.30/1.45 pm,
10 I was sent to theatre. Despite being 33 weeks pregnant
11 with triplets, I had to walk from the observation room
12 on the Labour Ward to the theatre. This was a few rooms
13 down from the Neonatal Unit.
14 "I was told to climb onto the bed and sit on the
15 edge ready to be given a spinal block.
16 "Father O&P&R was not in the theatre with me at
17 this point. He was getting his gown on.
18 "My hope and expectation was that Jim McCormack was
19 going to deliver the babies as he had scanned me every
20 week and reassured me that everything was going really
21 well. Unfortunately, he had booked annual leave. It
22 was very disappointing for me that he wasn't there.
23 I don't know the doctor that did the C-section.
24 "After receiving the spinal block, my legs started
25 to go numb and I was told to 'quickly' put my legs on

1 the table. My stomach was big as I was having triplets;
2 it was not easy for me and throughout the delivery
3 I felt very rushed. I was laying on the table and being
4 operated on when I felt pain; I was opened up at this
5 point. I was given further medication.
6 "When they started the surgery and I was opened up,
7 blood and fluid splattered up and over the screen and
8 onto the wall behind me. This also went onto my face.
9 I was told this was due to the pressure in my stomach.
10 "I had never experienced a C-section before. I was
11 told I would feel some pressure and pulling but that
12 I would not feel any pain. At one point I was in pain
13 and I said 'That's hurting'. The anaesthetist said
14 'I don't think that is hurting, it's pulling' and then
15 he gave me more medicine.
16 "When the boys were delivered,, I could hear them
17 crying. One of the nurses brought Child R over to me
18 for a few minutes. I was told that Child P and Child O
19 needed a little bit of oxygen but that this was not
20 unusual for babies born that early.
21 "The boys were then taken to the Neonatal Unit, and
22 I was taken to recovery.
23 "After being sewn up, I was taken to the recovery
24 suite opposite the theatre. Father O&P&R followed the
25 boys to the Neonatal Unit and was there for around an

1 hour before coming back to the recovery suite to check
2 on me.
3 "Whilst in recovery, I was shown some photos of the
4 boys so I could see them as I wasn't allowed down to the
5 Neonatal Unit until 1900 hours.
6 "At 1900 I went from the Maternity Ward to the
7 Neonatal Unit.
8 "When I arrived on the Unit, Father O&P&R had to go
9 home. I remember being with the boys on my own.
10 "I had a catheter in from the surgery. I remember
11 needing to go to the toilet. In the room there were six
12 bays and one bathroom. I was at the end of the ward and
13 had to walk to the other side where the toilet was.
14 "I could not physically get out of bed and walk
15 because my stomach was burning. The pain was so bad.
16 I called for someone to help but they took a while to
17 come.
18 "The stitches used for my C-section scar were not
19 dissolvable. I was told that I needed to air the scar
20 out. I went for a shower.
21 "I had never experienced a C-section before. Later
22 on, having experienced a second one, I can compare the
23 two. The C-section at the Countess of Chester Hospital
24 was a lot more painful. I wanted the midwife to help me
25 and apologised that I could not shower by myself. I was

1 made to feel that I was putting them out, as if they did
2 not want to help.
3 "Father O&P&R came back to the hospital and brought
4 our first child. I think this was in the morning before
5 lunch. I saw the boys on the Neonatal Unit twice this
6 day and I was there for around an hour each time.
7 "The boys were in separate rooms on the Neonatal
8 Unit. I was reassured that everything was fine, they
9 had no concerns. I cannot recall the precise date but
10 Lucy Letby was looking after two of the babies. She
11 showed Father O&P&R how to feed them. She told us how
12 lucky we were and that their weights were great.
13 "Father O&P&R changed Child P's nappy and took
14 pictures.
15 "Father O&P&R and I were told that they were going
16 to brain scan all three boys. Doctor V said this was
17 routine for all babies. After the scan results came
18 back, we were told everything looked fine and they had
19 no concerns.
20 "I wanted to express milk and Lucy Letby, who was
21 present on the day shift (I cannot recall the precise
22 date), showed me how to do this and gave me a leaflet.
23 "On a night in June, my mum came to visit during
24 the evening visiting times. The lights were low. Two
25 of the babies were in one room and one on their own in

1 another. Father O&P&R asked the nurses if there was an
2 issue with one of the babies and asked why they were
3 separated. He was told this was because of a lack of
4 space, so I was not concerned.
5 "We were told that Child P and Child O needed
6 a little bit of oxygen, but this was not unusual for
7 babies born that early. Otherwise, we were told that
8 they were healthy.
9 "Father O&P&R was asking the nurses if the babies
10 had come out fine, and if their weights were okay. We
11 were reassured that their weights were better than
12 expected and that they had been born healthy. I cannot
13 remember who reassured us, but I think that someone from
14 the Neonatal Unit would have been in the theatre so it
15 could have been that person.
16 "I was expecting my boys to go to the Neonatal Unit
17 due to the high risk of my pregnancy because we were
18 having triplets and they were premature.
19 "Throughout my pregnancy, I was told how well it
20 was going, so I did not expect the babies to need actual
21 treatment in the Neonatal Unit. The term 'feed and
22 grow' was used, and I expected the babies to go to the
23 Unit to feed and grow and then we would go home. So, we
24 basically understood their going to the Neonatal Unit to
25 be essentially precautionary.

1 "I was never given a specific timeframe as to how
2 long they would be in the Neonatal Unit. We assumed
3 that this would be dependent on their progress.
4 "I was not expecting the babies to need any special
5 treatment as we were told when they were born that they
6 were healthy -- there was nothing medically wrong with
7 them.
8 "Before birth, Father O&P&R and I were expecting
9 the babies to be 3lbs each at most. In fact they were
10 considerably bigger than we expected, reinforcing our
11 belief that they were in good health.
12 "On a date in June, Father O&P&R's dad was coming
13 to visit. You were only allowed to have one visitor
14 with one parent, so Father O&P&R was going with his dad
15 to see the boys and I stayed on the Maternity Ward.
16 "Around ten minutes after Father O&P&R had left the
17 Maternity Ward to go to the Neonatal Unit,, Father O&P&R
18 and Doctor U (who was the main Consultant) arrived at my
19 bed side. This alarmed me straight away because
20 I didn't why they were there. This was around 3 pm in
21 the afternoon.
22 "Doctor U assured me that there was nothing to
23 worry about, but that Child O needed some extra
24 breathing support so they had administered a breathing
25 tube. He told me this was not uncommon for babies in

1 the Unit and it was a regular occurrence. Despite this
2 reassurance, I wanted to go and see Child O for myself.
3 "Doctor U, myself and Father O&P&R got in the lift
4 to go down to the Neonatal Unit. I was in my
5 wheelchair. Doctor U walked us onto the Unit.
6 "We were confronted with a scene of complete chaos.
7 It was madness.
8 "Nurses were running around left and right grabbing
9 medicines and IVs. As soon as I went in, I knew it was
10 an issue with one of the boys.
11 "When Doctor U saw what was going on, it was
12 obvious he didn't have any idea what was happening and
13 I could see in his face that he was panicked and
14 shocked.
15 "I was left in my wheelchair and had to stay
16 outside the Unit in the hallway because it was so small
17 that there was no space for me. Doctor U didn't say
18 a word. Father O&P&R went over to ask what was going
19 on. He pulled Doctor U aside, but he didn't know what
20 was going on and he simply told us to give the staff
21 space to do their job.
22 "It was clear that Child O's collapse was
23 a complete shock to them.
24 "The Neonatal Unit staff were doing anything and
25 everything; there were IVs hooked up. I don't remember

1 the exact amount of IVs, just that he was given a lot of
2 different medications. Lucy Letby was on the ward at
3 this time; she was passing medicine to the doctors. It
4 looked like they didn't really know what they were doing
5 and were just trying anything they could think of.
6 "I called my mum and asked her to come straight
7 away. She arrived quite quickly.
8 "Child O passed away at 5.47 pm. I was there when
9 he died. He was passed over to me so I could hold him.
10 "As this was happening, and before Child O died,
11 Dr Brearey was called onto the Unit. At this point,
12 I was in a wheelchair in the corridor of the Unit. He
13 told me that Child O had been starved of oxygen. My mum
14 was present during this conversation. He told me that
15 it might be better if Child O didn't pull through
16 because the damage caused to his brain would be
17 life-changing.
18 "No one seemed to know how this had happened.
19 Everyone was in shock and disbelief.
20 "I thought that Child O maybe had something wrong
21 with him that went undetected like a disease or a virus.
22 This was just my assumption, however, as I wasn't told.
23 "The other boys were in a separate room to Child O.
24 I was told that the staff were going to do extra tests
25 on them.

"I am not sure which tests, but I understood they wanted to check if they had picked something up. They assured us they weren't looking for anything in particular and it was just routine.

"I felt maybe I had passed something onto the boys.

"I felt the nurses and doctors didn't have a clue what they were doing during the collapse. At the time, as a parent, I felt like they were doing an inadequate job.

"Much later, when we eventually went to Liverpool Women's Hospital, some of the staff there said they had heard on the phone that there was a problem with his liver. However, there was nothing concrete so we remained in the dark.

"We didn't learn anything further until just before the criminal trial.

"Father O&P&R and I were taken to the family room on the Neonatal Unit. A nurse whose name I don't remember asked if we wanted to dress Child O but I was too traumatised. I couldn't do it, so the nurse dressed him.

"They allowed any family to come onto the Unit to say goodbye. I remember there were quite a few family members present at this time.

"The nurses took Child O and I into the room where

Child R and Child P were, and they took them out of their cots so I could have a photo of them all together. This is the only picture I have of all three boys together. We could have had professional photos done but we didn't know if Child O had an undiagnosed illness that could be passed on to his brothers, so we didn't want to take any risk.

"On this night, I was given my own room with Child O and Father O&P&R stayed with us.

"I was very worried about Child R and Child P. I asked the midwife to phone down to the Neonatal Unit to see how they were doing.

"On a date in June, at about 6 am, I went down to the Neonatal Unit. This was before the night shift staff changed over.

"I was told by the nurse that the boys were 'little angels' and that she had no concerns. She told me to go and have some breakfast and to have a shower because everything was okay. At the criminal trial I found out that Child P had, in fact, been very unwell overnight but at the time I wasn't told this -- in fact I was told the exact opposite.

"I went back to the Maternity Ward to have some breakfast. After this, I went to have a shower.

"Whilst I was finishing showering, a nurse ran in

and told me that Child P was really poorly and I needed to get downstairs to the Unit right away. I went down in a wheelchair.

"As soon as I got to the Unit, I was confronted with the same chaos and panic as the day before. It was all happening again. They had pushed Child R to the back of the room and Child P was in real trouble.

"I phoned my mum to get her to come quickly.

"As soon as they managed to stabilise Child P and his stats were improving, he would deteriorate again. This went on for hours.

"We were given the family room for the day and went in and out, as Child P was being pumped with drugs and resuscitated over and over again. Father O&P&R and his dad stayed to watch as much as they could.

"In this period, I was just forgotten. I felt entirely forgotten and ignored. I had no medication or pain relief, and my mum had to get me some food so I could eat. If my mum hadn't been with me, I would not have thought about food or medication. No one was looking after me, and I had just had major surgery *(redacted)* days before.

"Lucy Letby was involved in the attempts to stabilise Child P. She was rushing in and out getting things on the instruction of the doctors.

"I think Dr Brearey was on shift. I remember him saying things looked more hopeful than they did with Child O. Child O did not recover from his collapse, whereas Child P came back round a few times.

"Before Child P died, the team had called for a transport team to take Child P to Liverpool Women's Hospital. The team eventually arrived, and the Consultant, Dr Rackham, took over. He seemed to be more senior. He was very calm. Other people seemed to listen to him, and he took control.

"Eventually, however, he said that he didn't know what had happened and could not believe what was happening, but that he could not do anything else for Child P.

"Child P passed away during late afternoon. I was holding him whilst he passed away.

"Father O&P&R begged Dr Rackham to take Child R to Liverpool Women's Hospital. Dr Rackham told us that he didn't know if he could due to space because he had come to take Child P. I thought if we didn't get Child R out, he was going to die. Father O&P&R and I did not know what was wrong at this point but I just knew we needed to get Child R out of the Countess of Chester Hospital. I didn't think anything malicious had happened at the time, but I did feel that something had

1 gone wrong in the Unit. I thought that possibly the
2 hospital staff had done something that they shouldn't
3 have. But we had no information as to what had happened
4 and why, and no one tried to provide any.
5 "Dr Rackham said that because the transfer had
6 already been arranged,, they could take Child R instead.
7 I asked to be transferred to Liverpool Women's Hospital
8 to be with him, but I was told it wasn't possible. The
9 only way I could be with him was to discharge myself.
10 I wasn't willing not to be with him, so a doctor checked
11 my stitches and I signed the paperwork to confirm
12 self-discharge.
13 "Whilst this was happening, Lucy Letby dressed
14 Child P in the clothes we set aside for him and put his
15 memory box together. She made a big deal about taking
16 photos and seemed quite upset. I remember my mum
17 thanking her for everything she had done.
18 "Our experience at Liverpool Women's Hospital was
19 completely different from the Countess of Chester
20 Hospital. When we got to Liverpool Women's Hospital,
21 I was in agony from my C-section. Father O&P&R got me
22 a wheelchair and we went to reception. Someone came to
23 meet us and we were buzzed into the ward. The nurse
24 looking after Child R was called Leah Murphy. She took
25 us to go and see him.

1 "They put us in a family room on the Neonatal Unit
2 and we slept there for a few nights. They made sure
3 that we were settled.
4 "On the ward, Father O&P&R and I noticed
5 a different level of cleanliness compared to the
6 Countess of Chester Hospital. There were clear hygiene
7 protocols. For example, we were told to wash our hands
8 before entering the Unit and then again before entering
9 the room. The nurse said that this was standard
10 procedure. Father O&P&R informed the nurse that they
11 didn't do this at the Countess of Chester Hospital.
12 "The room that Child R was in was huge; there was
13 enough space either side of his cot for any machines or
14 screens that were needed.
15 "The nurse asked if I had done skin-to-skin contact
16 with Child R. She couldn't believe that this hadn't
17 been offered to me at the Countess of Chester Hospital.
18 She took Child R out of his cot and put him on my chest
19 for the first time, which was really special.
20 "We stayed at Liverpool Women's Hospital for around
21 three weeks. This was mainly because they were being
22 extra cautious given the unexplained deaths of Child O
23 and Child P. I was very grateful. They said that Child
24 R was the only child in the Neonatal Unit who didn't
25 strictly need to be there, but they would keep him there

1 anyway as long as they had space.
2 "I think the nurse had been told that Child R's
3 siblings had passed away.
4 "They made the decision not to give milk to Child
5 R, but rather to give him nutrients down a line, as the
6 cause of what had happened to Child O and Child P was
7 unclear.
8 "The staff on the Unit were so thorough. Child R
9 had every organ checked.
10 "The nurse told me I could get Child R out of his
11 cot and I was scared, but she told me that skin-to-skin
12 contact was the best thing for a baby and they should
13 have done this at the the Countess of Chester Hospital.
14 "I was aware of postmortems. When I was waiting to
15 be discharged, the nurse said these would be done.
16 "Criminal Trial.
17 "As I was originally on the list to be a witness,
18 I didn't really know anything that was going on during
19 the trial itself. It was February when our part of the
20 trial started, and this was the week before I was taken
21 off the list. I therefore went to Manchester for most
22 of that part. If I couldn't make it to Manchester - for
23 example, on one day, there was too much snow --
24 I watched it from the video link in Chester Court.
25 "I found the trial extremely difficult. It was so

1 intense at Manchester being there in person. The
2 Defence were just doing their job, but they were saying
3 things like the doctors were lying about what had
4 happened and that was really hard. There were some
5 points when the Defence were questioning witnesses that
6 I had to leave the room as I couldn't cope with
7 listening.
8 "Father O&P&R and my mum also went every day and
9 stayed to listen to everything.
10 "I seem to remember speaking to a counsellor at
11 some point in Manchester to help me cope with listening
12 to the trial.
13 "When it came to the verdict, Father O&P&R didn't
14 feel able to go as it was too much for him mentally. It
15 also meant a lot of sitting around and doing nothing
16 just waiting for a decision to be made, hoping something
17 would happen.
18 "Instead, as it was over the school summer
19 holidays, Father O&P&R stayed with our children at home
20 and I went to the Court. I felt I had to be there.
21 I felt torn between the children I had at home and
22 making sure that someone was there for Child O and Child
23 P.
24 "I spent almost all of the summer holidays just
25 waiting and waiting for answers and coming back with

1 nothing. However, I was there the day that the verdict
2 was given.
3 "I remember that day very clearly. I was sat next
4 to a police officer who was holding my hand, and I just
5 sat and looked at the floor waiting for them to come in.
6 We were at the end as there was a list of names to go
7 through.
8 "When it finally came to us, I was relieved that
9 they had made the right decision and reached a guilty
10 verdict for both Child O and Child P's deaths.
11 "The police officer called Father O&P&R to let him
12 know the outcome.
13 "I had a sense of relief that we hadn't gone
14 through that very distressing process for nothing and
15 relieved that we had justice for our sons, but it
16 suddenly made everything very real.
17 "Impact.
18 "I went to see my GP for the first time at some
19 point in 2017 about the impact that everything had on my
20 mental health. Although things were bad after we lost
21 the boys, I think giving my statement in November 2017
22 was what pushed me into significant anxiety. I really
23 struggled.
24 "My GP prescribed me with anti-depressant
25 medication, but I wasn't offered any counselling or

1 other mental health related treatment through the NHS at
2 all.
3 "Once the police investigation had started I was
4 offered counselling with them and they put me in touch
5 with someone in Homicide Support who came to see me at
6 home and also arranged a counsellor. This was all
7 before the COVID pandemic. The counsellor was a trauma
8 counsellor and she came to see Father O&P&R and
9 I together at home.
10 "However, once the trial was starting, I was
11 originally going to have to give evidence and this meant
12 I couldn't see anyone at that stage. Eventually, at the
13 last minute, I was taken off the list and I didn't have
14 to give evidence. I don't know why this happened.
15 "The events we went through have impacted my faith
16 in the medical profession in a very big way. I found
17 out about the pregnancy with my youngest child before
18 the police made contact. At this time we had already
19 made the decision to never return to the the Countess of
20 Chester Hospital, I therefore chose to have my youngest
21 child at Arrowe Park Hospital as I couldn't bear the
22 thought of returning to Chester. I ended up having
23 another caesarean section as I wasn't in labour and the
24 child didn't want to arrive naturally. My experience in
25 theatre that day was very different to when I was at

1 Chester. The surgeon even told me that the caesarean
2 scar from Chester was 'so bad' he had taken it away and
3 'thrown it in the bin'. After my child was delivered,
4 they was given straight to me for skin-to-skin contact.
5 "The team at Arrowe Park were very sensitive to our
6 needs and put a butterfly sticker on my file to indicate
7 our previous loss.
8 "Throughout the criminal trial, I had support from
9 a team called Aspire who were at the Court all the time.
10 I was also given five after-care sessions via the police
11 which I took up, however these have now ended.
12 A referral was done via my GP for counselling, however
13 the appointment that was booked for me took place while
14 I was away so they just discharged me without even
15 contacting me to rebook. That was around October 2023
16 and I have had nothing since.
17 "There are also really small things which are
18 a constant reminder of the children we have lost. For
19 example, I had to call 111 when Child R had come home
20 because he had a temperature. When I spoke to them, it
21 meant I had to go through the whole process of
22 explaining that he was a triplet and born prematurely
23 and this meant the call handler had to ask me about his
24 brothers and how they were. There are constant
25 reminders all the time.

1 "I no longer trust any medics and I find this
2 really difficult when any of the children get ill, as
3 children often do. A few years ago, Child R got his
4 finger trapped ... and had to go for a x-ray. I was so
5 anxious about this and worried about the doctors that
6 I wouldn't allow him to go in on his own, as I just
7 don't trust anyone.
8 "Since the end of the criminal trial, things have
9 not really got any easier. We have children at home
10 that need us, so we just have to carry on, but it is
11 never ending. It feels like every time I pick myself
12 up, there is something else that comes along to knock me
13 back down.
14 "We now have to face the Inquiry, which is taking
15 place, and although we know it is important, it will
16 drag lots of very difficult memories up for us again.
17 "Further Questions in Rule 9 request.
18 "As far as the Datix reports are concerned, I did
19 not know they existed until we saw them in the criminal
20 trial.
21 "As to when I was first made aware of the number of
22 Neonatal deaths at the Neonatal Unit between
23 2015 and 2016, I think I first learned about this from
24 a phone call with the police. In the phone call I was
25 told they needed to speak with me and that they were

1 investigating the boys' deaths. The police officer then
2 came round to the house to speak to us. I think this
3 must have been around April/May 2017.
4 "Before that, all I was aware of was that the boys
5 would have a postmortem. From that, we got our first
6 explanation of how they had died. We had a phone call
7 from the Coroner and were told they had put the deaths
8 down to the boys being premature.
9 "In the report we received, the names and the dates
10 of the boys were wrong. I feel they did not give us
11 a good enough explanation. The health of the boys and
12 how well they were doing did not match what they were
13 saying.
14 "We found out about the wider problem when the
15 police came to our house; they said that they were
16 looking into the deaths. I thought it was something to
17 do with medical negligence. I didn't think it was going
18 to be murder. The police asked us to tell them what had
19 happened.
20 "On 3 July 2018, Father O&P&R got a call from our
21 Family Liaison Officer and they informed us that they
22 had arrested someone on suspicion of murder. This is
23 the first time we ever knew about this. Father O&P&R
24 got the call before we saw it on the news.
25 "Our Family Liason Officer then came to the house

1 that morning and told us that Lucy Letby had been
2 arrested.
3 "We were devastated and in a state of disbelief
4 because Lucy Letby was the one who was looking after the
5 boys.
6 "When we had been in the Neonatal Unit, Lucy Letby
7 did not stand out more than any of the other nurses.
8 She was visibly upset when the boys died. She put both
9 boys in the cot together and she was crying.
10 "It was Lucy Letby's idea to take photos of the
11 boys. She dressed them and then took photos of them
12 together.
13 "I was never told anything about Letby by the
14 Countess of Chester Hospital. It was only during the
15 trial I found out that she had been suspended and taken
16 off the ward. I think I may have also seen this on the
17 news.
18 "I do not believe that the Countess of Chester
19 Hospital were honest with us at any stage. In my view,
20 they never should have taken on our care in the first
21 place. We were not made aware of the higher mortality
22 rate in the Neonatal Unit - which we now know they were
23 aware of at that stage. I think as parents we should
24 have been informed of this.
25 "They knew that something untoward was going on and

1 continued to take on my care, even though we could have
2 been sent to a Neonatal Unit elsewhere.
3 "As far as medical records are concerned, I did not
4 know that we could ask for them, and if I had we would
5 have requested them.
6 "Father O&P&R and I were not offered any support or
7 counselling by the Countess of Chester Hospital. The
8 possibility of support was never even mentioned. The
9 first time we were offered support was through Homicide
10 Support and then at the criminal trial.
11 "I spoke to the Honeysuckle Counselling Team at
12 Liverpool Women's Hospital a few times; they gave me
13 some leaflets and arranged for Father O&P&R to see the
14 boys in a room, and they did a professional photo for
15 us.
16 "The Honeysuckle Team was not full counselling; it
17 was more just being made aware that there was support
18 available. Because of what I had been through, I needed
19 someone to give me support and push me because I could
20 not do it myself, but nobody did.
21 "Myself and Father O&P&R were only fully offered
22 support when we went to the criminal trial in 2023; this
23 was seven years after this happened. We were also
24 offered support through Homicide Support.
25 "I do not know what PALS is and have no experience

1 of it.
2 "Suggestions and Recommendations.
3 "I believe that the Countess of Chester Hospital
4 knew much more than they have admitted to publicly about
5 Letby's crimes and I understand from my solicitors that
6 by the time my children were born there, there were
7 already serious concerns about Letby. Obviously, we
8 want to see what evidence comes out about this in the
9 Inquiry, but clearly, hospital management should have
10 been much more responsive when concerns were raised,
11 rather than ignoring or covering up concerns to protect
12 the reputation of the hospital and the Neonatal Unit.
13 "The information sharing with us was not adequate.
14 It was worse than that - it was basically non-existent.
15 Everything I have since found out about what really
16 happened I have learned through the police, through the
17 trial and through my solicitors. Within the NHS there
18 is supposed to be a duty of candour. Nobody at the
19 Countess of Chester Hospital was candid with us. The
20 duty of candour needs to be made legally enforceable.
21 "I believe that there should be CCTV in every
22 Neonatal Unit, so that what happens to babies is
23 recorded on camera and can be checked.
24 "I also believe that there should be proper
25 monitoring of access to medicines, so it can be checked

1 who has accessed particular items.
2 "Finally, there should be clear protocols to
3 provide support, (to include counselling), full
4 information and guidance to parents who have been
5 bereaved or whose children have been harmed."
6 That concludes the statement of Mother O&P&R.
7 Thank you, my Lady.
8 **LADY JUSTICE THIRLWALL:** Thank you very much,
9 Mr Scorer.
10 Father O&P&R, I think we're going to have a short
11 break. If you just let us know when you are ready.
12 **MR SCORER:** Thank you, my Lady.
13 **(10.37 am)**
14 **(Short Break)**
15 **(10.44 am)**
16 **LADY JUSTICE THIRLWALL:** When you are ready.
17 **MR SCORER:** My Lady, I will now read the statement
18 of Father O&P&R.
19 **LADY JUSTICE THIRLWALL:** Thank you.
20 **FATHER O&P&R statement read**
21 **MR SCORER:** "I, Father O&P&R, will say as follows:
22 "I make this statement in response to the Inquiry's
23 Rule 9 request. This statement should be read in
24 conjunction with my police and Victim Impact statements.
25 "Experience of Countess of Chester Hospital.

1 "Before Mother O&P&R became pregnant in 2015, we
2 already had one child who was born at the Countess of
3 Chester Hospital. The birth went fine, there were no
4 complications and we considered that the care provided
5 was good.
6 "When Mother O&P&R found out she was pregnant
7 again, I went to the booking appointment and all
8 scanning and medical appointments at the Countess of
9 Chester Hospital with her, as it was important for me to
10 be involved in the process and to support her.
11 "I remember the day we found out we were having
12 triplets really clearly. It was at the 12-week scan and
13 while the sonographer was checking the imaging I was
14 sure I could see two heads on the screen. I told
15 Mother O&P&R what I could see and she thought I was
16 being silly, but the sonographer replied that she
17 thought that there were more than two. We then found
18 out there were three babies.
19 "We were so shocked that Mother O&P&R burst into
20 tears; partly from surprise/excitement and partly
21 because it suddenly hit us both that we would need to
22 find a way to *(redacted)* support three babies as well as
23 ourselves and our oldest child. It felt like a once in
24 a lifetime opportunity to welcome three children at
25 once. I felt really blessed in that moment.

1 "After we spoke to the Consultant at the Countess
2 of Chester Hospital we were referred to Liverpool
3 Women's Hospital the next day to make sure everything
4 was okay. We had to deal with a difficult conversation
5 about potentially stopping one baby's heart to help
6 another thrive, but Mother O&P&R and I both agreed that
7 we wanted to let things progress naturally. We had
8 a big talk about it but we were both on the same page
9 and wanted the best for all three children. Looking
10 back, the babies' heartbeat Liverpool Women's Hospital
11 wanted to stop was in fact Child R, so if we had gone
12 ahead with this we could have lost all of our boys.
13 "After that difficult conversation, things got
14 better and better. I recall all the doctors and
15 midwives being really surprised that Mother O&P&R was
16 doing as well as she was. It did feel at times like
17 they were all waiting for something bad to happen, but
18 everything was fine all the way through her pregnancy.
19 "As she got bigger, we made jokes about how she
20 would make it through the scan because the three growing
21 babies put so much pressure on her abdomen, that
22 applying the scanning equipment made her feel faint. On
23 one occasion she did actually pass out, but everyone was
24 delighted with her progress.
25 "However, we were told that the likelihood of

1 Mother O&P&R delivering at the Countess of Chester
2 Hospital was quite slim as they thought it unlikely that
3 they would have enough beds and nurses available to care
4 for them. We were warned that we would probably need to
5 travel some distance to go to another hospital for
6 delivery - Birmingham and London were mentioned but we
7 were told to expect to go anywhere. So I did not expect
8 our babies to be born at the Countess of Chester
9 Hospital. Myself and Mother O&P&R were explicitly told
10 throughout her pregnancy that they would only be born
11 there if there was a nurse and a bed for each baby.
12 I was told by the Consultants, Jill and Jim McCormack,
13 that it would be very unlikely that we would have them
14 at the the Countess of Chester Hospital.
15 "We had no set plans for our future working
16 arrangements once the babies had arrived, but our loose
17 idea was for Mother O&P&R to go back to work after about
18 nine months and for me to take over, and I would
19 eventually also go back to work once we were all in
20 a comfortable routine.
21 "Mother O&P&R had scans every two weeks at the
22 Countess of Chester Hospital except for a couple which
23 were performed at Liverpool Women's Hospital.
24 "We decided to find out the sex of the babies and
25 to figure out who was who, to make it easier to identify

1 them all. The babies stayed in the same position
2 throughout her pregnancy, so this made it easier to keep
3 track of them. I cannot be certain, but I think we
4 found out that they were all boys at around 20 weeks.
5 We named them.
6 "Mother O&P&R and I expected the boys to go onto
7 the Neonatal Unit due to the fact that we were having
8 triplets and this was high risk. I was told by
9 Dr McCormack that myself and Mother O&P&R would be able
10 to go and look around the Neonatal Unit at the Countess
11 of Chester Hospital but this was put off and we did not
12 end up going. The tour was supposed to put our minds at
13 rest and give us reassurance as we had never experienced
14 a Neonatal Unit before.
15 "Mother O&P&R started to have some tightenings at
16 around 30 weeks, so we thought it best to go to the
17 Countess of Chester Hospital to make sure that
18 everything was okay. When we got there, I really got
19 the impression that they weren't very happy that we had
20 come in, because Mother O&P&R wasn't ready to go into
21 labour. We knew that to be the case, having been
22 through this before; we went out of caution and concern,
23 but it felt as though caring for Mother O&P&R's
24 pregnancy was a little too much for them.
25 "While Mother O&P&R was admitted to the Countess of

1 Chester Hospital as a precaution, my family had to help
2 us with child care for our eldest child as I spent as
3 much time in the hospital with Mother O&P&R as I could,
4 in case something happened. Mother O&P&R was eventually
5 discharged home as she wasn't ready to go into labour.
6 "On an evening in June 2016 Mother O&P&R started
7 having contractions late at night, at home. We called
8 the hospital, and they told us to come straight in
9 because she was high risk.
10 "Again, it felt like they didn't really appreciate
11 us being there once we arrived - a date had been booked
12 for Mother O&P&R's caesarean section and we got the
13 impression that going in early was a big inconvenience
14 for them, even though she was obviously not in control
15 of her contractions starting.
16 "The first doctor we saw was really young and this
17 made me feel a little nervous.
18 "the Countess of Chester Hospital confirmed that in
19 fact, contrary to expectations, they did have enough
20 beds for all three boys if they did arrive and they
21 therefore agreed to keep Mother O&P&R in overnight.
22 They eventually confirmed that she would have the
23 caesarean section.
24 "The following day, Mother O&P&R was taken down to
25 theatre for the procedure and I went into the operating

1 theatre with her. It struck me how cold looking and
2 dingy the room felt, and it didn't fill me with
3 confidence. The state of the theatre was like something
4 out of a horror film, ;when I walked in there
5 I immediately felt uneasy. It was very cold and
6 unhygienic. When you go to a dentist, it is all
7 clinical and clean, but this was not the case with the
8 theatre. The room was really small with half a dozen
9 doctors. I was standing by Mother O&P&R's head but
10 I could also see the other side of the screen.
11 "My first impression of the lead surgeon was that
12 she was very young. The surgeon was of a slim build,
13 tall with curly hair; I cannot remember her name.
14 I remember asking Mother O&P&R if she was the person who
15 was going to be delivering the babies. It was my
16 expectation that Dr McCormack would be delivering the
17 boys but he had booked annual leave. We had put our
18 trust in Dr McCormack and he was there through the
19 pregnancy reassuring us that everything was going so
20 well. It was disappointing for him not to be there at
21 the end.
22 "As the boys were being delivered, I watched the
23 whole process including the first incisions being made
24 and the boys being pulled out. I was warned that
25 I might not want to watch but I did.

1 "The first incision they made caused a big spray of
2 blood to go across the room. It went so high, it
3 reached the wall behind Mother O&P&R and I and a small
4 amount landed on her head. Again, this left me feeling
5 somewhat nervous. I watched the boys come out one by
6 one and saw that they were all being checked over.
7 "It was a huge relief to see all of them come out
8 safely.
9 "When the boys were delivered, they were crying.
10 The nurses brought Child R over to see Mother O&P&R for
11 a few minutes. Whilst Mother O&P&R was being sewn back
12 up, I went over to see the boys to see if they were
13 doing okay. I was told one needed some assistance.
14 I asked the nurse if they were okay and she told me
15 everything was okay and he just needed some oxygen.
16 They assured me that all boys were born sound and
17 healthy with very good weights. After Child P had some
18 oxygen, he perked up. I asked lots of questions, if
19 they had come out fine and if their weights were okay.
20 I was reassured that their weights were better than
21 expected, they had been born healthy and normal.
22 I cannot remember who was specifically reassuring me.
23 I think it was someone from the Neonatal Unit who was in
24 theatre with us, so it could have been them.
25 "I was expecting the boys to go to the Neonatal

1 Unit because they were premature triplets. Due to how
2 well the pregnancy went and the reassurance we had, we
3 did not expect them to need any treatment. The doctors
4 used the term 'feed and grow'. Mother O&P&R and
5 I expected the babies to go to the Unit, feed and grow
6 and then go home. We did not expect them to need any
7 special treatment; there was nothing actually wrong with
8 them. The doctors and nurses reassured me that the boys
9 were healthy. I was expecting them to be less than 3lbs
10 at the biggest. In my eyes, they were considerably
11 bigger than what everyone expected.
12 "I believe that Mother O&P&R only saw Child R
13 immediately after the delivery, because Child P and
14 Child O needed some initial support. Because he was
15 more stable, a few photos were taken of Child R being
16 held next to Mother O&P&R by one of the nurses.
17 "After the boys were delivered, Mother O&P&R was
18 taken to the ward so she could be looked after, and
19 I went down to the Neonatal Unit to see the boys. I was
20 down there for around 45 minutes and was able to have
21 some skin-to-skin contact with Child R. After that,
22 I went upstairs to see Mother O&P&R.
23 "The following day] we had lots of family members
24 visiting that day, but Mother O&P&R was in a lot of pain
25 and she needed help with showering and her personal

1 care, so although I did try and spend as much time as
2 possible with the boys, I also had to balance this with
3 making sure Mother O&P&R was looked after and seeing
4 family.
5 "That night, I left the hospital and stayed at home
6 with our eldest child and then returned to hospital the
7 next day.
8 "On the following day, my dad came to the hospital
9 to see us and to meet the boys. You are only allowed
10 one parent plus one visitor on to the Neonatal Unit at
11 a time, or both parents, so Mother O&P&R and I agreed
12 that I would meet my dad and take him down there.
13 "I think I met him at the hospital reception, as
14 I recall that he didn't really know where to go, and we
15 then walked to the Neonatal Unit together.
16 "On the way down, I bumped into Dr U who was coming
17 to speak to Mother O&P&R. He didn't seem panicked, he
18 was calm. He reassured me that everything was fine and
19 there was no reason to be alarmed, but Child O needed
20 some help and they had put a breathing tube in. This
21 was around 3 pm.
22 "Dr U, my dad and I got into the lift and came down
23 to the Unit. When we walked through the doors you could
24 see Dr U didn't have a clue what was going on; I could
25 see in his face that he was panicked and shocked.

1 "Everything had been fine when I left to go and
2 meet my dad, but when we got back there it was absolute
3 pandemonium.
4 "Doctors and nurses were all running around and it
5 was extremely busy and overwhelming with the number of
6 doctors and nurses packed into the room. No one told me
7 what was happening, and they were all just rushing
8 around. There were lots of different things being put
9 into lines and tubes.
10 "All I got told was that there was a problem with
11 Child O and then I got ushered to one side and told
12 a doctor would come and see me.
13 "I went up to the ward to go and get Mother O&P&R.
14 I told her there had been a problem and she needed to
15 come down to the Unit.
16 "Mother O&P&R needed to be in a wheelchair because
17 of her surgery so I wheeled her down to the Unit. The
18 journey down there was agonising for her because every
19 time the wheelchair went round a corner, or over
20 a threshold or bump it caused her a lot of pain. When
21 we arrived, I couldn't get her close enough that she
22 could see Child O or be near him because of the
23 wheelchair and volume of people in there. She ended up
24 having to wait in the hallway.
25 "I was able to get back into the Unit and went to

1 try and find out what was happening. Mother O&P&R had
2 called her mum to come to the hospital and she arrived
3 and waited with Mother O&P&R.
4 "We didn't get any explanation of what was
5 happening even though I was standing close to what was
6 going on. We had no idea what had gone wrong. I know
7 that somebody mentioned swelling on his abdomen, and
8 this was something I could see for myself; his stomach
9 had popped out almost like a pot belly. His skin was
10 a different colour and it looked almost like there was
11 something pulsating through his veins.
12 "The doctors seemed as baffled as we were, and
13 no one could tell us why things had suddenly gone so
14 wrong. It was really shocking. I have no medical
15 training and it felt like the doctors were essentially
16 in the same boat as me.
17 "Shortly before we were given the news that they
18 would have to stop trying to resuscitate Child O, they
19 asked whether we wanted to have him christened. We both
20 did, so me, Mother O&P&R and her mum were present when
21 the priest came down and christened him.
22 "Shortly after he was christened, Child O passed
23 away.
24 "After he was gone, he was passed to Mother O&P&R
25 so that she could hold him. I was devastated.

1 "We were given sole use of the family room, which
2 was usually for all Neonatal Unit families to use. We
3 were conscious that there were other families on the
4 ward at the time that all of this was happening, so we
5 were grateful for a space where we could try and take
6 stock of what had happened and have some privacy.
7 "Mother O&P&R and I spent some time with Child O in
8 the family room before I had to deliver the awful news
9 to my mum.
10 "Someone suggested that we get a camera and take
11 some photos and they would give us a blank SD card so we
12 could keep them. I tried to dress Child O but
13 I couldn't bring myself to do it. He was cold and so
14 still and I just couldn't do it.
15 "Someone else dressed him and we took some more
16 photos and I also brought my mum up to see him. We were
17 in the room for a while and just sort of sat in there
18 for the evening.
19 "We took a photo of all the boys together on this
20 day and this is the only picture we have of the three of
21 them together.
22 "That night, Mother O&P&R was moved off the ward
23 and into a separate room which meant I could stay there
24 with her.
25 "I couldn't let Child O out of my sight. I wasn't

1 ready to be away from him, so he stayed in the room with
2 us all night in the cold cot. Neither Mother O&P&R nor
3 I slept that night. I knew it would be the last time
4 that I would see him. A nurse came and collected him in
5 the morning.
6 "Overnight, Mother O&P&R called down to the ward
7 a few times to make sure that Child P and Child R were
8 okay and each time they said everything was fine.
9 "On the following day, Mother O&P&R and I both went
10 down to the ward to see Child P and Child R first thing
11 in the morning. The nurse we saw at first was lovely
12 and said they had both been little angels. She said
13 they had been feeding well and opening their bowels as
14 normal and there was nothing to worry about.
15 "It later came out as part of the criminal trial
16 that there had been some minor issues to do with the
17 numbers on their charts, but I don't really recall what
18 this was, and it was apparently nothing significant.
19 "Mother O&P&R went back up to the ward so she could
20 have a shower and I stayed down on the Unit and,
21 similarly to the previous day, I had planned to go and
22 meet my dad.
23 "Literally just before I was due to go and collect
24 him, it all happened again.
25 "I had to go and get him and when he arrived I said

1 'Dad, it's all happening again'.
2 "We rushed back to the Unit, and it was like
3 déjà vu. It was almost an exact repeat of the day
4 before.
5 "Everyone was running around like headless chickens
6 looking like they had no idea what was wrong. I asked
7 one of the doctors what was going on and said 'it's
8 happening again, isn't it'. Nothing was said to me;
9 no one could explain it, again.
10 "They couldn't tell me what was happening, just
11 that they were doing everything they could for him. In
12 my mind, I could already see it was the same. Child P
13 had the same mottling on his skin, the same distension
14 on his belly and I just knew it was the same thing, even
15 though I didn't know what that thing was.
16 "I can't be sure, but I think there were doctors
17 there that day that hadn't been present the day before,
18 perhaps even more Consultants. I remember watching as
19 an incision was put into Child P's chest to help his
20 lungs and because there was no space, they had to put
21 a screen up in the hallway.
22 "Mother O&P&R was, again, stuck outside in her
23 wheelchair, also with no idea what was happening.
24 "There was another doctor at what looked like
25 a makeshift desk using a screen to look up how to

1 perform the chest drain and where the incisions and
2 tubes should go. It looked as though they were
3 following a tutorial and not as if they really knew what
4 they were doing.
5 His resuscitation went on for a really long time
6 and we were eventually told that they would arrange to
7 transfer him to Liverpool Women's Hospital. However,
8 they needed to wait for transport to come and get him.
9 That wait felt like it was hours, although, in reality,
10 it was probably much shorter.
11 "While all of this was happening, Lucy Letby was
12 involved in Child P's resuscitation.
13 "I saw a nurse Googling a procedure; she was
14 youngish. She had a PC screen in front of her and as
15 soon as I saw this come up on the screen I panicked.
16 I was confused as to why she was Googling this. The
17 procedure was a lung drain. On the screen there was an
18 image of a person with an arrow pointing to where the
19 incision should be. It was a medical diagram. I think
20 the staff heard me talking about it; I was angry at this
21 point. I can remember other staff coming over to the
22 computer to look at it; they all had a word with each
23 other and did the procedure. This was worrying me
24 because it is an everyday procedure, one that hospital
25 staff must do day in and day out.

"When the Consultant from Liverpool Women's Hospital Dr Rackham arrived, there was such a shift and change in the atmosphere. He was so good. He was calm and confident and gave clear instructions to everyone about what they should be doing. Despite how calm he was I could sense how shocked he was that nothing they had tried was working.

"Dr Rackham eventually came over to us and he said they had tried everything and there was nothing more they could do. They asked if we wanted him to be christened, which we did. His support was stopped shortly after he was christened.

"I remember Dr Rackham passing Child P to Mother O&P&R and saying he didn't know what had happened and that he couldn't believe it. He said that they had done everything they could have done.

"Mother O&P&R was holding Child P as he passed away. It was heartbreaking.

"I remember feeling quite angry at this stage and I felt as though the hospital could have done more to help the boys. I just felt that something wasn't right, and I knew that if they didn't take Child R to Liverpool Women's Hospital, he wouldn't survive.

"Mother O&P&R felt the same and I remember her saying to me 'take my boy out of here now'.

I approached the Consultant from Liverpool Women's Hospital and said that we weren't happy leaving Child R in the care of the Countess of Chester Hospital, knowing that something had gone really wrong with both our boys in just 24 hours. I told him I thought that if he stayed there, he would be next and I genuinely felt that to be true.

"In not so many words, he indicated that he agreed there was a risk to Child R and that because they had agreed to take one baby back with them, he made some calls to try and arrange it. He spent about 10-15 minutes making calls and explaining to the hospital what had happened, and it felt like he was having to fight for us. When we found out that he had managed to get it agreed, we were delighted. We really felt that Child R would be safer there.

"Shortly after this, I was out in the courtyard with Dr V. She gave me a hug and told me that they had tried everything. She couldn't believe that this had happened to both boys so quickly. I recall Dr V pulling me to one side and asking if we wanted there to be a postmortem report for Child P. She said that they don't always do one, but this can be arranged sometimes. I said we definitely wanted one done as I knew something wasn't right and I really pushed for this to be done.

She said it wasn't up to her to make the final decision, but she would try to keep us updated. Dr V was very upset and kept apologising to us, but it just felt like a lot of sorrys were given which didn't really help us because we didn't understand how it had happened. She told me that they would get to the bottom of it, she took me into her private office and explained a postmortem or autopsy might be needed and in this case we should argue one be done. I told her we needed answers and it needed to be done.

"Mother O&P&R and I were then taken to another family room at the other end of the Labour Ward. Child R and Child P were brought in together with Child P in a cold cot. Lucy Letby was present in that room, and she had dressed Child P. We took some photos of the boys together. Lucy Letby made a very big deal about taking photos of the boys and making memory boxes.

"In order for Mother O&P&R to be able to go with Child R to Liverpool Women's Hospital, she was forced to discharge herself. She still needed care and medication after her surgery and we asked several times for her care to be transferred, but they said this wasn't possible. We were never told why. This meant she had to sign paperwork to discharge herself even though she still needed support.

"Child R was then transferred in an ambulance and we were encouraged to go home in between to get some fresh clothes and to avoid following the ambulance, so we didn't panic if they had to pull over for any reason. The transfer team were brilliant and even texted us once Child R had arranged, so we knew he was safe and we could start our journey to the hospital.

"we drove to the hospital once we knew Child R had arrived. Mother O&P&R was in agony. Every time the car went over a bump, she was in a lot of pain and this was only adding to her upset.

"When we arrived at Liverpool Women's Hospital, I got Mother O&P&R a wheelchair and we went to reception. Someone came to meet us and we were buzzed in. They put us in the family room on the Neonatal Unit and we slept there for a few nights. The staff made sure that we were settled.

"Leah Murphy was the nurse looking after Child R; she came to see us and took us to see him.

"As soon as I arrived on the Unit, I noticed a different level of cleanliness on the Unit compared to the Countess of Chester Hospital. We were told to wash our hands before entering the Unit and the room. The nurse said that this was standard procedure. I told her we were never asked to do this at the Countess of

1 Chester Hospital. The room Child R was in was huge;
2 there was enough space either side for any machines or
3 screens that were needed.
4 "Every detail was explained to us. The nurse told
5 Mother O&P&R and I about the monitors and what it means
6 when they go off. They said not to worry unless we see
7 them worry. They were really reassuring as we were
8 already panicked. I think the nurse must have been told
9 that two siblings had passed away.
10 "We were there for three and a half weeks. We did
11 not need to be there; we were there as a precaution.
12 The staff made the decision to starve Child R as there
13 was no evidence from the Countess of Chester Hospital of
14 what had happened to his brothers. They said that they
15 would not feed him for now as they needed to take
16 precautions. They were so thorough. Child R had all
17 his organs checked. I felt like they knew more; they
18 handled situations so much better. We had seen a few
19 very poorly babies in there and not one of them died;
20 every baby pulled through and we knew that Child R was
21 in safe hands.
22 "The nurse told Mother O&P&R she could get Child R
23 out of his cot and she was scared. The nurse told us
24 that skin-to-skin was the best thing for a baby and that
25 we should have been doing this before. Mother O&P&R had

1 never had skin-to-skin contact with Child R before this.
2 She was scared that she would pass something on to him.
3 The staff said Child R was the only child in Intensive
4 Care who did not need to be there. During the three and
5 a half weeks, he moved down the rooms in stages.
6 "Before the boys were born we rented an old house
7 that had issues with damp and mould. It wasn't
8 something that bothered Mother O&P&R and I, but we
9 didn't feel comfortable taking Child R back to the
10 house, particularly because we still didn't know what
11 had happened to Child O and Child P. We couldn't take
12 any risks.
13 "We therefore stayed with our families initially.
14 [We were very grateful to be put up but it wasn't
15 really] the ideal situation.
16 "Mother O&P&R was very distressed and couldn't deal
17 with anything which meant I had to try and sort
18 everything out with the house, but it was difficult for
19 me, so I ended up asking my dad to arrange everything
20 for us.
21 "After we left hospital with Child R and were more
22 settled in our home, we just tried to cope with
23 day-to-day life as best we could. I was trying to work
24 but I was struggling emotionally. We received no help
25 from the Countess of Chester Hospital or the NHS. Then

1 we found out that the police investigation was starting,
2 and this really changed things.
3 "I had always known that something wasn't right in
4 what happened to the boys and although the police
5 involvement was some validation of my concerns, it was
6 also overwhelming.
7 "It sickened me to think that the police had to be
8 involved in a hospital investigation and as we weren't
9 told about the nature of the investigation, it made it
10 really difficult to understand and cope.
11 "There were so many different scenarios and
12 possibilities going through our heads about what might
13 have happened and why the police were involved. Mother
14 O&P&R blamed herself for what had happened to the boys,
15 thinking she had done something wrong during pregnancy
16 or passed something on to them. I blamed myself and
17 thought I might have passed something on to them. We
18 both blamed ourselves, although Mother O&P&R felt this
19 more strongly than I did. It was hard to try and tell
20 her it wasn't her fault; anything I told her she just
21 didn't want to hear.
22 "My gut feeling had always been that something
23 medically had been done wrong to the boys because of the
24 way their abdomens had been swollen and I just knew
25 something was not right. I didn't always think it was

1 malicious, but I thought something had been given
2 incorrectly with the amount of medicine they were
3 pumping into the boys, or even that CPR had been done
4 too vigorously. Mother O&P&R didn't really vocalise any
5 theories as much as me; she is much quieter and tends to
6 just keep to herself. It was only when the police had
7 shed light on the events that everything fell into place
8 with what I was thinking, and it all made sense from
9 what I had seen.
10 "Mother O&P&R was particularly anxious about being
11 kept in the dark and couldn't understand why we weren't
12 being told anything. It was very frustrating and made
13 us both really nervous.
14 "As time went on, the police started asking us more
15 and more about specific shifts and specific members of
16 staff and, over time, Lucy Letby's name came up more
17 frequently. Mother O&P&R and I both remembered her from
18 our time at the hospital.
19 "I remember the day they told us that she had been
20 arrested, and our hearts sank. It was so difficult to
21 understand at first because she had been so visibly
22 upset when Child P passed away. When she was working on
23 a shift she came across as quite robotic and cold, but
24 after Child P died, she appeared to be devastated.
25 "Criminal Trial.

1 "At the start of the trial, Mother O&P&R was
2 a potential witness, so she wasn't allowed to watch or
3 listen to anything relating to the proceedings. She
4 took herself off of all social media platforms and
5 avoided the news. I followed everything for the first
6 week religiously. I was glued to my phone and texting
7 my parents any developments that happened. It was
8 a strange time because Mother O&P&R and I couldn't
9 discuss any of it and we were very strict about this as
10 we were not willing to risk jeopardising any conviction.
11 "After around a week, I stopped following what was
12 happening because of not being able to speak to Mother
13 O&P&R about it. It was more important to me to support
14 Mother O&P&R than follow what was happening and I was
15 worried about slipping up.
16 "I started re-following events once Mother O&P&R
17 found out that she was no longer going to be a witness,
18 which was towards the end. That's also when the police
19 disclosed more information to us about what had happened
20 and the rest of the trial.
21 "A Family Liaison Officer came over to our house,
22 and Mother O&P&R's mum came too and that's when we got
23 all the information about what had happened to Child O
24 and Child P and how it all happened. This was the first
25 time we knew or had any idea of why the boys had died.

1 "We were given lots of paperwork to read, which
2 explained all the medical terms and what had happened,
3 but it was really hard to see it all written down. We
4 had spent all those years making up scenarios about what
5 might have happened and blaming ourselves and seeing it
6 there in black and white was devastating. Once we knew
7 what had happened, in a way, it seemed quite obvious.
8 We both used to watch medical dramas and have seen
9 episodes before where similar sorts of things happen,
10 and they always talk about how difficult it is to
11 detect.
12 "After we knew what had happened, we did start to
13 attend the trial -- either in person or by video link at
14 Chester. Both Mother O&P&R and I only attended anything
15 to do with our family. I didn't want to read into what
16 happened to the other children. I didn't feel I could
17 cope.
18 "It was a nightmare for us to get to Manchester
19 Crown Court to attend any of the Court days. We didn't
20 have a car which meant relying on a Family Liaison
21 Officer -- the children would have to go to our family
22 so they could be taken to school, we attended a full day
23 in Court and then it sometimes took us *(redacted)* hours
24 to get home because of traffic. Some weeks it was like
25 that for days on end.

1 "The verdict arrived during the school summer
2 holidays, but we didn't know when it could come and
3 no one could give us any idea of timescales for the
4 decision. We could either go there every day and wait
5 all day long, or chance it and not go. The children
6 were off school, so I stayed at home with them and
7 Mother O&P&R went to the Court every single day and
8 waited all day on her own, while I looked after the
9 kids.
10 "This was tough for me as I had been at the Court
11 all the way along for our parts, and then couldn't be
12 there for the most important bit.
13 "The day that the verdict was given Mother O&P&R
14 was at the Court. A police officer called me once the
15 decision had been read out. By this point, there was no
16 doubt in my mind that Lucy Letby was responsible, so
17 I ended up just finding it reassuring that the right
18 thing had been done.
19 "Mother O&P&R and I have both lost a lot of faith
20 in the medical profession now and this has only been
21 made worse by my experience of trying to get mental
22 health support.
23 "When it comes to our children and getting medical
24 treatment, I would say that Mother O&P&R and I are both
25 now quite anxious about them. We are very alert to any

1 health issues they might have and probably overly
2 anxious about them getting unwell. I am fine taking
3 them to the local doctor or GP but it's another issue if
4 we have to take them to hospital.
5 "I still have very vivid nightmares and don't sleep
6 well. Even at the weekend, I still cannot really sleep.
7 I am often sat up until 1 am unable to switch my brain
8 off and when I go to bed, I still about everything that
9 has happened.
10 "I have visions and nightmares approximately every
11 other night, of being back at the hospital. They tend
12 to be about the boys and are a mix of specific things
13 I remember happening at the time; the colour of their
14 veins and their veins pulsating is something which comes
15 up a lot. I also have angry dreams where I tell myself
16 I should have done more. I have also had angry dreams
17 about Lucy Letby.
18 "I cry a lot more than I used to before all of this
19 happened. I never used to cry about anything, only at
20 something like a family funeral. But now, I get upset
21 easily. I am more affected by emotional situations
22 generally if I see something sad. There was an incident
23 a while ago where I witnessed an older lady fall and hit
24 her head. I called an ambulance for her, and I think
25 she was okay. I wouldn't usually have been affected by

1 it, but I found it really harrowing to deal with and
2 remember the sound of her head hitting the floor.
3 "I am also now far more emotional when I think
4 about life in general. I often think about sad things
5 like my dad getting older and that worries and upsets
6 me, whereas I would usually just get on with things.
7 "The Inquiry's Further Questions.
8 "The Inquiry in its Rule 9 request has raised
9 various detailed questions concerning our dealings with
10 the Countess of Chester Hospital after our children's
11 deaths, particularly in the period 2017-18.
12 "I would like to answer these questions but I need
13 to explain that, unfortunately, I cannot add much to the
14 information already set out above, and set out in my
15 police and Victim Impact statements and in the
16 documentary record. I wish to help the Inquiry as much
17 as possible, but the simple fact is that as a result of
18 everything we went through, much of what occurred in the
19 period 2017-2018 is now a blur. As a result, I am
20 struggling to answer the Inquiry's detailed questions.
21 "When these events happened, all my instincts were
22 that something in the hospital had gone badly wrong.
23 I found it impossible to believe that these things could
24 happen without some serious mistake, failure or
25 culpability on the hospital's part. But I am obviously

1 not trained in science or medicine, so I was not in
2 a position to know what might have gone wrong, or even
3 where to start looking. More than that, I had lost two
4 children and was utterly devastated. My life had fallen
5 apart.
6 "Following the deaths of our children, we did not
7 receive any support or counselling from anyone. Had we
8 received some support, we might have been in a better
9 position to try to act on what our instincts were
10 telling us, which is that something had gone badly
11 wrong. As it was, our lives had been devastated, but
12 got no support and we had to fend for ourselves.
13 Moreover, even with counselling, we did not know how to
14 navigate our way around the system. We did not
15 understand how the coronial system worked, for example.
16 We had no idea where to start when it came to getting
17 hold of information and answers. We were in no fit
18 state mentally to take on a hospital which had no
19 interest in trying to help us or be honest with us.
20 "We only started to get meaningful information when
21 the police investigation got underway and we gradually
22 learnt more. Until then, we had been completely unaware
23 that there had been an abnormal number of baby deaths at
24 the Countess of Chester Hospital Neonatal Unit in
25 2015-16. The hospital knew, but didn't tell us. Then

1 we learnt a lot more at the trial. For example, we had
2 never seen the Datix reports before the trial. I didn't
3 even know they existed until the trial. The trial was
4 the first time we saw them.
5 "I confirm that we received some letters from Ian
6 Harvey. I am aware that there is a record of me calling
7 the hospital and that I was very distraught. I have no
8 memory now of making that call. Of course, I entirely
9 accept that I did make it, and that I would have been
10 very distraught. I simply have no memory of it. It was
11 such a traumatic time, and I have probably pushed things
12 out of my conscious memory in order to cope.
13 "I hope the Inquiry will recognise that very few
14 parents who experience the sort of trauma that we did
15 are realistically going to be in a position to take on
16 the system and get answers. Every parent in this
17 situation should be properly supported and given access
18 to high-quality counselling. But even with that, most
19 parents in this situation are not going to be able to
20 push for answers. We can only get answers if those in
21 positions of authority, who have information, are
22 required to be candid and honest. This simply did not
23 happen. I have heard talk about the duty of candour but
24 it was certainly not honoured by the Countess of Chester
25 Hospital in this case.

1 "Suggestions and Recommendations.
2 "I believe that the Countess of Chester Hospital
3 knew much more than they have admitted to publicly about
4 Letby's crimes and I understand from my solicitors that
5 by the time my children were born there, there were
6 already serious concerns about Letby. Obviously, we
7 want to see what evidence comes out about this in the
8 Inquiry, but clearly, hospital management should have
9 been much more responsive when concerns were raised,
10 rather than ignoring or covering up concerns to protect
11 the reputation of the hospital and the Neonatal Unit.
12 "The information sharing with us was not adequate.
13 It was worse than that - it was basically non-existent.
14 Everything I have since found out about what really
15 happened I have learned through the police, through the
16 trial and through my solicitors. Within the NHS, there
17 is supposed to be a duty of candour. Nobody at the
18 Countess of Chester Hospital was candid with us. The
19 duty of candour needs to be made legally enforceable.
20 "I believe that there should be CCTV in every
21 Neonatal Unit, so that what happens to babies is
22 recorded on camera and can be checked.
23 "I also believe that there should be proper
24 monitoring of access to medicines, so it can be checked
25 who has accessed particular items.

"Finally, there should be clear protocols to provide support (to include full counselling), full information and guidance to parents who have been bereaved or whose children have been harmed."

My Lady, that concludes the statement of the Father of O&P&R.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Mr Scorer.

Father O&P&R, thank you very much for being present today online and for providing the statement and allowing Mr Scorer to read it on your behalf. I don't underestimate for a moment how difficult it has been to prepare the statement and then to hear it read again.

Would you please pass on to Mother O&P&R my thanks for what she has done in preparing and providing the statement.

FATHER O&P&R: Of course.

LADY JUSTICE THIRLWALL: I completely understand why she is not online with you today and I am grateful to her for what she has done, as you have, on behalf of the Inquiry.

FATHER O&P&R: Okay, thank you very much.

LADY JUSTICE THIRLWALL: Can I just say to you that both of you have really explained very vividly what your experiences were in the Countess of Chester Hospital in

2016 awful experiences as you have described them -- and yet thanks to your quick thinking, at a time when you were devastated, you insisted and managed to achieve Child R being transferred to Liverpool Women's Hospital, where he seems to have thrived from the moment he got there, being skin-to-skin with his mother very early on.

FATHER O&P&R: Yes. We thank our lucky stars for getting him moved.

LADY JUSTICE THIRLWALL: Yes, yes. There's no question that that made a huge difference to him.

What comes across so well in your statements is your love for all of your children and I know that you still live and always will live with the loss of two of your children, but the love for all of them shines through in everything that you have done.

Can I also, on a practical note, thank you for the suggestions for recommendations that you have made. They are characteristically thoughtful and ones that are already being tested by the corporate witnesses. They are being asked what their views are about these very practical suggestions, so thank you both very much for making a significant contribution to the Inquiry. Thank you.

FATHER O&P&R: Thank you.

MS LANGDALE: My Lady, that concludes the evidence

in Part A.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Ms Langdale.

We will adjourn now and we will begin evidence tomorrow morning at 10 o'clock. Thank you all.

(11.25 am)

(The Inquiry adjourned until 10.00 am on Thursday, 26 September 2024)

INDEX

MOTHER O&P&R statement read 1
FATHER O&P&R statement read 30

FATHER O&P&R: [4] 61/17 61/22 62/7 62/24
LADY JUSTICE THIRLWALL: [12] 1/3 1/5 1/8 1/11 29/8 29/16 29/19 61/7 61/18 61/23 62/9 63/2
MR SCORER: [7] 1/4 1/7 1/10 1/14 29/12 29/17 29/21
MS LANGDALE: [1] 62/25

'

'Dad [1] 43/1
'feed [2] 9/21 37/4
'I [1] 6/14
'I don't [1] 6/14
'it's [1] 43/7
'little [1] 14/16
'quickly' [1] 5/25
'so [1] 23/2
'take [1] 45/25
'That's [1] 6/13
'thrown [1] 23/3

1

1.30/1.45 pm [1] 5/9
10 o'clock [1] 63/5
10-15 minutes [1] 46/12
10.00 [1] 63/7
10.02 [1] 1/2
10.37 [1] 29/13
10.44 [1] 29/15
11.25 [1] 63/6
111 [1] 23/19
12 weeks [1] 2/5
12-week [1] 30/12
16 [1] 58/25
18 [1] 57/11
1900 [1] 7/6
1900 hours [1] 7/5

2

20 [1] 33/4
2015 [1] 30/1
2015-16 [1] 58/25
2016 [4] 4/19 24/23 34/6 62/1
2017 [3] 21/19 21/21 25/3
2017-18 [1] 57/11
2017-2018 [1] 57/19
2018 [2] 25/20 57/19
2023 [2] 23/15 27/22
2024 [2] 1/1 63/8
23 [1] 3/3
2300 hours [1] 4/20
24 hours [1] 46/5
25 September 2024 [1] 1/1
26 September 2024 [1] 63/8

3

3 July 2018 [1] 25/20
3 pm [2] 10/20 38/21
30 [2] 3/10 33/16
33 [1] 5/10
34 [2] 3/6 4/18
3lbs [2] 10/9 37/9

4

45 minutes [1] 37/20

5

5.47 pm [1] 12/8

A

abdomen [2] 31/21 40/7
abdomens [1] 51/24
able [8] 4/7 20/14 33/9 37/20 39/25 47/18 53/12 59/19
abnormal [1] 58/23
about [56] 2/4 2/7 10/23 14/10 14/13 15/20 17/15 20/3 21/19 22/17 23/23 24/5 24/5 24/23 25/14 25/23 26/13 28/4 28/7 28/8 28/15 31/5 31/8 31/19 32/17 42/14 44/20 45/5 46/11 47/16 49/5 51/9 51/12 52/10 52/15 53/9 53/13 53/15 53/19 53/23 54/4 54/10 55/25 56/2 56/8 56/12 56/17 56/19 57/4 57/4 59/23 60/3 60/6 60/7 60/14 62/20
above [1] 57/14
absolute [1] 39/2
accept [1] 59/9
access [3] 28/25 59/17 60/24
accessed [2] 29/1 60/25
achieve [1] 62/3
across [3] 36/2 52/23 62/11
act [1] 58/9
active [1] 5/1
actual [1] 9/20
actually [4] 3/15 3/20 31/23 37/7
add [1] 57/13
adding [1] 48/11
adequate [2] 28/13 60/12
adjourn [1] 63/4
adjourned [1] 63/7
administered [1] 10/24
admitted [3] 28/4 33/25 60/3
affected [2] 56/21 56/25
after [34] 5/24 6/23 8/10 8/17 10/16 14/24 15/21 17/24 21/20 23/3 23/10 26/4 27/23 31/1 31/13 32/17 36/17 37/13 37/17 37/18 37/21 38/3 40/22 40/24 45/12 46/17 47/21 48/18 50/21 52/24 53/11 54/12 55/8 57/10
after-care [1] 23/10
afternoon [2] 10/21 16/15
again [13] 15/6 15/10 15/14 18/8 24/16 30/7 34/10 36/4 42/24 43/8 43/9 43/22 61/13
again' [1] 43/1
against [1] 2/23
ago [2] 24/3 56/23
agonising [1] 39/18
agony [2] 17/21 48/9
agreed [6] 31/6 34/21 38/11 46/8 46/10 46/15
ahead [2] 4/6 31/12
air [1] 7/19
alarmed [2] 10/19 38/19
alert [1] 55/25
all [53] 2/20 8/16 8/17 14/2 14/3 15/6 20/24 22/2 22/6 23/9 23/25 25/4 30/7 31/9 31/12 31/14 31/17 31/18 32/19 33/1 33/4 34/20 35/6 36/6 36/7 36/16 39/4 39/7 39/10 41/2 41/4 41/19 42/2 42/24 43/1 44/11 44/22 49/16 52/8 53/4 53/23 53/24 54/2 54/3 54/4 55/5 55/8 55/11 56/18 57/21 62/12 62/14 63/5
allow [1] 24/6
allowed [5] 7/4 10/13 13/22 38/9 53/2
allowing [1] 61/11
almost [4] 20/24 40/9 40/10 43/3
along [3] 2/15 24/12 55/11
already [9] 17/6 22/18 28/7 30/2 43/12 49/8 57/14 60/6 62/19
also [22] 3/9 6/8 20/8 20/15 22/6 23/10 23/17 26/16 27/23 28/24 32/19 35/10 38/2 41/16 43/23 51/6 53/18 56/15 56/16 57/3 60/23 62/16
although [6] 21/20 24/15 38/1 44/9 51/4 51/18
always [6] 46/23 51/3 51/22 51/25 54/10 62/13
am [16] 1/2 13/1 14/13 29/13 29/15 56/2 56/7 56/7 56/21 57/3 57/19 57/25 59/6 61/19 63/6 63/7
ambulance [3] 48/1 48/3 56/24
amount [3] 12/1 36/4 52/2
anaesthetist [1] 6/13
angels [1] 42/12
angels' [1] 14/17
angry [4] 44/20 45/19 56/15 56/16
annual [2] 5/21 35/17
another [8] 3/22 9/1 22/23 31/6 32/5 43/24 47/11 56/3
answer [2] 57/12 57/20
answers [6] 20/25 47/10 58/17 59/16 59/20 59/20
anti [1] 21/24
anti-depressant [1] 21/24
anxiety [1] 21/22
anxious [4] 24/5 52/10 55/25 56/2
any [30] 2/15 6/12 10/4 11/12 13/22 14/7 17/4 18/13 21/25 24/1 24/2 24/9 26/7 26/19 27/6 37/3 37/6 40/4 48/4 49/2 50/12 52/4 53/7 53/9 53/10 53/25 54/19 55/3 55/25 58/7
anyone [3] 22/12 24/7 58/7
anything [15] 2/3 11/24 12/5 13/3 13/15 16/13 16/24 19/18 26/13 50/17 51/20 52/12 53/3 54/14 56/19
anyway [2] 4/13 19/1
anywhere [2] 3/24 32/7
apart [1] 58/5
apologised [1] 7/25
apologising [1] 47/3
apparently [1] 42/18
appeared [1] 52/24
applying [1] 31/22
appointment [3] 1/25 23/13 30/7
appointments [1] 30/8
appreciate [1] 34/10
approached [1] 46/1
approximately [2] 5/9 56/10
April [1] 25/3
April/May 2017 [1] 25/3
are [19] 1/8 23/17 23/17 23/24 24/18 27/3 29/11 29/16 38/9 55/24 55/25 56/12 59/15 59/19 59/21 62/18 62/18 62/20 62/20
argue [1] 47/9
around [24] 3/3 3/10 4/7 4/10 4/20 6/25 8/6 10/16 10/20 11/8 18/20 20/15 23/15 25/3 33/4 33/10 33/16 37/20 38/21 39/4 39/8 43/5 53/11 58/14
around October 2023 [1] 23/15
arrange [3] 44/6 46/11 50/19
arranged [5] 17/6 22/6 27/13 46/23 48/6
arrangements [1] 32/16
arrested [3] 25/22 26/2 52/20
arrive [3] 3/14 22/24 34/20
arrived [16] 3/4 4/24 7/8 10/18 12/7 16/7 32/16 34/11 39/21 40/2 42/25 45/2 48/9 48/12 48/20 55/1
arrow [1] 44/18
Arrowe [2] 22/21 23/5
Arrowe Park [2] 22/21 23/5
as [99]
aside [2] 11/19 17/14
ask [3] 11/18 23/23 27/4
asked [16] 9/1 9/2 12/6 13/19 14/11 17/7 18/15 25/18 36/14 36/18 40/19 43/6 45/10 47/21 48/25 62/20
asking [5] 9/9 35/14 46/21 50/19 52/14
Aspire [1] 23/9
assistance [1] 36/13
assumed [1] 10/2

A

assumption [1] 12/22
assured [3] 10/22 13/3 36/16
at [112]
atmosphere [1] 45/3
attempts [1] 15/23
attend [2] 54/13 54/19
attended [2] 54/14 54/22
authority [1] 59/21
autopsy [1] 47/8
available [2] 27/18 32/3
avoid [1] 48/3
avoided [1] 53/5
aware [7] 19/14 24/21 25/4 26/21 26/23 27/17 59/6
away [15] 4/22 10/19 12/7 12/8 15/2 16/15 16/16 19/3 23/2 23/14 40/23 42/1 45/18 49/9 52/22
awful [2] 41/8 62/1

B

babies [33] 3/4 3/5 3/7 3/8 3/14 3/15 4/3 4/15 5/19 6/20 8/10 8/17 8/25 9/2 9/7 9/9 9/20 9/22 10/4 10/9 10/25 28/22 30/18 30/22 31/21 32/8 32/16 32/24 33/1 35/15 37/5 49/19 60/21
babies' [1] 31/10
baby [7] 3/18 19/12 32/11 46/10 49/20 49/24 58/23
baby's [1] 31/5
back [20] 2/14 7/1 8/3 8/18 14/23 15/7 16/4 20/25 24/13 31/10 32/17 32/19 36/11 39/2 39/25 42/19 43/2 46/10 50/9 56/11
bad [3] 7/15 21/20 31/17
bad' [1] 23/2
badly [2] 57/22 58/10
baffled [1] 40/12
balance [1] 38/2
basically [3] 9/24 28/14 60/13
bathroom [1] 7/12
bays [1] 7/12
be [92]
bear [1] 22/21
became [1] 30/1
because [34] 7/15 9/3 9/17 10/19 11/16 12/16 14/18 16/19 17/5 18/21 23/20 26/4 27/18 27/19 30/21 31/20 33/20 34/9 37/1 37/13 37/14 39/16 39/18 39/22 43/20 44/24 46/9 47/5 50/10 51/23 52/21 53/8 53/12 54/24
bed [6] 3/18 5/14 7/14 10/19 32/11 56/8
beds [3] 4/3 32/3 34/20
been [53] 5/3 9/12 9/14 9/15 12/13 14/20 15/19 17/6 18/17 19/2 25/3 26/1 26/6 26/15 26/24 27/2 27/18 28/10 29/4 29/5 33/21 34/11 36/21 36/24 39/1 39/14 42/12 42/13 42/16 43/17 49/8 49/25 51/22 51/23 51/24 52/1 52/3 52/19 52/21 55/10 55/15 55/18 55/20 56/25 58/8 58/11 58/22 58/23 59/9 60/9 61/3 61/4 61/12
before [35] 4/12 5/8 6/10 7/1 7/21 8/4 10/8 12/10 13/15 14/14 15/5 15/22 16/5 18/8 18/8 19/20 22/7 22/17 25/4 25/24 30/1 33/14 33/22 40/17 41/8 42/23 43/4 43/17 48/23 49/25 50/1 50/6 54/9 56/18 59/2
begged [1] 16/17
begin [1] 63/4
behalf [2] 61/11 61/20
behind [2] 6/8 36/3
being [29] 4/11 5/10 6/3 6/23 7/9 15/13 18/21 20/1 25/8 27/17 30/16 31/15 34/11 35/22 35/23 35/24 36/6 36/11 37/15 39/8 52/10 52/12 53/12 56/11 61/9 62/4 62/6 62/19 62/20
belief [1] 10/11
believe [13] 16/12 18/16 26/18 28/3 28/21 28/24 37/12 45/15 46/19 57/23 60/2 60/20 60/23
belly [2] 40/9 43/14
bereaved [2] 29/5 61/4
best [5] 19/12 31/9 33/16 49/24 50/23
better [8] 2/22 9/11 12/15 31/14 31/14 36/20 49/18 58/8
between [3] 20/21 24/22 48/2
big [7] 6/1 17/15 22/16 31/8 34/13 36/1 47/16
bigger [4] 2/2 10/10 31/19 37/11
biggest [1] 37/10
bin' [1] 23/3
Birmingham [2] 3/23 32/6
birth [4] 4/1 4/6 10/8 30/3
bit [3] 6/19 9/6 55/12
black [1] 54/6
blamed [3] 51/14 51/16 51/18
blaming [1] 54/5
blank [1] 41/11
blessed [1] 30/25
block [2] 5/15 5/24
blood [2] 6/7 36/2
blur [1] 57/19
boat [1] 40/16
booked [4] 5/21 23/13 34/11 35/17
booking [2] 1/25 30/7
born [17] 1/21 3/15 3/17 4/18 6/20 9/7 9/12 10/5 23/22 28/6 30/2 32/8 32/10 36/16 36/21 50/6 60/5
both [22] 1/9 2/6 21/10 26/8 30/21 31/6 31/8 38/11 40/19 42/9 42/12 46/4 46/20 51/18 52/13 52/17 54/8 54/14 55/19 55/24 61/24 62/21
bothered [1] 50/8
bottom [1] 47/6
bowels [1] 42/13
box [1] 17/15
boxes [1] 47/17
boy [1] 45/25
boys [55] 6/16 6/21 6/25 7/4 7/9 8/5 8/7 8/16 9/16 10/15 11/10 12/23 13/5 14/3 14/16 21/21 25/4 25/8 25/10 25/11 26/5 26/8 26/9 26/11 27/14 31/12 33/4 33/6 34/20 35/17 35/22 35/24 36/5 36/9 36/12 36/16 36/25 37/8 37/17 37/19 38/2 38/9 41/19 45/21 46/4 46/20 47/16 47/17 50/6 51/4 51/14 51/23 52/3 53/25 56/12
boys' [1] 25/1
brain [3] 8/16 12/16 56/7
break [2] 29/11 29/14
breakfast [2] 14/18 14/24
Brearey [2] 12/11 16/1
breathing [3] 10/24 10/24 38/20
brilliant [1] 48/5
bring [1] 41/13
brothers [3] 14/6 23/24 49/14
brought [5] 6/17 8/3 36/10 41/16 47/13
build [1] 35/12
bump [2] 39/20 48/10
bumped [1] 38/16
burning [1] 7/15
burst [1] 30/19
busy [1] 39/5
but [75]
butterfly [1] 23/6
buzzed [2] 17/23 48/14

C

C-section [4] 5/23 7/18 7/23 17/21
caesarean [5] 5/3 22/23 23/1 34/12 34/23
call [8] 23/19 23/23 24/24 24/24 25/6 25/20 25/24 59/8
called [13] 4/21 7/16 12/6 12/11 16/5 17/24 21/11 23/9 34/7 40/2 42/6 55/14 56/24
calling [1] 59/6
calls [2] 46/11 46/12
calm [4] 16/9 38/18 45/3 45/5
came [25] 8/3 8/17 8/23 16/4 17/22 20/13 21/8 22/5 22/8 25/2 25/15 25/25 38/8 38/22 40/21 42/4 42/15 45/8 48/14 48/19 52/16 52/23 53/21 53/22 58/16
camera [3] 28/23 41/10 60/22
can [10] 7/22 28/23 28/25 44/21 46/23 59/20 60/22 60/24 61/23 62/16
can't [1] 43/16
candid [3] 28/19 59/22 60/18
candour [5] 28/18 28/20 59/23 60/17 60/19
cannot [9] 5/7 8/9 8/21 9/12 33/3 35/13 36/22 56/6 57/13
car [2] 48/9 54/20
card [1] 41/11
care [13] 1/23 2/13 23/10 26/20 27/1 30/4 32/3 34/2 38/1 46/3 47/20 47/22 50/4
caring [1] 33/23
carry [1] 24/10
case [5] 33/21 34/4 35/7 47/8 59/25
catheter [1] 7/10
cause [1] 19/6
caused [3] 12/16 36/1 39/20
caution [1] 33/22
cautious [1] 18/22
CCTV [2] 28/21 60/20
certain [1] 33/3
certainly [1] 59/24
cervix [1] 4/25
chance [2] 2/22 55/5
change [1] 45/3
changed [3] 8/13 14/15 51/2
changing [1] 12/17
chaos [2] 11/6 15/5
characteristically [1] 62/18
charts [1] 42/17
check [2] 7/1 13/2
checked [8] 17/10 19/9 28/23 28/25 36/6 49/17 60/22 60/24
checking [1] 30/13
chest [3] 18/18 43/19 44/1
Chester [54] 1/20 1/21 2/1 2/10 2/13 2/16 2/25 3/11 3/16 3/21 4/2 4/8 4/21 7/23 16/23 17/19 18/6 18/11 18/17 19/13 19/24 22/20 22/22 23/1 23/2 26/14 26/18 27/7 28/3 28/19 29/25 30/3 30/9 31/2 32/1 32/8 32/14 32/22 33/11 33/17 34/1 34/18 46/3 48/22 49/1 49/13 50/25 54/14 57/10 58/24 59/24 60/2 60/18 61/25
Chester Court [1] 19/24
chickens [1] 43/5
child [131]
child care [1] 34/2
Child O [1] 14/9
Child P [1] 17/14

C

children [21] 1/15 20/19 20/21 23/18 24/2 24/3 24/9 28/6 29/5 30/24 31/9 54/16 54/21 55/5 55/23 58/4 58/6 60/5 61/4 62/12 62/14
children's [1] 57/10
chose [1] 22/20
christened [5] 40/19 40/21 40/22 45/11 45/12
clean [1] 35/7
cleanliness [2] 18/5 48/21
clear [5] 11/22 18/6 29/2 45/4 61/1
clearly [4] 21/3 28/9 30/12 60/8
climb [1] 5/14
clinical [1] 35/7
close [3] 3/6 39/21 40/5
clothes [2] 17/14 48/3
clue [2] 13/6 38/24
cold [6] 35/1 35/5 41/13 42/2 47/14 52/23
collapse [3] 11/22 13/7 16/3
collect [1] 42/23
collected [1] 42/4
colour [2] 40/10 56/13
come [21] 4/17 4/22 7/17 9/10 12/6 13/22 15/8 16/19 21/5 23/19 33/20 34/8 36/5 36/7 36/19 39/12 39/15 40/2 44/8 44/15 55/2
comes [6] 24/12 28/8 55/23 56/14 60/7 62/11
comfortable [2] 32/20 50/9
coming [5] 7/1 10/12 20/25 38/16 44/21
compare [2] 4/13 7/22
compared [2] 18/5 48/21
complete [2] 11/6 11/23
completely [3] 17/19 58/22 61/18
complications [2] 1/23 30/4
computer [1] 44/22
concern [1] 33/22
concerned [3] 9/4 24/18 27/3
concerning [1] 57/9
concerns [10] 8/9 8/19 14/17 28/7 28/10 28/11 51/5 60/6 60/9 60/10
concludes [3] 29/6 61/5 62/25
concrete [1] 13/13
confidence [1] 35/3
confident [1] 45/4
confirm [2] 17/11 59/5
confirmed [2] 34/18 34/22
confronted [2] 11/6 15/4
confused [1] 44/16
conjunction [2] 1/19 29/24
conscious [2] 41/3 59/12
consider [1] 5/1
considerably [2] 10/10 37/10
considered [1] 30/4
constant [2] 23/18 23/24
Consultant [6] 2/10 10/18 16/8 31/1 45/1 46/1
Consultants [3] 3/21 32/12 43/18
contact [6] 18/15 19/12 22/18 23/4 37/21 50/1
contacting [1] 23/15
continued [1] 27/1
contractions [4] 4/20 4/24 34/7 34/15
contrary [1] 34/19
contribution [1] 62/22
control [2] 16/10 34/14
convenient [1] 2/17
conversation [3] 12/14 31/4 31/13
conviction [1] 53/10
cope [7] 2/7 20/6 20/11 50/22 51/10 54/17 59/12
corner [1] 39/19
Coroner [1] 25/7
coronial [1] 58/15
corporate [1] 62/19
correct [1] 1/10
corridor [1] 12/12
cot [7] 18/13 18/18 19/11 26/9 42/2 47/14 49/23
cots [1] 14/2
could [57] 2/14 3/23 6/16 7/4 7/14 7/25 9/15 11/13 12/5 12/9 14/2 14/4 14/6 15/15 15/19 16/12 16/13 16/19 17/6 17/9 19/10 27/1 27/4 27/19 30/14 30/15 31/12 34/3 35/10 36/24 37/18 38/23 38/24 39/22 40/8 40/13 40/25 41/5 41/12 41/23 42/19 43/9 43/11 43/12 45/6 45/10 45/16 45/20 48/7 49/22 50/23 54/16 54/22 55/2 55/3 55/4 57/23
couldn't [18] 13/20 18/16 19/22 20/6 22/12 22/21 39/21 41/13 41/14 41/25 43/10 45/15 46/19 50/11 50/16 52/11 53/8 55/11
counselling [11] 21/25 22/4 23/12 27/7 27/11 27/16 29/3 58/7 58/13 59/18 61/2
counsellor [4] 20/10 22/6 22/7 22/8
Countess [49] 1/20 1/21 2/1 2/10 2/13 2/16 2/25 3/11 3/16 3/20 4/1 4/8 4/21 7/23 16/23 17/19 18/6 18/11 18/17 19/13 22/19 26/14 26/18 27/7 28/3 28/19 29/25 30/2 30/8 31/1 32/1 32/8 32/14 32/22 33/10 33/17 33/25 34/18 46/3 48/22 48/25 49/13 50/25 57/10 58/24 59/24 60/2 60/18 61/25
couple [1] 32/22
course [2] 59/8 61/17
Court [9] 19/24 20/20 23/9 54/19 54/19 54/23 55/7 55/10 55/14
courtyard [1] 46/17
covering [2] 28/11 60/10
COVID [1] 22/7
CPR [1] 52/3
crimes [2] 28/5 60/4
criminal [10] 13/16 14/19 19/16 23/8 24/8 24/19 27/10 27/22 42/15 52/25
Crown [1] 54/19
cry [2] 56/18 56/19
crying [3] 6/17 26/9 36/9
culpability [1] 57/25
curly [1] 35/13

D

dad [10] 10/12 10/14 15/15 38/8 38/12 38/22 39/2 42/22 50/19 57/5
damage [1] 12/16
damp [1] 50/7
dark [2] 13/14 52/11
date [6] 5/9 8/9 8/22 10/12 14/13 34/11
dates [1] 25/9
Datix [2] 24/18 59/2
day [34] 5/5 8/6 8/21 15/5 15/12 19/23 20/8 21/1 21/3 22/25 30/11 31/3 34/24 37/23 37/24 38/7 38/8 41/20 42/9 42/21 43/3 43/17 43/17 44/25 44/25 50/23 50/23 52/19 54/22 55/4 55/5 55/7 55/8 55/13
days [3] 15/22 54/19 54/25
deal [5] 17/15 31/4 47/16 50/16 57/1
dealings [1] 57/9
deaths [9] 18/22 21/10 24/22 25/1 25/7 25/16 57/11 58/6 58/23
decided [4] 2/23 3/8 5/5 32/24
decision [8] 19/4 20/16 21/9 22/19 47/1 49/12 55/4 55/15
Defence [2] 20/2 20/5
definitely [1] 46/24
delighted [2] 31/24 46/15
deliver [3] 4/3 5/19 41/8
delivered [5] 6/16 23/3 35/22 36/9 37/17
delivering [3] 32/1 35/15 35/16
delivery [4] 4/15 6/2 32/6 37/13
delivery - Birmingham [1] 32/6
dentist [1] 35/6
dependent [1] 10/3
depressant [1] 21/24
described [1] 62/1
desk [1] 43/25
desperately [1] 3/5
Despite [3] 5/10 11/1 45/5
detail [1] 49/4
detailed [2] 57/9 57/20
detect [1] 54/11
deteriorate [1] 15/10
devastated [6] 26/3 40/25 52/24 58/4 58/11 62/3
devastating [1] 54/6
develop [1] 3/4
developments [1] 53/7
diagram [1] 44/19
diamorphine [1] 5/7
did [41] 1/24 3/12 3/13 3/15 5/23 8/1 9/20 16/2 16/3 16/21 16/25 24/18 25/10 25/12 26/7 27/3 27/14 27/20 31/16 31/23 32/7 33/11 34/19 34/20 35/25 37/3 37/6 38/1 40/20 44/23 45/11 49/10 50/4 51/19 54/12 58/6 58/13 58/14 59/9 59/14 59/22
didn't [46] 2/3 4/25 10/20 11/12 11/17 11/19 12/4 12/15 13/6 13/15 14/5 14/6 16/11 16/19 16/20 16/24 18/11 18/24 19/18 20/13 22/13 22/24 25/17 34/10 35/2 38/14 38/17 38/24 40/4 43/15 45/14 45/22 47/4 47/5 48/4 50/9 50/10 51/21 51/25 52/4 54/15 54/16 54/19 55/2 58/25 59/2
die [1] 16/21
died [8] 12/9 12/10 16/5 25/6 26/8 49/19 52/24 53/25
difference [1] 62/10
different [9] 4/5 12/2 17/19 18/5 22/25 39/8 40/10 48/21 51/11
difficult [10] 19/25 24/2 24/16 31/4 31/13 50/18 51/10 52/20 54/10 61/12
dilating [1] 4/25
dingy [1] 35/2
disappointing [2] 5/22 35/20
disbelief [2] 12/19 26/3
discharge [4] 17/9 17/12 47/20 47/24
discharged [3] 19/15 23/14 34/5
disclosed [1] 53/19
discuss [1] 53/9
disease [1] 12/21
dissolvable [1] 7/19

D

distance [1] 32/5
distension [1] 43/13
distraught [2] 59/7 59/10
distressed [1] 50/16
distressing [1] 21/14
do [20] 5/5 8/22 11/21 12/24 13/20 16/13 18/11 24/3 25/17 26/18 27/20 27/25 41/13 41/14 42/16 44/25 45/10 46/23 48/25 54/15
doctor [14] 5/23 8/16 10/18 10/22 11/3 11/5 11/11 11/17 11/19 17/10 34/16 39/12 43/24 56/3
Doctor U [7] 10/18 10/22 11/3 11/5 11/11 11/17 11/19
doctors [15] 12/3 13/6 15/25 20/3 24/5 31/14 35/9 37/3 37/8 39/4 39/6 40/12 40/15 43/7 43/16
documentary [1] 57/16
doing [14] 11/24 12/4 13/7 13/8 14/12 20/2 20/15 25/12 31/16 36/13 43/11 44/4 45/5 49/25
don't [10] 5/23 6/14 11/25 13/18 22/14 24/7 42/17 46/23 56/5 61/11
done [22] 14/4 17/2 17/17 18/15 19/13 19/15 23/12 45/15 45/16 45/20 46/24 46/25 47/9 47/10 51/15 51/23 52/3 55/18 56/16 61/15 61/20 62/15
doors [1] 38/23
doubt [1] 55/16
down [24] 5/13 7/4 11/4 14/11 14/13 15/2 19/5 24/13 25/8 34/24 37/19 37/20 38/12 38/16 38/22 39/15 39/17 39/18 40/21 42/6 42/10 42/20 50/5 54/3
downstairs [1] 15/2
dozen [1] 35/8
Dr [18] 12/11 16/1 16/8 16/17 16/18 17/5 33/9 35/16 35/18 38/16 38/22 38/24 45/2 45/8 45/13 46/18 46/20 47/2
Dr Brearey [2] 12/11 16/1
Dr McCormack [3] 33/9 35/16 35/18
Dr Rackham [7] 16/8 16/17 16/18 17/5 45/2 45/8 45/13
Dr U [3] 38/16 38/22 38/24
Dr V [3] 46/18 46/20 47/2
drag [1] 24/16
drain [2] 44/1 44/17
dramas [1] 54/8
dreams [2] 56/15 56/16
dress [2] 13/19 41/12
dressed [5] 13/20 17/13 26/11 41/15 47/15
drove [1] 48/8
drugs [1] 15/13
due [7] 4/16 6/9 9/17 16/19 33/7 37/1 42/23
during [9] 8/23 12/14 13/7 16/15 19/18 26/14 50/4 51/15 55/1
duty [5] 28/18 28/20 59/23 60/17 60/19
déjà [1] 43/3
déjà vu [1] 43/3

E

each [6] 3/18 8/6 10/9 32/11 42/8 44/22
early [7] 3/4 3/9 3/14 6/20 9/7 34/13 62/6
easier [3] 24/9 32/25 33/2
easily [1] 56/21
easy [1] 6/2
eat [1] 15/19
edge [1] 5/15
either [4] 18/13 49/2 54/13 55/4
eldest [2] 34/2 38/6
else [3] 16/13 24/12 41/15
elsewhere [1] 27/2
emotional [2] 56/21 57/3
emotionally [1] 50/24
encouraged [1] 48/2
end [8] 7/12 21/6 24/8 33/12 35/21 47/12 53/18 54/25
ended [5] 22/22 23/11 39/23 50/19 55/17
ending [1] 24/11
enforceable [2] 28/20 60/19
enough [7] 4/2 18/13 25/11 32/3 34/19 39/21 49/2
entering [3] 18/8 18/8 48/23
entirely [2] 15/17 59/8
episodes [1] 54/9
equipment [1] 31/22
essentially [2] 9/25 40/15
even [16] 23/1 23/14 27/1 27/8 34/14 40/5 43/14 43/18 47/24 48/5 52/3 56/6 58/2 58/13 59/3 59/18
evening [4] 4/19 8/24 34/6 41/18
event [1] 4/8
events [4] 22/15 52/7 53/16 57/21
eventually [9] 13/10 16/7 16/11 22/12 32/19 34/4 34/22 44/6 45/8
ever [1] 25/23
every [17] 3/1 3/6 5/19 19/9 20/8 24/11 28/21 32/21 39/18 48/9 49/4 49/20 55/4 55/7 56/10 59/16 60/20
everyday [1] 44/24
everyone [5] 12/19 31/23 37/11 43/5 45/4
everything [31] 3/13 5/20 8/8 8/18 11/25 14/19 17/17 20/9 21/16 21/19 28/15 31/3 31/18 33/18 35/19 36/15 38/18 39/1 42/8 43/11 45/9 45/16 46/19 50/18 50/19 52/7 53/5 56/8 57/18 60/14 62/15
evidence [7] 22/11 22/14 28/8 49/13 60/7 62/25 63/4
exact [3] 12/1 14/22 43/3
example [5] 18/7 19/23 23/19 58/15 59/1
except [1] 32/22
excitement [1] 30/20
existed [2] 24/19 59/3
existent [2] 28/14 60/13
expect [7] 3/13 3/15 9/20 32/7 32/7 37/3 37/6
expectation [2] 5/18 35/16
expectations [1] 34/19
expected [7] 9/12 9/22 10/10 33/6 36/21 37/5 37/11
expecting [5] 9/16 10/4 10/8 36/25 37/9
experience [8] 1/20 4/5 17/18 22/24 27/25 29/25 55/21 59/14
experienced [5] 4/12 6/10 7/21 7/22 33/13
experiences [2] 61/25 62/1
explain [2] 43/9 57/13
explained [4] 47/7 49/4 54/2 61/24
explaining [2] 23/22 46/12
explanation [3] 25/6 25/11 40/4
explicitly [2] 3/16 32/9
express [1] 8/20
expressed [1] 5/2
extra [3] 10/23 12/24 18/22
extremely [2] 19/25 39/5
eyes [1] 37/10

F

face [4] 6/8 11/13 24/14 38/25
fact [7] 10/9 14/20 14/21 31/11 33/7 34/19 57/17
factors [1] 4/16
failure [1] 57/24
faint [1] 31/22
faith [2] 22/15 55/19
fall [1] 56/23
fallen [1] 58/4
families [3] 41/2 41/3 50/13
family [20] 2/7 13/17 13/22 13/23 15/12 18/1 25/21 25/25 34/1 37/23 38/4 41/1 41/8 47/12 48/15 53/21 54/15 54/20 54/21 56/20
far [3] 24/18 27/3 57/3
Father [43] 1/6 2/6 5/16 6/24 7/8 8/3 8/11 8/13 8/15 9/1 9/9 10/8 10/12 10/14 10/16 10/17 11/3 11/18 13/17 14/9 15/14 16/17 16/21 17/21 18/4 18/10 20/8 20/13 20/19 21/11 22/8 25/20 25/23 27/6 27/13 27/21 29/10 29/18 29/20 29/21 61/5 61/9 64/4
Father O [1] 29/18
fault [1] 51/20
February [1] 19/19
feed [4] 8/11 9/23 37/5 49/15
feeding [1] 42/13
feel [11] 6/11 6/12 8/1 16/25 20/14 25/10 31/16 31/22 34/17 50/9 54/16
feeling [3] 36/4 45/19 51/22
feels [1] 24/11
fell [1] 52/7
felt [25] 6/3 6/4 13/5 13/6 13/8 15/16 20/20 20/21 30/23 30/25 33/23 34/10 35/2 35/5 40/15 44/9 45/20 45/21 45/24 46/6 46/13 46/16 47/3 49/17 51/18
fend [1] 58/12
Fetal [1] 5/2
few [13] 5/12 6/18 13/23 16/4 18/2 24/3 27/12 36/11 37/15 42/7 48/16 49/18 59/13
fight [1] 46/14
figure [1] 32/25
file [1] 23/6
fill [1] 35/2
film [1] 35/4
final [1] 47/1
finally [3] 21/8 29/2 61/1
find [5] 3/8 24/1 30/22 32/24 40/1
finding [1] 55/17
fine [12] 3/6 3/13 8/8 8/18 9/10 30/3 31/18 36/19 38/18 39/1 42/8 56/2
finger [1] 24/4
finishing [1] 14/25
first [22] 1/21 2/4 4/5 8/4 18/19 21/18 24/21 24/23 25/5 25/23 26/20 27/9 34/16 35/11 35/23 36/1 42/10 42/11 52/21 53/5 53/24 59/4
fit [1] 58/17
five [1] 23/10
floor [2] 21/5 57/2
fluid [1] 6/7
follow [1] 53/14
followed [2] 6/24 53/5
following [9] 34/24

F

following... [8] 37/23 38/8 42/9 44/3 48/3 53/11 53/16 58/6
follows [2] 1/16 29/21
food [2] 15/18 15/20
forced [1] 47/19
forgotten [2] 15/16 15/17
found [16] 14/19 19/25 22/16 25/14 26/15 28/15 30/6 30/11 30/17 33/4 46/14 51/1 53/17 57/1 57/23 60/14
frequently [1] 52/17
fresh [1] 48/3
front [1] 44/14
frustrating [1] 52/12
full [5] 27/16 29/3 54/22 61/2 61/2
fully [1] 27/21
funeral [1] 56/20
further [4] 6/5 13/15 24/17 57/7
future [1] 32/15

G

gave [5] 6/15 8/22 27/12 45/4 46/18
general [1] 57/4
generally [1] 56/22
genuinely [1] 46/6
gestation [1] 2/5
get [30] 2/8 3/5 4/20 7/14 15/2 15/8 15/18 16/20 16/23 19/10 24/2 39/13 39/21 39/25 40/4 41/10 42/25 44/8 46/15 47/6 48/2 49/22 54/18 54/24 55/21 56/20 57/6 58/20 59/16 59/20
getting [7] 5/17 15/24 55/23 56/2 57/5 58/16 62/8
give [11] 2/22 11/20 19/4 19/5 22/11 22/14 25/10 27/19 33/13 41/11 55/3
given [22] 2/21 3/3 4/9 4/14 5/4 5/15 6/5 10/1 12/1 14/8 15/12 18/22 21/2 23/4 23/10 40/17 41/1 47/4 52/1 54/1 55/13 59/17
giving [3] 4/1 4/6 21/21
glued [1] 53/6
go [46] 3/24 4/15 5/25 7/8 7/11 9/16 9/22 9/23 10/17 11/2 11/4 14/17 17/25 20/14 21/6 23/21 24/4 24/6 32/5 32/7 32/17 32/19 33/6 33/10 33/16 33/20 34/5 35/6 36/2 36/25 37/5 37/6 38/14 39/1 39/13 42/21 42/23 42/25 44/2 47/18 48/2 49/6 54/21 55/4 55/5 56/8
going [30] 1/8 4/1 4/4 5/19 5/20 8/15 9/20 9/24 10/14 11/11 11/18 11/20 12/24 16/21 19/18 22/11 25/17 26/25 29/10 33/12 34/13 35/15 35/19 38/24 40/6 43/7 51/12 53/17 59/15 59/19
gone [10] 17/1 21/13 31/11 40/6 40/13 40/24 46/4 57/22 58/2 58/10
good [8] 1/3 1/4 1/23 10/11 25/11 30/5 36/17 45/3
goodbye [1] 13/23
Googling [2] 44/13 44/16
got [23] 11/3 15/4 17/20 17/21 24/3 24/9 25/5 25/20 25/24 31/13 31/19 33/18 33/18 34/12 38/22 39/2 39/10 39/11 48/13 53/22 58/12 58/21 62/5
gown [1] 5/17
GP [4] 21/18 21/24 23/12 56/3
grabbing [1] 11/8
gradually [1] 58/21
grateful [4] 18/23 41/5 50/14 61/19
great [1] 8/12
grow [2] 9/23 37/5
grow' [2] 9/22 37/4
growing [2] 3/7 31/20
guidance [2] 29/4 61/3
guilty [1] 21/9
gut [1] 51/22

H

had [182]
hadn't [5] 5/3 15/19 18/16 21/13 43/17
hair [1] 35/13
half [3] 35/8 49/10 50/5
hallway [3] 11/16 39/24 43/21
hand [1] 21/4
handled [1] 49/18
handler [1] 23/23
hands [3] 18/7 48/23 49/21
happen [5] 20/17 31/17 54/9 57/24 59/23
happened [35] 12/18 16/12 16/25 17/3 19/6 20/4 22/14 25/19 27/23 28/16 34/4 41/6 42/24 45/14 46/13 46/20 47/5 49/14 50/11 51/4 51/13 51/14 53/7 53/19 53/23 53/24 54/2 54/5 54/7 54/12 54/16 56/9 56/19 57/21 60/15
happening [17] 11/12 12/10 15/6 16/13 17/13 39/7 40/1 40/5 41/4 43/1 43/8 43/10 43/23 44/11 53/12 53/14 56/13
happens [2] 28/22 60/21
happy [4] 2/12 2/17 33/19 46/2
hard [3] 20/4 51/19 54/3
harmed [2] 29/5 61/4
harrowing [1] 57/1
Harvey [1] 59/6
has [8] 29/1 55/20 56/9 57/8 60/25 61/12 61/15 61/20
have [99]
having [14] 2/6 2/21 4/5 4/17 6/1 7/22 9/18 22/22 30/11 33/7 33/21 34/7 39/24 46/14
he [73]
head [4] 35/9 36/4 56/24 57/2
headless [1] 43/5
heads [2] 30/14 51/12
health [6] 10/11 21/20 22/1 25/11 55/22 56/1
healthy [6] 9/8 9/12 10/6 36/17 36/21 37/9
hear [3] 6/16 51/21 61/13
heard [3] 13/12 44/20 59/23
heart [1] 31/5
heartbeat [2] 2/22 31/10
heartbreaking [1] 45/18
hearts [1] 52/20
held [1] 37/16
help [14] 7/16 7/24 8/2 20/11 31/5 34/1 37/25 38/20 43/19 45/21 47/4 50/24 57/16 58/19
her [44] 12/6 15/8 17/17 30/9 30/10 31/18 31/21 31/22 31/24 32/10 33/2 34/15 35/1 35/13 36/4 37/25 39/14 39/17 39/17 39/18 39/20 39/21 40/2 40/20 41/24 43/22 44/14 45/24 47/1 47/7 47/9 47/21 47/21 48/11 48/24 51/20 51/20 51/20 52/17 55/8 56/24 56/24 57/2 61/20
here [1] 45/25
herself [5] 47/20 47/24 51/14 52/6 53/4
high [5] 9/17 33/8 34/9 36/2 59/18
high risk [3] 9/17 33/8 34/9
high-quality [1] 59/18
higher [1] 26/21
him [41] 12/9 12/21 13/21 16/1 16/10 16/16 17/8 17/9 17/10 17/14 17/25 18/18 18/25 19/5 20/14 21/11 24/6 35/20 38/12 38/13 39/22 40/19 40/21 40/25 41/15 41/16 42/1 42/4 42/4 42/24 42/25 43/11 44/7 44/8 45/10 46/5 48/19 49/15 50/2 62/8 62/10
his [30] 5/17 10/14 11/13 12/16 13/12 14/6 15/10 15/14 16/3 17/14 18/13 18/18 19/10 23/23 24/3 24/6 38/25 40/7 40/8 40/9 40/11 43/13 43/14 43/19 44/5 45/11 49/14 49/17 49/23 62/6
hit [2] 30/21 56/23
hitting [1] 57/2
hold [3] 12/9 40/25 58/17
holding [3] 16/16 21/4 45/17
holidays [3] 20/19 20/24 55/2
home [17] 4/19 7/9 9/23 20/19 20/21 22/6 22/9 23/19 24/9 34/5 34/7 37/6 38/5 48/2 50/22 54/24 55/6
Homicide [3] 22/5 27/9 27/24
honest [3] 26/19 58/19 59/22
Honeysuckle [2] 27/11 27/16
honoured [1] 59/24
hooked [1] 11/25
hope [2] 5/18 59/13
hopeful [1] 16/2
hoping [1] 20/16
horror [1] 35/4
hospital [101]
hospital's [1] 57/25
hour [2] 7/1 8/6
hours [6] 4/20 7/5 15/11 44/9 46/5 54/23
house [7] 25/2 25/15 25/25 50/6 50/10 50/18 53/21
how [24] 2/7 5/8 8/11 8/11 8/22 9/19 10/1 12/18 14/12 23/24 25/6 25/12 31/19 35/1 37/1 43/25 45/5 45/6 47/5 53/24 54/10 58/13 58/15 61/12
however [10] 2/12 12/22 13/13 16/11 21/1 22/10 23/11 23/12 31/25 44/7
hug [1] 46/18
huge [4] 18/12 36/7 49/1 62/10
hurting [1] 6/14
hurting' [1] 6/13
hygiene [1] 18/6

I

I about [1] 49/5
I agreed [1] 38/11
I also [6] 28/24 38/2 41/16 56/15 60/23 62/16
I am [9] 13/1 56/2 56/7 56/21 57/3 57/19 57/25 59/6 61/19
I and [1] 36/3
I approached [1] 46/1
I are [1] 55/24
I arrived [3] 4/24 7/8 48/20
I asked [5] 14/11 17/7 36/14 36/18 43/6
I believe [5] 28/3 28/21 37/12 60/2 60/20
I blamed [1] 51/16
I both [3] 31/6 42/9

I

I both... [1] 52/17
I bumped [1] 38/16
I called [4] 4/21 7/16 12/6 56/24
I can [2] 7/22 44/21
I can't [1] 43/16
I cannot [8] 5/7 8/9 8/21 9/12 33/3 35/13 36/22 57/13
I completely [1] 61/18
I confirm [1] 59/5
I could [21] 6/16 7/4 7/14 7/25 11/13 12/9 14/2 15/19 17/9 19/10 27/19 30/14 30/15 34/3 35/10 38/24 40/8 41/23 43/12 45/6 54/16
I couldn't [9] 13/20 19/22 20/6 22/12 22/21 39/21 41/13 41/25 53/8
I cry [1] 56/18
I did [12] 1/24 3/15 9/20 16/21 16/25 24/18 27/3 32/7 35/25 38/1 51/19 59/9
I didn't [10] 2/3 10/20 16/24 19/18 22/13 25/17 43/15 54/15 54/16 59/2
I do [2] 26/18 27/25
I don't [6] 5/23 11/25 13/18 22/14 42/17 61/11
I ended [3] 22/22 50/19 55/17
I entirely [1] 59/8
I expected [3] 9/22 33/6 37/5
I feel [1] 25/10
I felt [11] 6/3 6/4 13/5 13/6 13/8 15/16 20/20 20/21 30/25 45/20 49/17
I find [1] 24/1
I first [1] 24/23
I followed [1] 53/5
I found [6] 14/19 19/25 22/16 26/15 57/1 57/23
I genuinely [1] 46/6
I get [1] 56/20
I go [1] 56/8
I got [5] 15/4 38/22 39/10 39/11 48/13
I had [28] 2/25 3/10 5/7 5/11 6/10 7/10 7/21 13/5 15/17 15/21 18/15 20/6 20/20 20/21 21/13 23/8 23/19 23/21 27/4 27/18 41/8 42/21 42/25 50/17 51/3 52/9 55/10 58/3
I hadn't [1] 5/3
I have [13] 14/3 23/16 28/15 28/16 40/14 55/19 56/10 56/16 59/7 59/11 59/23 60/14 60/15
I hope [1] 59/13
I immediately [1] 35/5
I into [1] 13/25
I just [7] 16/22 21/4 24/6 41/14 43/14 45/21 61/23
I knew [4] 11/9 42/3 45/22 46/24
I know [2] 40/6 62/12
I left [2] 38/5 39/1
I make [2] 1/17 29/22
I may [1] 26/16
I met [1] 38/13
I might [2] 35/25 51/17
I need [1] 57/12
I needed [3] 7/19 15/1 27/18
I never [1] 56/19
I no [1] 24/1
I noticed [2] 18/4 48/20
I often [1] 57/4
I only [1] 54/14
I panicked [1] 44/15
I phoned [1] 15/8
I pick [1] 24/11
I really [3] 21/22 33/18 46/25
I recall [3] 31/14 38/14 46/20
I remember [14] 7/9 7/10 13/23 16/1 17/16 21/3 30/11 35/14 43/18 45/13 45/19 45/24 52/19 56/13
I said [3] 6/13 42/25 46/24
I saw [3] 8/5 44/13 44/15
I see [1] 56/22
I seem [1] 20/10
I should [1] 56/16
I signed [1] 17/11
I simply [1] 59/10
I slept [1] 42/3
I spent [3] 20/24 34/2 41/7
I spoke [2] 23/20 27/11
I started [2] 4/20 53/16
I stayed [2] 10/15 42/20
I still [2] 56/5 56/8
I stopped [1] 53/11
I tell [1] 56/15
I therefore [2] 19/21 22/20
I think [18] 8/4 9/13 16/1 19/2 21/21 24/23 25/2 26/16 26/23 29/10 33/3 36/23 38/13 43/16 44/19 49/8 56/24 57/3
I thought [7] 2/1 12/20 16/20 17/1 25/16 46/5 52/1
I together [1] 22/9
I told [6] 30/14 39/14 46/5 47/9 48/24 51/20
I took [1] 23/11
I tried [1] 41/12
I understand [4] 1/5 1/8 28/5 60/4
I understood [1] 13/1
I used [1] 56/18
I walked [1] 35/4
I wanted [3] 7/24 8/20 11/2
I was [102]
I wasn't [7] 7/4 12/22 14/21 17/10 21/25 22/23 41/25
I watched [3] 19/24 35/22 36/5
I went [18] 1/25 3/11 3/25 7/6 7/20 11/9 14/13 14/23 14/24 15/2 20/20 21/18 30/7 34/25 36/12 37/19 37/22 39/13
I were [6] 2/6 8/15 10/8 13/17 27/6 47/11
I wheeled [1] 39/17
I will [1] 29/17
I wish [1] 57/16
I witnessed [1] 56/23
I would [10] 3/20 6/11 6/12 15/19 32/18 38/12 42/4 57/6 57/12 59/9
I wouldn't [2] 24/6 56/25
Ian [1] 59/5
idea [9] 11/12 26/10 32/17 40/6 43/6 43/23 53/25 55/3 58/16
ideal [1] 50/15
identify [1] 32/25
if [35] 2/14 3/3 3/18 8/1 9/1 9/9 9/10 12/15 13/2 13/19 14/5 15/19 16/19 16/20 18/15 19/22 27/4 29/11 31/11 32/11 34/20 35/14 36/12 36/14 36/18 36/19 44/3 45/10 45/22 46/5 46/21 48/4 56/3 56/22 59/20
ignored [1] 15/17
ignoring [2] 28/11 60/10
ill [1] 24/2
illness [1] 14/5
image [1] 44/18
imaging [1] 30/13
immediately [2] 35/5 37/13
impact [5] 1/19 21/17 21/19 29/24 57/15
impacted [1] 22/15
important [4] 24/15 30/9 53/13 55/12
impossible [1] 57/23
impression [3] 33/19 34/13 35/11
improving [1] 15/10
inadequate [1] 13/8
incident [1] 56/22
incision [3] 36/1 43/19 44/19
incisions [2] 35/23 44/1
include [2] 29/3 61/2
including [1] 35/23
inconvenience [1] 34/13
incorrectly [1] 52/2
increased [1] 3/1
indeed [2] 61/8 63/3
INDEX [1] 64/2
indicate [1] 23/6
indicated [1] 46/8
information [11] 17/3 28/13 29/4 53/19 53/23 57/14 58/17 58/20 59/21 60/12 61/3
informed [3] 18/10 25/21 26/24
initial [1] 37/14
initially [3] 1/24 3/1 50/13
injected [1] 5/7
Inquiry [9] 24/14 28/9 57/8 57/16 59/13 60/8 61/21 62/22 63/7
Inquiry's [4] 1/17 29/22 57/7 57/20
insisted [1] 62/3
instead [2] 17/6 20/18
instincts [2] 57/21 58/9
instruction [1] 15/25
instructions [1] 45/4
intense [1] 20/1
Intensive [1] 50/3
interest [1] 58/19
into [23] 3/11 3/25 4/4 5/7 13/25 17/23 21/22 25/16 30/19 33/20 34/5 34/25 38/16 38/22 39/6 39/9 39/25 41/23 43/19 47/7 52/3 52/7 54/15
investigating [1] 25/1
investigation [5] 22/3 51/1 51/8 51/9 58/21
involved [5] 15/23 30/10 44/12 51/8 51/13
involvement [1] 51/5
is [25] 1/14 6/14 14/3 24/10 24/12 24/14 24/15 25/22 27/25 28/18 28/22 35/6 41/20 44/24 52/5 54/10 56/14 57/17 57/19 58/10 59/6 60/17 60/21 61/19 62/11
isn't [1] 43/8
isn't it' [1] 43/8
issue [3] 9/2 11/10 56/3
issues [3] 42/16 50/7 56/1
it [158]
it' [1] 43/8
it's [3] 6/14 43/1 56/3
items [2] 29/1 60/25
its [1] 57/8
itself [1] 19/19
IVs [3] 11/9 11/25 12/1

J

jeopardising [1] 53/10
Jill [1] 32/12
Jim [3] 4/6 5/18 32/12
job [3] 11/21 13/9 20/2
jokes [1] 31/19
journey [2] 39/18 48/7
July [1] 25/20
June [6] 4/19 5/9 8/23 10/12 14/13 34/6
June 2016 [1] 4/19
just [34] 12/1 12/5 12/22 13/4 13/15 15/16 15/21 16/22 20/2 20/16 20/24 21/4 23/14 24/6 24/10 27/17 29/11 36/15 39/7 41/14 41/17 42/23 43/10 43/14 45/21 46/5 47/3 50/22

J

just... [6] 51/20 51/24 52/6 55/17 57/6 61/23
justice [1] 21/15

K

keep [6] 18/25 33/2 34/21 41/12 47/2 52/6
kept [2] 47/3 52/11
kids [1] 55/9
knew [22] 2/8 11/9 16/22 25/23 26/25 28/4 33/21 42/3 43/14 44/3 45/22 46/24 48/6 48/8 49/17 49/20 51/24 53/25 54/6 54/12 58/25 60/3
knock [1] 24/12
know [28] 4/22 5/23 11/19 12/4 12/18 14/5 16/11 16/19 16/22 19/18 21/12 22/14 24/15 24/19 26/22 27/4 27/25 29/11 38/14 40/6 43/15 45/14 50/10 55/2 58/2 58/13 59/3 62/12
knowing [1] 46/3
known [1] 51/3

L

labour [7] 3/25 5/1 5/12 22/23 33/21 34/5 47/12
lack [1] 9/3
lady [8] 1/4 1/7 29/7 29/12 29/17 56/23 61/5 62/25
landed [1] 36/4
Langdale [1] 63/3
large [1] 3/11
last [2] 22/13 42/3
late [2] 16/15 34/7
later [3] 7/21 13/10 42/15
laying [1] 6/3
lead [1] 35/11
leaflet [1] 8/22
leaflets [1] 27/13
Leah [2] 17/24 48/18
Leah Murphy [2] 17/24 48/18
learn [1] 13/15
learned [3] 24/23 28/16 60/15
learnt [2] 58/22 59/1
leave [3] 5/21 20/6 35/17
leaving [1] 46/2
left [7] 10/16 11/8 11/15 36/4 38/5 39/1 50/21
leg [1] 5/7
legally [2] 28/20 60/19
legs [2] 5/24 5/25
less [1] 37/9
let [6] 2/23 4/21 21/11 29/11 31/7 41/25
Letby [16] 8/10 8/20 12/2 15/23 17/13 26/1 26/4 26/6 26/13 28/7 44/11 47/14 47/16 55/16 56/17 60/6
Letby's [4] 26/10 28/5 52/16 60/4
letters [1] 59/5
level [2] 18/5 48/21
Liaison [3] 25/21 53/21 54/20
Liason [1] 25/25
life [4] 12/17 50/23 57/4 58/4
life-changing [1] 12/17
lifetime [1] 30/24
lift [2] 11/3 38/22
light [1] 52/7
lights [1] 8/24
like [24] 12/4 12/21 13/8 20/3 24/11 30/23 31/16 34/10 35/3 40/9 40/10 40/15 43/2 43/5 43/6 43/24 44/9 46/13 47/3 49/17 54/24 56/20 57/5 57/12
likelihood [1] 31/25
likely [1] 3/22
line [1] 19/5
lines [1] 39/9
link [2] 19/24 54/13
list [4] 19/17 19/21 21/6 22/13
listen [3] 16/10 20/9 53/3
listening [2] 20/7 20/11
Literally [1] 42/23
little [6] 2/19 6/19 9/6 33/24 34/17 42/12
live [2] 62/13 62/13
liver [1] 13/13
Liverpool [21] 2/11 2/14 2/18 13/10 16/6 16/18 17/7 17/18 17/20 18/20 27/12 31/2 31/10 32/23 44/7 45/1 45/22 46/1 47/19 48/12 62/4
lives [1] 58/11
local [1] 56/3
London [2] 3/24 32/6
long [5] 5/8 10/2 19/1 44/5 55/5
longer [2] 24/1 53/17
look [5] 4/7 4/9 33/10 43/25 44/22
looked [10] 8/18 12/4 16/2 21/5 37/18 38/3 40/10 43/24 44/2 55/8
looking [11] 8/10 13/3 15/21 17/24 25/16 26/4 31/9 35/1 43/6 48/18 58/3
loose [1] 32/16
loss [2] 23/7 62/13
lost [5] 21/20 23/18 31/12 55/19 58/3
lot [12] 4/23 7/24 12/1 20/15 37/24 39/20 47/4 48/10 55/19 56/15 56/18 59/1
lots [5] 24/16 36/18 37/23 39/8 54/1
love [2] 62/12 62/14
lovely [1] 42/11
low [2] 4/11 8/24
lucky [2] 8/12 62/7
Lucy [15] 8/10 8/20 12/2 15/23 17/13 26/1 26/4 26/6 26/10 44/11 47/14 47/16 52/16 55/16 56/17
Lucy Letby [13] 8/10 8/20 12/2 15/23 17/13 26/1 26/4 26/6 44/11 47/14 47/16 55/16 56/17
Lucy Letby's [2] 26/10 52/16
lunch [1] 8/5
lung [1] 44/17
lungs [2] 3/4 43/20
lying [1] 20/3

M

machines [2] 18/13 49/2
made [30] 8/1 17/15 18/2 19/4 20/16 21/9 21/16 22/18 22/19 24/21 26/21 27/17 28/20 31/19 31/22 33/2 34/17 35/23 36/1 46/10 47/16 48/16 49/12 51/9 52/8 52/12 55/21 60/19 62/10 62/17
madness [1] 11/7
main [1] 10/18
mainly [1] 18/21
major [1] 15/21
make [10] 1/17 19/22 29/22 31/3 31/20 32/25 33/17 42/7 47/1 59/9
makeshift [1] 43/25
making [7] 20/22 38/3 46/12 47/17 54/4 59/8 62/22
malicious [2] 16/24 52/1
managed [3] 15/9 46/15 62/3
management [2] 28/9 60/8
Manchester [5] 19/21 19/22 20/1 20/11 54/18
Manchester - for [1] 19/22
many [2] 46/8 51/11
match [1] 25/12
Maternity [4] 7/6 10/15 10/17 14/23
may [2] 25/3 26/16
maybe [2] 12/20 13/5
McCormack [6] 4/6 5/18 32/12 33/9 35/16 35/18
me [83]
meaningful [1] 58/20
means [1] 49/5
meant [8] 20/15 22/11 23/21 23/23 41/23 47/23 50/17 54/20
media [1] 53/4
medical [10] 22/16 25/17 27/3 30/8 40/14 44/19 54/2 54/8 55/20 55/23
medically [2] 10/6 51/23
medication [5] 6/5 15/17 15/20 21/25 47/20
medications [1] 12/2
medicine [5] 5/2 6/15 12/3 52/2 58/1
medicines [3] 11/9 28/25 60/24
medics [1] 24/1
meet [6] 17/23 38/9 38/12 39/2 42/22 48/14
members [3] 13/24 37/23 52/15
memories [1] 24/16
memory [5] 17/15 47/17 59/8 59/10 59/12
mental [3] 21/20 22/1 55/21
mentally [2] 20/14 58/18
mentioned [3] 27/8 32/6 40/7
met [1] 38/13
midwife [2] 7/24 14/11
midwives [1] 31/15
might [9] 12/15 35/25 47/8 51/12 51/17 54/5 56/1 58/2 58/8
milk [2] 8/20 19/4
mind [2] 43/12 55/16
minds [1] 33/12
minor [1] 42/16
minute [1] 22/13
minutes [5] 6/18 10/16 36/11 37/20 46/12
mistake [1] 57/24
mix [1] 56/12
moment [3] 30/25 61/12 62/5
monitoring [2] 28/25 60/24
monitors [1] 49/5
months [1] 32/18
more [33] 2/16 3/4 6/15 7/24 16/2 16/8 26/7 27/17 28/4 28/10 30/17 37/15 41/15 43/18 45/9 45/20 49/17 50/21 51/19 52/14 52/15 52/16 53/13 53/19 56/16 56/18 56/21 57/3 58/3 58/22 59/1 60/3 60/9
Moreover [1] 58/13
morning [7] 1/3 1/4 8/4 26/1 42/5 42/11 63/5
mortality [1] 26/21
most [4] 10/9 19/21 55/12 59/18
mother [85]
Mother O [2] 30/15 35/14
mottling [1] 43/13
mould [1] 50/7
moved [4] 5/3 41/22 50/5 62/8
Mr [3] 29/9 61/8 61/11
Mr Scorer [3] 29/9 61/8 61/11
Ms [1] 63/3
Ms Langdale [1] 63/3
much [26] 1/11 13/10 15/15 19/23 20/14 28/4 28/10 29/8 31/21 33/24 34/3 38/1 44/10 49/18 52/5 52/5 57/13 57/16 57/18 60/3 60/9 61/7 61/9 61/22 62/21 63/2
mum [13] 8/23 12/6 12/13 15/8 15/18 15/19 17/16 20/8 40/2 40/20 41/9 41/16 53/22
murder [2] 25/18 25/22
Murphy [2] 17/24

M

Murphy... [1] 48/18
must [3] 25/3 44/25 49/8
my [95]
my Lady [7] 1/4 1/7 29/7 29/12 29/17 61/5 62/25
myself [13] 7/25 11/2 11/3 17/9 24/11 27/20 27/21 32/9 33/9 40/8 41/13 51/16 56/15

N

name [3] 13/18 35/13 52/16
named [2] 3/9 33/5
names [2] 21/6 25/9
nappy [1] 8/13
naturally [2] 22/24 31/7
nature [1] 51/9
navigate [1] 58/14
near [1] 39/22
need [12] 4/15 9/20 10/4 18/25 24/10 30/21 32/4 37/3 37/6 49/11 50/4 57/12
needed [24] 6/19 7/19 9/5 10/23 15/1 16/23 18/14 24/25 27/18 36/13 36/15 37/14 37/25 38/19 39/14 39/16 44/8 47/8 47/9 47/10 47/20 47/25 49/3 49/15
needing [1] 7/11
needs [3] 23/6 28/20 60/19
negligence [1] 25/17
Neither [1] 42/2
Neonatal [43] 4/7 4/12 4/16 5/13 6/21 6/25 7/5 7/7 8/5 8/7 9/14 9/16 9/21 9/24 10/2 10/17 11/4 11/24 13/18 14/11 14/14 18/1 18/24 24/22 24/22 26/6 26/22 27/2 28/12 28/22 33/7 33/10 33/14 36/23 36/25 37/19 38/10 38/15 41/2 48/15 58/24 60/11 60/21
nervous [3] 34/17 36/5 52/13
never [14] 6/10 7/21 10/1 22/19 24/11 26/13 26/20 27/8 33/13 47/23 48/25 50/1 56/19 59/2
news [5] 25/24 26/17 40/17 41/8 53/5
next [6] 5/5 21/3 31/3 37/16 38/7 46/6
NHS [4] 22/1 28/17 50/25 60/16
night [9] 8/23 14/8 14/14 34/7 38/5 41/22 42/2 42/3 56/11
nightmare [1] 54/18
nightmares [2] 56/5 56/10
nights [2] 18/2 48/16
nine [1] 32/18
no [35] 1/22 8/9 8/19 11/17 12/18 14/17 15/17 15/20 17/3 17/4 24/1 27/25 30/3 32/15 38/19 39/6 40/6 40/13 40/14 43/6 43/9 43/20 43/23 49/13 50/24 53/17 55/3 55/15 58/12 58/16 58/17 58/18 59/7 59/10 62/9
no one [6] 12/18 15/20 39/6 40/13 43/9 55/3
nobody [3] 27/20 28/18 60/17
non [2] 28/14 60/13
non-existent [2] 28/14 60/13
nor [1] 42/2
normal [3] 1/22 36/21 42/14
not [69]
note [1] 62/16
nothing [14] 4/13 10/6 10/22 13/13 20/15 21/1 21/14 23/16 37/7 42/14 42/18 43/8 45/6 45/9
noticed [2] 18/4 48/20
November [1] 21/21
November 2017 [1] 21/21
now [12] 23/11 24/14 26/22 29/17 49/15 55/20 55/25 56/20 57/3 57/19 59/8 63/4
now' [1] 45/25
numb [1] 5/25
number [3] 24/21 39/5 58/23
numbers [1] 42/17
nurse [24] 3/18 5/1 13/18 13/20 14/16 14/25 17/23 18/9 18/10 18/15 19/2 19/10 19/15 32/11 36/14 42/4 42/11 44/13 48/18 48/24 49/4 49/8 49/22 49/23
nurses [14] 4/3 6/17 9/1 9/9 11/8 13/6 13/25 26/7 32/3 36/10 37/8 37/16 39/4 39/6
nutrients [1] 19/5

O

o'clock [1] 63/5
O's [1] 11/22
observation [1] 5/11
obvious [2] 11/12 54/7
obviously [4] 28/7 34/14 57/25 60/6
occasion [1] 31/23
occurred [1] 57/18
occurrence [1] 11/1
October [1] 23/15
off [11] 4/9 5/8 19/21 22/13 26/16 33/11 41/22 49/6 53/4 55/6 56/8
offered [7] 18/17 21/25 22/4 27/6 27/9 27/21 27/24
office [1] 47/7
officer [8] 21/4 21/11 25/1 25/21 25/25 53/21 54/21 55/14
often [3] 24/3 56/7 57/4
okay [11] 9/10 14/19 31/4 33/18 36/13 36/14 36/15 36/19 42/8 56/25 61/22
old [1] 50/6
older [2] 56/23 57/5
oldest [1] 30/23
on [101]
once [12] 22/3 22/10 30/23 30/25 32/16 32/19 34/11 48/5 48/8 53/16 54/6 55/14
one [39] 2/18 2/20 6/12 6/17 7/12 7/22 8/25 8/25 9/2 10/13 10/14 11/10 12/18 15/20 17/4 19/23 26/4 30/2 31/5 31/23 36/5 36/6 36/13 37/16 38/10 38/10 39/6 39/11 40/13 43/7 43/9 44/24 46/10 46/21 46/23 46/24 47/9 49/19 55/3
ones [1] 62/18
online [3] 1/6 61/10 61/19
only [20] 3/18 3/25 10/13 14/3 17/9 18/24 26/14 27/21 32/10 37/12 38/9 41/20 48/11 50/3 52/6 54/14 55/20 56/19 58/20 59/20
onto [8] 5/14 6/8 6/8 11/5 12/11 13/5 13/22 33/6
opened [2] 6/4 6/6
opening [1] 42/13
operated [1] 6/4
operating [1] 34/25
opportunity [2] 4/9 30/24
opposite [2] 6/24 14/22
option [1] 2/21
or [30] 3/23 12/21 15/17 15/20 18/13 21/25 27/6 28/11 29/5 38/11 39/19 39/20 39/22 47/8 49/2 50/25 51/16 52/3 53/2 53/25 54/13 55/5 56/3 57/24 58/1 58/2 58/7 58/19 60/10 61/4
order [2] 47/18 59/12
organ [1] 19/9
organs [1] 49/17
originally [2] 19/17 22/11
other [13] 2/19 7/13 12/23 16/9 22/1 26/7 35/10 41/3 44/21 44/23 47/12 54/16 56/11
others [1] 2/22
Otherwise [1] 9/7
our [45] 2/7 3/15 8/4 10/10 17/18 18/7 19/19 20/19 21/15 23/5 23/7 25/5 25/15 25/20 25/25 26/20 30/23 31/12 32/8 32/15 32/16 33/12 34/2 35/17 38/6 46/4 48/7 48/23 50/13 50/22 51/12 52/18 52/20 53/21 54/15 54/21 55/11 55/23 57/9 57/10 58/6 58/9 58/11 58/14 62/7
ourselves [4] 30/23 51/18 54/5 58/12
out [50] 3/8 7/14 7/20 8/1 9/10 14/1 14/19 15/13 15/24 16/21 16/23 18/18 19/10 22/17 25/14 26/7 26/15 28/8 28/15 30/6 30/11 30/18 31/23 32/24 32/25 33/4 33/22 35/4 35/24 36/5 36/7 36/19 40/1 40/9 41/25 42/15 44/25 45/25 46/14 46/17 49/23 50/18 51/1 53/17 55/15 57/14 57/14 59/12 60/7 60/14
outcome [1] 21/12
outside [2] 11/16 43/22
over [20] 6/7 6/17 11/18 12/9 14/15 15/14 15/14 16/8 20/18 32/18 36/6 36/10 36/12 39/19 44/21 45/8 48/4 48/10 52/16 53/21
overly [1] 56/1
overnight [3] 14/20 34/21 42/6
overwhelming [2] 39/5 51/6
own [5] 7/9 8/25 14/8 24/6 55/8
oxygen [5] 6/19 9/6 12/13 36/15 36/18

P

P's [4] 8/13 21/10 43/19 44/12
packed [1] 39/6
page [1] 31/8
pain [9] 4/23 6/4 6/12 6/12 7/15 15/18 37/24 39/20 48/10
painful [1] 7/24
PALS [1] 27/25
pandemic [1] 22/7
pandemonium [1] 39/3
panic [2] 15/5 48/4
panicked [5] 11/13 38/17 38/25 44/15 49/8
paperwork [3] 17/11 47/24 54/1
parent [4] 10/14 13/8 38/10 59/16
parents [7] 26/23 29/4 38/11 53/7 59/14 59/19 61/3
Park [2] 22/21 23/5
part [5] 19/19 19/22 42/15 57/25 63/1
Part A [1] 63/1
particular [3] 13/4 29/1 60/25
particularly [3] 50/10 52/10 57/11
partly [2] 30/20 30/20
parts [1] 55/11
pass [3] 31/23 50/2 61/14
passed [14] 12/8 12/9 13/5 14/6 16/15 16/16 19/3 40/22 40/24 45/17 49/9 51/16 51/17 52/22
passing [2] 12/3 45/13
PC [1] 44/14

P

people [2] 16/9 39/23
perform [1] 44/1
performed [1] 32/23
perhaps [1] 43/18
period [3] 15/16 57/11 57/19
perked [1] 36/18
person [5] 9/15 20/1 35/14 44/18 54/13
personal [1] 37/25
phone [6] 13/12 14/11 24/24 24/24 25/6 53/6
phoned [1] 15/8
photo [3] 14/2 27/14 41/19
photos [10] 7/3 14/4 17/16 26/10 26/11 37/15 41/11 41/16 47/15 47/17
physically [1] 7/14
pick [1] 24/11
picked [1] 13/2
picture [2] 14/3 41/20
pictures [1] 8/14
place [5] 2/4 23/13 24/15 26/21 52/7
placenta [1] 2/20
plan [1] 2/17
planned [1] 42/21
plans [1] 32/15
platforms [1] 53/4
please [1] 61/14
plus [1] 38/10
pm [4] 5/9 10/20 12/8 38/21
point [9] 5/17 6/5 6/12 12/11 16/22 20/11 21/19 44/21 55/15
pointing [1] 44/18
points [1] 20/5
police [23] 1/19 21/4 21/11 22/3 22/18 23/10 24/24 25/1 25/15 25/18 28/16 29/24 51/1 51/4 51/7 51/13 52/6 52/14 53/18 55/14 57/15 58/21 60/15
police officer [2] 21/11 25/1
poorly [2] 15/1 49/19
popped [2] 5/2 40/9
position [4] 33/1 58/2 58/9 59/15
positions [1] 59/21
possibilities [1] 51/12
possibility [1] 27/8
possible [5] 3/6 17/8 38/2 47/23 57/17
possibly [1] 17/1
postmortem [3] 25/5 46/22 47/8
postmortems [1] 19/14
pot [1] 40/9
potential [1] 53/2
potentially [1] 31/5
practical [2] 62/16 62/21
precaution [4] 3/12 4/16 34/1 49/11
precautionary [1] 9/25
precautions [1] 49/16
precise [2] 8/9 8/21
pregnancy [16] 1/22 2/2 3/2 3/17 4/14 4/17 9/17 9/19 22/17 31/18 32/10 33/2 33/24 35/19 37/2 51/15
pregnant [4] 1/24 5/10 30/1 30/6
premature [3] 9/18 25/8 37/1
prematurely [1] 23/22
prepare [1] 61/13
preparing [1] 61/15
prescribed [1] 21/24
present [7] 8/21 12/14 13/24 40/20 43/17 47/14 61/9
pressure [3] 6/9 6/11 31/21
previous [3] 2/2 23/7 42/21
priest [1] 40/21
privacy [1] 41/6
private [1] 47/7
probability [1] 4/11
probably [4] 32/4 44/10 56/1 59/11
problem [4] 13/12 25/14 39/10 39/14
problems [1] 2/15
procedure [7] 18/10 34/25 44/13 44/17 44/23 44/24 48/24
proceedings [1] 53/3
process [4] 21/14 23/21 30/10 35/23
profession [2] 22/16 55/20
professional [2] 14/4 27/14
progress [3] 10/3 31/7 31/24
progressed [1] 3/2
proper [2] 28/24 60/23
properly [1] 59/17
protect [2] 28/11 60/10
protocols [3] 18/7 29/2 61/1
provide [3] 17/4 29/3 61/2
provided [1] 30/4
providing [2] 61/10 61/15
publicly [2] 28/4 60/3
pull [2] 12/15 48/4
pulled [3] 11/19 35/24 49/20
pulling [2] 6/11 46/20
pulling' [1] 6/14
pulsating [2] 40/11 56/14
pumped [1] 15/13
pumping [1] 52/3
push [2] 27/19 59/20
pushed [4] 15/6 21/22 46/25 59/11
put [19] 4/9 5/25 17/14 18/1 18/18 22/4 23/6 25/7 26/8 31/21 33/11 33/12 35/17 38/20 39/8 43/19 43/20 48/15 50/14
putting [1] 8/1

Q

quality [1] 59/18
question [1] 62/10
questioning [1] 20/5
questions [6] 24/17 36/18 57/7 57/9 57/12 57/20
quick [1] 62/2
quickly [4] 3/5 12/7 15/8 46/20
quieter [1] 52/5
quite [9] 2/7 12/7 13/23 17/16 32/2 45/19 52/23 54/7 55/25

R

R's [6] 10/12 19/2 33/23 34/12 35/9 53/22
Rackham [7] 16/8 16/17 16/18 17/5 45/2 45/8 45/13
raised [3] 28/10 57/8 60/9
ran [1] 14/25
rate [1] 26/22
rather [3] 19/5 28/11 60/10
ray [1] 24/4
re [1] 53/16
re-following [1] 53/16
reached [2] 21/9 36/3
read [13] 1/9 1/13 1/18 29/17 29/20 29/23 54/1 54/15 55/15 61/11 61/13 64/3 64/4
read in [2] 1/18 29/23
ready [8] 1/12 3/24 5/15 29/11 29/16 33/20 34/5 42/1
real [2] 15/7 21/16
realise [1] 1/24
realistically [1] 59/15
reality [1] 44/9
really [38] 5/20 12/4 15/1 18/19 19/18 20/4 21/22 23/17 24/2 24/9 28/15 30/12 30/25 31/15 33/18 34/10 34/16 35/8 38/14 40/14 42/17 44/3 44/5 46/4 46/15 46/25 47/4 49/7 50/15 51/2 51/10 52/4 52/13 54/3 56/6 57/1 60/14 61/24
reason [3] 3/19 38/19 48/4
reassurance [3] 11/2 33/13 37/2
reassured [7] 5/20 8/8 9/11 9/13 36/20 37/8 38/18
reassuring [4] 35/19 36/22 49/7 55/17
rebook [1] 23/15
recall [6] 8/9 8/21 31/14 38/14 42/17 46/20
receive [1] 58/7
received [4] 25/9 50/24 58/8 59/5
receiving [1] 5/24
reception [3] 17/22 38/13 48/14
recognise [1] 59/13
recommendations [3] 28/2 60/1 62/17
record [2] 57/16 59/6
recorded [2] 28/23 60/22
records [1] 27/3
recover [1] 16/3
recovery [4] 6/22 6/23 7/1 7/3
redacted [3] 15/22 30/22 54/23
refer [1] 2/14
referral [1] 23/12
referred [2] 2/11 31/2
regular [1] 11/1
reinforcing [1] 10/10
related [1] 22/1
relating [1] 53/3
relief [3] 15/18 21/13 36/7
relieved [2] 21/8 21/15
religiously [1] 53/6
relying [1] 54/20
remained [1] 13/14
remember [23] 5/8 7/9 7/10 9/13 11/25 13/19 13/23 16/1 17/16 20/10 21/3 30/11 35/13 35/14 36/22 43/18 44/21 45/13 45/19 45/24 52/19 56/13 57/2
remembered [1] 52/17
reminder [1] 23/18
reminders [1] 23/25
rented [1] 50/6
repeat [1] 43/3
replied [1] 30/16
report [2] 25/9 46/22
reports [2] 24/18 59/2
reputation [2] 28/12 60/11
request [4] 1/18 24/17 29/23 57/8
requested [1] 27/5
required [1] 59/22
response [2] 1/17 29/22
responsible [1] 55/16
responsive [2] 28/10 60/9
rest [2] 33/13 53/20
result [2] 57/17 57/19
results [1] 8/17
resuscitate [1] 40/18
resuscitated [1] 15/14
resuscitation [2] 44/5 44/12
return [1] 22/19
returned [1] 38/6
returning [1] 22/22
reviewed [1] 5/5
right [9] 1/7 11/8 15/2 21/9 45/21 46/25 51/3 51/25 55/17
risk [7] 4/16 9/17 14/7 33/8 34/9 46/9 53/10
risks [1] 50/12
robotic [1] 52/23
room [28] 5/11 7/11 8/25 12/23 13/17 13/25 14/8 15/7 15/12 18/1 18/9 18/12 20/6 27/14 35/2 35/8 36/2 39/6 41/1 41/8 41/17 41/23 42/1 47/12 47/14 48/15 48/23 49/1

R

rooms [3] 5/12 8/7 50/5
round [3] 16/4 25/2 39/19
routine [3] 8/17 13/4 32/20
Rule [4] 1/18 24/17 29/23 57/8
Rule 9 [2] 1/18 29/23
running [3] 11/8 39/4 43/5
rushed [2] 6/3 43/2
rushing [2] 15/24 39/7

S

sad [2] 56/22 57/4
safe [2] 48/6 49/21
safely [1] 36/8
safer [1] 46/16
said [30] 3/12 4/11 4/25 6/13 6/13 8/16 13/11 16/11 17/5 18/9 18/23 19/15 25/15 42/8 42/12 42/12 42/25 43/7 43/8 45/8 45/15 46/2 46/22 46/24 47/1 47/22 48/24 49/6 49/14 50/3
same [9] 15/5 31/8 33/1 40/16 43/12 43/13 43/13 43/14 45/24
sank [1] 52/20
sat [4] 21/3 21/5 41/17 56/7
saw [11] 8/5 11/11 24/19 25/24 34/16 36/6 37/12 42/11 44/13 44/15 59/4
say [6] 1/16 11/17 13/23 29/21 55/24 61/23
saying [5] 16/2 20/2 25/13 45/14 45/25
scan [7] 2/4 2/12 3/6 8/16 8/17 30/12 31/20
scanned [1] 5/19
scanning [2] 30/8 31/22
scans [2] 2/25 32/21
scar [3] 7/18 7/19 23/2
scared [3] 19/11 49/23 50/2
scenarios [2] 51/11 54/4
scene [1] 11/6
school [4] 20/18 54/22 55/1 55/6
science [1] 58/1
Scorer [3] 29/9 61/8
scream ... 61/11
screen [8] 6/7 30/14 35/10 43/21 43/25 44/14 44/15 44/17
screens [2] 18/14 49/3
SD [1] 41/11
second [2] 2/12 7/22
section [11] 5/4 5/6 5/23 6/10 7/18 7/21 7/23 17/21 22/23 34/12 34/23
see [39] 4/10 5/2 7/4 10/15 11/2 11/13 14/12 17/25 21/18 22/5 22/8 22/12 27/13 28/8 30/14 30/15 35/10 36/7 36/10 36/12 36/12 37/19 37/22 38/9 38/24 38/25 39/12 39/22 40/8 41/16 42/4 42/10 43/12 48/19 48/19 49/6 54/3 56/22 60/7
seeing [2] 38/3 54/5
seem [2] 20/10 38/17
seemed [6] 12/18 16/8 16/9 17/16 40/12 54/7
seems [1] 62/5
seen [5] 26/16 49/18 52/9 54/8 59/2
self [1] 17/12
self-discharge [1] 17/12
senior [1] 16/9
sense [3] 21/13 45/6 52/8
sensitive [1] 23/5
sent [2] 5/10 27/2
separate [3] 8/7 12/23 41/23
separated [1] 9/3
September [2] 1/1 63/8
serious [3] 28/7 57/24 60/6
sessions [1] 23/10
set [4] 17/14 32/15 57/14 57/14
settled [3] 18/3 48/17 50/22
seven [1] 27/23
several [1] 47/21
sewn [2] 6/23 36/11
sex [2] 3/8 32/24
sharing [3] 2/20 28/13 60/12
she [78]
shed [1] 52/7
shift [5] 8/21 14/14 16/1 45/2 52/23
shifts [1] 52/15
shines [1] 62/14
shock [2] 11/23 12/19
shocked [4] 11/14 30/19 38/25 45/6
shocking [1] 40/14
short [2] 29/10 29/14
shorter [1] 44/10
shortly [4] 40/17 40/22 45/12 46/17
should [20] 1/18 19/12 26/20 26/23 28/9 28/21 28/24 29/2 29/23 44/2 44/19 45/5 47/9 49/25 56/16 59/17 60/8 60/20 60/23 61/1
shouldn't [1] 17/2
showed [2] 8/11 8/22
shower [5] 7/20 7/25 14/18 14/24 42/20
showering [2] 14/25 37/25
shown [1] 7/3
siblings [2] 19/3 49/9
sickened [1] 51/7
side [7] 7/13 10/19 18/13 35/10 39/11 46/21 49/2
sight [1] 41/25
sign [1] 47/24
signed [1] 17/11
significant [3] 21/22 42/18 62/22
silly [1] 30/16
similar [1] 54/9
similarly [1] 42/21
simple [1] 57/17
simply [3] 11/20 59/10 59/22
since [4] 23/16 24/8 28/15 60/14
single [1] 55/7
sit [1] 5/14
sitting [1] 20/15
situation [3] 50/15 59/17 59/19
situations [2] 49/18 56/21
six [1] 7/11
skin [16] 18/15 18/15 19/11 19/11 23/4 23/4 37/21 37/21 40/9 43/13 49/24 49/24 50/1 50/1 62/6 62/6
sleep [2] 56/5 56/6
slept [3] 18/2 42/3 48/16
slim [2] 32/2 35/12
slipping [1] 53/15
small [4] 11/16 23/17 35/8 36/3
smaller [2] 2/19 2/21
snow [1] 19/23
so [68]
social [1] 53/4
sole [1] 41/1
solicitors [4] 28/5 28/17 60/4 60/16
some [33] 3/10 6/11 7/3 10/23 13/11 14/18 14/23 15/18 20/4 20/11 21/18 27/13 32/5 33/15 36/13 36/15 36/17 37/14 37/21 38/20 41/6 41/7 41/11 41/15 42/16 46/10 47/15 48/2 51/5 54/24 57/24 58/8 59/5
somebody [1] 40/7
someone [11] 7/16 9/13 17/22 20/22 22/5 25/22 27/19 36/23 41/10 41/15 48/14
something [31] 12/20 13/2 13/5 16/25 17/2 20/16 24/12 25/16 26/25 31/17 34/4 35/3 40/8 40/11 45/21 46/4 46/24 50/2 50/8 51/3 51/15 51/16 51/17 51/22 51/25 52/1 56/14 56/20 56/22 57/22 58/10
sometimes [2] 46/23 54/23
somewhat [1] 36/5
sonographer [2] 30/13 30/16
sons [1] 21/15
soon [5] 11/9 15/4 15/9 44/15 48/20
sorrys [1] 47/4
sort [3] 41/17 50/17 59/14
sorts [1] 54/9
sound [2] 36/16 57/2
space [9] 9/4 11/17 11/21 16/19 18/13 19/1 41/5 43/20 49/2
speak [4] 24/25 25/2 38/17 53/12
speaking [1] 20/10
special [3] 10/4 18/19 37/7
specific [4] 10/1 52/15 52/15 56/12
specifically [1] 36/22
spend [1] 38/1
spent [5] 20/24 34/2 41/7 46/11 54/4
spinal [2] 5/15 5/24
splattered [1] 6/7
spoke [3] 23/20 27/11 31/1
spray [1] 36/1
stabilise [2] 15/9 15/24
stable [1] 37/15
staff [14] 11/20 11/24 12/24 13/11 14/15 17/2 19/8 44/20 44/21 44/25 48/16 49/12 50/3 52/16
stage [4] 22/12 26/19 26/23 45/19
stages [1] 50/5
stand [1] 26/7
standard [2] 18/9 48/24
standing [2] 35/9 40/5
stars [1] 62/7
start [5] 48/7 53/1 54/12 58/3 58/16
started [10] 4/20 5/24 6/6 19/20 22/3 33/15 34/6 52/14 53/16 58/20
starting [4] 1/9 22/10 34/15 51/1
starve [1] 49/12
starved [1] 12/13
state [4] 5/4 26/3 35/3 58/18
statement [16] 1/13 1/14 1/17 1/18 21/21 29/6 29/17 29/20 29/22 29/23 61/5 61/10 61/13 61/16 64/3 64/4
statements [5] 1/9 1/19 29/24 57/15 62/11
stats [1] 15/10
stay [2] 11/15 41/23
stayed [13] 10/15 14/9 15/15 18/20 20/9 20/19 33/1 38/5 42/1 42/20 46/6 50/13 55/6
steroids [1] 3/3
sticker [1] 23/6
still [8] 41/14 47/20 47/25 50/10 56/5 56/6 56/8 62/13
stitches [2] 7/18 17/11
stock [1] 41/6
stomach [5] 2/2 6/1 6/9 7/15 40/8
stop [2] 31/11 40/18
stopped [3] 2/22 45/11 53/11
stopping [1] 31/5
straight [5] 4/22 10/19 12/6 23/4 34/8
strange [1] 53/8
strict [1] 53/9
strictly [1] 18/25
strong [1] 4/24
strongly [1] 51/19
struck [1] 35/1
struggled [1] 21/23

S

struggling [2] 50/24 57/20
stuck [1] 43/22
such [2] 45/2 59/11
suddenly [3] 21/16 30/21 40/13
suggested [1] 41/10
suggestions [4] 28/2 60/1 62/17 62/21
suite [2] 6/24 7/1
summer [3] 20/18 20/24 55/1
support [24] 10/24 22/5 23/8 27/6 27/8 27/9 27/10 27/17 27/19 27/22 27/24 27/24 29/3 30/10 30/22 37/14 45/11 47/25 53/13 55/22 58/7 58/8 58/12 61/2
supported [1] 59/17
supportive [1] 2/8
supposed [3] 28/18 33/12 60/17
sure [10] 13/1 18/2 20/22 30/14 31/3 33/17 38/3 42/7 43/16 48/17
surgeon [3] 23/1 35/11 35/12
surgery [5] 6/6 7/10 15/21 39/17 47/21
surprise [2] 5/3 30/20
surprise/excitement [1] 30/20
surprised [1] 31/15
survival [1] 2/23
survive [1] 45/23
suspended [1] 26/15
suspicion [1] 25/22
swab [1] 3/12
swelling [1] 40/7
switch [1] 56/7
swollen [1] 51/24
system [3] 58/14 58/15 59/16

T

table [2] 6/1 6/3
take [18] 14/7 16/6 16/17 16/20 17/6 26/10 27/1 32/18 38/12 41/5 41/10 45/22 46/10 49/15 50/11 56/4 58/18 59/15
taken [14] 6/21 6/22 6/23 13/17 19/20 22/13 23/2 26/15 26/20 34/24 37/15 37/18 47/11 54/22
taking [5] 17/15 24/14 47/17 50/9 56/2
talk [3] 31/8 54/10 59/23
talking [1] 44/20
tall [1] 35/13
team [8] 16/5 16/6 16/7 23/5 23/9 27/11 27/16 48/5
tears [1] 30/20
tell [6] 25/18 40/13 43/10 51/19 56/15 58/25
telling [1] 58/10
temperature [1] 23/20
ten [1] 10/16
ten minutes [1] 10/16
tend [1] 56/11
tends [1] 52/5
term [2] 9/21 37/4
terms [1] 54/2
tested [1] 62/19
tests [2] 12/24 13/1
texted [1] 48/5
texting [1] 53/6
than [20] 2/2 2/19 9/11 10/10 16/2 26/7 28/4 28/11 28/14 30/17 36/20 37/9 37/11 51/19 53/14 56/18 58/3 60/3 60/10 60/13
thank [15] 1/11 29/7 29/8 29/12 29/19 61/7 61/9 61/22 62/7 62/16 62/21 62/22 62/24 63/2 63/5
thanking [1] 17/17
thanks [2] 61/14 62/2
that [263]
that - it [2] 28/14 60/13
that's [4] 1/7 1/10 53/18 53/22
theatre [11] 5/10 5/12 5/16 6/24 9/14 22/25 34/25 35/1 35/3 35/8 36/24
their [18] 3/4 8/12 8/25 9/10 9/11 9/24 10/3 11/21 14/2 20/2 36/19 36/20 42/13 42/17 51/24 56/13 56/14 62/20
them [50] 3/9 3/20 4/17 4/21 6/16 7/4 8/1 8/11 10/7 11/23 12/25 14/1 14/2 21/5 22/4 23/20 24/19 25/18 26/11 26/11 27/4 27/5 32/4 32/13 33/1 33/3 33/5 33/24 34/14 36/7 36/24 37/3 37/6 37/8 37/9 41/12 41/21 46/10 49/7 49/19 51/16 51/17 55/6 55/25 56/2 56/3 56/4 59/4 62/1 62/14
then [22] 2/5 6/14 6/21 9/23 18/8 25/1 25/25 26/11 27/10 30/17 37/6 38/6 38/15 39/11 47/11 48/1 50/25 54/23 55/11 58/22 58/25 61/13
theories [1] 52/5
there [104]
There's [1] 62/9
therefore [4] 19/21 22/20 34/21 50/13
these [6] 19/15 23/11 57/12 57/21 57/23 62/20
they [152]
thing [6] 19/12 42/10 43/14 43/15 49/24 55/18
things [18] 2/23 15/25 16/2 20/3 21/20 23/17 24/8 31/7 31/13 39/8 40/13 51/2 54/9 56/12 57/4 57/6 57/23 59/11
think [26] 2/3 6/14 8/4 9/13 12/5 16/1 16/24 19/2 21/21 24/23 25/2 25/17 26/16 26/23 29/10 33/3 36/23 38/13 43/16 44/19 49/8 51/7 51/25 56/24 57/3 57/4
thinking [3] 51/15 52/8 62/2
this [114]
thorough [2] 19/8 49/16
those [2] 54/4 59/20
though [8] 27/1 33/23 34/14 40/5 43/15 44/2 45/20 47/24
thought [14] 2/1 12/20 15/20 16/20 17/1 22/22 25/16 30/15 30/17 32/2 33/16 46/5 51/17 52/1
thoughtful [1] 62/18
three [13] 2/20 8/16 14/3 18/21 30/18 30/22 30/24 31/9 31/20 34/20 41/20 49/10 50/4
threshold [1] 39/20
thrive [1] 31/6
thrived [1] 62/5
through [26] 2/8 12/15 21/7 21/14 22/1 22/15 23/21 27/9 27/18 27/24 28/16 28/16 28/17 31/18 31/20 33/22 35/18 38/23 40/11 49/20 51/12 57/18 60/15 60/15 60/16 62/15
throughout [7] 3/17 4/14 6/2 9/19 23/8 32/10 33/2
Thursday [1] 63/8
tightening [1] 3/10
tightenings [1] 33/15
time [35] 8/6 12/3 13/7 13/24 14/21 16/25 18/19 21/18 22/18 23/9 23/25 24/11 25/23 27/9 28/6 34/3 38/1 38/11 39/19 41/4 41/7 42/3 42/8 44/5 48/9 52/14 52/16 52/18 53/8 53/25 56/13 59/4 59/11 60/5 62/2
timeframe [1] 10/1
times [6] 8/24 16/4 27/12 31/16 42/7 47/21
timescales [1] 55/3
today [2] 61/10 61/19
together [12] 2/9 14/2 14/4 17/15 22/9 26/9 26/12 38/15 41/19 41/21 47/13 47/16
toilet [2] 7/11 7/13
told [77]
tomorrow [1] 63/5
too [6] 13/20 19/23 20/14 33/24 52/4 53/22
took [19] 2/4 7/16 8/13 13/25 14/1 16/8 16/10 17/24 18/18 23/11 23/13 26/11 41/15 41/19 47/7 47/15 48/19 53/4 54/23
torn [1] 20/21
touch [1] 22/4
tough [1] 55/10
tour [1] 33/12
towards [2] 5/3 53/18
track [1] 33/3
traffic [1] 54/24
trained [1] 58/1
training [1] 40/15
transfer [3] 17/5 44/7 48/5
transferred [4] 17/7 47/22 48/1 62/4
transport [2] 16/6 44/8
trapped [1] 24/4
trauma [2] 22/7 59/14
traumatic [1] 59/11
traumatised [1] 13/20
travel [2] 3/22 32/5
treatment [6] 9/21 10/5 22/1 37/3 37/7 55/24
trial [25] 13/16 14/19 19/16 19/19 19/20 19/25 20/12 22/10 23/8 24/8 24/20 26/15 27/10 27/22 28/17 42/15 52/25 53/1 53/20 54/13 59/1 59/2 59/3 59/3 60/16
tried [6] 17/4 41/12 45/7 45/9 46/19 50/22
triplet [2] 4/17 23/22
triplet's [1] 2/21
triplets [11] 1/25 2/6 2/19 2/20 4/4 5/11 6/1 9/18 30/12 33/8 37/1
trouble [1] 15/7
true [1] 46/7
trust [3] 24/1 24/7 35/18
try [8] 38/1 40/1 41/5 46/11 47/2 50/17 51/19 58/9
trying [5] 12/5 40/18 50/23 55/21 58/19
tube [2] 10/25 38/20
tubes [2] 39/9 44/2
tutorial [1] 44/3
twice [1] 8/5
two [12] 2/19 2/22 3/1 7/23 8/10 8/24 30/14 30/17 32/21 49/9 58/3 62/13

U

ultrasound [1] 2/4
unable [1] 56/7
unaware [1] 58/22
unclear [1] 19/7
uncommon [1] 10/25
underestimate [1] 61/12
understand [11] 1/5 1/8 4/14 28/5 47/5 51/10 52/11 52/21 58/15 60/4 61/18
understood [2] 9/24 13/1
underway [1] 58/21
undetected [1] 12/21
undiagnosed [1] 14/5
uneasy [1] 35/5
unexplained [1] 18/22

U

unfortunately [2] 5/21 57/13
unhygienic [1] 35/6
unit [67]
Unit - which [1] 26/22
unless [1] 49/6
unlikely [3] 3/19 32/2 32/13
until [7] 7/5 13/15 24/19 56/7 58/22 59/3 63/7
untoward [1] 26/25
unusual [2] 6/20 9/6
unwell [2] 14/20 56/2
up [31] 6/4 6/6 6/7 6/23 11/25 13/2 22/22 23/11 24/12 24/16 28/11 33/12 36/12 36/18 39/13 39/23 41/16 42/19 43/21 43/25 44/15 47/1 50/14 50/19 52/16 53/15 54/4 55/17 56/7 56/15 60/10
updated [1] 47/2
upset [6] 17/16 26/8 47/3 48/11 52/22 56/20
upsets [1] 57/5
upstairs [1] 37/22
us [63] 2/12 2/17 4/11 8/11 9/13 11/5 11/20 13/3 14/9 16/18 17/23 17/25 18/1 21/8 24/10 24/16 25/2 25/10 25/18 25/21 26/1 26/19 27/15 28/13 28/19 29/11 30/21 33/13 34/2 34/8 34/11 35/19 36/24 38/9 40/13 41/11 42/2 45/8 46/14 47/2 47/3 47/4 48/5 48/14 48/15 48/19 48/19 49/4 49/23 50/20 52/13 52/14 52/19 53/19 54/18 54/23 55/3 58/10 58/19 58/19 58/25 60/12 60/18
use [2] 41/1 41/2
used [6] 7/18 9/22 37/4 54/8 56/18 56/19
ushered [1] 39/11
using [1] 43/25
usually [3] 41/2 56/25 57/6
utterly [1] 58/4

V

validation [1] 51/5
various [1] 57/9
veins [3] 40/11 56/14 56/14
verdict [5] 20/13 21/1 21/10 55/1 55/13
very [43] 1/11 2/8 3/11 3/19 5/22 6/3 14/10 14/20 16/9 18/23 21/3 21/14 21/16 22/16 22/25 23/5 24/16 29/8 32/13 33/19 35/5 35/12 36/17 47/2 47/16 49/19 50/14 50/16 52/12 53/9 55/25 56/5 59/7 59/10 59/13 61/7 61/9 61/22 61/24 62/6 62/20 62/21 63/2
via [2] 23/10 23/12
Victim [3] 1/19 29/24 57/15
video [2] 19/24 54/13
view [1] 26/19
views [1] 62/20
vigorously [1] 52/4
virus [1] 12/21
visibly [2] 26/8 52/21
visions [1] 56/10
visit [2] 8/23 10/13
visiting [2] 8/24 37/24
visitor [2] 10/13 38/10
vivid [1] 56/5
vividly [1] 61/24
vocalise [1] 52/4
volume [1] 39/23
vu [1] 43/3

W

wait [4] 39/24 44/8 44/9 55/4
waited [2] 40/3 55/8
waiting [6] 19/14 20/16 20/25 20/25 21/5 31/17
walk [3] 5/11 7/13 7/14
walked [4] 11/5 35/4 38/15 38/23
wall [2] 6/8 36/3
want [8] 8/2 14/7 22/24 28/8 35/25 51/21 54/15 60/7
wanted [13] 3/5 7/24 8/20 11/2 13/2 13/19 31/7 31/9 31/11 40/19 45/10 46/21 46/24
ward [18] 5/12 7/6 7/12 10/15 10/17 12/2 14/23 17/23 18/4 26/16 37/18 39/13 41/4 41/22 42/6 42/10 42/19 47/12
warned [3] 3/21 32/4 35/24
was [439]
was February [1] 19/19
wash [2] 18/7 48/22
wasn't [20] 5/22 7/4 12/22 14/21 17/8 17/10 21/25 22/23 33/20 34/5 41/25 45/21 46/25 47/1 47/22 50/7 50/14 51/3 51/20 53/2
watch [4] 15/15 35/25 53/2 54/8
watched [3] 19/24 35/22 36/5
watching [1] 43/18
way [10] 2/15 17/9 22/16 30/22 31/18 38/16 51/24 54/7 55/11 58/14
we [231]
we're [1] 29/10
Wednesday [1] 1/1
week [5] 5/20 19/20 30/12 53/6 53/11
weekend [1] 56/6
weekly [1] 3/1
weeks [14] 2/5 3/1 3/3 3/6 3/10 4/18 5/10 18/21 32/21 33/4 33/16 49/10 50/5 54/24
weights [6] 8/12 9/10 9/11 36/17 36/19 36/20
welcome [1] 30/24
well [11] 3/7 5/21 9/19 25/12 30/22 31/16 35/20 37/2 42/13 56/6 62/11
went [43] 1/25 3/11 3/25 6/8 7/6 7/20 11/9 11/18 12/21 13/10 14/13 14/23 14/24 15/2 15/11 15/12 17/22 19/21 20/8 20/20 21/18 22/15 27/22 30/3 30/7 33/22 34/25 36/2 36/12 37/2 37/19 37/22 39/13 39/19 39/25 42/9 42/19 44/5 48/10 48/13 52/14 55/7 57/18
were [175]
weren't [5] 13/3 33/19 46/2 51/8 52/11
what [68]
wheelchair [10] 11/5 11/15 12/12 15/3 17/22 39/16 39/19 39/23 43/23 48/13
wheeled [1] 39/17
when [59] 1/11 1/25 3/25 4/24 6/4 6/6 6/16 7/8 10/5 11/11 12/8 13/10 17/20 19/14 19/19 20/5 20/13 21/8 22/25 23/19 23/20 24/2 24/21 25/14 26/6 26/8 27/22 28/10 29/11 29/16 30/6 33/18 35/4 35/6 36/9 38/23 39/1 39/2 39/20 40/20 42/25 45/1 46/14 48/12 49/6 52/6 52/22 52/22 53/18 53/22 55/2 55/23 56/8 57/3 57/21 58/16 58/20 60/9 62/2
where [12] 7/13 13/25 38/14 41/5 44/1 44/18 54/9 56/15 56/23 58/3 58/16 62/5
whereas [2] 16/4 57/6
whether [1] 40/19
which [18] 13/1 18/19 23/11 23/17 24/14 26/22 32/22 41/1 41/23 45/11 47/4 50/17 53/18 54/1 54/20 56/14 58/10 58/18
while [8] 7/16 23/13 30/13 33/25 41/17 44/11 55/8 56/23
whilst [5] 7/3 14/25 16/16 17/13 36/11
white [1] 54/6
who [22] 8/20 9/13 10/18 18/24 21/4 22/5 23/9 26/4 29/1 29/4 30/2 32/25 32/25 35/14 36/22 36/23 38/16 50/4 59/14 59/21 60/25 61/3
whole [2] 23/21 35/23
whose [3] 13/18 29/5 61/4
why [11] 9/2 10/20 17/4 22/14 40/13 44/16 47/23 51/13 52/11 53/25 61/19
wider [1] 25/14
will [8] 1/16 24/15 29/17 29/21 59/13 62/13 63/4 63/4
willing [2] 17/10 53/10
wish [1] 57/16
Within [2] 28/17 60/16
without [2] 23/14 57/24
witness [4] 1/14 19/17 53/2 53/17
witnessed [1] 56/23
witnesses [2] 20/5 62/19
Women [17] 2/14 2/18 13/11 16/6 16/18 17/7 17/18 17/20 18/20 27/12 31/10 32/23 44/7 45/1 45/23 46/1 47/19
Women's [4] 2/11 31/3 48/12 62/4
word [2] 11/18 44/22
words [1] 46/8
wore [1] 5/8
work [3] 32/17 32/19 50/23
worked [1] 58/15
working [3] 32/15 45/7 52/22
worried [4] 2/7 14/10 24/5 53/15
worries [1] 57/5
worry [4] 10/23 42/14 49/6 49/7
worrying [1] 44/23
worse [3] 28/14 55/21 60/13
would [53] 2/7 2/8 3/4 3/17 3/20 3/22 4/7 4/11 4/15 6/11 6/12 9/14 9/23 10/2 10/3 12/16 15/10 15/19 18/25 19/15 20/17 25/5 27/4 30/21 31/20 32/3 32/4 32/10 32/13 32/13 32/18 33/9 34/22 35/16 38/12 39/12 40/18 41/11 42/3 42/4 44/6 46/6 46/16 47/2 47/6 49/15 50/2 54/21 55/24 57/6 57/12 59/9 61/14
wouldn't [3] 24/6 45/23 56/25
written [1] 54/3
wrong [15] 10/6 12/20 16/22 17/1 25/10 37/7 40/6 40/14 43/6 46/4 51/15 51/23 57/22 58/2 58/11

Y

years [3] 24/3 27/23 54/4
yes [3] 62/7 62/9 62/9
yet [1] 62/2
you [33] 1/8 1/11 10/13 29/7 29/8 29/11 29/11 29/12 29/16 29/19 35/6 38/9 38/23 61/7 61/9 61/14 61/19 61/20 61/22 61/23 61/24 62/1 62/2 62/3

Y

you... [9] 62/12 62/15 62/16 62/17 62/21 62/23 62/24 63/2 63/5
you're [1] 1/12
young [2] 34/16 35/12
youngest [2] 22/17 22/20
youngish [1] 44/14
your [7] 61/11 61/24 62/2 62/11 62/12 62/12 62/14