1 Thursday, 3 October 2024
2 **(10.00 am)**
3 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
4 **MR DE LA POER:** My Lady, our first witness today is
5 Dr Newby. May I ask her to come forward, please.
6 **LADY JUSTICE THIRLWALL:** Thank you.
7 DR ELIZABETH NEWBY (affirmed)
8 Questioned by MR DE LA POER
9 **LADY JUSTICE THIRLWALL:** Thank you very much,
10 Dr Newby, it is not easy but now you have got the oath
11 out of the way, do sit down.
12 **A.** Thank you.
13 **MR DE LA POER:** Dr Newby, can you confirm that you
14 have given a witness statement to the Inquiry dated
15 4 June 2024?
16 **A.** I have.
17 **Q.** Is the content of that witness statement true
18 to the best of your knowledge and belief?
19 **A.** It is.
20 **Q.** We are going to begin by briefly reviewing
21 your medical career. You qualified in 1998; is that
22 right?
23 **A.** I qualified from medical school in 95.
24 **Q.** You subsequently undertook paediatric training
25 at a number of hospitals, including Alder Hey on

1 a number of occasions, Manchester Children's Hospital
2 and Liverpool Women's Hospital?
3 **A.** Yes, that's correct.
4 **Q.** You joined the Countess of Chester Hospital in
5 2005 in general paediatrics and neonatology; is that
6 correct?
7 **A.** Yes. Yes, I -- I did my final training post
8 at the Countess in 2005 and then I became a Consultant
9 there in 2006.
10 **Q.** So does it follow from that that you had more
11 than a decade of experience working in the paediatric
12 department and indeed the neonatal unit before
13 June 2015, most of which time you were a Consultant?
14 **A.** That's correct, yes.
15 **Q.** Whilst you were working at the Countess of
16 Chester, did you sit on the Medicines Management
17 Committee?
18 **A.** I did.
19 **Q.** Now, a case that we have heard something about
20 involved a nurse being convicted of murdering patients
21 at Stepping Hill?
22 **A.** Mmm hmm.
23 **Q.** Was that something whilst you were at the
24 Countess that you were aware of?
25 **A.** Yes.

1 **Q.** We know that that particular nurse was
2 administering drugs as a weapon against patients?
3 **A.** Mm-hm.
4 **Q.** Did the Medicine Management Committee ever
5 discuss that case that you can recall to talk about how
6 there may be steps to be taken to put further
7 protections in place for medicines?
8 **A.** No, no. I suppose the remit of that committee
9 was to look at new guidance that was produced within the
10 hospital that pertained to treatments which would
11 include drugs, et cetera, and to discuss any issues
12 around those drugs from a pharmacy point of view,
13 procurement, supply, et cetera, administration.
14 **Q.** So management didn't include, for that
15 committee's purpose --
16 **A.** No.
17 **Q.** -- risk management --
18 **A.** No.
19 **Q.** -- in relation to medicines?
20 **A.** No.
21 **Q.** Thank you very much.
22 Returning to your career, you left the Countess of
23 Chester in February of 2016; is that right?
24 **A.** Yes.
25 **Q.** You took up a Consultant post at Stockport NHS

1 Foundation Trust?
2 **A.** Yes.
3 **Q.** At least as at the date of your witness
4 statement, you were still there?
5 **A.** I am still there, yes.
6 **Q.** Is your role the Clinical Director of
7 Paediatrics?
8 **A.** It is.
9 **Q.** I have already mentioned the Stepping Hill
10 Hospital. That's the hospital within the Foundation
11 Trust that you moved to in the spring of 2016?
12 **A.** (Nods)
13 **Q.** Although we are jumping in a sense to the end
14 of our timeline here as we are dealing with your career,
15 when you arrived at Stepping Hill it was less than
16 a year after the nurse had been sentenced for using
17 medicines as a weapon?
18 **A.** (Nods)
19 **Q.** Was that a topic of conversation within
20 Stepping Hill at that time?
21 **A.** Yes, to some degree still, yes, it had been
22 relatively recent, yes.
23 **Q.** When you arrived there and were among the
24 people who were directly witness, many of them, to those
25 events, did that provoke any thought process on your

1 part about the experience that you had just had at the
2 Countess of Chester?
3 **A.** Yes, yes, of course. I -- the -- the case
4 in -- in Stockport, I believe, there had been some a lot
5 of evidence, there was insulin missing, insulin found,
6 et cetera. There was a lot more procedures in place in
7 Stockport around drug safety, lock -- you know,
8 medicines locked away et cetera as a result of that,
9 that incident.
10 **Q.** So I suppose one specific thought process that
11 may have occurred to you, and you tell us whether it
12 did, is I wonder if insulin was being used at the
13 Countess of Chester and whether that might have
14 explained the experience that you had just had. Was
15 that a thought process that you had?
16 **A.** I -- at that time I didn't believe -- I didn't
17 think of insulin, no.
18 **Q.** So we will come and have a look at the detail
19 of each of the events at the Countess. But before we
20 do, let's just deal with -- here it is paragraph 5 of
21 your witness statement if you want to turn it up, so we
22 are just going to deal with some particular matters
23 relating to the arrangements and situation at the
24 Countess of Chester.
25 The first matter you deal with is you talk about

1 the divisional structure and we have heard something
2 about this already but in summary, the Inquiry knows
3 that there came a point in time when the paediatric
4 department was put in the Urgent Care Division and that
5 resulted in it being separated in terms of the
6 divisional structure from the obstetrics --
7 **A.** Yes.
8 **Q.** -- which was in Planned Care?
9 **A.** Yes.
10 **Q.** Just tell us from your perspective, whether
11 you thought firstly that that change was a good thing?
12 **A.** No. We -- we were all quite concerned about
13 it at the time because of the -- the obvious link
14 between obstetrics and neonates and a lot of the need
15 for shared risk and governance and being in two
16 different divisions seemed to make that difficult,
17 really.
18 **Q.** Was that something that you or any of your
19 Consultant colleagues to your knowledge raised at the
20 time?
21 **A.** I believe so, yes.
22 **Q.** Do you know with whom it was raised? Was it
23 just raised within the division or do you know whether
24 that concern went higher than that?
25 **A.** I don't know if it went higher.

1 **LADY JUSTICE THIRLWALL:** Where did the idea come
2 from?
3 **A.** I don't know, to be perfectly honest.
4 **LADY JUSTICE THIRLWALL:** I'm sorry to ask you that
5 out of the blue.
6 **A.** No, no it's okay. I think it was to -- I this
7 is an assumption, but to sort of streamline the -- the
8 number and layers of management tiers.
9 **LADY JUSTICE THIRLWALL:** Thank you.
10 **MR DE LA POER:** Speaking in general terms, do you
11 think that divisional change made any impact, positive
12 or negative, on how the events on the neonatal unit were
13 managed and resolved whilst you were there?
14 **A.** I -- I think it -- I think it perhaps gave us
15 less of a voice at the table higher up, if you like.
16 When we were a separate division and we were Women's and
17 Children, we -- you know, we were more equal in a way
18 to the medical or the surgical division and then we got
19 swallowed -- that's not really the right word, but
20 swallowed up into Urgent and Planned Care and I think
21 that probably made things difficult, yes.
22 **Q.** Staying with general matters of operation and
23 practice. Just dealing very briefly with the debrief
24 process that took place on the ward: you tell us in your
25 witness statement -- you don't need to turn it up unless

1 you want to, and I will give you the reference if you
2 do, but it was usual to have a debrief after a death but
3 not after non-fatal collapses?
4 **A.** Yes, I suppose -- I suppose that would be the
5 case. I -- I don't know if that would be the case now
6 but I think that was, that was the case at the time,
7 yes.
8 **Q.** Staying with the formal response to particular
9 incidents, I would just like to ask you a few questions
10 about the Datix system.
11 **A.** Mm-hm.
12 **Q.** In your own words, what was your understanding
13 at the time about when it was appropriate to fill in
14 a Datix form?
15 **A.** So if you were concerned that care hadn't gone
16 as it should have done and there was something
17 particular that you wanted to highlight, for example
18 a drug error or an administration error or a piece of
19 equipment that was faulty during a resus situation which
20 would have impacted on the teams' ability to manage that
21 patient.
22 **Q.** What about being specific here. If there was
23 a sudden and unexpected death on the neonatal unit but
24 there weren't any identified at the time, errors of
25 care, would that serious event in and of itself prompt

1 a Datix?
2 **A.** Yes, it would, yes. Yes. Certain serious
3 events would produce -- would always produce a Datix
4 anyway because whether there was anything apparent at
5 the time, it may be that things become apparent when
6 that case is reviewed.
7 **Q.** What about where there is a very serious but
8 non-fatal collapse, perhaps requiring resuscitation.
9 Was that a sufficiently serious event that it could
10 prompt a Datix even if there was no error in care or
11 potential error in care identified?
12 **A.** I think that would probably be a little bit
13 more of a grey area. Some people might say yes, some
14 people might say no.
15 **Q.** Had you received any formal training and
16 refresher training about the filling in of Datixes or
17 was this just a culture that developed and feeding off
18 your colleagues and seeing what they did?
19 **A.** Yes, it was something that we -- we did in our
20 every day practice. The Datix system is clunky, I think
21 is the right word. It -- in filling in a Datix it can
22 be quite difficult to do it because the system only
23 allows for a number of drop down boxes and you have to
24 kind of put your incident into a category and sometimes
25 you think, well, the category doesn't exist for this

1 incident.
2 So it's -- it can be quite a difficult system to
3 work with sometimes.
4 **Q.** Whose responsibility did you understand it to
5 be to fill in a Datix when an event requiring one
6 occurred?
7 **A.** So if it -- so it's everybody's responsibility
8 to submit and fill in Datix at the end of the day if
9 they have flagged up something that's of concern. But
10 I suppose things like deaths which were serious
11 incidents, they -- it would tend to be the shift leader
12 or the nurse in charge after the -- after the death
13 because the -- the medical staff and the nursing staff
14 were -- were busy dealing with the aftermath and so on.
15 **Q.** In your experience, was there any
16 co-ordination between people who were involved in an
17 instance where a Datix might be needed to say "This is
18 going to need a Datix, would you mind being the one to
19 fill it in or will you make sure that one is filled in?"
20 Did that sort of conversation happen or was it just
21 assumed people would go back to their places of work and
22 some or more of them may fill in such a form?
23 **A.** No, we would have just expected that would
24 have happened because it was -- it was a mandatory
25 reportable Datix.

1 **Q.** But you would have expected the nursing staff
2 or the nursing managers to do it --
3 **A.** Yes.
4 **Q.** -- rather than it being your responsibility in
5 that situation?
6 **A.** Yes.
7 **Q.** Dealing with relationships within the
8 department and you deal with this at your paragraphs 16
9 and following if you want to turn it up. That's on
10 page 4.
11 **A.** Mm-hm.
12 **Q.** You say this:
13 "I felt that, as a group of Consultants we had
14 a good relationship with the paediatric and neonatal
15 nursing teams."
16 **A.** (Nods)
17 **Q.** Now, I would just like to give you
18 an alternative perspective on that for your comment.
19 Eirian Powell, the nursing manager, has suggested that
20 "Consultants thought all staff members worked cohesively
21 because staff did exactly what they were told to do by
22 the Consultants without challenging them".
23 What would be your reaction or comment on that
24 characterisation of the relationship?
25 **A.** I -- I am quite surprised at that, to be

1 honest. That wasn't the impression I had at all.
2 **Q.** She suggests that doctors were quick to
3 criticise nurses when errors were made. Again was that
4 your experience?
5 **A.** No.
6 **Q.** You were also asked to comment about the
7 relationship with management. Now, you didn't have any
8 managerial role yourself, so what was your impression
9 about the attitude of the paediatric Consultant body
10 about the senior managers in terms of how receptive they
11 were, how engaged they were, how helpful they were,
12 those sort of things? Was there a shared opinion about
13 senior management and how approachable they were?
14 **A.** So I suppose I -- as you say, I wasn't in
15 a leadership role at the time so I was a little bit
16 removed from it. Dr Jayaram was the Clinical Director
17 at the time. But there was always the impression that
18 paediatrics didn't have much of a voice at the table.
19 I think that can be true up to a point in quite
20 a lot of district general hospitals. It's quite a small
21 part of the hospital, if you like, compared to the
22 larger adult medical and surgical specialties.
23 But I think my experience in Chester is different
24 to my experience in Stockport from that point of view.
25 **Q.** That precisely anticipated my next question.

1 You describe in light of your experience at
2 Stockport that the culture at the Countess was, to use
3 your word, "impersonal"?
4 **A.** Yes.
5 **Q.** I was just going to ask you just to amplify
6 what you mean by that, please?
7 **A.** I suppose it -- that the -- the higher
8 management tiers, it didn't feel welcoming, it didn't
9 feel like you would -- you know, you would just walk up
10 and bang on their door and say "I have got a problem".
11 You know, they seemed perhaps a bit detached and
12 not visible.
13 **Q.** So we are going to turn in a moment to look at
14 the timeline of events, starting in 2015, but just two
15 areas of policy and procedure to ask you about. The
16 first is safeguarding training?
17 **A.** Mm-hm.
18 **Q.** Now had you received safeguarding training
19 whilst you were at the Countess of Chester?
20 **A.** Yes, we -- we all underwent mandatory
21 safeguarding training, yes.
22 **Q.** Were you aware, if not of the detail, but of
23 the generality of working together?
24 **A.** Yes.
25 **Q.** Had you had any specific training in relation

1 to what to do if you suspected a member of staff of
2 posing a threat to patients?
3 **A.** No.
4 **Q.** Looking back on it now, do you think that is
5 something that you should have had some training on?
6 **A.** Yes.
7 **Q.** How did you view the role of the safeguarding
8 department within the hospital, what did you think it
9 was there for?
10 **A.** To give advice on safeguarding matters. We
11 would go to our safeguarding team to discuss children
12 that we had seen on the ward, where there was perhaps
13 an allegation of physical abuse, for example.
14 **Q.** The way you were thinking about safeguarding
15 at the time, did you view a member of staff posing
16 a risk to a patient, particularly a vulnerable neonate,
17 as being a safeguarding issue?
18 **A.** I -- I suppose I didn't think about it that
19 way at the time. But it obviously is, it is. Yes.
20 **Q.** Just trying to get under --
21 **A.** Yes.
22 **Q.** -- why that might be the case. Why do you,
23 what do you think the explanation is for why you didn't
24 view it in safeguarding terms?
25 **A.** I suppose a -- a safeguarding investigation

1 would be led by social care, children's social care,
2 whereas in my head I supposed I perceived that if it was
3 a matter of wrongdoing and harm being caused by a member
4 of staff, then that was a police matter.
5 **Q.** Were you aware that in a multi agency response
6 to a safeguarding, you get both --
7 **A.** Yes, of course.
8 **Q.** -- the local authority and the police?
9 **A.** Of course yes, of course. No, I completely
10 understand the police would be involved in a section 47
11 investigation.
12 **Q.** The second area of policy and procedure is
13 Sudden Unexpected Death in Infancy and Childhood and
14 procedure and you deal with this in your witness
15 statement so we can take it reasonably shortly,
16 I believe, but was your position understanding at the
17 time that the SUDiC process didn't apply to babies who
18 died in hospital?
19 **A.** I suppose, no, no. No. No.
20 **Q.** Have you followed any of the Inquiry evidence
21 that has pointed to Working Together and the
22 Pan Cheshire guidance?
23 **A.** (Nods)
24 **Q.** Can you see the point that's being made about
25 that?

1 **A.** Yes, of course, of course, yes.
2 **Q.** So again just trying to understand how you may
3 have come to understand that it didn't apply, what do
4 you think the explanation for that is?
5 **A.** So for the Child D whose -- whose death I was
6 involved with, I felt at the time that the correct
7 course of action was to phone the Coroner and discuss
8 the unexpected death with the Coroner as I felt at the
9 time I was working within -- although it was very
10 unexpected, that I was working within a medical model,
11 there was evidence of sepsis and I -- you know,
12 although, although it was unexpected, she had been
13 unwell and therefore I -- I discussed that with the
14 Coroner and I thought I was working within that model
15 rather than it was a completely unexpected and
16 unexplained death.
17 **Q.** We are going to come and have a look in
18 a little bit more detail of Child D now, so I think that
19 would be convenient for us to do.
20 You deal with your involvement in Child D's care
21 from paragraph 27?
22 **A.** Mmm mm.
23 **Q.** Which is on page 6 of your witness statement.
24 What you tell us is that you have some -- and I am
25 looking here at paragraph 28 -- independent recall of

1 the case, although you have of course provided
2 statements to both Coroner and the police about Child D
3 as you say, as the 24 hours was so difficult and
4 therefore memorable, can you just help us to understand
5 what stood out in terms of your memory of that last
6 24 hours and why it is that period is still with you
7 today?
8 **A.** We -- you know, it's very unusual to get
9 a death on a neonatal unit, particularly a child that's
10 not known, for example, to have significant congenital
11 abnormalities.
12 It was -- it was a very difficult and traumatic
13 event that night for all the staff that were dealing
14 with it.
15 **Q.** Your response, as you tell us, to those very
16 difficult circumstances once Child D had died was to
17 contact the Coroner?
18 **A.** Mm-hm.
19 **Q.** Just help us with what your discussion was,
20 what it was that you wanted to tell the Coroner or the
21 Coroner's office, officer, about the death and what you
22 were expecting to happen as a result of that
23 conversation?
24 **A.** So I would have -- I can't remember the -- the
25 details of the conversation, to be honest, but my --

1 I would have discussed -- I would have given him the
2 case history and discussed that I couldn't, that it was
3 an unexpected event that I couldn't fully explain and
4 I would, and I -- I -- I wanted a postmortem in order to
5 for everybody, really, for myself and for the family
6 to -- to help everybody to understand what had happened.
7 **Q.** One of the things you say in terms is that
8 this as a death was unexpected?
9 **A.** Yes.
10 **Q.** Having had your conversation with the Coroner,
11 did you also discuss it later that morning, the case,
12 with Dr Brearey?
13 **A.** I did, yes.
14 **Q.** Was Dr Brearey's view based on what you told
15 him that it was the death had most likely been caused by
16 sepsis?
17 **A.** (Nods)
18 **Q.** Was that a view that at the time, not being
19 a firm conclusion, that you tended to agree with?
20 **A.** I did, yes.
21 **Q.** Did the discussion include what you describe
22 as lesions on Child D's abdomen?
23 **A.** Yes.
24 **Q.** What you tell us at paragraph 33 is that you
25 tried to arrange an immediate debrief, you say you don't

1 recall that but having looked at the email
2 correspondence?
3 **A.** Yes, I obviously did.
4 **Q.** That is --
5 **A.** Yes.
6 **Q.** But you don't have a recollection of whether
7 or not that debrief took place?
8 **A.** I think, I think I don't recall, I think
9 I don't recall it because it didn't take place in the
10 end. Everybody worked shifts, the nursing staff, the --
11 the trainees and I think I -- I must have tried to
12 arrange it but in the end it was impossible to get
13 everybody together, for everybody's shifts patterns to
14 align and it didn't and it never came together.
15 **Q.** Should there have been a debrief? I mean, how
16 important was --
17 **A.** It's definitely -- without a doubt it is good
18 practice to have a debrief it allows people that --
19 a safe space after an event to -- to offload a little
20 bit because it's -- you know, these events are very
21 traumatic. So it allows for some offloading and some
22 emotional support. But also for people to say and bring
23 any immediate thoughts to the table about what could
24 have done better or what went well.
25 **Q.** Of course the context for Child D's death was

1 that just earlier in the month Child A had died and
2 Child C had died and we also know, and we will come to
3 in a moment, Child B had collapsed. Were you aware of
4 those -- those events even if you weren't directly
5 involved in them yourself?
6 **A.** Yes.
7 **Q.** So Child D's death compounded, is this fair to
8 say, what everybody was feeling in terms of the distress
9 and worry about those events?
10 **A.** Yes.
11 **Q.** So is it fair to say that in those
12 circumstances at the very least it is unfortunate that
13 there was no debrief for everybody to come together --
14 **A.** Yes.
15 **Q.** -- and decompress?
16 **A.** Yes, I -- we wouldn't, we didn't manage to
17 come together as a group but I certainly would have had
18 individual conversations with people.
19 **Q.** We are going to look at some of those in
20 a moment. In fact, we will come to one now.
21 You are aware that Dr Lambie says that she spoke to
22 you, just paraphrasing what she said, that it was some
23 time later, and that she says that you were very
24 interested in the sudden colour change that you had
25 observed and that you said that you had witnessed

1 something similar in another infant patient around the
2 same time.
3 Do you have a recollection of that conversation and
4 what you might have been talking about?
5 **A.** I don't, to be honest. I don't recall seeing
6 the lesions in another patient, no.
7 **Q.** Was the rash something that at the time from
8 a medical point of view you were very interested in?
9 **A.** Yes.
10 **Q.** Or interested to understand?
11 **A.** Oh no, yes, yes, we spent a lot of time
12 discussing it on -- on the night of the events myself
13 and the Registrar that was on -- on-call spent some time
14 discussing what could possibly be the aetiology of it
15 and we did as a group afterwards as well.
16 **Q.** Do you know who that Registrar was?
17 **A.** Dr Brunton.
18 **Q.** Doctor?
19 **A.** Brunton.
20 **Q.** Brunton, thank you. We are going to move
21 forward to 23 June and an email and I wonder if this can
22 be brought on screen at INQ0025743.
23 If we can go to page 2, please, this is an email
24 which you are sent by Dr Gibbs?
25 **A.** Mm-hm.

1 **Q.** And he talks about, and we don't need to go
2 over all the detail, I hope that you recollect from the
3 papers the Inquiry provided you with seeing this email.
4 But he is raising the fact that Dr Lambie had come to
5 see him and was very concerned about all four cases
6 A,B,C and D and drawing attention to the strange
7 purpuric looking rash, as he describes it?
8 **A.** (Nods)
9 **Q.** He goes on to say that the junior doctors were
10 looking for something to be done about it.
11 **A.** Mm-hm.
12 **Q.** What was your feeling at the time about
13 whether something should be done about these four cases?
14 **A.** Yes. No, no, definitely, I knew that the
15 trainees were very concerned about it and we were very
16 concerned about it as well.
17 Each baby had appeared to be infected, septic, we,
18 we were concerned that we had some bug on the unit,
19 maybe contamination of some equipment, one of the
20 ventilators, for example, so we were extremely concerned
21 about it.
22 **Q.** If we scroll up, we might need to stay on the
23 full page view because it is the bottom of the page that
24 we will be interested in, we are going to see an email
25 from you. So if we go to the -- we can see you reply

1 copying all your colleagues in to it: I agree, you say.
2 "I have just been grilled by Dave Harkness."
3 Dr Harkness?
4 **A.** Mm-hm.
5 **Q.** "This is causing a lot of concern/upset. Can
6 we pull something together fairly soon? I think we need
7 to meet with both, probably separately would be better."
8 What do you recollect that Dr Harkness was saying
9 to you?
10 **A.** That he was also -- that he was also obviously
11 very concerned about the three deaths and he also
12 mentioned the link between the -- the rashes that were
13 seen on each baby.
14 **Q.** Thank you. We can take that down but we are
15 going to put another document up and we are going to
16 move forward about a month in time. This is INQ0036166.
17 If we go, this is a meeting, so you can see between
18 the senior clinicians, you are indicated as being
19 present second from the top of the list, and if we go
20 over the page, there are a number of matters discussed
21 at that meeting on 29 June, I think I said we move
22 forward a month; in fact we have only moved forward
23 three days.
24 If we look at three paragraphs up from the bottom:
25 "There was also an issue raised around the fact

1 that the three recent neonatal deaths, the Registrars
2 had been quite worried and felt nothing had been done.
3 Behind the scenes reviews are going on but it was felt
4 that formal debriefs would probably take place rather
5 than any specific meeting to discuss all three."
6 So that's the discussion between you all as
7 recorded in the notes?
8 **A.** Mm-hm.
9 **Q.** Are you able to help us with why it wasn't
10 thought a good idea to discuss all three deaths
11 together?
12 **A.** No, I don't -- I don't know. I don't recall
13 that. I do -- I do recall a decision being taken to ask
14 Dr Subhedar, who is one of the Consultant neonatologists
15 at the Liverpool Women's Hospital to come and review
16 them all.
17 So no, I -- I don't know what I can't recall that.
18 **Q.** Thank you, that can come down.
19 If we move forward in your witness statement to
20 paragraph 37, which is where you deal with a Neonatal
21 Mortality Meeting on that, on 29 July. There was
22 a review of Child D's death.
23 You talk there about the discussion which took
24 place and in the final sentence of paragraph 38, you say
25 the consensus at that time, and pending Dr Subhedar's

1 review and any other investigation that was ongoing, was
2 it was likely that Child D had died of sepsis?
3 **A.** Mm-hm.
4 **Q.** It also appears, and we can bring up the INQ
5 at this point, 0003297, please, that Child D is the one
6 just over the page, we don't need to turn to that.
7 We can see that Child C's death was discussed?
8 **A.** Mm-hm.
9 **Q.** We can see at the top the period of assessment
10 is June 2015. Taking that on its face, that would
11 include Child A's death?
12 **A.** Mmm.
13 **Q.** But Child A doesn't appear to have been
14 discussed at the meeting?
15 **A.** Mmm.
16 **Q.** We have just looked at a meeting that happened
17 a month earlier where it seems to have been resolved
18 that all three deaths wouldn't be considered at the same
19 meeting. Are you able to shed any light on why Child A
20 wasn't also discussed where the period of assessment
21 appears to include the date of Child A's death?
22 **A.** I don't know to be honest. I really don't.
23 **Q.** Can you, sitting here now, see any advantage
24 of all three deaths possibly with Child B as well-being
25 discussed given what had been said in the earlier

1 emails, all being discussed together formally being
2 minuted and everybody sharing their different
3 impressions, thoughts and plans for how it should be
4 managed, can you see that as being a good thing?
5 **A.** Of course, yes.
6 **Q.** So if we take that down, we will move forward
7 in our chronology. Child E was murdered on 4 August.
8 **A.** (Nods)
9 **Q.** On 5 August, Child F experienced
10 a deterioration. Now, I don't think you were involved
11 in the care of Child F at that time but I just want to
12 ask you about something that Dr Gibbs has said about it.
13 Are you aware of the insulin and C-peptide result that
14 came in a week later from the Liverpool laboratory?
15 **A.** I wasn't aware of it until almost -- after
16 Letby was arrested and we were coming up to the trial.
17 **Q.** Dr Gibbs has characterised that as
18 a collective failure of the Consultants. Is that
19 an opinion that you would subscribe to too?
20 **A.** At the end of the day it was there, it was
21 a result that was in the department and any of us could
22 have looked at it at any time.
23 **Q.** We will move forward, please, to a meeting
24 that you had with the parents of Child D. The Mother of
25 Child D has given evidence and I just want to tell you

1 what she has said.
2 She said that you told her that the evidence
3 pointed towards sepsis?
4 **A.** Mmm mm.
5 **Q.** She said, "what were the test results? Did
6 she have an infection?"
7 **A.** Mm-hm.
8 **Q.** Her recollection is that you replied "no, she
9 didn't", and then she goes on to say you couldn't
10 explain.
11 **A.** Yes.
12 **Q.** Now doing the best you can, do you have
13 a recollection of meeting the Mother of --
14 **A.** I do definitely remember meeting with the
15 parents, yes, yes.
16 **Q.** And just having heard what her recollection of
17 events is, do you have a recollection of saying that,
18 does that sound like something that you might have said
19 based upon the facts or do you remember things
20 differently?
21 **A.** I think I would have been explaining about
22 blood culture results and that although we felt that she
23 did have an infection and she was septic as she
24 presented that way, the blood cultures hadn't proven
25 that. But that is something that is often the case in

1 neonates.
2 **Q.** Now, we have mentioned Dr Subhedar already.
3 He, as you tell us at your paragraph 48, came to present
4 the findings of his review?
5 **A.** Mm-hm.
6 **Q.** You say that was on a Wednesday or Thursday
7 lunchtime teaching session. You say this:
8 "I remember that it was felt that, although it was
9 unusual to have such a cluster of deaths on a neonatal
10 unit, there was medical explanation for each death and
11 no major deficiencies in care were found."
12 So that's your recollection of your response to the
13 presentation given by Dr Subhedar?
14 **A.** (Nods)
15 **Q.** The first thing is, doing the best you can, do
16 you know whether that presentation was before or after
17 the death of Child I in late October 2015?
18 **A.** Gosh. I -- I don't. I think it was before to
19 be honest. But I -- I -- yes.
20 **Q.** So far as Child A was concerned, and
21 I appreciate that was not a child who you were directly
22 involved in the care of, but you say that there was
23 a medical explanation for each death?
24 **A.** Mmm.
25 **Q.** Are you able to help us with what the medical

1 explanation was being said at that time for the death of
2 Child A?
3 **A.** I can't remember, to be honest.
4 **Q.** There was, we know, on 12 October and you deal
5 with this in your witness statement, a table top meeting
6 to review the case of Child D following the postmortem
7 findings?
8 **A.** (Nods)
9 **Q.** Do you have any recollection of what you
10 thought upon reading the postmortem findings of
11 Child D's?
12 **A.** I suppose I -- it confirmed my belief, there
13 was evidence on the postmortem of congenital pneumonia,
14 ie infection, and therefore a medical model of sepsis
15 seemed reasonable and appropriate.
16 **Q.** So if we just take stock at this moment in
17 time about what you were thinking was happening on the
18 neonatal unit, before the death of Child I.
19 **A.** Mm-hm.
20 **Q.** Were you concerned about the deaths which had
21 occurred?
22 **A.** Yes, very.
23 **Q.** Were you suspicious at that time that any of
24 the deaths were unnatural?
25 **A.** No.

1 **Q.** Before the death of Child I, did anybody else
2 suggest to you that they were suspicious that the deaths
3 might not be natural?
4 **A.** No.
5 **Q.** So we move forward to Child I, please. I am
6 picking up here starting at paragraph 51 of your witness
7 statement, which is on page 11. You tell us you have
8 some limited recollection of events on 13 October. Now,
9 Child I died on the 23rd and Child I's death was
10 preceded by a number of deteriorations or collapses?
11 **A.** Yes.
12 **Q.** You tell us that your recollection is that you
13 were called in urgently on 13 October; is that right?
14 **A.** Yes.
15 **Q.** That you found Dr Neame performing
16 resuscitation?
17 **A.** (Nods)
18 **Q.** That Child I responded to the resuscitation
19 and was transferred to intensive care?
20 **A.** Mm-hm.
21 **Q.** One of the matters that the Inquiry is
22 investigating is whether or not it was the case that
23 Letby was moved from having responsibility for
24 Child I over the period that Child I collapsed in
25 relation to one specific shift?

1 **A.** (Nods)
2 **Q.** Is that something that you were aware of if it
3 happened at the time?
4 **A.** No.
5 **Q.** Now, had it been the case that somebody on
6 a neonatal unit thought that Letby should be moved off
7 the care of Child I for Child I's protection, so not to
8 do with Letby's welfare but for Child I's protection, is
9 that something that you should have been told about?
10 **A.** Yes. Yes. Yes.
11 **Q.** What do you think your reaction would have
12 been if you were told that such a step had been taken?
13 **A.** I have -- I would have wondered what on earth
14 was going on really and if, if -- that we -- did not
15 more than that need to be done?
16 **Q.** Now, Child I died on 23 October 2015. That
17 was thought of as a sudden and unexpected death at the
18 time?
19 **A.** (Nods)
20 **Q.** If that was the thinking, in your view should
21 a Datix have been completed?
22 **A.** (Nods) Yes. Sorry.
23 **Q.** Now, you tell us at paragraph 54 that you can
24 recall a discussion with Dr Gibbs, plus Dr Brearey
25 and/or Dr Jayaram?

1 **A.** Yes.
2 **Q.** You say in terms of the date of it:
3 "... following my involvement with the collapse of
4 Child I in October 2015"?
5 **A.** Yes.
6 **Q.** So we know your involvement was the 13th?
7 **A.** Yes.
8 **Q.** We know Child I died on the 23rd?
9 **A.** Yes.
10 **Q.** Was that discussion before Child I died or
11 after Child I died?
12 **A.** I have -- I can't recall. I -- I can't
13 recall. It -- yes, I can't.
14 **Q.** Well, if you just think about it, if --
15 **A.** It can't have been, it can't have been before,
16 it can't have been.
17 **Q.** I was just going to suggest that.
18 **A.** Yes, it can't have been, yes.
19 **Q.** Because if that had occurred before and then
20 Child I had died, that would have been?
21 **A.** It can't have been yes, it couldn't have been.
22 **Q.** And as best you can, just tell us what your
23 recollection is about what was said to you and by whom
24 in that discussion?
25 **A.** I can't remember precisely who started the

1 conversation. I was asked if Letby had been there on
2 the night that I was called in to that resuscitation and
3 I replied that I had seen her.
4 The conversation was then around the fact that she
5 was always on duty when these events had happened and
6 then also some counter arguments that we were in fact
7 a very small unit with a very small pool of nursing
8 staff, so it was not inconceivable that the same poor
9 person might be on duty for a, for a number of events.
10 Yes, but, I -- I felt the idea that anyone was
11 suggesting that someone was doing this quite difficult.
12 Yes.
13 **Q.** Was the possibility that it was deliberate
14 harm that was occurring said out loud?
15 **A.** No. It was more that she was always there.
16 **Q.** So that was an implication that you took?
17 **A.** Yes, an implication that -- that this -- this
18 pattern had been noted. I -- Dr Brearey was reviewing
19 and Eirian Powell were reviewing all the deaths and
20 I knew that they were looking at things like which
21 incubators each of the baby was in, which equipment was
22 used, which staff were on duty et cetera because that
23 had all been discussed when Dr Brearey had reviewed the
24 first three deaths.
25 **Q.** What you say in your statement at paragraph 54

1 in the middle:
2 "I found it hard to comprehend that a health care
3 professional could be deliberately harming babies and
4 I remember expressing that at the time. However what
5 was happening on the unit was clearly not normal so it
6 had to be considered. They wanted to raise their
7 concerns to the Hospital. I do not know exactly when
8 this happened or the sequence of events that led to the
9 RCPCH review into the neonatal unit or the sequence of
10 events that led up to the Hospital calling in the police
11 to investigate as I left the trust at the end of
12 February 2016"?
13 **A.** Yes.
14 **Q.** That's what you say in your witness statement?
15 **A.** Yes.
16 **Q.** They wanted to raise their concern with the
17 hospital. Was that something that was expressly
18 discussed at the meeting?
19 **A.** Not, not at that time I think. That was --
20 I suppose as 2015 went on and into 2016, the thought
21 that something awful could be happening kind of, you
22 know, solidified in people's minds really.
23 It was completely out of normality that we should
24 have so many deaths on the unit.
25 **Q.** So does that -- am I to understand from that

1 answer that there were more conversations after that
2 first one as the concerns coalesced?
3 **A.** Yes.
4 **Q.** Who was involved among your Consultant
5 colleagues with those conversations, was it just the
6 same three people you have named or were any of the
7 other Consultants involved?
8 **A.** Mainly the three named, yes.
9 **Q.** When you say "mainly", that might suggest
10 that --
11 **A.** I can't remember who else was involved.
12 **Q.** A possibility of others?
13 **A.** I wouldn't be able to, you know, name --
14 **Q.** Did there come a point at any time in your
15 presence when anybody actually articulated out loud:
16 maybe she's doing this on purpose?
17 **A.** No.
18 **Q.** Now what Working Together talks about in terms
19 of the need for a response is if somebody may pose
20 a risk.
21 **A.** Mmm.
22 **Q.** Is that in fact what was being said in these
23 conversations that you were a party to?
24 **A.** Yes.
25 **Q.** So given that that was what was being said,

1 should something have been done immediately that that
2 was said?
3 **A.** In -- in hindsight yes. It -- it was very
4 difficult. There was an air of disbelief about it. The
5 only -- the only thing that we could say at the time was
6 that she happened to be on the -- she happened to be on
7 all the shifts. No one had ever seen anything, heard
8 anything.
9 There were lots of counterarguments that she was
10 a very, very competent nurse, everyone had observed good
11 practice, et cetera.
12 So I suppose we -- we -- it just became a very
13 difficult situation as to -- to -- know where to go.
14 **Q.** Just so that we are clear about the time
15 period, we know that you left at some point in
16 February 2016?
17 **A.** Yes.
18 **Q.** The first conversation, the other end of the
19 bookend, is at the end of October 2015, are you able to
20 be any more specific than that date range as to when
21 things really coalesced in terms of the index of
22 suspicion or concern?
23 **A.** I suppose the beginning of 2016.
24 **Q.** You aren't sure if any of your other
25 Consultant colleagues other than Dr Brearey, Dr Gibbs

1 and Dr Jayaram were involved in this?
2 Why do you think at that stage all seven of you
3 didn't get together to talk about it?
4 **A.** I don't know really. I suppose it was just
5 there was a bit of disbelief about it, really.
6 **Q.** Now, your statement to the Coroner is
7 date-stamped as being received on 26 October 2015 but
8 you tell us in your witness statement you in fact wrote
9 that statement at the time of Child D's death?
10 **A.** Yes.
11 **Q.** So when you wrote it, none of this was in your
12 mind?
13 **A.** No.
14 **Q.** And obviously we know Child I's death was on
15 the 23rd so there are only three days in which you may
16 have had a conversation before the Coroner received that
17 statement. So that's the background.
18 **A.** (Nods)
19 **Q.** Bearing in mind that Child D's case was with
20 the Coroner, do you think that there was any point when
21 you should have been contacting the Coroner to say:
22 there is this concern which at least my colleagues have
23 about what was going on in the NNU?
24 **A.** Yes. At the end of the day, yes.
25 **Q.** We have talked about your colleagues' concern.

1 Can we just be clear. In terms of your personal
2 opinion, obviously you were hearing what they were
3 saying, did there ever come a stage whilst you were at
4 the Countess of Chester where you suspected or was it
5 the position that you were listening to the suspicions
6 of others but holding a different opinion yourself?
7 **A.** Yes. I suppose I -- I did -- I did struggle
8 with the idea that somebody was doing this, yes.
9 **Q.** So again this is a difficult question perhaps
10 to answer directly. But if somebody had said to you:
11 might Letby be harming children?, having heard all of
12 the arguments, were you in a position of saying: yes,
13 I did think she might be, or were you thinking: no, on
14 balance I don't think she might be? Or were you just:
15 I don't know?
16 **A.** I just don't know. It was -- yes.
17 **Q.** So it isn't the position then that you were
18 you can say with certainly "I was suspicious"?
19 **A.** Yes, yes.
20 **Q.** Just a couple more events to review.
21 We know that in January 2016, Eirian Powell
22 produced a chart of --
23 **A.** Mmm.
24 **Q.** -- which nurses were on duty and which nurses
25 were allocated to babies and on the chart produced in

1 January, Letby's name is highlighted in red?
2 **A.** Mm-hm.
3 **Q.** Is that a chart that you saw whilst you were
4 at the Countess of Chester?
5 **A.** No.
6 **Q.** Was that a chart that anybody who had seen it
7 talked to you about and said: a chart's been done and
8 her name is there?
9 **A.** (Shakes head)
10 **Q.** Sorry --
11 **A.** No, sorry.
12 **Q.** Not at all, you don't need to apologise at
13 all.
14 Now the thematic review of Neonatal Mortality
15 Meeting attended by Dr Brearey, Dr V and Dr Subhedar
16 occurred on 8 February 2016, when I think you were on
17 the cusp of leaving the hospital?
18 **A.** Yes.
19 **Q.** You left later that month?
20 **A.** Uh-huh.
21 **Q.** Were you aware of that meeting taking place at
22 the time?
23 **A.** No.
24 **Q.** Although you had spoken to Dr Gibbs,
25 Dr Brearey and Dr Jayaram about those concerns or

1 suspicions that they may have had, the meeting that was
2 to look at the detail of all of the deaths, that wasn't
3 something that they had spoken to you about?
4 **A.** I can't remember it, no.
5 **Q.** So, for example, your view wasn't sought
6 beforehand about what you wanted said at the meeting
7 about babies that you had had care of?
8 **A.** No.
9 **Q.** Presumably if you can't remember it you also
10 don't have a recollection of anyone telling you
11 afterwards what happened at it?
12 **A.** No.
13 **Q.** We are now right on the cusp of your
14 departure, we know that the CQC did an inspection in the
15 middle of February and they spoke to Consultants on
16 17 February 2016?
17 **A.** (Nods)
18 **Q.** Were you one of the Consultants who attended
19 that or did you not go to that particular?
20 **A.** I didn't attend.
21 **Q.** Do you feed anything into that, so did you say
22 to any of your Consultant colleagues who you thought
23 might attend: please can you tell them about this or
24 that?
25 **A.** No.

1 **Q.** Then some time around late February, possibly
2 even mid-February, is it right that you left the Trust?
3 **A.** Yes. I -- I can't remember precisely when but
4 my leaving date was the end of February, but I no doubt
5 took some leave and I don't know when my last working
6 day would have been.
7 **Q.** So if we just come to some general matters.
8 I am looking here at page 12 of your witness statement
9 and paragraph 59. You say this:
10 "I would have expected the Hospital to have been
11 extremely concerned about the number of deaths
12 irrespective of the cause of them and undertaken
13 a review. It may be that the RCPCH review constituted
14 that review but I was not party to those discussions."
15 **A.** Mm-hm.
16 **Q.** When you say the hospital?
17 **A.** Mmm.
18 **Q.** In terms of human beings --
19 **A.** Yes.
20 **Q.** -- who are you meaning?
21 **A.** Well, the -- the, the senior leadership team
22 would -- we were -- we were holding regular Mortality
23 Meetings under the governance framework and I rightly or
24 wrongly at the time thought that those would have been
25 fed up the governance chain to the Urgent Care Division

1 and, therefore, to -- to the Exec Team.
2 And -- and as with I suppose any incident reporting
3 system, Datix reporting system, individual incidents in
4 themselves are really important but it is trends in
5 a way that are more important because they help you to
6 identify a system issue or a -- whatever may be causing
7 the problem and those trends should be put together and
8 viewed at a higher level.
9 **Q.** In light of what you have been told by
10 Dr Brearey, Dr Jayaram and Dr Gibbs, in terms of their
11 index of suspicion, what, if anything, did you think
12 they were doing by way of notifying the senior
13 management of the hospital, following the articulation
14 of that suspicion to you?
15 **A.** I -- I suppose at that time in October it was
16 more just a "we have noticed she is always there". You
17 know, could -- you know ...
18 Then I suppose as time -- as time went on those
19 concerns started to coalesce. I know around the time
20 I left or whether it was just after, it sort of becomes
21 a bit hazy as to what I actually was there for and then
22 what I was told had happened by my colleagues afterwards
23 in a way, that Dr Brearey and I assume Dr Jayaram as
24 well had asked for a meeting with the senior management
25 team to discuss what was happening on the neonatal unit.

1 **Q.** That may be something that you think you were
2 told when you were there, but it may be something you
3 have learned subsequently?
4 **A.** Yes, I mean I obviously kept in touch with my
5 colleagues after I had left and it was around February
6 time. But I say whether that was just before or just
7 after I left, I am not sure.
8 **Q.** Was there any discussion between yourselves
9 about whether the police should be contacted if there
10 were discussions about the need to raise it with the
11 senior management?
12 **A.** We -- no, I suppose we felt that we needed to
13 we needed to discuss -- you know, discuss the concerns
14 and then they would help and guide us with what to go
15 with what to do next. It was difficult. As I say, we
16 didn't -- no one had ever seen anything happen. It was
17 just a feeling that she was always there.
18 **Q.** What you say at paragraph 61 is that you don't
19 know the exact date that they raised their concerns with
20 the senior management but that should have triggered
21 a request for a police investigation by the hospital as
22 this should have been taken very seriously.
23 So was it your expectation that one thing would
24 lead to another?
25 **A.** (Nods) Yes.

1 **Q.** At your paragraph 63 you say:
2 "I was extremely concerned about the number of
3 deaths and collapses on the neonatal unit as we all were
4 as a group of Consultants."
5 Then a little bit further down, about halfway down:
6 "I did find it hard to comprehend that a health
7 care professional might be responsible but what was
8 happening on the neonatal unit was not normal.
9 Everything needed to be considered so I backed them in
10 raising concerns. I did not raise these concerns
11 personally but I was aware that Dr Brearey and
12 Dr Jayaram would raise them they acted as spokesperson
13 for us group of consultants. I do not know at what
14 point they raised them."
15 Does that really summarise what your position is?
16 **A.** Yes, yes, I think that refers to that end
17 period, around February. Yes.
18 **Q.** Now, after you left, the Coroner instructed
19 Dr Mecrow to conduct a review of the case. Did you ever
20 see Dr Mecrow's report?
21 **A.** Not, not at the time. But, no, no.
22 **Q.** So that report is dated 9 June 2016. Now,
23 let's be clear, Dr Mecrow does end up agreeing with the
24 pathologist, although points to areas of inconsistencies
25 see but Dr Mecrow described Child D's death as

1 disturbing due to her collapse being so sudden and
2 unexpected.
3 Would you associate yourself with that description
4 in relation to Child D?
5 **A.** It was very unexpected. Yes.
6 **Q.** The final matter I wanted to ask you about,
7 Dr Newby, were your reflections.
8 **A.** Mmm.
9 **Q.** You were asked by the Inquiry to consider
10 CCTV?
11 **A.** Mmm.
12 **Q.** If I just pick out one phrase, it is
13 paragraph 82, you say "very difficult to answer".
14 **A.** Mmm.
15 **Q.** I just would like you, please, just to speak
16 to that about what your thoughts are about the utility,
17 value or challenges of CCTV on a neonatal unit?
18 **A.** Yes. I could -- I could completely understand
19 why the question would be raised. I -- to -- whether
20 you could set up a system that could capture absolutely
21 everything and would mean that, you know, for example
22 someone appearing to give one medicine but giving
23 another, how, how would C -- I don't know.
24 And, you know, there is an awful lot of very
25 private and intimate care that goes on on a neonatal

1 unit. Whether CCTV is -- whether families would feel
2 CCTV is appropriate in that setting, but then these
3 events have -- have been really shocking and awful and
4 I am sure families seek to feel reassured.
5 **Q.** Are there any other matters that you would
6 like to draw to the Inquiry's attention in terms of you
7 having had an opportunity to think about this very
8 deeply and also have the experience of being a Clinical
9 Director at a different hospital?
10 **A.** Yes, yes, I think -- I think there was just
11 this feeling of not knowing what to do and I think in
12 a way it almost made it a little bit more, more
13 difficult to come up with a name because having come up
14 with a name and a person being put forward, kind of led
15 to this counter narrative being put forward as well;
16 that it couldn't possibly be because she was so lovely,
17 she was such a competent nurse, you know, no one had
18 ever seen ...
19 And therefore it perhaps allowed for this doctors
20 versus -- it became sort of an almost adversarial thing
21 that the doctors were accusing the nurses and everyone
22 was sort of digging in their position whereas maybe what
23 we had to say was: this isn't right and could it be that
24 someone is, I don't know, maybe, maybe that -- I don't
25 know if that would have been easier and not allowed this

1 real adversarial position that developed, that developed
2 to happen. If we had just perhaps taken a step back and
3 reported the -- and reported the incident rather than
4 trying to work out who had done it, if you like.
5 **Q.** So to raise the possibility of unnatural death
6 at the first instance, but not to ascribe it to any one
7 person?
8 **A.** Yes, because we didn't there was no, at the
9 time there was -- there was -- there was no -- there
10 didn't appear to be any evidence.
11 **MR DE LA POER:** Dr Newby, thank you very much.
12 Those are all the questions I have, my Lady.
13 Questioned by LADY JUSTICE THIRLWALL
14 **LADY JUSTICE THIRLWALL:** Thank you, Dr Newby, for
15 your very thoughtful evidence. Can I just take you back
16 to something that you said quite early on when you were
17 being asked about the change in the divisional
18 structure, the sort of relegation of paediatrics?
19 **A.** Mmm.
20 **LADY JUSTICE THIRLWALL:** To move from the top
21 table, which I understand. You said that it was a small
22 part of the hospital so you could understand possibly
23 the thinking behind it. But you said: my experience in
24 Chester was different from my experience in Stockport.
25 I just wondered what was your experience in

1 Stockport?
2 **A.** I suppose that paediatrics does have more of
3 a voice.
4 **LADY JUSTICE THIRLWALL:** Was that the case when you
5 went there?
6 **A.** Yes.
7 **LADY JUSTICE THIRLWALL:** Yes.
8 **A.** Yes, and, and we are -- we always remained
9 Women's and Children in Stockport, although at one stage
10 we gained Diagnostics and then lost them again. But
11 it -- I think that divisional structure was more helpful
12 than it is than the two large Urgent and Planned Care
13 divisional structure that we had at the Countess.
14 **LADY JUSTICE THIRLWALL:** Yes. Thank you very much
15 indeed.
16 **A.** Thank you.
17 **MR DE LA POER:** My Lady, we are slightly ahead of
18 where we would normally be for our break, but what that
19 really means is that we are absolutely on target for our
20 plan for today. Can I invite us -- or invite my Lady to
21 direct that we resume at half past?
22 **LADY JUSTICE THIRLWALL:** Yes, certainly. So
23 Dr Newby, that completes your evidence, thank you very
24 much indeed and you are free to go. We will resume at
25 11.30.

1 **(11.10 am)**
2 **(A short break)**
3 **(11.30 am)**
4 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
5 **MR DE LA POER:** My Lady our next witness is
6 Dr Saladi.
7 **LADY JUSTICE THIRLWALL:** Would you like to come to
8 the desk, Dr Saladi.
9 DR SATYANARAYANA MURTHY SALADI (sworn)
10 Questioned by MR DE LA POER
11 **LADY JUSTICE THIRLWALL:** Do sit down.
12 **MR DE LA POER:** Could you please give us your full
13 name?
14 **A.** My name is Satyanarayana Murthy Saladi.
15 **Q.** Dr Saladi, is it correct that you have
16 provided a witness statement to this Inquiry dated
17 17 June of 2024?
18 **A.** That is correct.
19 **Q.** Thank you very much indeed.
20 Can you confirm for us, please, that the content of
21 that witness statement is true to the best of your
22 knowledge and belief?
23 **A.** That is correct.
24 **Q.** Reviewing your career, did you start your
25 medical training in India obtaining MBBS in 1991?

1 **A.** That is correct.
2 **Q.** And an MD in paediatrics in 1996?
3 **A.** Yes, that is correct.
4 **Q.** Did you subsequently train in the
5 United Kingdom and obtain membership of the Royal
6 College of Paediatrics and Child Health in 1998?
7 **A.** That is correct.
8 **Q.** A Certificate of Completion of Specialist
9 Training in April 2009?
10 **A.** Yes.
11 **Q.** Just before you completed that, so in
12 November 2008, did you join the Countess of Chester
13 Hospital as a paediatric Consultant?
14 **A.** That is correct.
15 **Q.** And to bring us up to date, did you continue
16 in that role until June of 2023?
17 **A.** That is correct.
18 **Q.** So I am just going to deal with what you can
19 tell us about your perception of relationships between
20 different people working at the Countess of Chester and
21 the focus here, please, Dr Saladi, is on the period 2015
22 to 2017.
23 So at the start of that period, please, how were
24 relationships between the Consultants?
25 **A.** Very good.

1 **Q.** The Consultant body and the junior doctors?
2 **A.** Very good.
3 **Q.** The Consultant body and the nurses?
4 **A.** Good, very good.
5 **Q.** You were in the hearing room when I read out
6 to your colleague Dr Newby what Eirian Powell has said
7 of her perception of the relationship?
8 **A.** (Nods).
9 **Q.** I will just remind you: "that Consultants
10 thought all staff members worked cohesively because
11 staff did exactly what they were told to do by the
12 Consultants without challenging them".
13 What can you tell us about your experience of that
14 and your comment upon her view?
15 **A.** No, I think it -- it was a cooperative unit
16 and we could challenge each other easily and they did
17 challenge us in -- where they thought it was
18 appropriate. It was not antagonistic, we worked as
19 a team. It was a cohesive team. And I am proud to be
20 a team member of there.
21 **Q.** So far as how any change that may have taken
22 place in 2016 is concerned, did you perceive any change
23 with any of the relationships that I have just talked
24 about between the Consultants, between Consultants and
25 doctors, or between Consultants and nurses?

1 **A.** Not in terms of the relations. Obviously the
2 Consultants, us as a body, were under stress but
3 I suspect that applies to all groups because we were
4 understaffed and we were having busy periods and during
5 that time there were more unwell children. But not in
6 terms of the relations.
7 **Q.** In the period 2015 to 2017 what was your view
8 of the senior management of the hospital?
9 **A.** I did not have any direct contacts with the
10 senior management. The managers I see are the business
11 manager, which we meet in the Monday meetings. But
12 I didn't think they had much authority to change things.
13 They needed to take it up higher level to get any things
14 changed and the people who are actually making changes
15 I wasn't sure who -- who had that.
16 **Q.** So in 2015, if the Chief Executive
17 Tony Chambers had walked on to the paediatric unit,
18 would you have known who he was?
19 **A.** Yes, yes.
20 **Q.** Had you had any direct communication with him?
21 **A.** Not directly with him.
22 **Q.** What about the Medical Director, Mr Harvey?
23 **A.** Yes, I know, but not direct contact with him.
24 It's not as if there were -- I think there were -- they
25 didn't come to -- we are in a different building in the

1 hospital so maybe they were -- we don't -- we don't see
2 them often apart from the emails. They used to
3 communicate to us but not sort of person-to-person
4 contact but that's maybe we are a small department in
5 a different building.
6 **Q.** Do you think that the fact that you were
7 a small department in a different building made any
8 difference to how connected you were to the whole
9 management structure of the hospital?
10 **A.** As I said, because I was not in a management
11 role, I didn't know the difficulties my colleagues were
12 facing, but I could easily interact with other
13 Consultants, we used to meet in the meetings and things
14 like that. So -- but, yes, I didn't have much contact
15 directly with the senior management.
16 **Q.** If a problem had arisen in 2015 that you
17 thought you would need to take to the senior management,
18 what was your expectation about how that particular
19 group of people would have dealt with it?
20 **A.** I probably wouldn't have taken it directly
21 myself. I would have raised it through my leads which
22 was Dr Jayaram and Dr Brearey and usually -- they used
23 to take them up so I didn't need to directly email or
24 contact the senior managers at any stage, except in
25 probably -- that was in June or July 2016, that's when

1 I probably directly contacted some of them.
2 **Q.** We will come to that.
3 **A.** Yes.
4 **Q.** Moving away from the topic of relationships.
5 Safeguarding. Had you received training in
6 safeguarding?
7 **A.** Yes.
8 **Q.** Had you received any training in terms of how
9 you should deal with a situation where you suspected
10 a colleague of posing a risk to patients?
11 **A.** I think the important point here is suspicion
12 because safeguarding training is all related to when do
13 we suspect babies are harmed, are coming to harm. So we
14 know what to do when we are already having suspicion,
15 I think.
16 But we know what sort of situations we need to
17 suspect babies coming to harm, we had training, but
18 that's mainly related to child protection in the
19 community and I suspect we did not have that sort of
20 training when to suspect that sort of -- that sort of
21 thing in the hospital itself.
22 We were told if you see abusive behaviour, if you
23 see a Consultant or a colleague coming drunk and things
24 like that, which is easy to understand. But I don't
25 think we had what are the situations where you need to

1 suspect apart from these obvious situations where you
2 are seeing a racist behaviour, or sort of bullying
3 behaviour, or a drunken behaviour, that sort of things,
4 we know that is wrong and it is easy to suspect and it
5 is easy to raise concerns. But I don't think beyond
6 that we had any sort of training.
7 **Q.** So far as the process for Sudden Unexpected
8 Death in Infancy and Childhood was concerned, what was
9 your understanding in 2015 as to whether that applied to
10 deaths of neonates on the neonatal unit?
11 **A.** Yes. I understood that it applied and when we
12 were having unexpected deaths we were following the
13 route which my understanding is to discuss the concerns
14 with the Coroner.
15 **Q.** What we can see from the guidance is that
16 a number of steps are identified at an early stage when
17 following that procedure including contacting, for the
18 Countess of Chester, Dr Mittal?
19 **A.** (Nods)
20 **Q.** And for the convening of a multi agency
21 meeting, which would involve local authority and police.
22 Did you understand that aspect of the Sudden Unexpected
23 Death in Infancy and Childhood to apply?
24 **A.** I suspect my understanding was that was more
25 related to outside the hospital because inside the

1 hospital we were thinking more in terms of the Coroner,
2 because I suspect -- the suspicion I think that is
3 where, where we are, the suspicion of something unusual
4 or, yes, maybe I am not framing it correctly.
5 But my thinking was the right person to discuss
6 this is Coroner because they are the ones who sort of we
7 contact immediately within the first -- probably if it
8 is daytime straight away or if it is something happened
9 in the nighttime, then first thing in the morning. We
10 do discuss with the -- Dr Mittal but that's more of
11 there is something called Part B to complete that forms
12 which needs to be done in sort of 24, 48 hour's time
13 whereas Coroners is immediate because they are the ones
14 making a decision whether they are ordering a Coronial
15 postmortem or they are leaving it for us to discuss with
16 the parents to whether they want a hospital postmortem.
17 So I didn't think I was giving more importance to
18 Coroner, informing the Coroner rather than going in that
19 other route.
20 **Q.** Who did you understand within the hospital had
21 responsibility for making sure that you followed the
22 right procedures when it came to those sudden unexpected
23 deaths?
24 **A.** I suspect we discussed all deaths and all the
25 morbidity in our Perinatal Morbidity Mortality Meetings

1 and if there was -- if we thought we were not following
2 I thought that would have been where we would have --
3 could maybe we should have done differently. I am not
4 sure whether I am following your question or whether my
5 answer is what you are asking.
6 **Q.** I understand you to be saying that you relied
7 upon your colleagues to at those meetings to correct any
8 failure to follow the correct procedure, is that what
9 you said?
10 **A.** Yes, when we are discussing with the Dr Mittal
11 our safeguarding team which is not usually not in the
12 context of safeguarding, it is because of unexpected
13 death, we do discuss but that is not usually immediate
14 when they are next available which may be in a couple of
15 days' time.
16 But that's mainly about information, saying that we
17 had an unexpected death and we have discussed with
18 Coroner and this is what is happening. And then I will
19 fill the form when it comes so that you know what our
20 clinical thinking was.
21 **Q.** In 2015, were you aware of the crimes of
22 Beverley Allitt?
23 **A.** Yes.
24 **Q.** Were you aware of the situation at Stepping
25 Hill Hospital where a nurse had been using insulin to

1 kill patients?
2 **A.** I cannot remember now whether I was aware at
3 that time.
4 **Q.** Now, we are going to turn please, Dr Saladi,
5 to look at what you say in your statement about events.
6 **A.** Mm-hm.
7 **Q.** Can I say at the outset that I do understand
8 that a number of occasions you have asserted you don't
9 have a memory, I am going to try and help you with that
10 as far as possible?
11 **A.** Okay.
12 **Q.** So at paragraph 12 on page 2, you deal with
13 Child A and Child B and in particular at paragraph 13,
14 you make a number of statements about Child A and I am
15 just going to read those out so if you have got them in
16 front of you:
17 "I was not involved in the care at the time of the
18 deterioration and death of Child A. At the time it was
19 unexpected but we were thinking if it was related to
20 maternal health.
21 "I do not recall any discussions about unusual
22 patterns of discolouration of Child A.
23 "I did not have any concerns about Child A apart
24 from if it was related to maternal health condition.
25 "I do not remember if I attended any debrief."

1 Doing the best you can, do you remember providing
2 any care to Child A?
3 **A.** Yes.
4 **Q.** You do?
5 **A.** Yes.
6 **Q.** Can you help us, please, with your
7 recollection of Child A's condition when you provided
8 that care?
9 **A.** Well, I attended -- Child A is one of the
10 twins and I attended the delivery when the twins were
11 born and I think I was resuscitating -- I am not sure
12 without seeing the notes, but I think I am resuscitating
13 Child B who was more sicker at the time of birth and my
14 colleagues were resuscitating Child A but I know Child A
15 is much more stable than Child B at the time of birth.
16 **Q.** So at the time of birth, did you have any
17 sense at all that Child A might die?
18 **A.** No.
19 **Q.** We are going to come in a moment to some
20 contemporaneous records about Child A, not in the
21 medical notes, but before we do, Child B suddenly
22 deteriorated on 9 June of 2015 and you say this at your
23 paragraph 14:
24 "In relation to Child B.
25 "At the ward round on 10 June I was looking for

1 medical causes which caused the deterioration and if it
2 was related to maternal health condition.
3 "I cannot recall what I was thinking at the time
4 I was probably thinking was it related to sepsis which
5 can give rise to rashes rather than related to maternal
6 health condition which was one of the parental concerns
7 at the time. It was also possible the rash seen by me
8 was much different to the rash seen by the junior doctor
9 earlier as some rashes change with time."
10 **A.** Mm-hm.
11 **Q.** Now, Dr V's record notes:
12 "Purple discolouration almost resolved ??? cause."
13 Were you sighted on the fact -- sorry, I will ask
14 that question different.
15 Were you aware of Dr V having seen the rash and did
16 you talk to Dr V about the rash?
17 **A.** I do not remember if I have seen -- I have
18 discussed about the rash with the Dr V. But I think
19 again not based on the recollection of the event but
20 looking at the notes, I know that the child had rash the
21 previous night which had subsided and by the time
22 I think I have documented the notes that it is quite
23 localised only in some areas and usually for
24 paediatricians there are lots or different types of
25 rashes. The worrying type of rashes are the rashes

1 because of serious infections and usually those rashes
2 are progressive, that means they are getting worse in
3 front of you or they are becoming much more like
4 a bruise and things like that. Whereas something which
5 sort of disappears or not usually are not usually
6 a concern. At least at that stage because there are
7 lots of causes for the rash and some of the rashes can
8 happen in the newborn period as well.
9 So probably that's why you didn't stick it -- stick
10 out to me that much.
11 **Q.** This rash was associated with a sudden and
12 unexpected deterioration in Child B. Does that make it
13 potentially more significant because?
14 **A.** Yes, I would be thinking of infection and
15 I would now check whether we have looked for infection
16 and whether we have covered the baby with antibiotics.
17 **Q.** I think you have told us that in an infection
18 the rash will progress or turn into a bruise. In fact,
19 the --
20 **A.** Not necessarily all the time.
21 **Q.** But the opposite was happening in this case
22 that the rash was resolving and becoming more localised?
23 **A.** Yes, but it doesn't mean infection and rash
24 has to always progress. It can decrease as well.
25 **Q.** Did you take any steps to try to investigate

1 the reasons for Child B's collapse?
2 **A.** At that stage, there was a lot of concern
3 whether it is related to maternal health condition,
4 though our initial reading from the -- from the
5 literature is probably not.
6 But we were trying to contact the various
7 specialists whether it is in fact related to it or not,
8 so we were trying to contact the teams in London and
9 I can't say definitely at London but definitely we are
10 trying to contact different teams, whether that can
11 explain this sort of deterioration and we thought we had
12 treated for the other possible causes for the rash like
13 infection.
14 **Q.** We are going to have a look at a document
15 which we looked at this morning, INQ0025743. This is
16 an email from Dr Gibbs the day after Child D died. And
17 it is on the second page. Thank you very much.
18 We can see that that you are one the recipients of
19 this email; do you see that?
20 **A.** Yes, I can see that.
21 **Q.** Again, just by way of summary, Dr Gibbs is
22 talking about Dr Lambie coming to talk about the
23 concerns of the Registrars?
24 **A.** Mm-hm.
25 **Q.** Were you aware before this email came into

1 your inbox of the concerns of the Registrars?
2 **A.** No.
3 **Q.** Did you speak at any time to any Registrar
4 about them being worried about the deaths and/or the
5 rashes?
6 **A.** No.
7 **Q.** When you received this email, did you note the
8 fact that according to Dr Gibbs, there seems to have
9 been a rash in Child A, Child B and Child D? So he says
10 that Child C didn't have the rash, so that's what
11 Dr Gibbs is saying in the first paragraph?
12 **A.** Sorry, what was the question?
13 **Q.** So the question was: did you note when you
14 read it that Dr Gibbs was bringing together those four
15 cases?
16 **A.** Yes.
17 **Q.** Saying in the case of three of them, there was
18 this rash?
19 **A.** I cannot remember whether -- whether what
20 I was thinking when I saw this email because I was
21 reminded of this email only when I received through the
22 Inquiry. So I cannot remember what I thought at that
23 time.
24 **Q.** Because you had been involved in the care of
25 both Child A and Child B?

1 **A.** Yes.
2 **Q.** And you had information you could provide
3 about what you had seen about Child B's rash; is that
4 right?
5 **A.** Again, as I said, the rash I have seen I did
6 not think it was anything serious, so probably that's
7 why it didn't trigger anything. So probably that's why
8 this email, I did not remember this email until you sent
9 me through the Inquiry because the rash I have seen is
10 based on what I -- what was documented in the ward
11 rounds, did not sound very serious.
12 **Q.** So do you have any memory of speaking to any
13 of your colleagues to try and understand their
14 experience of the rashes for any of these four babies to
15 see if you could further understand what Dr Gibbs was
16 talking about?
17 **A.** No.
18 **Q.** Again, we looked at it this morning. There
19 was a meeting a few days later, INQ0036166, and I will
20 just help you with the part so that you have it in front
21 of you.
22 We can see at the top there that it is a meeting
23 that you attended and over the page just to remind you,
24 Dr Saladi --
25 **A.** Mm-hm.

1 **Q.** -- that third paragraph from the top again
2 mentioning that the Registrars had been quite worried.
3 That's twice in a week that either there is an email
4 discussion or there is a discussion in person about the
5 junior doctors being worried. What did you think about
6 the concerns that you were being told about?
7 **A.** See, I don't think at this stage the junior
8 doctors were describing what they were seeing. The --
9 I suspect because this meeting again I do not have any
10 recollection of it because I suspect if they said some
11 junior doctors have seen a rash, and there is a concern,
12 obviously there were concerns for all of us at that
13 stage because for all the taps in the neonatal unit we
14 had filters and there were growing pseudomonas from the
15 taps even though I do not remember we actually grew that
16 bug from any of the babies.
17 So maybe I was thinking that is that related to the
18 neonatal unit, the taps and things like that rather than
19 this is a different type of rash which is different to
20 what we see in infections because again until you sent
21 me this, this summary of the meeting, I didn't --
22 I didn't recollect it. I suspect that's because what
23 was discussed in the meeting was we were thinking maybe
24 it is related to the taps and things like that.
25 **Q.** So in terms of how you felt about the

1 situation at the end of June on the neonatal unit, and
2 by that I mean the fact that there had been three deaths
3 in quick succession plus a collapse of the twin of one
4 of those who had died, were you worried?
5 **A.** Yes. In the sense we know in the neonatal
6 units deaths can happen, particularly if there is any
7 outbreak of infection so there can be grouping of the
8 deaths and I suspect we were all thinking, or at least
9 I was thinking that this is all related to are we
10 missing some bug, something else which was happening.
11 But that's why we are having these bad faith with the
12 more --
13 **Q.** From your point of view, is that you doing
14 your best to reconstruct your memory or is that
15 something that you have a positive recollection of
16 thinking at the time?
17 **A.** Is there a difference between those two?
18 **Q.** Well, one is "I can remember thinking that"
19 and another is saying, "Well that's probably what I was
20 thinking, I don't actually remember".
21 **A.** Yes, second one. I don't actually remember
22 but I would have thought having a few deaths grouped
23 together is not unusual. It's rare but it is not
24 unusual and usually the sort of things which when we are
25 investigating is some sort of bug or something like

1 that.
2 **Q.** But in fact none of the investigations came
3 back --
4 **A.** That is correct.
5 **Q.** -- to say that that was the explanation for
6 the cluster, did they?
7 **A.** That is correct.
8 **Q.** So let's move forward in our timings. Were
9 you aware of the death of Child E at the beginning of
10 August 2015?
11 **A.** I know -- I was involved in one death of the
12 baby during this entire period, I was directly involved
13 in the resuscitation and death of one baby which is not
14 in the indictment and I was involved indirectly with the
15 death of Baby A because I was taking care of the --
16 I was involved with the resuscitation of the baby in the
17 previous 24/48 hours.
18 Most of the other babies I was not directly
19 involved in. So I would have known them from when I am
20 coming back next day to the work that we had this death
21 or when we were discussing the deaths in the Perinatal
22 Morbidity Mortality Meetings.
23 **Q.** Did the fact that there was now a fourth death
24 in a very short period of time increase the level of
25 concern that you had about there being a potential

1 problem on the neonatal unit?
2 **A.** Probably. I cannot remember. But, yes.
3 **Q.** The day after Child E died, Child F had
4 a deterioration and we know now, and it was available
5 shortly afterwards, so about a week later, that the
6 insulin and C-peptide levels relative to each other
7 indicated that external insulin had been administered?
8 **A.** Mm-hm.
9 **Q.** Dr Gibbs has described that as a collective
10 failure that was serious in terms of all of the
11 Consultants. Do you agree with that?
12 **A.** I do agree because if the babies have been in
13 the unit for a few weeks, if babies are being in the
14 unit for two months, all of us would have seen those
15 babies in our hot weeks at least twice and in the other
16 times, we would be in -- we would be knowing about those
17 babies only when we are on-call.
18 So it depends on how long the baby stayed. If the
19 baby has stayed for at least two months we would have
20 opportunity to go to review the notes and we could have
21 seen the results but it may not have picked up an
22 abnormal result when we are looking at the trends
23 because of the system we had. But we could have seen --
24 I suspect we would have looked for it more if the baby
25 was unwell or if there were continuing concerns about

1 the baby.
2 But, yes, we -- we could have seen, we should have
3 spotted. But I accept that as a collective failure.
4 **Q.** Returning to your witness statement,
5 paragraph 20 on page 4. You speak about Child H. What
6 you say in relation to Child H at paragraph 22:
7 "It was not clear why Child H had deteriorated
8 hence why I sought help from the tertiary unit as
9 documented in the notes. Any [unexpected] deterioration
10 in a child is worrying."
11 **A.** Yes.
12 **Q.** At the time that you were contacting the
13 tertiary unit, and you were worried as you tell us about
14 the unexpected deterioration, did you think back to the
15 events which had happened just in the last few months
16 and in particular the deaths and sudden deterioration of
17 Child B?
18 **A.** I don't think our mental focus would be going
19 that far when we are seeing a sick child, what we would
20 be considering is: is it something which is so unusual
21 that we are not seeing? So is it an uncommon
22 presentation of an uncommon condition so that we are not
23 seeing or we don't have experience managing and that's
24 the reason to discuss with the tertiary units where
25 they, they do the neonatology every day so they might

1 have experience in seeing this condition.
2 So it is in terms of getting that advice, I don't
3 think in that situation I would have the presence of
4 mind to think about all the deaths which have gone on in
5 that year.
6 **Q.** So after this unexpected unexplained
7 deterioration had occurred, you didn't go to see your
8 colleagues to say "why does this keep happening", or
9 anything along those lines?
10 **A.** So we are now discussing only about the
11 deaths, but I suspect at that stage we are not seeing
12 the babies who are having collapsed and deaths but we
13 also have other patients as well so I suspect I cannot
14 see how my mind was working.
15 But maybe we weren't putting all the information
16 together. Maybe we weren't discussing, we were
17 discussing that particular child at that time rather
18 than maybe we were or maybe we were discussing the
19 patients who are coming in that Perinatal Morbidity
20 Mortality Meeting rather than taking a bigger overview.
21 Maybe that's why we, we probably missed looking at it
22 because we -- here we are discussing only about these
23 babies. But we were discussing about all the other
24 patients where we had question marks and where we had
25 morbidity issues, not just in the neonatal unit on the

1 children's ward as well.
2 So I don't know whether I am answering you
3 properly.
4 **Q.** I am going to just move forward because it may
5 be that we are going to have an example of such
6 a discussion in a moment that I want to ask you about.
7 **A.** Okay.
8 **Q.** So we will move forward to Child I please,
9 October 2015. As I understand it, you had some
10 involvement in Child I's care when Child I died; is that
11 right?
12 **A.** Child I's care during the stay, yes.
13 **Q.** Yes. Did Child I's death cause the concern
14 that you have told us there was about the cluster back
15 in June, did that have any effect on the concern you had
16 about the neonatal unit more widely at that time?
17 **A.** I suspect we were always looking at medical
18 causes. So I remember this baby because we were seeing
19 this baby with abdominal distension and we are sending
20 them to the regional units and they are coming back
21 because they are not finding anything.
22 So we were scratching our head. Are we missing
23 something else or are the surgeons missing something
24 else? Why is a baby suddenly deteriorating here and
25 goes and they are doing investigations, they are saying

1 they are not finding anything and coming back.
2 So I suspect that should have raised concerns. But
3 I think our focus is still looking at medical conditions
4 and I suspect we were still thinking there is something
5 medical condition which we have not yet understood.
6 So I don't think we sort of connected with all the
7 other previous deaths.
8 **Q.** Now, you will have heard Dr Newby this morning
9 talk about a conversation that she had with Dr Gibbs,
10 Dr Brearey and/or Dr Jayaram as she describes it
11 following death of Child I. Did any of your Consultant
12 colleagues come to you to talk to you about their
13 concerns following the death of Child I?
14 **A.** I was definitely discussing with the
15 Dr Brearey about the babies I was involved in,
16 particularly a baby who died with cardio cause, whether
17 the death -- the cardio cause can explain actually the
18 death and he was trying to get the information from the
19 cardiologist so we were having discussion. But
20 I suspect he was discussing with the -- the colleagues
21 or the discussions were not a group discussions but with
22 the concerned colleagues who were involved in the care
23 or the resuscitation at the time.
24 So I -- I wasn't aware of ...
25 **Q.** One of the things that formed part of the

1 discussion we are told is the fact that Dr Brearey was
2 pointing out that one member of staff appeared to be
3 a common factor at these recent events. Did he have
4 such a conversation with you about that?
5 **A.** I do not remember having such conversation
6 until that email, until the seniors meeting on the
7 Monday -- June or July.
8 **Q.** So that's 27 June, we will come to that
9 meeting which was the --
10 **A.** Yes, before that I wasn't -- I don't think
11 I was aware because I don't think I was aware. I am
12 saying that because I was sleepless for two nights after
13 the seniors meeting and that's what sleepless in
14 thinking and then trying to write that email.
15 So I don't think I would have heard Lucy Letby's
16 name before that.
17 **Q.** Now, if I move forward and I am moving over
18 Child J here because it may be that Mr Baker has some
19 questions for you about Child J, to early 2016. It may
20 be you have already answered this question, Dr Saladi.
21 We know that in January of 2016 a chart was
22 produced showing which staff or nursing staff were on
23 duty or allocated to babies and Lucy Letby's name was
24 marked in red as it appeared on the chart.
25 Did anybody talk to you about that work being done?

1 Were you told that that sort of staffing analysis was
2 under way?
3 **A.** In June 2016.
4 **Q.** January 2016?
5 **A.** January?
6 **Q.** So six months before that meeting.
7 **A.** I don't think so. I am not sure whether, was
8 there -- was it there in the meeting?
9 **Q.** So it is a document that was produced.
10 **A.** Okay.
11 **Q.** There is no email that suggests that you
12 received it. I am just wondering whether you -- anybody
13 spoke to you about it or anything like that that you can
14 recollect?
15 **A.** I cannot recollect.
16 **Q.** The thematic review of Neonatal Mortality
17 Meeting took place on 8 February. Were you asked, you
18 didn't attend?
19 **A.** I didn't attend.
20 **Q.** Were you asked to give any input to that
21 meeting beforehand, did Dr Brearey ask for you to
22 formally say to him what you wanted raised at the
23 meeting?
24 **A.** As I said, he did discuss about the deaths
25 where I was involved in and we were having discussions

1 but I -- I don't think he specifically asked me about
2 other babies or whether -- I don't recollect me being
3 asked to contribute to that thematic review.
4 **Q.** We know that the thematic review was
5 circulated to all the Consultants on 2 March?
6 **A.** Mm-hm.
7 **Q.** We can look at it if we need to but I am sure
8 you will take it from me that one of the first key theme
9 or common theme that's identified is the sudden and
10 unexpected deterioration of all of the babies that the
11 document reviews?
12 **A.** Mm-hm.
13 **Q.** Did you notice that at the time that you
14 received the report?
15 **A.** I think so.
16 **Q.** What was your reaction to seeing all of those
17 babies put one after another with that apparently being
18 a common theme?
19 **A.** Well, again, unexpected deaths, when we think
20 it is unexpected we discuss with Coroner and they go to
21 the postmortem. By the time the results come, it will
22 take anywhere between three to six months time and so
23 that's when we will know for sure what was the reason.
24 So I suspect, I am thinking that the Coroner's
25 postmortem will give an answer because at least in the

1 patient I was involved in, it did give an answer even
2 that there is a cardiac cause.
3 So I -- that would have been my thinking, that,
4 yes, the postmortem might give an answer.
5 **Q.** So to put that answer another way, do you
6 agree with this: didn't seeing that make you more
7 concerned about what might be happening on the neonatal
8 unit?
9 **A.** Well, there is concern that we had increased
10 deaths, there is also a concern that as I mentioned
11 about the taps. So we are thinking probably of still
12 medical conditions.
13 So we were thinking or at least I was thinking that
14 whether we are going through a bad patch.
15 **Q.** Were you aware of any plan to speak to the
16 senior hospital management about the increase in deaths
17 on the neonatal unit?
18 **A.** At what time?
19 **Q.** Well, in early 2016.
20 **A.** I do not recollect that. I don't know,
21 I don't think so.
22 **Q.** So certainly nobody told you that as far as
23 you can remember: we are going to need to --
24 **A.** As far as I can remember.
25 **Q.** "We are going to need to raise this with

1 senior management"?
2 **A.** Yes, I cannot remember now.
3 **Q.** If we move forward to Child L in April 2016,
4 again Dr Gibbs has characterised the fact that the
5 C-peptide insulin ratio did not lead to immediate action
6 as being a collective failure which was serious.
7 Do you agree with that also in the case of Child L?
8 **A.** If as -- as I explained before if the baby was
9 in the unit for a few weeks all of us would have seen
10 and all of us would have had opportunity to look at the
11 results, though they may not be obvious when we are
12 looking at the trends. Because we would be looking at
13 the results of the last couple of days and then if there
14 is still concern, then we will be looking at the trends.
15 I don't think it would have shown up in the trends
16 and I don't think we would be looking at the trends
17 unless there is still concern about the baby. So I am
18 not -- I agree that it is a character failure but I do
19 not remember at what stage I became aware of that.
20 **Q.** On 11 May of 2016 Dr Brearey met with
21 Mr Harvey, the Medical Director, and Ms Kelly, the
22 Director of Nursing and Safety. Did you know that that
23 meeting was happening at the time that it happened?
24 **A.** As Clinical Leads he will be meeting so
25 I wouldn't have suspected that being any -- anything

1 different.
2 **Q.** So do you have a memory of him telling the
3 Consultants, you in particular: I am going to meet with
4 the Medical Director to discuss the neonatal unit and
5 the rise in mortality?
6 **A.** I cannot remember now.
7 **Q.** It may follow from your last answer but I will
8 ask to be sure. Do you have any recollection of
9 Dr Brearey speaking to you after that meeting and
10 telling you what was discussed at the meeting?
11 **A.** Is that in --
12 **Q.** In May of 2016?
13 **A.** I do not remember.
14 **Q.** We do know that Dr Brearley sent an email
15 after that meeting talking about it. INQ0005721.
16 I will just remind you, it is up on screen now. Again
17 this is an email that's sent to you and other Consultant
18 colleagues in which he talks about the meeting.
19 In bold, Dr Brearey makes a specific request about
20 notifying him and Eirian Powell if there was any baby
21 who deteriorates suddenly or unexpectedly or needs
22 resuscitation.
23 Now, do you have any recollection, Dr Saladi, of
24 having received this email and thought about what that
25 might mean?

1 **A.** I don't think I thought about what that might
2 mean. I thought this is -- I cannot recollect what my
3 thoughts were at that stage, but we know that there was
4 more babies unwell, more deaths at the time so I thought
5 it is getting more information. Information gathering.
6 **Q.** Thank you, could we take this down, please.
7 You were involved in the care of Child N when
8 Child N deteriorated on 15 June?
9 **A.** Mm-hm.
10 **Q.** My first question about this is: were you
11 aware that Child N had deteriorated on 3 June?
12 **A.** I cannot remember now and I do not know
13 whether I was involved with the deterioration of the
14 baby subsequently where I was involved, whether I had,
15 whether I had the presence of mind to --
16 **Q.** Dr Saladi, it may be my fault but can I just
17 ask you to speak up a bit?
18 **A.** I cannot remember whether I remembered about
19 the previous episode at that time.
20 **Q.** Well, Child N's deterioration on the 15th was
21 sudden and unexpected; is that right?
22 **A.** Mm-hm.
23 **Q.** Dr Brearey had just a few days later sent
24 an email saying that he wanted to know about that. Did
25 you speak to him or Eirian Powell about the sudden and

1 unexpected collapse of Child N?
2 **A.** I don't remember, specifically speaking, but
3 Dr Brearey was actually helping me in that
4 resuscitation. So he knew about that deterioration
5 because we had difficulty in securing the airway in that
6 baby.
7 **Q.** Now, the Mother and Father of Child N have
8 given evidence to the Inquiry about speaking to you?
9 **A.** (Nods)
10 **Q.** They say that you were not able to give
11 a reason for the collapse and it seemed to them that you
12 didn't have any answers.
13 **A.** (Nods)
14 **Q.** Is that the way that you recollect the
15 conversation you had with them?
16 **A.** I remember the consultation I had with them
17 after the baby was discharged and they first came and it
18 was a very stressful consultation for me, that's why
19 I remember, because the parents were rightly upset and
20 rightly angry for the baby deteriorating and needing to
21 go to the Alder Hey Intensive Care Unit.
22 And I remember because my mouth was completely dry
23 and I couldn't say -- my words weren't coming out
24 properly and -- but I could understand where they are
25 coming from and the feeling. And now I do not remember

1 the exact words but I think they said: you have provided
2 substandard care and they were asked quite a few
3 questions, they did stuff I remember, but I thought --
4 I wasn't sure whether they were pointing the -- that
5 I provided the substandard care, or me as part of the
6 Trust provided the substandard care.
7 And I don't remember now but I probably would have
8 directed them to the PALS that -- the complaints
9 department, and I remember worrying about that meeting
10 because I discussed with my Consultants. They didn't
11 say anything about GMC but I thought they were unhappy
12 with the care I have provided and they -- I was
13 discussing with my colleagues that the parents are going
14 to refer to GMC, what do I do?
15 The parents said usually -- my colleagues said
16 usually parents don't do that, they don't lightly refer
17 to GMC they probably will make a PALS complaint and now
18 we do what we can because obviously we have to accept
19 that the care was not adequate because the baby did end
20 up in the intensive care and I did not have all the
21 answers. But I don't think I received a PALS complaint
22 as well because I had the notes with me for the next few
23 weeks.
24 So I thought they were referring -- that was the
25 recollection I had. So does that answer what you are

1 asking me?
2 **Q.** Thank you, I have got no more questions about
3 your conversation with the Mother and Father of Child N.
4 **LADY JUSTICE THIRLWALL:** Would you mind if I ask
5 one?
6 **MR DE LA POER:** My Lady, of course.
7 **LADY JUSTICE THIRLWALL:** You told us what you were
8 worried about and what you thought they might do, but
9 are you able to remember, because this is an episode
10 which you do seem to have a good memory of, can you
11 remember what you told them about what had happened to
12 their baby?
13 **A.** In that meeting my mouth was completely dry,
14 I was not able to speak well but I explained as much as
15 I could and I knew that I was not able to answer their
16 questions well because I did not have the answers myself
17 but --
18 **LADY JUSTICE THIRLWALL:** So you agree --- sorry to
19 cut across you -- because I think they said it seemed it
20 them that you didn't have any answers. Was that
21 reasonable impression for them to get?
22 **A.** I think so.
23 **LADY JUSTICE THIRLWALL:** Yes.
24 **A.** I think so.
25 **LADY JUSTICE THIRLWALL:** You are sure about that,

1 I don't want to lead you into it if it is not what you
2 mean.
3 **A.** Yes, I think so.
4 **LADY JUSTICE THIRLWALL:** All right, thank you.
5 **MR DE LA POER:** Dr Saladi, I am going to move
6 forward to the meeting that you have mentioned a number
7 of times now which is on 27 June of 2016. This is the
8 Monday meeting which you speak about in your witness
9 statement. It's paragraph 33 if you want to turn that
10 up on page 6.
11 You have told us already that that meeting caused
12 you sleepless -- two sleepless nights before you then
13 sent an email on the 29th. Can you, as best as you can,
14 just tell us what was being said at that meeting and by
15 whom?
16 **A.** I think it was Dr Brearey who was explaining
17 in that meeting and obviously I already knew certain
18 things that we had increased mortality in that -- in
19 that period. But that was the first time that
20 I realised that there was one member of staff who was
21 associated with that meeting -- with all -- all these
22 deaths. And the question was: what do we do next?
23 And if I remember correctly, it's about: can you
24 refer a nurse or any member of staff, just because they
25 happen to be associated, not causally, but with the

1 events, okay?
2 And that was, I was thinking of my own time when
3 I came to UK, because I trained in India and the UK
4 practice was different. So I was when I first came to
5 the UK I was going and attending all the sick children
6 because I wanted to know how is the things different.
7 So to blame somebody just because they were there
8 I am not saying they were blaming but we were discussing
9 at that stage; what do we do next? That was difficult
10 for me to swallow at that stage, even though I didn't
11 know what to do as well.
12 But I knew, remembering from -- again from the
13 description, that they were looking at the rota. But
14 I thought looking at the rota just to say somebody is
15 there or not is not a definitive way of answering the
16 question because at that stage we had two ways of
17 entering the neonatal unit. One is the main entrance,
18 which is with swipe access and the people who have the
19 swipe access are the neonatal doctors and nurses.
20 And then from the back of the neonatal unit, we had
21 stairs to the postnatal ward, which are controlled by
22 the digital lock. And obviously as far as I understand
23 the only people who know that digital lock is again the
24 paediatric -- the doctors and paediatric -- our neonatal
25 nurses, not the paediatric nurses.

1 So to say if somebody is there definitely in the
2 unit at that time we need to know who could have
3 accessed the postnatal ward as well and I know postnatal
4 ward also is accessed by the swipe card. So that means
5 somebody needs to look at at least minimum the rotas of
6 the paediatric doctors and paediatric nurses and the
7 doctors in the postnatal ward and the midwives in the
8 postnatal ward and I didn't think Steve would have
9 easily accessed that information because we were working
10 in two different departments.
11 And to definitely say that somebody is there, we
12 need that swipe access, that only the Trust could have
13 had or the police could have had and that's why in the
14 email.
15 **Q.** We will come to the email in a moment.
16 I think you have -- so these were the thoughts that were
17 going through your mind on the 27th --
18 **A.** Yes, yes.
19 **Q.** -- that a more detailed investigation needed
20 to be done?
21 **A.** Yes.
22 **Q.** Now, there is an email -- and I can take you
23 to it but I hope you will be able to remember it -- from
24 Dr Brearey in which he sends what he describes as the
25 consensus of the Consultants the day after that meeting,

1 that Letby should be excluded from the unit. Was that
2 the conclusion of you all at that meeting on the 27th?
3 **A.** See, after -- see in those couple of days
4 before I sent the email we, I remember we had quite
5 a few meetings so I am not sure at what point that email
6 came. But I can't see the email here.
7 **Q.** Let's bring it up. INQ0003116, page 2. It is
8 28 June there. You are not sent a copy of this but I am
9 asking you about it because --
10 **A.** Yes, okay.
11 **Q.** -- he speaks about the consensus.
12 So if you look at the third paragraph:
13 "There has been a watchful waiting approach since
14 our last meeting with Ian and Alison in March. However,
15 since the episodes and deaths last week there was
16 a consensus at the senior paediatricians' meeting that
17 we felt on the basis of ensuring safety on the NNU this
18 member of staff should not have any further patient
19 contact on the NNU."
20 **A.** Death of the last week.
21 **Q.** So this is the day after that meeting on the
22 27th and he begins the email with:
23 "I thought it might be helpful to put down in
24 an email what was discussed at the senior
25 paediatricians' meeting yesterday lunchtime."

1 **A.** This is after the senior paediatrician --
2 **Q.** Exactly, the day after. And he is saying the
3 conclusion was of all of the Consultants Letby ought not
4 to have access to patients?
5 **A.** I think so.
6 **Q.** Was that your view as well?
7 **A.** Yes.
8 **Q.** We are now going to have a look at your email,
9 the 29 June 2016, sent in the morning INQ0003112. We
10 are going to go to page 3, please. You can see that
11 email begins there -- I know that this is an email that
12 you have looked at closely recently, Dr Saladi, to try
13 to put your thoughts together.
14 But if I just summarise what the email says, it is
15 that you reached the conclusion and you have set out
16 your reasons in the email that the police were the right
17 people to investigate?
18 **A.** Mm-hm.
19 **Q.** Is that right?
20 **A.** That is correct. Police, I didn't know if
21 there is some -- some other agency which could help. So
22 that question mark was there because if I can explain my
23 thought process at this stage. When we are providing
24 a neonatal care, particularly in a district general
25 hospital, we see four groups of setbacks, okay, one is

1 unexpected setback, so this is a baby who is receiving
2 a care in the neonatal unit, may be on the ventilator,
3 their oxygen levels comes -- goes down and the alarms go
4 off or it could be a baby who is feeling well until
5 then, suddenly they stop absorbing the feeds or they
6 might start vomiting or the baby who is suddenly well
7 not opens the bowels. Various what we call setbacks.
8 These are the common problems which we see and all the
9 paediatricians and the neonatal nurses who work in the
10 neonatal unit are experienced with this, that these are
11 the setbacks and we explain to the parents as well, that
12 the stay in the neonatal unit is two steps forward and
13 a step backward because of these unexpected setbacks,
14 that is a common experience.
15 So in these setbacks babies might actually need
16 some extra oxygen and sometimes we might need to even
17 give some extra breaths while we clear their airways and
18 make them settle. So they might even need very brief
19 respiratory support as well.
20 Then the next group of conditions what I would
21 consider is unexpected setbacks leading on to cardio
22 respiratory collapses. Those are much less common
23 because babies' hearts usually do not stop, as long as
24 they are getting oxygen they keep going, so they don't
25 decrease. So somebody who is needing full cardio

1 respiratory resuscitation, it can occur in the -- at the
2 time of birth, but after that it is quite -- well, it is
3 less common at least in my experience and usually they
4 do respond and if that is probably the situations where
5 we discuss with regional units, particularly if we
6 cannot explain why they have deteriorated. And if the
7 investigation showed a reason for the explanation, and
8 if that can be managed in the district hospital, they
9 might stay with us.
10 Or if it is something which cannot be managed or if
11 it is something which needs regional centres, we send
12 them to the regional units which might need like
13 surgical intervention, a cardiac intervention, things
14 like that.
15 Then the next step up is unexpected setbacks
16 leading on to death. These are extremely rare in the
17 district general hospital. We do have deaths in the
18 neonatal units but they are usually expected deaths.
19 They are expected because there is an antenatally
20 detected abnormality which we know is not survivable and
21 there are some conditions like that. Or they are very
22 extremely preterm and they know that again they are not
23 survivable. And usually in these situation we inform
24 the parents, we prepare them and so those are the deaths
25 which normally happen in a district hospital.

1 Unexpected deaths are very rare in district
2 hospital because we usually manage to stabilise them and
3 they are usually sent to the regional units and if they
4 are very, very unwell they might deteriorate and they
5 might die in the regional unit after a few days or
6 a decision might be done taken in the regional centre
7 with the discussion with the parents to withdraw the
8 care.
9 So that's in the district hospital. Unexpected
10 deaths in a district hospital are extremely rare and
11 that's why we usually discuss all of them with Coroner
12 because the usual condition is -- for unexpected deaths
13 is some unrecognised kind of anomalies, cardiac anomaly
14 and that's where we might ask for a Coroner's postmortem
15 or they might say, well, suggest to parents and if they
16 are interested, go for hospital postmortem so that we
17 find out the cause.
18 Then the next category is unexpected deaths which
19 were unexplained even after investigations. They are
20 extremely rare and I think this is my opinion,
21 unexpected deaths which remain unexplained in a district
22 -- in a district general hospital a paediatrician might
23 see only a couple in their career and I already seen one
24 that year and during that meeting when I am hearing that
25 there are lots more unexpected deaths, which are

1 unexplained by the other colleagues as well, that is
2 a concern.
3 I probably did not recognise when we were having
4 these in the perinatal morbidity and mortality meetings
5 because we do not know the information of -- we discuss
6 them usually before the pathology reports are available.
7 So I probably did not recognise that these remained
8 unexplained until all that information is produced or
9 Dr Brearey is discussing at that stage.
10 So that is a concern, we are having a cluster of
11 unexpected but unexplained deaths at that time and the
12 worry is: could this be due to infection because we had
13 the taps, all the taps covered with filters.
14 So that means something else is going on and if
15 somebody is saying that one person is also associated
16 with all these deaths, that is even more worrying and
17 the -- sort of that's a suspicion and if we have
18 suspicion and I thought one of the teams who can deal
19 with suspicion is the police because we are not good
20 with dealing with suspicion.
21 And that was the reason I wrote that email and
22 I said in the last but one paragraph, "it is unreliable
23 information", maybe I should have said "it is incomplete
24 information" because of the reason I mentioned before,
25 that when we are suspecting we need much more

1 information than just looking at the rotas.
2 **Q.** Dr Saladi, you go on to say in your email --
3 we don't need to look at it, I am sure you remember very
4 well -- that you recognise the police were able to do
5 wider enquiries such as looking into people's lives
6 searching this their homes, that sort of thing?
7 **A.** Yes.
8 **Q.** So thank you very much --
9 **A.** And I think after that we met the senior
10 managers either that evening or the next day.
11 **Q.** We are going to have a look at that.
12 **A.** Okay.
13 **Q.** We are going to have a look at that.
14 **A.** Yes.
15 **Q.** I just need to ask you one question just to
16 see if you can help us with it.
17 Over the page, on the screen we are just going to
18 look at the top of it, just to see if you can help us
19 with one very small part of this.
20 You say:
21 "We have moved this particular staff member from
22 night shifts to day shifts and from ITU care to HDU/SCBU
23 care."
24 Can you just help us. The Inquiry has received a
25 great deal of evidence about movement from night shifts

1 to day shifts. Who told you that Letby had been moved
2 from ITU to HDU/SCBU care?
3 **A.** I thought most of the information was coming
4 from Dr Brearey. But I don't know whether this was some
5 other team member spoke, but that was my recollection.
6 At least that information was given, but I cannot say
7 who gave that information.
8 **Q.** Thank you. If we move up, please, this email
9 thread. We will see on page 2 that Mr Harvey, there we
10 are, we can stop there, has sent an email to all the
11 Consultants saying:
12 "It has already been discussed and action is being
13 taken. All emails cease forthwith."
14 What was your reaction to receiving that email?
15 **A.** I was hoping that this will generate
16 a discussion because I know the senior the ward manager
17 had a different opinion about probably the deaths and
18 particularly about Lucy Letby and maybe I thought if you
19 could explain these, what I was explaining to you, these
20 unexpected and unexplained deaths why we were giving
21 importance, which all the Consultants had at that time,
22 maybe they would.
23 But that opportunity did not arise because ...
24 Yes, I don't know whether I -- did I answer your
25 question?

1 **Q.** You have, thank you. So we can take that
2 document down. We are going to move forward to the
3 meeting that you have mentioned on 29 June. It was at
4 ten past 5 and we have some notes of that meeting.
5 INQ0003371.
6 This is a meeting we can see that you are
7 identified at the top as having attended. Also present
8 "TC", Tony Chambers, "AK", Alison Kelly, "IH",
9 Ian Harvey and the initials on the far right "SPC" we
10 understand to stand for Stephen Cross.
11 I just want to ask you about one thing you are
12 recorded as saying at page 2, please. About a quarter
13 of the way down you use a phrase that that I think you
14 have used with us:
15 "Preterm babies two steps forward one step back
16 don't suddenly deteriorate, these babies are relatively
17 stable sudden deteriorate and collapse."
18 And can you recall saying that to the Senior
19 Executives in that meeting?
20 **A.** I might have said if they have documented.
21 **Q.** I beg your pardon?
22 **A.** I might have said if they have documented.
23 **Q.** Yes.
24 **A.** I don't remember that.
25 **Q.** But that was something that you were thinking

1 at the time as you have told us?
2 **A.** Yes, yes.
3 **Q.** Do you remember at this meeting whether
4 Stephen Cross said anything about the police, if not
5 necessarily at this meeting but at the meetings that
6 were taking place at this time that he was attending?
7 **A.** In that period, when we were discussing about
8 what is an extra way -- how do we proceed, the thing
9 I remember senior managers were saying is: this is
10 coming across as doctors versus nurses, so that is why
11 we will involve a external body, completely independent,
12 which will have representation from the RCPCH and they
13 will have a nurse representation as well, probably from
14 Royal College of Nursing, and if they say that this
15 is -- if they agree with what you are saying, then we
16 will go with the police.
17 At least that's what I remember. That was the
18 outcome of our discussions.
19 **Q.** My question was particularly about anything
20 that Stephen Cross may have said about the police and
21 whether you had a recollection of him saying anything at
22 all at that time about whether the police should or
23 shouldn't be called or --
24 **A.** I think there was talk of red tape and also
25 like the media vans will be all on our grounds and so

1 there was some concern that we will be in the media
2 spotlight at -- yes.
3 **Q.** Now, I will just read it out to you. What you
4 say of this meeting in your witness statement is:
5 "However, the feeling I seem to remember from the
6 time was that the senior management seem to have made up
7 their mind with the investigation they have conducted
8 without taking our concerns into consideration."
9 That's what you have put in your witness statement.
10 Can you just tell us about why you said that in your
11 witness statement? We can take this document down,
12 thank you very much.
13 **A.** So when we were having this discussion, the
14 question was we were having unexpected, unexplained
15 deaths and we are seeing one member of staff identified
16 with it. How do you proceed with it? Obviously
17 I worked with Lucy and she appeared as a competent
18 nurse, so I did not have any direct worry or suspicion
19 on her.
20 So I thought they will gather information, they
21 will get all of us together, when I say all of us at
22 least all the Consultants and the ward managers of the
23 neonatal unit and maybe the deputy manager, and get all
24 of us together and share the information as to why they
25 are supporting her so strongly. Would they still do the

1 same if we can put our thing forward as well?
2 Unfortunately that has not happened. By the time
3 that we went there they were already talking about,
4 well, there were not enough Datix reports, we have
5 looked at the -- so it -- I was thinking that they were
6 looking for information sharing, at least exploring our
7 concerns. That did not happen and that's why I thought
8 they had already made up their mind.
9 **Q.** I think there will just be time to look at the
10 last meeting in June, 30 June of 2016. This is
11 INQ0003362. It should come up on your screen.
12 We can see you are identified as being present as
13 are some of the others that I have already mentioned.
14 We can also see "DN" as the, or what appears to be "DN"
15 anyway as the second initial along.
16 Do you have any recollection of attending a meeting
17 that Sir Duncan Nichol, the Chair of the board,
18 attended?
19 **A.** I do not recollect. I don't know. I might
20 have met, but I don't remember now.
21 **Q.** And if we go over the page just to look at
22 something that Dr Jayaram is recorded as saying. At the
23 very top he is recorded as saying:
24 "Starting point what is safe reduce service but
25 staff member not addressed. Discuss going to police..."

1 And a word that I won't attempt to decipher:
2 "... impact of an investigation."
3 I will just -- can you recollect a discussion where
4 there was, on the one hand, being suggested that the
5 unit was downgraded but, on the other hand, Dr Jayaram
6 and/or any of the other doctors present pointing out
7 that downgrading the unit didn't address the specific
8 concern?
9 **A.** Yes.
10 **Q.** What was the reaction as you perceived it from
11 the senior managers as to when that point was made?
12 **A.** Well, I think that's what I was saying; that
13 they were looking at it as doctors versus nurses and
14 they would get an independent input from a team, RCPCH,
15 who are independent from us, with representation from
16 the nurses and if they say -- if they agree with us then
17 they -- then they would be going to the police.
18 At least that is the way I understood it.
19 **Q.** Just two more parts. Page 4, please, of these
20 notes. We can see about halfway down, next to the word
21 "Ravi", in terms of what was being said at that meeting:
22 "Concern potentially member of staff causing harm.
23 Recurring theme."
24 What I just wanted to ask you about, Dr Saladi, is
25 do you have a recollection of that being said in those

1 terms? So it's not just that we are worried about
2 a member of staff, but it's that we are worried about
3 a member of staff causing harm, so deliberately causing
4 harm?
5 **A.** Which date was it?
6 **Q.** This is the 30th.
7 **A.** The 30th. I think after I sent my email
8 because we were discussing -- because at that stage, we
9 weren't -- we weren't sure what she could be doing and
10 that is when in one of those meetings people were
11 talking about these rashes, "Do you remember this rash?"
12 And then I think Ravi had done some research and
13 then he said, "Yes, these sort of rashes were seen in
14 the air embolism."
15 If it was after that email, yes, it could have --
16 **Q.** We had moved over that email. But that email
17 was sent that morning. So it was sent on the morning of
18 the 30th.
19 **A.** And this is after that?
20 **Q.** Exactly.
21 **A.** Yes, it would have. It goes with that then.
22 **Q.** The final thing to ask you about about this
23 meeting if we just go over the page and this is just the
24 note. We can see a heading "Actions":
25 "Review nurse deep dive, exploring new model,

1 actioning new model, planning team, comms plan, press
2 release TV, downgrade and exclude might as well ring the
3 police now."
4 **LADY JUSTICE THIRLWALL:** "If".
5 **MR DE LA POER:** "If", forgive me. Thank you very
6 much indeed:
7 "Is everyone comfortable?"
8 And then some people are recorded apparently in
9 response to that question. I haven't seen your name
10 there but we can see that Dr Brearey, "Steve B":
11 "I made my views clear, nagging after last night.
12 We will take on observations; felt obs..."
13 Again I am not sure of that word. It might be
14 meeting.
15 **LADY JUSTICE THIRLWALL:** (inaudible)
16 **MR DE LA POER:** Yes, thank you, my Lady.
17 So at the end of this meeting, were you happy about
18 the decision that there be a review and a nurse deep
19 dive as opposed to the police being called?
20 **A.** See, I might be clumping all the meetings
21 together because I can't remember which day which
22 meeting has happened.
23 But my recollection is the reason -- we did discuss
24 about the police but the reason they did not say is
25 well, it is appearing like doctors versus nurses and we

1 need independent input and -- because if you are calling
2 police, then all the media spotlight will be on us,
3 nobody will be coming to our labour ward or neonatal
4 unit. So let's get an independent input and if that
5 shows, then we will go to the police.
6 **Q.** In terms of the concerns that you had about
7 any risk that Letby might pose, what did you think
8 needed to be done while all this process was going on?
9 **A.** I thought by then -- see, when we were having
10 these meetings in those first few days, if I remember
11 correctly, Lucy was away on leave so she was not
12 supposed to be coming for at least a couple of weeks and
13 there were quite a few meetings in those two weeks and
14 at some stage I think the management decided that she is
15 not going to come into clinical work.
16 Whether they decided or whether we had to insist,
17 I cannot remember. But that decision was made at that
18 stage in those two weeks.
19 **MR DE LA POER:** My Lady, would that be a convenient
20 moment?
21 **LADY JUSTICE THIRLWALL:** Yes. Actually just before
22 we do, I'm sorry Ms Killingback, can you put that
23 document back, please. It finished 00018 and can we go
24 to the previous page. Yes, that is the page. Thank
25 you.

1 **A.** Sorry, Madam, I have never seen these.
2 **LADY JUSTICE THIRLWALL:** You have not seen these
3 notes before?
4 **A.** Before you sent this to me. So I have seen
5 this report for the first time when the Inquiry sent
6 this.
7 **LADY JUSTICE THIRLWALL:** Yes, so that's a few
8 months ago, isn't it?
9 **A.** Yes, but I have not seen at the time of our
10 discussions.
11 **LADY JUSTICE THIRLWALL:** No, no, I understand that.
12 It was just there is a comment that you made or is
13 attributed to you about a third of the way down the
14 page. Do you see, I think that's your name there, isn't
15 it, "Saladi", and you are recorded as saying:
16 "Why review now and not before?"
17 It may be it speaks for itself but I wondered if
18 you could recall why you said that at that meeting.
19 **A.** "Why review now and not before?"
20 **LADY JUSTICE THIRLWALL:** You have told us about the
21 doctors v nurses and then we'll bring the RCPCH in and
22 that they will decide and then we will go to the police.
23 I just wondered if you recalled why you said, "Why
24 haven't you done this before?" if you did say that, and
25 if you can't remember just --

1 **A.** I can't remember.
2 **LADY JUSTICE THIRLWALL:** All right.
3 **A.** Sorry.
4 **MR DE LA POER:** My Lady, I just wonder if I
5 might --
6 **A.** I might be talking about the nursing deep
7 dive, I don't know. I am speculating now.
8 **LADY JUSTICE THIRLWALL:** No, that's all right. You
9 don't need to do that. Yes, sorry, Mr De La Poer.
10 **MR DE LA POER:** I don't know whether there is just
11 one other matter that I could draw attention to on this
12 page.
13 Dr Saladi, about two-thirds of the way down by your
14 name, it reads:
15 "You are looking at us, that's what it is using 2
16 different..."
17 **LADY JUSTICE THIRLWALL:** Words?
18 **MR DE LA POER:** Words?
19 **A.** Cards.
20 **MR DE LA POER:** Cards.
21 **LADY JUSTICE THIRLWALL:** Cards, yes.
22 **MR DE LA POER:** "... security review."
23 Again, does that help your recollection at all
24 about what you were saying question when you said:
25 "You are looking at us, that's what it is?"

1 **A.** I think they were talking about they were
2 looking at -- they were looking at who accessed the unit
3 with swipe cards, so I might have made some --
4 **LADY JUSTICE THIRLWALL:** I see, yes.
5 **A.** So I think it might be about the swipe cards,
6 I think.
7 **MR DE LA POER:** Thank you very much indeed.
8 My Lady, is that a convenient moment?
9 **LADY JUSTICE THIRLWALL:** It is. Does that conclude
10 the witness or is there more to come this afternoon?
11 **MR DE LA POER:** There is some more to come this
12 afternoon --
13 **LADY JUSTICE THIRLWALL:** That's fine.
14 **MR DE LA POER:** -- including Mr Baker. I will have
15 a few more questions.
16 **LADY JUSTICE THIRLWALL:** Of course.
17 **MR DE LA POER:** Then Mr Baker will be asking some
18 questions.
19 **LADY JUSTICE THIRLWALL:** Thank you. I wasn't
20 trying to hurry you, I was trying to work out where we
21 were.
22 Thank you very much, Dr Saladi. As you will have
23 observed we are going to take a break now and we will
24 start again at five past 2 and then there will be some
25 more questions for you but someone will look after you

1 over lunchtime. 5 past 2.
2 **(1.05 pm)**
3 **(The luncheon adjournment)**
4 (2.05 pm)
5 **LADY JUSTICE THIRLWALL:** Yes, Mr De La Poer.
6 **MR DE LA POER:** My Lady, thank you.
7 Dr Saladi, we are moving forward in our chronology
8 to 13 July 2016 when there was a meeting and I am just
9 going to ask for the notes to come up and we are just
10 going to look at one line within those notes, you have
11 seen them before because they were provided to you by
12 the Inquiry. It is INQ0003365 and if we could move
13 forward to page 4, please.
14 Now, Dr Saladi, at the bottom of this page, you
15 will see the date Wednesday, 13 July 1 pm. You will see
16 your name appearing just to the right of that dateline.
17 This is a meeting at which, as the Inquiry
18 understands it, senior managers presented activity and
19 acuity data to a group of Consultants, so that's the
20 contents of this meeting.
21 We can see it began with an outline from Ian Harvey
22 just below that and then we can see three or four lines
23 down at 1.12, so 12 minutes into the meeting, we see
24 your name, "left room" and then further along the line:
25 "distressed".

1 My question, Dr Saladi, is whether you can shed any
2 light on whether you recall leaving a meeting with
3 Senior Executives shortly after it began in a distressed
4 state?
5 **A.** I do not remember.
6 **Q.** Thank you. We can bring that down now, thank
7 you very much. Continuing to move forward through the
8 chronology, we know that you and your fellow Consultants
9 met with the RCPCH on 1 September 2016. You deal with
10 this in your witness statement at page 37 -- sorry,
11 forgive me, paragraph 37, my mistake, the page number is
12 page 8.
13 I want to ask you a couple of questions about that
14 meeting. Firstly what you say in the witness statement
15 was that you were disappointed to learn that they, the
16 RCPCH, were not looking at the deaths. Can you just
17 tell us what you meant by that and what you understood
18 the RCPCH was looking at?
19 **A.** Yes. So when we met the Senior Executives at
20 the end of June, I think, when we presented our concerns
21 and the fact that Lucy was there, at least from the
22 point of view of rotas, their statement, their argument
23 is well -- I am not sure argument is right word but what
24 they said is: it's coming across as doctors versus
25 nurses, so we will get an independent review which

1 involves doctors as well as nurses.
2 So as far as I am concerned RCPCH was coming to
3 look at the deaths of the babies and we met them as
4 a group and the first thing they said is: we are not
5 looking at the deaths --
6 **Q.** Sorry, no, you speak, please?
7 **A.** Yes. And then they asked us about our
8 protocols, whether we are having time for SPA that what
9 is supposed to happen this in a well-functioning
10 department and we sort of answered all of them,
11 obviously we had some issues with our rotas and things
12 like that, we expressed all of them. And -- but it was
13 very difficult to get a report of that and when we
14 called -- I don't know, I think I also called RCPCH,
15 they said it is the property of the Trust and they -- it
16 is their, in their -- I don't know the right word remit
17 or in their gift whether they went to provide the report
18 to us or not.
19 And it took quite a few months for us to get the
20 report and when we got the report it was on a printed
21 sheet which the Trust said we cannot disseminate and
22 within 24 hours or 48 hours they actually published that
23 report on the Trust website, which is of poor quality,
24 when I said poor quality, it is not the actual pdf
25 document of the RCPCH, I don't think they would have

1 sent such poor quality document. It's a image of the
2 pages which were reconverted into a pdf document which
3 could not be searched and I didn't know whether RCPCH
4 realised that the Trust was misusing their report in
5 such a way.
6 I don't think you have it because I don't see that
7 in your bundle, but I do have a copy of that in my Trust
8 things which I don't have access any more. But what it
9 showed is very bad print, difficult to read, the things
10 which are easy to read are in the bold and they never
11 mention in the bold that they were not investigating the
12 deaths and they came out with more than 20
13 recommendations which were all in bold. So people just
14 go to what is in bold.
15 **Q.** Can I just take you back, please, to that
16 meeting on 1 September because I just had one question
17 before we move forward in our timeline?
18 **A.** Yes, yes.
19 **Q.** Thank you very much indeed, Dr Saladi.
20 It is this: at the meeting that you had with the
21 RCPCH you and your colleagues said to the assessors who
22 had come that you were worried about a nurse on the unit
23 potentially causing deliberate harm; is that right?
24 **A.** Yes, yes.
25 **Q.** Yes. We will carry on with looking at the

1 chronology, we will get to the point of --
2 **A.** Yes, sorry.
3 **Q.** No, no need to apologise.
4 There was a meeting on 26 January 2017. You deal
5 with this in your witness statement at paragraph 55,
6 which was an Executive and Paediatric Consultant meeting
7 that you describe it as, at page 10.
8 You say that although you don't remember the exact
9 contents of the meeting why it was held or who led the
10 meeting, that's your (a) you say:
11 "I do remember the red face of Tony Chambers, his
12 forceful voice and him banking on the table."
13 And you say:
14 "It appeared as if the senior management had
15 completed the investigation without seeking any input
16 from or sharing the report of their commissioning review
17 with the senior clinicians."
18 Just please, if you can, in short summary form,
19 just give us your impression of that meeting and in
20 particular what you perceived to be the attitude of the
21 senior managers towards the paediatric Consultants?
22 **A.** I remember that meeting we were all sitting
23 round the table, Mr Tony Chambers were standing and they
24 sort of said they have finished the investigations and
25 banged the table like this (indicated) and they said we

1 are drawing a line under it and they said what we need
2 to do, like writing an apology letter and things like
3 that and obviously he was angry, red, that's the
4 recollection of the meeting.
5 **LADY JUSTICE THIRLWALL:** Did you say you were angry
6 or he is?
7 **A.** He.
8 **LADY JUSTICE THIRLWALL:** He was angry?
9 **A.** Mm-hm.
10 **MR DE LA POER:** Now, I am going to summarise the
11 next section of events for you and perhaps you can just
12 listen to my summary. Is it right, and the Inquiry have
13 seen all of these letters, that after that meeting,
14 there was a back and forth in terms of letters from the
15 seven of you Consultants to Mr Chambers and then him
16 replying, building to a position where the paediatric
17 Consultants said that they wanted the Coroner to be told
18 about their concerns?
19 **A.** That is correct.
20 **Q.** Is that right?
21 **A.** (Nods)
22 **Q.** It was early in that period, I think it was
23 around the 7th or so of February, that the paediatric
24 Consultants were given access, all of you, to the RCPCH
25 report?

1 **A.** (Nods)
2 **Q.** You have told us -- and the word you use in
3 your witness statement is that you had to fight for it?
4 **A.** Yes.
5 **Q.** Now, I am not going to put them up on screen
6 but you have had an opportunity to refresh your memory
7 from a WhatsApp chat that you and your colleagues had at
8 the time just before the report was released to you and
9 just summarise for us how you were feeling at that time,
10 so 7 February, about how the senior managers were
11 treating you as a Consultant body?
12 **A.** Is that after we saw the RCPCH report?
13 **Q.** Just before. It was just before and there was
14 a message just after?
15 **A.** Our communication, the relations between the
16 senior staff and the senior managers and the Consultants
17 had broken down, okay, and they were not sharing the
18 information and we had to fight for it and in the
19 meantime, two of my Consultant colleagues were involved
20 in -- I don't know whether a grievance process was
21 already going or it started subsequently.
22 So, and my feeling remained the same, that they are
23 making decisions without taking our views into
24 consideration, particularly our concerns that quite
25 a few deaths remained unexplained, they are not just

1 unexpected but remained unexplained.
2 I don't think they were looking at that aspect of
3 the thing well. That's what I thought.
4 **Q.** We know that during this period of time there
5 was conversation about Letby returning to the ward.
6 What was your position at that time about whether Letby
7 should be permitted to come back to the ward?
8 **A.** I don't think I was aware that she is going to
9 come back to the ward but we all has -- have decided
10 that before Lucy can come back to the unit they need to
11 look at the deaths and they need to have a good
12 explanation as to why these unexpected -- what is the
13 reason for these unexplained deaths.
14 So we were not happy for her to have patient
15 contact without explanation for these unexplained,
16 unexpected deaths.
17 **Q.** Was there any plan agreed between you
18 Consultants as to what you might do if the senior
19 managers insisted upon Letby coming back to the ward?
20 **A.** We were discussing at that stage what -- what
21 do we do and everybody, the way whistleblower, the way
22 the report is sent, the way contact some media and give
23 our concerns that this is all being hushed up by the
24 Trust.
25 But I don't think we had any firm plan as to what

1 we would be doing because we were continuing to insist
2 that Trust investigate the deaths properly and, yes, it
3 is speculation for me to say what we would have done if
4 she has come back. But I don't think we would have just
5 sat down and let her come back to the unit without our
6 concerns properly answered.
7 **Q.** In April, 12 April of 2017, you met with
8 Simon Medland QC, as he was then?
9 **A.** Mmm mm.
10 **Q.** And you deal with this at paragraph 62. There
11 are just two aspects of that meeting that I would like
12 you to deal with, please.
13 Firstly, what did you understand the purpose of
14 that meeting to be?
15 **A.** I think my understanding is how do we present
16 the case to the police. So he was trying -- before the
17 meeting our understanding is he was going to help us in
18 sort of not formulate, make it explain probably to the
19 police what are our concerns so that it's clear in our
20 all minds.
21 So I thought it was to clarify the thoughts in such
22 a way. Whereas when we actually met him, it transpired
23 that that was not the case. He was trying to -- again
24 he was trying to prove how it appeared as if they are
25 looking for proof from us. And well, we thought he was

1 saying that there was not enough proof and the police
2 wouldn't take it, police wouldn't spend their time and
3 energy on this but at least he heard all our concerns.
4 **Q.** Well, I was just going to ask you in order to
5 complete the picture, what you say at paragraph 62(c)
6 is:
7 "He was the first person in any capacity from the
8 trust management to ask for my side of the story and
9 I feel some of my colleagues felt the same"?
10 **A.** I agree with that.
11 **Q.** So was Mr Medland open to listening to what
12 you all had to say?
13 **A.** Exactly.
14 **Q.** Dr Saladi, there is one matter further that
15 I just need to ask you about. It involves us just going
16 back slightly in our timeline because one of the areas
17 the Inquiry is investigating is what information was
18 provided to the Coroner and I would just like to deal
19 with that event now.
20 Now, we know from records that you gave evidence to
21 the Inquest into the death of Child A on
22 10 October 2016?
23 **A.** Mm-hm.
24 **Q.** We also know that there were some witness
25 preparation sessions, did you participate in any witness

1 preparation sessions for giving evidence?
2 **A.** From the Trust's solicitors?
3 **Q.** Yes.
4 **A.** Yes.
5 **Q.** Did you have any discussion with Dr Jayaram
6 about what you might say to the Coroner about Child A's
7 death?
8 **A.** I do not remember.
9 **Q.** Now, can I make this clear. There is no
10 evidence that the Inquiry has yet seen that you were
11 ever asked a direct question about generalised concerns?
12 **A.** Yes.
13 **Q.** But can we just look at what you knew when you
14 went into that witness box to give evidence to the
15 Coroner?
16 **A.** Yes.
17 **Q.** So we will just run through very briefly what
18 you have told us: you had attended a meeting on 27 June
19 earlier that year during which colleagues raised the
20 possibility that Letby was killing babies?
21 **A.** Yes.
22 **Q.** You had written an email two days later in
23 which you said that you thought the police should be
24 called?
25 **A.** Yes.

1 **Q.** As you have told us you had been part of email
2 correspondence which suggested that air embolism may
3 have been used as a way of killing babies?
4 **A.** Yes.
5 **Q.** You attended a number of meetings with
6 Executives at which the concerns your colleagues had
7 were being repeated about the fact that they thought
8 deliberate harm may have been caused. You were aware
9 that Letby had been excluded as at that time due to the
10 fact that she might be responsible?
11 **A.** (Nods)
12 **Q.** You had attended the RCPCH meeting on
13 1 September, so just a month or so before, at which you
14 and your colleagues were telling the RCPCH that you were
15 worried that the deaths might not be natural?
16 **A.** (Nods)
17 **Q.** All of that you have told us already and of
18 course you told us with Child A that as far as your
19 interaction with Child A was concerned, was that they
20 were the healthier of the two babies when you had
21 dealings with them and that you had no reason to think
22 that Child A was going to die when you interacted with
23 Child A and provided care.
24 So my question, Dr Saladi is this: did you tell the
25 Coroner any of that?

1 **A.** No.
2 **Q.** The question which follows is: why not?
3 **A.** Again I think that was probably my first,
4 maybe first or second appearance of Inquest and I was
5 stressed and advice we got from the solicitors was
6 answer the questions, what is asked, don't answer what
7 you think was asked and keep it brief and do not
8 speculate.
9 So if the Coroner has asked me, I would have
10 probably said. But because it wasn't asked, because
11 what I didn't know is what is speculation at that stage.
12 So that's why I didn't -- I didn't -- I agree I didn't.
13 **Q.** Did you think that the information that we
14 have just run through was irrelevant to the Coroner or
15 did you think that it might be relevant?
16 **A.** See, we were discussing with that particular
17 child and as far as I am aware, Coroner is aware of the
18 deaths. I didn't need to tell them, okay.
19 **LADY JUSTICE THIRLWALL:** Why do you think that?
20 **A.** Sorry?
21 **LADY JUSTICE THIRLWALL:** Why did you think the
22 Coroner was aware of all the deaths?
23 **A.** Well, because when we were having these
24 unexpected deaths, we were referring them to the
25 Coroner.

1 **LADY JUSTICE THIRLWALL:** I understand.
2 **A.** So there would -- he would I would expect know
3 that there were increased deaths as well. What was your
4 next question?
5 **MR DE LA POER:** Well, my question was whether you
6 thought it might be relevant information for the Coroner
7 to know when he makes a determination about the legal
8 questions that he's got to answer about the death of
9 Child A.
10 **A.** I was thinking whether rightly or wrongly that
11 I was answering in relation to Baby A my involvement, if
12 I had any suspicion, and my answers were brief and to
13 that point, what he asked.
14 It is probably in retrospect mistake for me to not
15 share my concerns but that is because of inexperience,
16 I think. I did not have any experience with the
17 Coroner's process and that is why I am much more open
18 now rather than just answering what you are asking,
19 whereas at that stage, I was just answering what is
20 being put to me.
21 **Q.** So does it come to this: your position today
22 is that you should have told the Coroner that
23 information?
24 **A.** Not just that. The Coroner should have asked
25 me.

1 **MR DE LA POER:** Dr Saladi, that concludes the
2 questions that I have for you. My Lady, my learned
3 friend Mr Baker Kings Counsel has Rule 10 permission to
4 ask questions on behalf of the Families that he
5 represents.
6 **LADY JUSTICE THIRLWALL:** Very good, Mr Baker.
7 Questioned by MR BAKER
8 **MR BAKER:** Dr Saladi, when you gave evidence at the
9 Inquest, did you feel under pressure not to reveal your
10 concerns regarding Child A?
11 **A.** No. I was not -- are you saying I was under
12 pressure not to reveal? No, I was not under pressure
13 much.
14 **Q.** So you would have been entirely free to
15 volunteer your concerns?
16 **A.** I was under pressure of my own volition, not
17 because somebody has pressurised me, because it was new
18 to me to give evidence like that. So I was under
19 pressure and I was answering only what I was asked.
20 Does that make sense?
21 **Q.** You knew what the purpose of the Inquest was
22 though, Dr Saladi, was to find out the cause of
23 Child A's death?
24 **A.** Yes.
25 **Q.** Did you not think that that might have been

1 helpful information to the Coroner that you had
2 suspicions that someone may have murdered Child A?
3 **A.** Yes, I did think that way yes, it might have
4 been -- it's probably my mistake, I didn't consider from
5 that point of view.
6 **Q.** Are you sure you weren't concerned about the
7 consequences for you if you did reveal that?
8 **A.** No, in what way?
9 **Q.** Well, did you feel concerned that those who
10 employed you might put your job at threat?
11 **A.** No, no.
12 **Q.** I am going to ask you some questions in
13 general about the early part of the chronology of
14 events, so when people first became concerned about
15 deaths and collapses on the ward. You said in evidence,
16 and indeed it was said by Dr Newby, that there was
17 a concern amongst some that there may be a source of
18 infection on the ward causing collapses and deaths?
19 **A.** There was concern, yes.
20 **Q.** Yes. That concern was dealt with by
21 investigations as to potential sources of infection,
22 wasn't it?
23 **A.** Yes.
24 **Q.** Those investigations revealed no source of
25 infection?

1 **A.** There was no infection in the babies, that is
2 correct.
3 **Q.** Yes, not just in the babies, in the ward
4 either.
5 **A.** Well, we were having bugs from the taps.
6 **Q.** But filters were put over the taps?
7 **A.** I think even with the filters they were still
8 isolating the bugs.
9 **Q.** But the issue when it came to the babies is
10 that the babies were investigated for infection?
11 **A.** That is correct.
12 **Q.** Reliable evidence was obtained that those
13 babies had not been infected by any contamination from
14 the ward?
15 **A.** Yes.
16 **Q.** Yes. In relation to the rashes that had been
17 seen in Child A, B and D, you saw a rash in Child B and
18 you gave evidence that you were aware that people were
19 contacting various specialist teams for advice regarding
20 the rash?
21 **A.** No, for advice regarding the deterioration,
22 not about the rash.
23 **Q.** I see. The discussions about the rash in the
24 unit were: this is something that nobody could quite
25 explain what it was?

1 **A.** I do not think at that stage I was aware of
2 all the discussions which were going on about the
3 rashes.
4 **Q.** But you were aware that if a rash was
5 something that you couldn't explain, but you weren't
6 concerned about it because it had disappeared in
7 Child B?
8 **A.** Yes. Well, as I said, rashes are common and
9 we would worry if there are progressive rashes. So we
10 were worried as to why the baby deteriorated needing
11 resuscitation, but I probably did not pick up the
12 significance of the rash which was noticed in the night
13 which has become less prominent by the time I saw in the
14 morning.
15 **Q.** But the point is this: This was a rash, one
16 that you saw, that you were not able to explain. It
17 didn't fit with anything that you had seen before?
18 **A.** Well, at that stage I was thinking it is
19 probably some sort of infection which is causing the
20 rash.
21 **Q.** But infections cause rashes that persist; they
22 are not transient?
23 **A.** Not necessarily, yes, they can be transient.
24 **Q.** And you were unaware of discussions on the
25 ward regarding other people's concerns about rashes?

1 **A.** At that stage, yes.
2 **Q.** When it came to looking into the collapses and
3 deaths of the children on the unit, the concerns that
4 you had amongst your colleagues is that these collapses
5 were all unexpected and unexplained?
6 **A.** Unexpected, unexplained usually it is not
7 something we have that information prospectively. That
8 takes as I said a detailed postmortem examination which
9 was not available at that stage.
10 **Q.** But the concerns that you and your Consultant
11 colleagues were having were as you said in your email of
12 June 2016, that these collapses and deaths were
13 unexpected and unexplained?
14 **A.** That is correct, yes.
15 **Q.** Yes. And so looking --
16 **A.** That is in retrospect.
17 **Q.** Yes, retrospect.
18 **A.** Yes.
19 **Q.** But the point is that looking at these
20 collapses and deaths even retrospectively, you were not
21 able to find a source that explained why the children
22 collapsed, let alone a common source?
23 **A.** Yes, that is correct.
24 **Q.** So in the case of Child D, who I think you
25 were involved in, there was a suspicion that their death

1 may have been caused by infection but in fact there was
2 no clear evidence that Child D did have an infection
3 causing symptoms prior to their collapse. Do you recall
4 that?
5 **A.** I will have to see the notes, but ...
6 **Q.** Well, if you don't recall, it's okay. We can
7 put that to other witnesses. But unexpected and
8 unexplained is important, isn't it?
9 **A.** It is.
10 **Q.** Because --
11 **A.** It is.
12 **Q.** -- in the context of a neonatal unit --
13 **A.** It is.
14 **Q.** -- collapses when they occur are usually
15 expected, but in any event can always be explained?
16 **A.** Sorry, say the second part?
17 **Q.** So collapses in a neonatal unit are commonly
18 expected --
19 **A.** (Nods)
20 **Q.** -- and usually can be explained?
21 **A.** Yes, it may not always be expected, unexpected
22 can still happen. But usually explainable.
23 **Q.** Yes. So it is the combination of unexpected
24 and unexplained that is important?
25 **A.** That is correct.

1 **Q.** Yes. Finally, I want to ask you very briefly
2 about an interaction that you had with the family of
3 Child J in December 2015. If I just explain to you
4 briefly the background to that interaction.
5 What happened was Mother and Father J complained
6 that they had found Child J in the COT with their nappy
7 off, their stoma bag off and a towel soaked in faeces
8 wrapped around them and they were concerned because
9 Child J had a Broviac line which was a potential source
10 of infection if it got dirty.
11 Do you recall having a meeting that you attended
12 with Family J and a nurse regarding that incident?
13 **A.** I do not recall the meeting. I might have met
14 but I don't remember.
15 **Q.** At that meeting, the nurse said to Family J
16 that they were probably just over-tired and should go
17 home and rest in response to their complaint. Does that
18 refresh your memory?
19 **A.** No.
20 **Q.** Regarding usual practice or your impression of
21 how perhaps people should have behaved, if a child with
22 a Broviac line was left covered in faeces or wrapped in
23 a faeces-soaked towel, it would be entirely reasonable
24 for their parents to be concerned by that, wouldn't it?
25 **A.** Absolutely, yes.

1 **Q.** Yes. That should have led to the filling in
2 of a Datix form, shouldn't it?
3 **A.** I would agree.
4 **Q.** It should have led to an acceptance that their
5 complaint was a reasonable one, not advice to go home
6 and have a rest?
7 **A.** I would agree, yes.
8 **MR BAKER:** Yes. Thank you, my Lady, I have no
9 further questions.
10 Questioned by LADY JUSTICE THIRLWALL
11 **LADY JUSTICE THIRLWALL:** Thank you very much
12 indeed.
13 I wonder if I can just ask one question.
14 Dr Saladi, you were asked the last question you
15 were asked by Mr De La Poer was about what you should
16 have told the Coroner and he asked: is your position
17 that you should have told the Coroner about the other
18 concerns? And you said: not just that, he should have
19 asked me.
20 The reason he should have asked you is because?
21 **A.** He knows that we will be under stress and we
22 may not be coming forth, coming forth with the
23 information. I am not saying that, see he has
24 experience, he knows that we will be under stress and
25 I don't know whether he will be aware of the legal

1 advice we will be given, so that is be brief, answer
2 only what you are asked and don't speculate.
3 So that is why I am saying maybe because he is
4 experienced and in that situation, that is a -- I am not
5 experienced in giving Inquests. But he is experienced
6 in running Inquests and I would have expected if he was
7 aware of -- because I was when we were going to the
8 Inquest we are not thinking of all the things, maybe we
9 should, but we are just thinking about what did we do,
10 what is my involvement, did I do anything wrong? Did
11 I miss anything? Our mental process goes like that.
12 **LADY JUSTICE THIRLWALL:** Well, you can speak about
13 your mental process. One of the things you mentioned
14 a bit earlier was that the Coroner knew all about these
15 earlier incidents.
16 **A.** Speculation, yes, because we would have at
17 least -- I sent two, I spoke to Coroner twice --
18 **LADY JUSTICE THIRLWALL:** Yes.
19 **A.** -- myself about these babies and I know my
20 colleagues referred some of the babies to the Coroner as
21 well.
22 So by the time the Inquiry came the Coroner would
23 have the information that there are more deaths in the
24 unit. It is from that point I mention. I wasn't trying
25 to be critical of Coroner. I was just -- I don't want

1 to come across like that.
2 **LADY JUSTICE THIRLWALL:** No, all right. Thank you
3 very much indeed, Dr Saladi. That concludes your
4 evidence. Is there something else you want to say?
5 **A.** I want to say two things, madam.
6 **LADY JUSTICE THIRLWALL:** Very well.
7 **A.** One is about the RCPCH evidence. I think the
8 Trust used the RCPCH evidence in such a way that it
9 showed our department in a bad way initially and they
10 used that to say that all these deaths were due to
11 a poorly run department and if you want I can explain
12 why, how that is done.
13 The second thing is I want to apologise to all
14 parents for not able to prevent the deaths and prevent
15 the harm done and it is a guilty feeling I carry and
16 I think I will carry for the rest of the life. I am
17 profoundly sorry for that.
18 **LADY JUSTICE THIRLWALL:** Thank you, Dr Saladi.
19 Mr De La Poer, do you want to ask anything arising
20 out of the penultimate observation?
21 **MR DE LA POER:** Nothing, thank you very much
22 indeed.
23 **LADY JUSTICE THIRLWALL:** Thank you very much. You
24 are free to go, thank you, Dr Saladi.
25 Now, there is one more witness for this afternoon

1 and I am told it will be more convenient were we to
2 start her evidence at 3 o'clock, so we will do that and
3 then we will run through to the end of the day. Thank
4 you.
5 **(2.42 pm)**
6 **(A short break)**
7 **(3.00 pm)**
8 **LADY JUSTICE THIRLWALL:** Ms Langdale.
9 **MS LANGDALE:** My Lady, may I call Dr Holt.
10 DR SUSIE HOLT (affirmed)
11 Questioned MS LANGDALE
12 **LADY JUSTICE THIRLWALL:** Thank you very much,
13 Dr Holt, sit down.
14 **MS LANGDALE:** Can you give us your name and
15 qualifications, please.
16 **A.** My name Dr Susannah Holt, I am known as Susie,
17 and my qualifications are Bachelor of Medical Sciences
18 and a Bachelor of Medicine and Bachelor of Surgery from
19 the University of Nottingham.
20 **Q.** Can you tell us your role at the Countess of
21 Chester Hospital from March 2016?
22 **A.** In March 2016 I was employed as a locum
23 Consultant and then in April 2016 I was employed as
24 a substantive Consultant. I was a general paediatrician
25 with an interest in gastroenterology.

1 **Q.** You have provided for us, Dr Holt, a statement
2 dated 4 June 2024. Do you have that with you?
3 **A.** I do, yes.
4 **Q.** Can you confirm that the contents are true and
5 accurate, as far as you are concerned?
6 **A.** They are, yes.
7 **Q.** You tell us at paragraph 4 when you first
8 became aware that there was an issue, you describe it as
9 an increased number deaths on the neonatal unit. When
10 you were interviewing, did you have any idea about that?
11 **A.** No.
12 **Q.** You tell uses it was at a meeting in April
13 with Dr Jayaram and Dr Brearey. What did they tell you
14 in April 2016?
15 **A.** There had been a death on the neonatal unit
16 and it was brought up in the Consultants' meeting the
17 following Monday and it was then I became aware that
18 there was some concerns about an increased death rate on
19 the neonatal unit. The exact details of the
20 conversation I'm afraid I couldn't recall now, but I was
21 aware that there was this death and some preceding that
22 and it was after that I asked for more information.
23 **Q.** So there was a death preceding that meeting.
24 In the first conversation you had, were all neonatal
25 deaths grouped as deaths or was there a discussion about

1 unexpected and unexplained deaths, distinct from other
2 deaths?
3 **A.** I couldn't -- I can't recall that kind of
4 detail, I am sorry.
5 **Q.** But you describe it as you not aware of
6 an increased number of deaths on the unit, so do I take
7 it it is more likely to have been a broader looking at
8 deaths or you just can't remember?
9 **A.** I can't remember.
10 **Q.** You tell us at paragraph 8 you can't remember
11 being involved in any specific debriefs or discussions,
12 is that the whole team that you were working at the
13 Countess of Chester in relation to any babies?
14 **A.** I wasn't involved in the resuscitation of the
15 deaths of any of the babies and therefore I wouldn't
16 expect to be and wouldn't anticipate being involved in
17 the hot debriefs that may have followed.
18 With regards to the Postnatal Mortality Review
19 Tool, which was the way this which neonatal deaths are
20 reviewed as standard, I did attend those in accordance
21 with my leave and other things, but again I'm afraid to
22 say with nine years I couldn't tell you exactly which
23 meetings I was involved in and which discussions.
24 **Q.** Do you know if you attended anything in
25 relation to Babies O and P, the two of three triplets

1 who died?
2 **A.** I can't remember, I'm sorry.
3 **Q.** You of course aren't there in 2015 with the
4 earlier deaths?
5 **A.** No.
6 **Q.** We asked you whether you had read or
7 understood NHS whistleblowing policies and knew how to
8 raise concerns generally and you said you had a paper
9 copy on your desk. In 2016 was that the case?
10 **A.** Yes. So I -- I don't know where it came from
11 but I had a paper copy of the NHS whistleblowing policy
12 and I had read it in relation to some of these worries.
13 In terms of what date I got it I couldn't tell you
14 though. I just know I had read it during that time.
15 **Q.** At some point in that year. You tell us in
16 your statement that between you as consultants you are
17 discussing issues of whistleblowing and the like, but if
18 we look at your statement, you say at paragraph 12:
19 "'We first wondered about calling the police. In
20 an email sent some months before that if I could change
21 one thing in my life and all of this stuff things I have
22 done, I could change one thing in my life. I would have
23 called the police that day."
24 I just want to ask you what email you are talking
25 about there? Is it the one we know that Dr Saladi sent

1 to colleagues about the police and we are all -- we
2 could all be suspects and the police should be called?
3 **A.** May I just read that paragraph?
4 **Q.** Paragraph 12.
5 **A.** Yes. (Pause)
6 **Q.** Do you see you refer to an email?
7 **A.** Sorry. You will just need to give me a second
8 I have got it. I will just read it.
9 **Q.** Okay.
10 **A.** Thank you.
11 **Q.** While you are doing that perhaps we can have
12 document 003112, page 3, Dr Saladi's email on 29 June.
13 **A.** I remember the email and when I received it.
14 **Q.** Is it the one that's just coming on the screen
15 because that's in June?
16 **A.** Sorry, it's ...
17 **Q.** 29 June, do you see that? If we go to page 4,
18 please, Ms Killingback. It's not there. INQ0003112,
19 page 3 and 4.
20 **LADY JUSTICE THIRLWALL:** We have looked at it.
21 **MS LANGDALE:** It was one from Dr Saladi. Should
22 I read it out to you?
23 **A.** It's appeared.
24 **Q.** Next page. That's page 1, so we are
25 looking -- if we go to page 4. You see this is the one

1 from him. You see that:
2 "I believe we need help from outside agencies"?
3 **A.** Yes.
4 **Q.** "We are all under suspicion. The only agency
5 who can investigate all of us I believe is the police."
6 It is that one, is it?
7 **A.** Yes.
8 **Q.** I just wanted to anchor the time of your
9 paragraph 12, so it is that one in June.
10 **A.** Yes, I think that is the one it relates to.
11 **Q.** Right, so if we go back to your statement now,
12 that can go down. If we go to paragraph 12, you
13 there -- perhaps we can have that page of your statement
14 on the screen to help others INQ0101112, page 3. Page 3
15 and 4.
16 You set out a number of observations there and how
17 you felt about not calling the police. It is page 3 at
18 the bottom, that's right?
19 **A.** Yes.
20 **Q.** Then if we go to page 4, we see the end the
21 quote. So if we go to the next page, thank you,
22 Ms Killingback.
23 Can you see there:
24 "... we all read ferociously. We read the GMC
25 guidance on whistleblowing. We talked to our defence

1 union. We all read all the case reports about Beverley
2 Allitt."
3 So you are talking about this time, June 2016, yes?
4 After you have received that?
5 **A.** The email was received, it's the first time
6 I think we had put in writing about talking to the
7 police. The context of that interview was kind of my
8 ramblings, I am not sure I would describe them all to
9 being exactly in June 16.
10 **Q.** Not the same time?
11 **A.** Yes, it was more a description -- the way in
12 which the questions were asked in that interview, it was
13 more of probably a bit of an emotional offload about how
14 hard it was at that time.
15 **Q.** Yes, I understand.
16 **A.** As opposed to a specific time point.
17 **Q.** So if we look at the content of it though, not
18 tying you to June thereafter at some point you tell us
19 that you read GMC guidance on whistleblowing, talked to
20 defence unions, what role could they have for you at
21 this point?
22 **A.** So we agreed at one stage to liaise with our
23 various defence unions and we all -- you pay your
24 defence union so you choose a different defence union
25 depending on arrangements about what any different

1 actions that we could take a different course of action.
2 **Q.** So did you talk to them about going to the
3 police or phoning the police or anything like that; you
4 can't remember?
5 **A.** I don't think it was specifically about
6 a question. I think it was more that we were in
7 a situation where we had a concern about a raised number
8 of deaths and that we had reported it and a lot of the
9 advice we got back was to continue to pursue within our
10 Trust because I think their feeling was the Trust have
11 heard you and they are taking steps.
12 **Q.** So when you say you had reported it, reported
13 it within the Trust to management?
14 **A.** (Nods)
15 **Q.** Raised concerns with management?
16 **A.** Yes.
17 **Q.** You say we had read all the case reports about
18 Beverley Allitt. Do you remember doing that?
19 **A.** I do, yes.
20 **Q.** You say you lived in this sort of slightly
21 dark world of just what did others do and how did they
22 do it. What did you mean by that?
23 **A.** How did that come to the attention of the
24 authorities and how did it get investigated? And
25 actually it transpired that it was through a different

1 means, actually, the death rate was noticed in the
2 intensive care unit of the tertiary hospital.
3 **Q.** So you found that out at the time or you
4 learned that subsequently?
5 **A.** At and around that time that was information
6 I found out.
7 **Q.** You say here:
8 "I think we were wrong to put faith in the
9 management system to make the right decisions. Because
10 I think, you know, reputation of course, it would cause
11 damage."
12 Do you want to elaborate on what you meant by that?
13 **A.** I was a brand new Consultant and I put faith
14 that the leaders within the organisation, the Medical
15 Director, the Chief Executive, would know and understand
16 how to, I don't know, process our concerns and apply due
17 diligence to scrutinise, you know, and look into our
18 worries. I don't think that is what happened and I felt
19 one of the -- one of the senses I got was that it was
20 protecting their own reputation and being concerned
21 about negative publicity for the hospital.
22 **Q.** You say at paragraph 13 that you:
23 "... recall that we, as a group of consultant
24 paediatricians, spoke to the Local Negotiating
25 Committee representative, at the time, Dr Sean Tighe"?

1 **A.** Yes.
2 **Q.** Were you involved in any discussion with him
3 or what did you understand had been, if not the
4 discussion with him?
5 **A.** No, I wasn't involved in the initial
6 discussion with him. He then attended a paediatric
7 meeting at some point so I do remember meeting him. But
8 again there were so many meetings there is a bit of
9 a blur as to what happened and in what order. But
10 I believe I know Steve Brearey was involved in
11 a discussion with him.
12 **Q.** You say there were lots of meetings. Were you
13 all on a corridor I have seen references to a corridor,
14 did you have offices or where were you based in the
15 hospital?
16 **A.** Yes. So we were based on the ground floor the
17 Women's and Children's building behind a fobbed door and
18 there were essentially sorry -- five offices off that
19 corridor and then our secretary's office and a further
20 three offices for the paediatricians off their -- off
21 the sort of bigger secretarial room.
22 **Q.** So plenty of chance for informal corridor
23 conversations as well as meetings?
24 **A.** Yes.
25 **Q.** Did you ever have management popping down to

1 see any of you there or other individuals from other
2 departments?
3 **A.** I had very little interaction with senior
4 management in terms of Medical Director, Chief
5 Executive, head of nursing, very limited interactions
6 with them during this timescale in 2016 and through to
7 2017.
8 I had a lot of interactions with my clinical lead
9 who was Dr Jayaram and with the sort of our business
10 managers so the people within our division who were
11 responsible for the day-to-day working rota
12 co-ordination, that kind of stuff.
13 **Q.** Who were your business managers?
14 **A.** They changed a number of times over the --
15 over the time even I was there. But it was -- certainly
16 I worked with -- I cannot even remember all their names,
17 I am sorry. Emma Jane was one of them at one stage who
18 was our paediatric service manager. But the only
19 interaction I had in the offices was when Sir Duncan
20 came to see me. I don't think he came specifically to
21 see me but he came, but this would have been much later
22 on.
23 **Q.** I am going to ask you about that when you met
24 him later?
25 **A.** Okay.

1 **Q.** But as a routine you wouldn't get any visits
2 from the board on the corridor?
3 **A.** No.
4 **Q.** In terms of training, you say:
5 "I did have training from the Trust [at
6 paragraph 14] on the processes used to review deaths
7 retrospectively in adults."
8 But it didn't cover child deaths or processes.
9 Can I ask you what your understanding was then
10 about what should be done where there was an unexpected
11 or unexplained death of a child in the hospital?
12 **A.** So I think this is a really interesting point
13 and it's something that I have thought a lot about
14 since. The sudden unexplained Unexpected Death in
15 Childhood policy is and should be applied in the
16 hospital as much as it would be in the community.
17 I think perhaps there was a bias in our thinking in that
18 we would very rarely over the course of a career use it
19 in hospital. The way in which it is written I would
20 suggest leans more towards the kind of community deaths
21 which is more typically where we would have met it as
22 a learning opportunity as a trainee doctor and in all
23 honesty, you know, throughout your careers, sudden
24 unexpected death in hospital is actually really, really
25 rare. Really rare.

1 **Q.** So I take it from that you didn't know that
2 you should refer to safeguarding boards or Child Death
3 Overview Panel or anything like that at that time when
4 there was a sudden and unexpected death in hospital?
5 **A.** So you wouldn't refer to a Child Death
6 Overview Panel, that would be standard process is that
7 all deaths are reviewed in a Child Death Overview Panel
8 that's part of the Child Death Review process.
9 **Q.** In 2016 was that your understanding?
10 **A.** Yes. Would I refer to safeguarding? So you
11 wouldn't usually refer a child after death to
12 safeguarding. That wouldn't be considered standard
13 process. You would refer a child that you were
14 concerned had come to harm to safeguarding, yes,
15 wherever that had happened.
16 **Q.** Might an unexpected and unexplained death
17 raise a question of harm, how could you conclude that if
18 it was unexpected and unexplained, that there wasn't
19 harm caused?
20 **A.** Sorry, say that again?
21 **Q.** You said you wouldn't unless there was harm,
22 so you wouldn't automatically refer a death, but
23 a sudden and unexpected and unexplained death might be
24 as a consequence of harm, might it, so you can't
25 eliminate that such a death hasn't been caused by harm,

1 so would you refer it?
2 **A.** But you would go through the process so --
3 sorry, it is the terminology is a bit different. So if
4 you recognised something was a sudden unexpected and
5 unexplained death there is not one referral there is
6 a whole process that you would go through which would
7 involve an immediate and urgent phone call actually to
8 different agencies to put in motion a Joint Agency
9 Response and that would include police, social services,
10 and then you would also proceed with standardised
11 documentation.
12 So, yes, it is a safeguarding process but it's
13 different to sort of a safeguarding referral, if that
14 makes sense.
15 **Q.** Do you know or did you know who were the
16 designated doctors for safeguarding in the hospital at
17 that time?
18 **A.** Yes.
19 **Q.** Who were they?
20 **A.** So my mind's gone blank and I shared an office
21 with her, so that is unforgiveable. Howie, sorry.
22 **Q.** Dr Howie Isaac?
23 **A.** Yes, was our designated doctor for
24 safeguarding and Dr Rajiv Mittal was our designated
25 doctor for child death.

1 **Q.** Overview panel. Did you have any dealings
2 with either of them?
3 **A.** As I said, I shared an office with Howie Isaac
4 for some of my first year as a Consultant and Rajiv and
5 Howie regularly attended Consultant meetings and had
6 offices on the same corridor as the general
7 paediatricians at that time.
8 **Q.** So do I take it when you had these concerns in
9 2016 and talking to your fellow Consultants, you would
10 have been talking to do Howie Isaac, or she would have
11 heard of it in any event because you were sharing an
12 office?
13 **A.** Yes, I would think so. It is really
14 difficult, isn't it, because I can't pinpoint any dates
15 for you, but like I say, they would attend some of our
16 Monday meetings and they were very much part of our
17 wider department, so I do think they would have been
18 aware of the concerns.
19 I would caveat that with I was only there for
20 a very short period of time, from the March -- and as
21 I said I really didn't know anything about it until the
22 April -- until the July when it was really very we were
23 it was more open because she had been moved off the
24 unit.
25 **Q.** Do you think in conversations with either

1 Dr Issac or others you were conflating deaths and
2 unexpected and unexplained deaths? In other words,
3 could have been talking about a higher mortality rate or
4 deaths without being specific each time about whether
5 a death was unexplained and unexpected?
6 **A.** We wouldn't in regular conversation be
7 emphasising, as you are in this process, "unexplained,
8 unexpected". But actually I would take you back to the
9 context of working in a district general hospital with
10 that level of neonatal unit, we wouldn't expect to have
11 that number of deaths over that period of time, so it
12 would have raised an anomaly that we were having so many
13 in a relatively short period. But like I say, I was
14 only there for the latter part of some of that, so can't
15 attest to the earlier conversations that may have gone
16 on, for example around February time when I know there
17 was a review done, because I saw it.
18 **Q.** You saw that February mortality review?
19 **A.** (Nods)
20 **Q.** When did you first see that?
21 **A.** That was in the April when I was told about
22 the concerns and as part of that, Steve and Ravi said
23 I could have a look at and see any of the relevant
24 information.
25 **Q.** What did you make of that when you first

1 looked at that?
2 **A.** Hard to say. It's devastating to even think
3 that. It's devastating when any child dies and so it is
4 devastating when you have a run of deaths and every
5 single one of those babies is somebody's loved one and
6 I never lost sight of that and I don't think the other
7 Consultants did either.
8 So you are inquisitive as to what, where, how has
9 this happened and your first thoughts are always about
10 medical causes I guess because that's my training. You
11 know, can they be explained by infection or ... and
12 I think if I remember rightly within that report, you
13 know, they had thought about things like superbugs which
14 is obviously very important to consider, and they had
15 thought about common medications and rare side-effects.
16 So.
17 **Q.** Had investigated and eliminated them?
18 **A.** Difficult to eliminate them but investigated
19 ed them and then thought about ways and means of
20 modifying the sort of guidance going forward, the
21 treatment plans, et cetera.
22 If I am honest, I don't think I really knew what to
23 think. I was very taken aback by it all and took a bit
24 of time really to process it.
25 **Q.** You work in palliative care don't you?

1 **A.** Yes.
2 **Q.** You, we can see from documents I am going to
3 take you to now, were very sensitive to what parents
4 were being told and how they were being told things; is
5 that fair?
6 **A.** (Nods)
7 **Q.** If we go, please, Ms Killingback to 0014414,
8 page 1 and 2. Dr Holt, what should come up, my Lady, it
9 is tab 5 for you, is external communication from the
10 Countess of Chester Hospital dated Thursday, 7 July at
11 2 pm.
12 This is at a time when the unit is about to be
13 downgraded. We see there what is stated in paragraph 1:
14 "Temporarily changing the admission arrangements
15 for our neonatal unit to focus predominantly on lower
16 risk babies after 32 weeks."
17 Paragraph 3:
18 "We have seen in some of our most poorly babies
19 those with high dependency needs an increase in neonatal
20 mortality rates for 2015 and 2016 compared to previous
21 years. In light of this we have asked for
22 an independent review of our neonatal service from the
23 Royal College of Paediatrics and Child Health and the
24 Royal College of Nursing which is expected to be
25 completed by the end of August."

1 We know before that the Consultants were sharing
2 various emails about a draft and statistical variations
3 and goodness knows what, and I am not going to take you
4 to that, Dr Gibbs was taken to this yesterday, but you,
5 in the middle of that, raise -- I think we were also
6 taken to this in Dr Gibbs' evidence at INQ0002693,
7 page 7, the question of what will the families be told?
8 **A.** Yes.
9 **Q.** We see there page 7. You say:
10 "What will be said to families who have experienced
11 an infant death if they contact one of us, the unit, the
12 Countess? Do we need to inform them by letter
13 separately? Where will we signpost them as this will
14 inevitably impact on their grief? Depending on how you
15 interpret duty of candour I believe the Trust are
16 obligated to inform the families."
17 You set the guidance out.
18 First and foremost you say what is the right thing
19 to do and then you talk about the duty. So that can
20 come down, if we may.
21 But can you explain to us what you were worried
22 about with that press statement in terms of the impact
23 on individuals who had had their babies looked after at
24 the Countess of Chester and worse, died at the Countess
25 of Chester?

1 **A.** I couldn't imagine how awful for any family to
2 read in the press or hear on the radio about mortality
3 rates and, you know, there being a change to the
4 designation of the unit where their baby may potentially
5 have been cared for before dying.
6 I thought it would just leave them, yes, shocked,
7 floundering and jumping to -- well, jumping to
8 conclusions and I thought the most appropriate and the
9 kindest thing to do would be to have actually spoken to
10 the families before we put that on the website. And
11 spoken to them in person if at all possible.
12 **Q.** What did you think they deserved to be told
13 before that was put on the website or should be told?
14 **A.** I think it -- I think it's really, really
15 difficult but I think the bottom line is that people who
16 have accessed the NHS deserve honesty and we are allowed
17 not to have all the answers at that time but they
18 deserved to know that there were some suspicions around
19 whether the deaths were natural and could be explained
20 by medicine or not. I don't think we can hide
21 information from essentially the general public, our
22 stakeholders.
23 **Q.** The Inquiry has heard evidence from parents
24 that they weren't either aware it was happening, when it
25 did happen they didn't get the report before others and

1 when they did get a report, it was a redacted report.
2 What do you say about that level of communication
3 with grieving parents?
4 **A.** I think it was cruel and I think we should do
5 better.
6 **Q.** The external communication refers to
7 an independent review from the RCPCH and also the Royal
8 College of Nursing. As far as you were aware, working
9 there, was anything ever obtained from the Royal College
10 of Nursing or requested of them?
11 **A.** Do you mean with regard to the review?
12 **Q.** Yes.
13 **A.** There was a senior nurse on the review panel
14 from -- who was representing the Royal College of
15 Nursing because I knew of her through palliative care.
16 **Q.** Right, so who was that? Which person?
17 **A.** You are going to challenge my memory today.
18 **Q.** Was it a doctor a nurse?
19 **A.** No, it was a nurse.
20 **Q.** Neonatal nurse?
21 **A.** Yes.
22 **Q.** Alex Mancini?
23 **A.** Yes Alex Mancini, thank you.
24 **Q.** That's the reference to the Royal College of
25 Nursing because she was on that board of review?

1 **A.** Yes, so my understanding is that she would
2 have been approached by the Royal College of Nursing as
3 their representative on that panel because I know the
4 other members were from the Royal College of Paediatrics
5 and Child Health.
6 **Q.** Soon after that communication from the
7 hospital, you attended a meeting in July 2016 with the
8 management, I think in the boardroom. You refer to it
9 at paragraph 35 in your statement and go on about that
10 later as well and you refer to a position paper that was
11 presented. Do you remember the meeting that I am
12 talking about?
13 **A.** Yes.
14 **Q.** Can I ask you please to have on the screen
15 just to check, this is one of a number of the documents
16 that were presented then INQ0003492, page 1. While
17 that's just being rotated, I think there were a number
18 of documents that were presented to you, wasn't there,
19 in that meeting?
20 **A.** Yes, but I do mainly rely on my -- the
21 information from my interview but, yes, there were
22 a number -- I think there were a number presented but
23 this is the one that I remember with the graphs of
24 acuity on it.
25 **Q.** That's right. So if we go on to page 2, 3, if

1 we could just move through that document, please, there
2 is a number of graphs on it, description of mortality
3 rates.
4 Can you tell us what you were being told in that
5 meeting? We know -- if I can give you the context, we
6 know from minutes Tony Chambers, Dr ZA, Dr Gibbs,
7 Stephen Cross, Dr Jayaram, yourself, can you remember
8 how many others were there?
9 **A.** No, but I remember the message that we were
10 being given which I couldn't corroborate because
11 I hadn't been there in the earlier part of -- well,
12 I hadn't been there in 2010, for example, that we were
13 being told that the rise of acuity and busyness on the
14 unit, that perhaps an increased number of deaths was
15 inevitable.
16 **Q.** There are various days between deaths
17 presented we see here, I am not going to take you to
18 them. But you remember following that at the time and
19 seeing that paper prepared I think by Alison Kelly and
20 Ruth Millward, you will be asked about that in due
21 course. That can come down, thank you.
22 So you saw that paper?
23 **A.** (Nods)
24 **Q.** You have given evidence in your statement
25 about it. How helpful did you find that review into the

1 concerns that you had as a Consultant and with your
2 fellow Consultants about the rise of unexpected and
3 unexplained deaths?
4 **A.** I thought it was unhelpful.
5 **Q.** Why did you think it was unhelpful?
6 **A.** I am not sure what role statistics have to
7 play in this situation. The death of each and every
8 baby needed to be scrutinised to understand whether
9 these were sudden, whether they were unexpected, and
10 that had been part of the sort of thematic review to
11 look at where it perhaps wasn't easy. It feels like it
12 should be easy to know if it is unexpected and
13 unexplained and that's not always the case in medicine.
14 But I think the individual patients were what was
15 important and the matters around what happened to each
16 of them rather than an arbitrary statistic like number
17 of days between deaths. I am not sure how that added
18 any useful evidence.
19 **Q.** You say, if you go to paragraph 39 of your
20 statement:
21 "We were shown charts and graphs of neonatal
22 activity and acuity ..."
23 Is that a word used frequently, "acuity", in the
24 NHS?
25 **A.** Yes.

1 **Q.** "... Acuity with the number of deaths
2 superimposed on it. They showed how there were busier
3 periods in 2014 and again in 2015 but it was not
4 a continuously increasing trend. I do not think acuity
5 on the ward was as a significant contributing factor.
6 It did forgot feel like it was an unmanageable workload.
7 We were busy but not so much that impacted on patient
8 safety in my opinion."
9 That was the evidence of fellow Registrars
10 yesterday, Dr Neame I think said it was no different
11 from other hospitals.
12 Was that your sense of the position on the ground?
13 **A.** Yes, it was. I would agree with Dr Neame.
14 I didn't have a comparison to draw to because I had
15 worked -- the last neonatal unit I had worked was Wirral
16 University Teaching Hospital's which is a different
17 grade of unit. But certainly going to Chester and
18 undertaking ward rounds I felt confident that I had the
19 time to see each of the patients, to consider where they
20 were up to, make a plan for their future care, feed back
21 to the families if they were there and present and then
22 manage any of the sort of troubleshooting of perhaps
23 babies who were newly delivered or on the postnatal
24 ward. I didn't feel like I couldn't do the work that
25 felt necessary to keep that cohort of patients safe on

1 a day-to-day basis.
2 **Q.** Were you doing daily ward rounds at that time?
3 **A.** We weren't -- as Consultants we weren't doing
4 daily ward rounds at that time. We were doing --
5 I think we did two Consultant-led ward rounds in our hot
6 weeks and then it was later on that we separated the
7 rotas and had daily ward rounds, daily Consultant-led
8 ward rounds. The patients on the days that we didn't do
9 a Consultant-led ward round would still be seen by
10 a senior paediatric trainee and we would always touch
11 base with them afterwards to make sure that they were
12 happy with plans for the day, anything untoward, both
13 from a patience safety point of view but also from
14 a trainee experience point of view that you want to make
15 sure that you are delivering good patient care and good
16 training.
17 **Q.** So what was your sense in the meeting? If we
18 go your statement again at paragraph 39 you say:
19 "The conclusions [at that meeting], in my opinion,
20 were reached by extrapolation rather than evidenced."
21 Whose conclusions, what do you mean by that?
22 **A.** If I remember rightly it was Ian Harvey who
23 presented the graphs about how busy the unit was and it
24 was therefore kind of concluded in the report but it was
25 spoken through on the day I think by Ian Harvey that you

1 know this was a reason to -- a way of explaining the
2 increased death rate and I would go on to say it's
3 really important that we did consider all factors, so it
4 wasn't to be instantly dismissed. It did need thought
5 and consideration because, you know, there are -- if
6 that had been a contributing factor, you would want to
7 take steps to remediate that, that would feel like
8 a much easier intervention.
9 But yes, it was the conclusion of the report but as
10 explained to us and articulated in that meeting by
11 Ian Harvey.
12 **Q.** You say that at the end of the meeting you
13 recall Tony Chambers said: so do you think we are doing
14 enough? Do you remember that now, can you hear him
15 saying that now?
16 **A.** Yes, I can hear him saying that.
17 **Q.** What was your response to that?
18 **A.** I live in Chester, I had two of my children in
19 the Countess of Chester Hospital and I was in my
20 mid-30s. So I had friends, one in particular who was
21 pregnant at the time, and my benchmark of good treatment
22 is how my family and friends would want to be treated
23 and with Lucy Letby still delivering care on the
24 neonatal unit because we hadn't done an investigation
25 that I felt was sufficient, I was really concerned, and

1 wouldn't have wanted that care for my friends, for my
2 family, and therefore I didn't consider it good enough
3 for the general public.
4 **Q.** You said that at the meeting?
5 **A.** Yes. I -- I remember giving the example of my
6 friends and not wanting them to have care there because
7 it didn't feel safe with the current uninvestigated
8 concerns.
9 **Q.** It appears that the meeting then had
10 a discussion about using covert surveillance on the unit
11 or one-to-one supervision of the nurses, including
12 Letby. Can you talk us through that discussion, what
13 was raised at that point in light of the concerns being
14 expressed by the paediatricians and you about patient
15 safety and babies?
16 **A.** So I think much like we had I have done
17 afterwards, you know, people were throwing up ideas to
18 think about, well, you know, what are the potential ways
19 we can improve the safety on the unit and reassure
20 people?
21 So it was very appropriate to think of the
22 different measures we might consider. I think they were
23 quite flawed and very difficult to do in the kind of
24 timescales that we were talking about. I have toiled
25 over the thought of CCTV and I know it comes up later in

1 my statement. But, you know, fundamentally to put CCTV
2 cameras over the cots of every single neonatal bed
3 across the country and make sure that they all remained
4 working and checked and all rest of it and then to have
5 some quite covert potentially means of harming babies,
6 I wasn't sure it would be good enough, even if it could
7 be done really quickly, both in the Countess of Chester
8 but also in the wider neonatal world.
9 **Q.** It appears that after that meeting, Letby was
10 taken off clinical duties and transferred to work at the
11 risk department, wasn't she?
12 **A.** Yes.
13 **Q.** The RCPCH report was commissioned?
14 **A.** (Nods)
15 **Q.** What did you understand the RCPCH report was
16 going to address?
17 **A.** I think this is where I was very naive.
18 I thought it would address our concerns and I thought it
19 would do a service review as well. I thought it would
20 be the two things.
21 **Q.** Can I just pause there. What concerns, just
22 summarise for me at that point in time what your
23 concerns were as a group of paediatricians as far as you
24 are concerned?
25 **A.** So our concerns were that we had a higher than

1 expected death rate in a neonatal unit, we had no -- we
2 had some medical explanation in part for some of the
3 deaths but as a cohort and it really was that as a group
4 when you looked at it all together, we were very
5 concerned that there was something else happening and we
6 were then aware of this uncomfortable association with
7 one particular team member.
8 **Q.** With Letby, who you discussed in the meeting?
9 **A.** Yes.
10 **Q.** Was that an uncomfortableness, even now I can
11 hear it as you are answering the question and just
12 saying "and we thought Letby might be involved". Was
13 that difficult to say at the time?
14 **A.** Yes.
15 **Q.** Why?
16 **A.** Just on a human nature, that what human wants
17 to hurt, to me any living creature, and then taking it
18 down to, you know, to hurt a baby, to hurt a defenceless
19 baby, to hurt the families, it's abhorrent in society to
20 think of people intentionally inflicting harm.
21 In the caring profession, it doesn't make any
22 difference, actually it is that fundamental respect for
23 human life, but we are in a position of privilege to
24 look after the patients that we look after. And I am so
25 grateful to the patients that I have looked after in my

1 ten years as a Consultant and I dread to think how many
2 years as a doctor. I think we are given trust and
3 respect that we will do our best and it just feels even
4 now even when the verdicts came out, it just felt
5 devastating to realise that someone had caused --
6 someone had murdered these babies.
7 **Q.** So when you say "the RCPCH would deal with our
8 concerns", you are in no doubt that there were concerns
9 about an individual and they knew that that they may be
10 involved in harming the babies?
11 **A.** Yes.
12 **Q.** Were you interviewed with the RCPCH in a group
13 or people or individually, can you remember?
14 **A.** I was interviewed in a group.
15 **Q.** Was it with Dr ZA, Dr V, was it that group?
16 You probably don't know the ciphers, do you?
17 **A.** I think it was, because if I remember rightly
18 Dr Jayaram and Dr Brearey were separate. So I think it
19 was that and there were only seven of us there at the
20 time.
21 **Q.** So you were together as Consultants?
22 **A.** Yes.
23 **Q.** Can you remember if you were asked directly
24 what your concerns were and if you raised how you have
25 expressed them now, the concerns about how this group of

1 deaths could be explained, an individual, did you say an
2 individual?
3 **A.** Yes.
4 **Q.** But not by name, or you did, or by rank, did
5 you say who it was, a nurse?
6 **A.** I am really sorry I can't give you that detail
7 with any accuracy. We did mention an individual that we
8 were concerned about an individual and -- but I wouldn't
9 know whether we said she was a nurse or whether we
10 actually named her.
11 **Q.** When did you eventually see the RCPCH report
12 or a version of it?
13 **A.** I think it was in late January/early
14 February 2017.
15 **Q.** Can I ask that you have a look please at
16 INQ0009618, page 9. This is a page -- it will come up
17 on the screen?
18 **A.** Thank you.
19 **Q.** It is a page from the RCPCH report, we know
20 there is two versions, a so-called confidential copy
21 and a disseminated copy. This is from the confidential
22 and you will see findings about an individual nurse.
23 Did you receive a copy with this section in it? Did you
24 read that? Take your time to have a look at it.
25 **A.** I don't think I saw this version. No.

1 **Q.** And we see on the next page, if you can just
2 go to page 10:
3 "Advise the Trust to follow corporate processes in
4 responding to allegations of misconduct by opening an
5 investigation. Also recommended a full and detailed
6 independent Casenote Review is required on the deaths
7 prioritising those that were unexpected."
8 So a recommendation that unexpected deaths needed
9 interrogation and also misconduct investigation. But
10 you say you didn't see that?
11 **A.** I --
12 **Q.** That version?
13 **A.** So I don't remember seeing the page you showed
14 me earlier entitled "The Nurse". I didn't see that
15 page. I was aware of I didn't know the bit about
16 corporate processes but I did know that they had
17 recommended a further Casenote Review because that was
18 the Jane Hawdon review, so I was aware of parts of what
19 you have shown me.
20 **Q.** We will come on to Jane Hawdon's review in
21 a moment, if I may. Dealing with the RCPCH, please can
22 we have INQ0101113, page 12. That's a document you
23 helpfully provided, Dr Holt, to the Inquiry and it is
24 the RCPCH in the news and it is an update that you
25 received as a member I believe, of a sort of press

1 what's going on?
2 **A.** Yes.
3 **Q.** Have a look at paragraph 2. What it says
4 about the hospital. Can you read us what it says there
5 and why that concerned you when you read it?
6 **A.** I thought it was inaccurate.
7 **Q.** Sorry, can you tell us what it says?
8 **A.** Sorry so:
9 "The RCPCH has been referenced across the papers
10 this morning as an invited review of the Countess of
11 Chester Hospital's neonatal unit which raised a string
12 of concerns about issues of staffing, led to a police
13 investigation. A neonatal nurse was arrested yesterday
14 on suspicion of murdering eight babies and a suspicion
15 of the attempted murder of six more."
16 My feelings on this were that it was --
17 **Q.** That can go down now, thank you.
18 **A.** It was unfair to talk about a string of
19 concerns regarding staffing. I think if they were going
20 to -- we acknowledge and accepted there were some parts
21 of that review process that had good and sound learning
22 for the Countess of Chester, but I felt it presented
23 a negative overview rather than a balanced opinion and
24 I thought the way in which it was written implied that
25 they had been instrumental in a police investigation and

1 that doesn't sit then and it doesn't sit now with my
2 opinion of what that review process did.
3 **Q.** You set out -- if you can go to your statement
4 please at paragraph 47, you say:
5 "I thought the RCPCH would use their neonatal
6 experience and knowledge to discredit the 'Position
7 Paper' and point out some of the errors in the thinking
8 of the Trust board members."
9 And you thought:
10 "... the RCPCH would reinforce our view that the
11 British Association of Perinatal Medicine ... staffing
12 levels were aspirational and not adhered to by many
13 units and therefore unlikely to be a major contributing
14 factor. I thought they would reaffirm that these deaths
15 were suspicious by nature of their gestation, timing and
16 unknown mode of death."
17 Is that still your view?
18 **A.** Yes. I think -- I don't know how much
19 discussion has been had before, so forgive me if
20 I repeat anything but the BAPM standards for nursing
21 were a very sort of set out and actually in a unit like
22 ours would at times mean you have got more staff on than
23 you need for the patients there, which -- yes, more
24 staff, perhaps better patient safety, but also we are in
25 a resource limited system and need to use resource

1 wisely.
2 So it's a set of objectives that look at actually
3 what is a safe staffing level rather than a blanket
4 level, I think would have been more helpful and as it
5 says there, you know, a lot of units around us,
6 certainly within the region, would also not have met the
7 BAPM staffing criteria so it felt unfair to sort of
8 highlight us.
9 **Q.** Did you think -- you also say at paragraph 53
10 the statement was factually incorrect. Did you think it
11 could create the wrong impression about the actual
12 concerns and the real issue from your perspective? Real
13 issue that there were unexpected deaths and you were
14 concerned that there was an association of one person
15 with those unexpected deaths?
16 **A.** I mean, if I am honest the Royal College
17 shouldn't have been sending out soundbites like that.
18 I don't think they do any more, I think it is unhelpful
19 and I think ...
20 **Q.** We know you followed it up with a meeting,
21 shall we take you there?
22 **A.** Yes.
23 **Q.** INQ00127440001, yourself and Dr Brearey went
24 to meet with a Jo Revill. We see here a note from
25 apology revenue he will to Russell Viner:

1 "Dear Russell and Mike,
2 "Emily and I met with two doctors [this is in July
3 2019] from the Countess of Chester last week to talk to
4 them about the background to our Invited Review service
5 and the ongoing investigation focusing on the College's
6 role during this period. The two doctors, Steve Brearey
7 and Suzy Holt, were very open with us and said they
8 valued having the chance to come to the College to talk
9 about their concerns."
10 If we go over the page, you set out your various
11 concerns and you say:
12 "The doctors had asked for the police to be called
13 in following concerns about the unexplained deaths of
14 eight babies during 2015 and 2016. The Hospital's
15 Medical Director decided not to do so and instead called
16 the College to do an Invited Review.
17 "In terms of reference, this review began as
18 a straightforward description of a service review but
19 then the Trust added a clause which asked us to look
20 into unexplained deaths. This is obviously not what our
21 IR process was designed to do and would have involved
22 different experts, as far as I can understand."
23 So it continues and you make reference:
24 "Following our review a Casenote Review was ordered
25 and carried out by Jane Hawdon but she didn't review all

1 of the cases. The doctors felt that this report [that
2 is the Hawdon report] was less comprehensive and work
3 the doctors had already done and there was a feeling
4 that the reviewers wanted to focus on BAPM standards.
5 "In their view, the Trust used our report to try to
6 keep the focus on the issue of staffing levels on the
7 ward."
8 So it continues.
9 Was that the Jane Hawdon report that you were
10 referring to there, just to check that?
11 **A.** Yes.
12 **Q.** What was the feedback from that from the Royal
13 College? You said a moment ago you wouldn't think they
14 would do that now, but what response did you get raising
15 those concerns?
16 **A.** Not -- I don't recall any further follow-up
17 from the Royal College after we expressed concerns to --
18 in that meeting. Interestingly, we asked then for
19 a full unredacted copy of the report and actually would
20 have preferred it to have been delivered by the Royal
21 College so that we knew it wouldn't have been redacted
22 and we were told that we couldn't have it.
23 **Q.** Whose property were you told it was?
24 **A.** Ian Harvey's.
25 **Q.** So unless Ian Harvey gave you a full copy, you

1 weren't entitled. Are you a member of the Royal
2 College?
3 **A.** I am a member of the Royal College, yes.
4 **Q.** So what happens if you are a member, what do
5 you get for that?
6 **A.** It's an annual subscription with access to
7 some events, we are expected to have membership as part
8 of our employment as a Consultant paediatrician. I also
9 sit on one of the committees at the Royal College, one
10 of the training committees at the Royal College, but --
11 and I think you have to be a member in order to sit on
12 those as well.
13 **Q.** But you say you felt let down by their
14 response to this and the information they provided
15 publicly --
16 **A.** Yes.
17 **Q.** -- about their review?
18 **A.** I did.
19 **Q.** You also comment in your statement about
20 Jane Hawdon's report and the value of that report and
21 what was needed if she was going to have a look at the
22 babies. What do you say about that what was needed to
23 do a forensic review of the babies?
24 **A.** I would counter this with I am not a forensic,
25 forensically trained. I do Child Death Reviews a lot in

1 my current post and I think it is a really important
2 part of what we do so that we make sure we continue
3 learning.
4 You need to have access to all the relevant
5 information and that is not always easily kept in one
6 place, there is often multiple sources of patient notes
7 because and it will depend on different hospitals how
8 they record things.
9 But you would need to make sure you had view of
10 medical notes, nursing notes, feed charts would be
11 really important, medication charts if they are not done
12 electronically, the observation scores so heart rate,
13 respiratory rate, things like that?
14 **Q.** X-ray reports?
15 **A.** X-ray, yes.
16 **Q.** Blood results?
17 **A.** X-ray, imaging, you would want all of those
18 things at your disposal. But I also think in such
19 a situation where your colleagues, albeit colleagues you
20 don't know, are raising concerns I wouldn't want to do
21 a review without asking them for statements or being
22 aware of what their concerns were. I think you risk
23 being blinkered and not knowing what you don't know.
24 **Q.** Moving forward, 26 January 2017. You weren't
25 able to attend a meeting where your colleagues were

1 required or requested to send an apology letter but
2 I think you signed up to an apology letter in any event
3 with them, didn't you?
4 **A.** (Nods)
5 **Q.** Shall we go to the apology letter it is
6 00031870001. There we are.
7 Tell us how you felt about doing that?
8 **A.** Devastated. I didn't feel it was appropriate.
9 I felt I didn't feel I had a choice and I am quite
10 embarrassed that we ever wrote that letter and sent it.
11 I don't know how it makes the Families feel to -- to see
12 that and have read that. I think it's -- I think it's
13 awful.
14 **Q.** Did you have much discussion between
15 yourselves at the time about the wisdom of that or the
16 expectation that you do that?
17 **A.** Yes, we had a lot of discussion about it.
18 **Q.** It can go down now, thanks.
19 **A.** We had a lot of discussion about it. And
20 I think the consensus was that we didn't feel we had
21 a choice and as you can see in the text of the letter,
22 it was an apology for how --
23 **Q.** She felt?
24 **A.** -- she felt.
25 **Q.** Rather than any suggestion that she was

1 innocent?
2 **A.** Yes.
3 **Q.** You were also aware that a further requirement
4 of the meeting was that Dr Jayaram and Dr Brearey were
5 to attend mediation with Letby.
6 **A.** Yes.
7 **Q.** What did you all make of that and how did you
8 think they were coping with that request?
9 **A.** It was -- it was a pretty astonishing time.
10 The challenge we had was that all of us feel very
11 passionately about our service and I say that even
12 though I don't work there any more, we all felt
13 passionately about our service and wanting to be able to
14 continue to offer a service and we were providing an
15 amazing service to the paediatric patients as well as
16 the redesignated neonatal unit and eating disorder
17 service and training the next generation of doctors.
18 I think we all felt that working with our board was
19 going to be better for the population than all of us
20 ending up on gardening leave, which felt like was the
21 insinuation from that January meeting, that if we didn't
22 toe the line then we wouldn't be remaining in our jobs
23 and I think it's important to remember at this point
24 that there was already talk of her returning to the
25 neonatal unit and we still didn't think sufficient

1 investigation had taken place.
2 So there was a degree of thinking actually we need
3 to also keep our voice and not be silenced to prevent
4 that happening.
5 **Q.** It comes very clearly across from your
6 statement in that earlier interview you did with
7 Facere Melius, you were anxious, weren't you, it wasn't
8 simply about whether you would lose your job, you were
9 very anxious and stressed knowing that the Trust
10 Executives were taking steps for her to return to
11 clinical work?
12 **A.** (Nods)
13 **Q.** Just can you expand on that, how that felt at
14 that time knowing that that was the projection?
15 **A.** It's difficult because now we have got the --
16 now we have the foresight of what actually happened it
17 changes how perhaps you felt at the time. But there was
18 so much swirling for us all. You know, it's easy now
19 that there is -- it is not easy, that's a poor choice of
20 word. We now know she has been tested in a court of law
21 and found guilty, but at that time we were still dealing
22 with uncertainty. We were still dealing with: can this
23 possibly be true, is that what's been happening? How do
24 we feel about her being returned to the unit and also
25 trying to do your job day-to-day et cetera?

1 So --
2 **Q.** Sorry.
3 **A.** It is horrendous.
4 **Q.** Sorry to cut across. Who was advocating for
5 Letby at that time? You say she may be coming back.
6 Amongst the nursing or management or doctors, if there
7 were any, you know, who was advocating for her being
8 permitted to be there?
9 **A.** I don't know, if I am honest. Certainly none
10 of the medical Consultants that -- the seven of us, none
11 of us were advocating for her return. I wasn't involved
12 in as many of the meetings with the senior nurses on the
13 neonatal unit.
14 **Q.** So you wouldn't know what they were saying?
15 **A.** I have had second-hand information about some
16 of the meetings but no, I wasn't involved in those
17 meetings directly.
18 **Q.** Okay, don't be worried that it is second-hand.
19 What was your impression about which nurses or senior
20 nurses were supportive of her position as far as you
21 were aware at that time?
22 **A.** If memory serves me right the previous Nurse
23 Manager, Eirian, had been incredibly supportive of Lucy.
24 **Q.** Eirian Powell?
25 **A.** Yes, Powell. I believe she actually retired

1 from work that Christmas, I can't remember.
2 **Q.** She was supportive of her. Anyone else? Was
3 Alison Kelly, as far as you were aware or not?
4 **A.** My understanding is that Alison Kelly was very
5 supportive. My -- I didn't really speak to any of the
6 nurses on the neonatal unit about it, I didn't feel it
7 was within my remit but I know many of them were good
8 friends with Lucy and were really traumatised and
9 themselves torn about what to think and how to think.
10 **Q.** Dr Gibbs gave evidence that he knew
11 Eirian Powell supported her and was positive of her and
12 that caused him to -- I don't know if there was
13 a reference to dithering but there was certainly
14 a reference to a pause in his thinking.
15 You at paragraph 76 say:
16 "You cannot have casual conversations about these
17 types of concerns [meaning your concerns that Letby was
18 harming babies] even with close family. I worried they
19 would not believe me. It all seemed so far-fetched;
20 like a storyline out of a movie and not something that
21 happens in 'real life'. I considered resigning."
22 Was the fact that there were other people
23 expressing very positive views about her at that time,
24 did that impact upon how clearly or how sighted you were
25 on the essential concerns?

1 **A.** Yes, I mean, obviously it would because we --
2 the fact that we knew with certainty around the death
3 rate, the facts that we knew without certainty how that
4 this come about and you had people that you worked with
5 and respected advocating very strongly for her and so
6 much so that Lucy turned up on a Christmas night out
7 that December, that John and I had gone to represent the
8 medical workforce on, and, you know, the two things just
9 seemed so hard to balance; that the nurses were so
10 supportive of her that they would still be inviting her
11 to come on a social evening, I think it was Eirian's
12 joint retirement do.
13 It was really, really hard to hold in mind and
14 balance all of these kind of conflicting and troubling
15 different opinions.
16 **Q.** So you are at a social event with her at this
17 time and is it all medical nursing staff?
18 **A.** It was the neonatal nurses and, like I say,
19 just myself and John went, having discussed it -- when
20 we became aware on the day we discussed it with the
21 police because I come back to you are desperately trying
22 to continue to work with these colleagues to provide
23 safe and excellent care and I just -- I couldn't believe
24 it when she turned up, I didn't think she would come and
25 so you are then faced with this.

1 **Q.** Just to be clear which December, which year?
2 Was this before your apology letter?
3 **A.** I think it was -- I think it was December 2016
4 but I might need to check that date.
5 **Q.** We know there were at least -- there was at
6 least one tea party to reintroduce her to the neonatal
7 unit; do you know anything about that?
8 **A.** I didn't.
9 **Q.** From what you are saying, it wouldn't surprise
10 you there was still social interaction with her at that
11 point?
12 **A.** (Nods)
13 **Q.** Can I ask you about a letter, please, at
14 INQ0003095, page 1, tab 11, my Lady. 30 January 2017.
15 A letter from the Consultants to Mr Chambers. You sent
16 your letter of apology at that point. You say:
17 "Although it was made clear that the Trust board
18 has drawn a line under this issue ..."
19 Just pausing there, that's a phrase that we hear
20 a lot "draw a line". Who's drawing a line and why?
21 **A.** So --
22 **Q.** Have you got some water there, Dr Holt?
23 **A.** I have some, thank you. Frog in my throat
24 from talking too much.
25 That is what it was reported the words

1 Tony Chambers used in the January meeting that I wasn't
2 in attendance at.
3 **Q.** " ... would be grateful for written
4 clarification on the board's understanding of the reason
5 for the increased number of unexpected and unexplained
6 deaths on the neonatal unit between June 2015 and
7 July 2016 and the actions that you and the board now
8 expect us paediatricians to take."
9 And you say there:
10 "Also each of us would appreciate the opportunity
11 to read the RCPCH Invited Review report and the report
12 of the Casenote Review undertaken by the external
13 neonatologists prior to these reports being released
14 publicly. Obviously these reports are extremely
15 sensitive and so we assure you that they will not be
16 disclosed outside our Consultant paediatric group."
17 Did you get that report at that time, from what you
18 have said earlier no?
19 **A.** So we were told we could go and pick up
20 a report from the -- a copy of the report from the Exec
21 office but it was not a full unredacted report.
22 **Q.** If we go to INQ0003117, page 1. Another
23 letter from you all on 10 February 2017. You tell us in
24 your statement you sent this because you had read and
25 considered the review reports from the RCPCH and

1 Dr Hawdon and had a chance to discuss them as a group.
2 Were you all in agreement that they didn't provide
3 reassurance around the deaths and collapses? We see
4 what you say here, if we go to the next page as well,
5 please, Ms Killingback.
6 You concluded this letter:
7 "It's been eight months since we escalated our
8 concerns to you and we do not consider any further
9 discussion within the Trust is in the best interests of
10 affected families or neonatal staff. Please be assured
11 that we as a paediatric consultant body are making this
12 request because patient safety is our absolute priority.
13 We hope a comprehensive external investigation will be
14 in the best interests of the bereaved families and those
15 affected by these sad events."
16 Do you know what response you got to that?
17 **A.** I think after this there was a verbal
18 agreement that the Trust would have a discussion with
19 the police but then what actually transpired was that
20 they were then invited -- told to go to a meeting with
21 a barrister.
22 **Q.** Can I just ask you to look at a couple of
23 emails before we go to that. Just give me a moment. If
24 we can go, please, to INQ0003395, page 2.
25 So what will be shown in a moment, Dr Holt, is

1 an email from Dr Brearey to Mr Harvey cc'ing you and
2 fellow Consultants. I would like to remind you of
3 summary of a meeting and agree the summary, I don't know
4 whether it is accurate and have a look at paragraph 2:
5 "... making it clear there is general
6 dissatisfaction from the Consultant body with the way
7 the Trust has handled this difficult situation since it
8 was escalated. All the paediatricians voiced concerns
9 at the time and all now feel their professional opinions
10 have not been given due regard."
11 If we go to the next page, page 3. It concludes
12 saying:
13 "Nim Subhedar stated at our meeting he too was
14 concerned the cause of death and/or deteriorations
15 remained unexplained in several cases. They should
16 undergo further detailed review".
17 Et cetera.
18 Then we see the response, if we can go to page 1 of
19 the same series, Ms Killingback, from Mr Harvey:
20 "Given the circulation list I felt it was important
21 to respond especially since these notes have
22 a particular slant and I am wary if I didn't respond
23 this might become the only version of the truth.
24 "I am surprise there is no reference to the
25 conversation about the Coroner. I am aware that you

1 have each had a letter from Tony Chambers that was able
2 to give more detail and confirm. Stephen Cross and
3 I had had a detailed conversation with both the Coroner
4 and the deputy."
5 What did you understand was the position of the
6 Coroner at this point and the Coroner's involvement?
7 **A.** So I know that some of the cases were
8 discussed with the Coroner at the time and I know that
9 the Coroner went on to request postmortems in some of
10 the cases. My understanding was that when Ian Harvey
11 spoke to the Coroner that he felt he had no role to play
12 and wouldn't consider reopening any inquiries.
13 **Q.** Is that what you understood from Mr Harvey?
14 **A.** That's what -- I don't know where I understood
15 it from, that's what I understood at the time.
16 **Q.** Okay. So you don't know who told you that or
17 who communicated that?
18 **A.** I think there is an email alluding to it.
19 **Q.** If we look at the third paragraph, Mr Harvey
20 in this email is at pains to say:
21 "It might have been stated, but it was not agreed
22 either, that there were small changes in the acuity,
23 I certainly would dispute this, or that by extrapolation
24 this couldn't play a part. I for one would not limit
25 myself to looking for a single cause."

1 So he is at pains there to set out what we see.
2 How frustrating was that, given the position you
3 had all taken on that issue and your experience of other
4 hospitals and staffing, et cetera?
5 **A.** I think we were just used to hearing that
6 response from him by this stage. We knew that they --
7 and by "they" I mean Alison, Ian, Tony and Stephen had
8 a very fixed opinion and it felt like we were struggling
9 to convince them of the need to think differently.
10 **Q.** Give me one moment.
11 The meeting with Simon Medland QC, what did you
12 understand that was arranged for? We know it took place
13 12 April.
14 **A.** It was -- it was a strange request of us. We
15 thought they had agreed to discuss it with the police
16 and then we were told that we were going to meet with
17 this barrister to think about how they framed the
18 information to give to the police or something along
19 those lines, which I think we were very disappointed
20 that there was another meeting with someone other than
21 a representative of Cheshire Constabulary.
22 **Q.** Do you think Mr Medland, as he then was, had
23 all of the information about your concerns before then
24 or do you think he came in not really understanding or
25 knowing the level of concerns, what was your sense of

1 that?
2 A. My sense of that meeting was that he came in
3 with a similar pattern of thinking to the people that
4 I have already mentioned.
5 Q. Senior management?
6 A. Yes. I think he came in well versed in what
7 they thought was going on and I found the meeting
8 really, really difficult.
9 Q. The decision to involve the Child Death
10 Overview Panel was raised in that meeting, wasn't it?
11 A. (Nods)
12 Q. With a view to what, what was the suggestion
13 I think you thought you may have raised it first,
14 somebody raised it in any event?
15 A. In his meeting in his minutes that we did see
16 afterwards, he says he suggested it. The way I remember
17 that meeting kind of unfolding was we -- there was
18 a sort of amount of discussion at the beginning about
19 what the meeting was for and a kind of understanding
20 that we were perhaps at odds even from the outset. Then
21 we did a lot of the talking and explained why we had
22 concerns.
23 Q. Which of the Consultants did most the talking
24 about the concerns, out of interest?
25 A. I'm sorry, I wouldn't be able to tell you.

1 Q. Okay.
2 A. And then he asked a few questions and then he
3 spoke a bit about there was a sense of disbelief in him
4 that we could be suggesting that these were potentially
5 criminal acts and I think he was trying to play it down
6 and then when it became -- it felt like he then realised
7 that that wasn't going to be an outcome of the meeting
8 so then there were a few other suggestions made, one of
9 which was CDOP.
10 Q. Child Death Overview Panel?
11 A. The Child Death Overview Panel, sorry, yes.
12 And another of which was that, you know, a further
13 internal review by somebody else.
14 Q. Was the purpose of the -- or the mention of
15 the Child Death Overview Panel at that stage to
16 highlight that there was a representative from the
17 police on that and that was a route to the police or was
18 it separately talking about the Child Death Overview
19 Panel, as far as you were aware?
20 A. I think it was slightly separate but I think
21 for me the -- it was a bit of: actually, it does put us
22 in front of the police, though, and that felt like --
23 that felt like a priority.
24 Q. That was in fact the way through wasn't it
25 with Nigel Wenham and the Child Death Overview Panel,

1 how eventually, not long thereafter actually, the
2 referral to the police was achieved?
3 A. Yes, yes.
4 Q. That meeting with Simon Medland was 12 April.
5 16 April, it looks as though you all had a meeting
6 with Sir Duncan Nichol, the Chair of the board. Can
7 I ask, please, that we look at INQ00066821, please, and
8 Dr Gibbs chooses to circulate to you all an email
9 summary of the actions Sir Duncan proposed taking at the
10 end of the meeting.
11 Were you all there at that meeting? Can you
12 remember or not?
13 A. Sorry.
14 Q. So it may have been a number of consultants
15 but you don't know if you were there. Did you know
16 Sir Duncan, would you have known him if he walked in the
17 room now?
18 A. Yes, I do know Sir Duncan. I had cared for
19 one of his family members.
20 Q. Don't worry about that, so you would recognise
21 him?
22 A. Yes.
23 Q. So if we look at what this letter says.
24 Sir Duncan, paragraph 3:
25 "... repeated several times he had come to listen

1 and he had understood what we were saying but it was not
2 his role to take sides. He thought it was highly
3 regrettable that there had been a breakdown in the
4 relationship between ourselves and senior managers.
5 "Sir Duncan urged us to try to repair these
6 relationships for the future, especially given the
7 challenge of the forthcoming reorganisation of Women's
8 and Children's Services in Cheshire and Wirral, although
9 he wasn't sure to what extent this would be possible
10 with Ian Harvey, given that he is leaving in a few
11 months.
12 "Actions: for communication and trust between
13 senior managers and paediatricians to improve
14 specifically to involve us prior to press releases
15 involving neonates and when there were meetings with
16 other bodies regarding our services."
17 Was that because he's got the point you were upset
18 by the communications not engaging families or parents
19 and also --
20 A. I mean.
21 Q. -- an RCPCH review?
22 A. Yes, it was communications as a whole. We
23 always wondered what was said to, for example, the
24 Coroner, what was said to Jane Hawdon before the review.
25 We always wondered whether people arrived with a set

1 bias and felt that if we had been involved in some of
2 these setting of terms then actually we might not have
3 seen so much biased thinking.
4 **Q.** Number 3:
5 "Sir Duncan offered to be our Executive Children's
6 Champion and we should use him in whatever way we felt
7 appropriate and he would work with Rachel, who will
8 remain our Non-Executive Children's Champion."
9 I am not sure that's the right name, but we will
10 see when we come to the Non-Executive Directors. But
11 what did you understand that role of Executive
12 Children's Champion was about?
13 **A.** It's a way of hospital boards trying to have
14 a sense of what's going on in the many departments that
15 make up a hospital. What I would say is that we did
16 meet Rachel, but it was infrequent and certainly not
17 helpful through this process and I don't really remember
18 what Sir Duncan did as our Executive Children's
19 Champion.
20 **Q.** What about going to the police at this point?
21 There is no reference here to whether he has expressed
22 a view about going to the police by16 April, that's what
23 you were saying at this point. Was there any -- that's
24 what you wanted championing, was there any movement on
25 that at this meeting?

1 **A.** Can you just remind me, what date was the
2 meeting with the CDOP panel?
3 **Q.** Sorry, say that again?
4 **A.** What date was the meeting with the CDOP panel?
5 **Q.** I can't remember now?
6 **A.** I think these happened very close.
7 **Q.** This is 16 April 2018 with Sir Duncan?
8 **A.** I think we had already ...
9 **LADY JUSTICE THIRLWALL:** I will look it up.
10 **MS LANGDALE:** 12 April. No, that was the meeting
11 with Simon Medland where you discussed the CDOP panel.
12 **A.** I think we had the meeting with the CDOP panel
13 in the diary at this point and what I would say is we --
14 we were slightly exhausted with our Trust and so my
15 focus was certainly on that next meeting with external
16 agencies.
17 **Q.** Did you have -- you can't even remember if you
18 were at that meeting with Sir Duncan in 2018?
19 **A.** I was because John makes notes that "I think
20 you two" and then mentions one of the other Consultants
21 and me were taking notes. So I was definitely at that
22 meeting. John gets details right.
23 **Q.** Was that the only time you met him in the work
24 situation?
25 **A.** No so I -- he -- he came down to the offices

1 and I happened to be on on-call one evening and I had
2 a conversation with him then but I couldn't tell you
3 where in the timeline that happened. We only really had
4 much to do with Sir Duncan in this sort of period of
5 2018, though.
6 **Q.** Going back to your statement, 110, just
7 a couple of things if I may. You went to speak to
8 Mr Green -- is it Mr Green or Dr Green?
9 **A.** I believe it is Mr Green.
10 **Q.** I thought he was Dr Green, a pharmacist,
11 Director of Pharmacy, who did the grievance procedure or
12 was investigating that. You say you went to speak to
13 him. When was that roughly? Much later or?
14 **A.** Yes.
15 **Q.** Have a look at your statement.
16 **A.** Yes, this was.
17 **Q.** Was it after you left the Trust, it looks as
18 though --
19 **A.** It was actually, yes, it was, it was at and
20 around the time I was leaving the Trust, if I remember
21 rightly.
22 **Q.** That's 2020?
23 **A.** Yes.
24 **Q.** So what did you say to him about that process
25 then or about the grievance?

1 **A.** I sat on one of the pharmacy groups at the
2 Countess and so I knew Chris through that interaction
3 and it became apparent that there was an exchange of
4 emails that was between Chris and Steve that was
5 probably steeped in kind of anger from the -- the
6 grievance process and I was keen to make sure that it
7 didn't impact -- I cannot even remember what the issue
8 was, but it didn't have an impact on our sort of
9 decision-making going forward.
10 I think we had become so aware that people were
11 given an incorrect account of us and the concerns that
12 we were raising and I got on very well with Chris,
13 I respected him, and I just wanted to ensure that he
14 wasn't acting under false pretences. So I had
15 a conversation with him about the grievance process and
16 about the concerns that we were raising and he did seem
17 to express surprise that he hadn't perhaps been given
18 full disclosure of the situation at the time.
19 **Q.** So that was long after it had been completed?
20 **A.** (Nods)
21 **Q.** Did you say: we had to send a letter of
22 apology and say what you felt about that?
23 **A.** I wouldn't know the details, I'm sorry. It
24 was a long time ago.
25 **Q.** No, I meant that you sent a letter of apology

1 to Letby, did he know that?
2 **A.** I don't know if he knew that or not.
3 **Q.** You didn't discuss her specifically, you just
4 concerned what your concerns were as Consultants?
5 **A.** Yes, yes.
6 **Q.** What did you make of the facts, what did you
7 hear about of the grievance process at the time and any
8 findings, did you know about that at the time it was
9 going on?
10 **A.** It was a really difficult time. It put a huge
11 amount of psychological stress on the whole Consultant
12 body and specifically on Ravi and Steve who really
13 struggled with it, so much so that Steve couldn't be
14 a part of the process. And we were really surprised and
15 saddened when Ravi got, again, a redacted version of the
16 grievance that there seemed to be statements in there
17 that were not evidenced and we didn't recognise as being
18 our behaviour at the time that had been upheld and was
19 sort of almost substantiated by this grievance
20 procedure.
21 **Q.** Were you interviewed as part of that or not?
22 **A.** No.
23 **Q.** So as you sit there, there was a grievance
24 procedure where your conduct was questioned and put
25 together, but there was no investigation into Letby for

1 the concerns you were all raising about her and her link
2 to unexpected deaths?
3 **A.** (Nods)
4 **Q.** What do you make of that now?
5 **A.** I don't think the grievance process followed
6 the recommended procedures and I think it should not
7 have happened, and I feel angry with those in a position
8 of responsibility who subjected us to that and have
9 never apologised for their behaviours at the time.
10 **Q.** Never apologised to you or generally?
11 **A.** I think they've got a lot of apologies to
12 make. I am not the most important person they need to
13 apologise to, in my humble opinion. That would be
14 The Families.
15 **Q.** I want to ask you about one document, if I
16 may. My Lady, I won't be much longer but there is one
17 document I would like to put to Dr Holt. Please,
18 INQ00067250001. That will come up in a moment.
19 Do you see this? So this is a table and, as far as
20 the Inquiry is aware, it looks as though it has been --
21 and I would like your help with this -- put together by
22 paediatric Consultants.
23 **A.** (Nods)
24 **Q.** Pausing there, there is a lot of writing you
25 all had to do about this, wasn't there? A lot of time

1 must have been taken by all of you.
2 **A.** Yes.
3 **Q.** You nod. That's not picked up. But how much
4 time was this taking, setting all these things out in
5 different ways in different versions and letters and
6 emails?
7 **A.** Hours and hours and hours of time. We all
8 worked significantly beyond our hours, and it was not
9 uncommon to find someone in the offices until very late
10 at night because at no point did we stop delivering care
11 to other children and young people. So this was all
12 done on top of Consultant roles.
13 **Q.** And correct me if I am wrong, but it looks as
14 though on the left there is some comment about
15 a communication, reply by management, and your comment
16 is on the right as a Consultant body. It gets a little
17 bit confusing to the left when I go through the whole
18 document. Is that because different people are
19 inputting into it?
20 **A.** Yes, different people inputted into it. So we
21 circulated this, just to try and not duplicate
22 information so that people would add a different
23 opinion. But, yes, try not to --
24 **Q.** You all put your own view or opinion in boxes
25 and added it and circulated it. What was it prepared

1 for?
2 **A.** It was in the back and forth of letters with
3 our management structure, essentially, trying to
4 highlight where we felt there were shortcomings in how
5 the matters were dealt with and how we were treated.
6 **Q.** It is not dated, as far as I am aware, but
7 obviously we can see the items that you are commenting
8 on. But if I look at the first page, paediatrician's
9 comments, you say here in, and you are referring to
10 a statement that has been made earlier:
11 "The statement is does not correlate with the
12 statements and actions of the board. Ian Harvey made
13 a public statement in February 2017 saying this means
14 that when we speak with parents, we can now share full
15 and accurate information on an individual basis. This
16 took no account of the four sets of parents for whom
17 there was no accurate information regarding the cause
18 for their babies' deaths. We cannot quantify the impact
19 on their grief of such misinformation."
20 So you were identifying this, although you hadn't
21 presumably yourselves had contact with parents at this
22 point, either. You could just see there was a chasm
23 there, a massive chasm to say the least?
24 **A.** Yes.
25 **Q.** If you go to page 9 of the same document,

1 please. The concern in the left-hand column:
2 "Please advise us why the medical director chose to
3 select only some negative comments from the reports and
4 to omit to mention that further investigation had been
5 recommended by an external reviewer."
6 And then the box on the right-hand side, third
7 paragraph:
8 "It was very clear in the meeting that the
9 Executives who spoke were trying to portray the neonatal
10 unit as a failing and stretched service with Consultants
11 who were being unprofessional, making unfounded
12 allegations against an innocent nurse. Selections of
13 the reports were selected to support this view. This
14 could be interpreted as a form of selection bias."
15 Do you see that?
16 **A.** Yes.
17 **Q.** Those reports of course, in part, continue to
18 be stated and quoted and cited, don't they?
19 **A.** Yes.
20 **Q.** How do you feel about that in terms of how
21 accurate that is?
22 **A.** Just angry. Angry that -- angry that we were
23 represented in that way because I don't think it is
24 a fair reflection on the service that we were providing
25 then, and that I hope they continue to provide now, and

1 I think -- yes, I don't think any -- I don't think
2 anything has sort of -- it's all remained almost as
3 a sort of paperwork from the time, so none of it's been
4 challenged since.
5 But I would kind of highlight that the most
6 important thing out of all of this time has happened and
7 that was getting investigation into the children's
8 deaths. I don't want that to get lost in this arguing
9 between us and the executive. I don't think those in
10 management should remain in NHS management. I don't
11 think they have shown the morals, the leadership, and
12 the compassion of managers I would want to see in an NHS
13 of the future.
14 **Q.** What do you think is important in terms of
15 qualities for senior managers in the NHS?
16 **A.** I think it is an incredibly hard job. I think
17 the NHS has many and wide-ranging issues, but I think
18 it's really important that managers remain accountable
19 to the most important people, and they are our patients,
20 and in order to be accountable you need to be able to be
21 visible, you need to have good processes in place, you
22 need to employ the right people and have the right
23 people around you.
24 But I think when things like this come up, you have
25 to be inquisitive, diligent and thorough and, yes,

1 I don't think they were.
2 **Q.** Finally, in terms of the culture within the
3 hospital, how would you describe the relationships
4 between the doctors and managers during the period
5 I have been taking you through?
6 **A.** It's important not to label all of the
7 managers as managers if that -- as in the same
8 terminology, because actually we had our service
9 managers, which is the sort of immediate level that we
10 interact with more frequently, and I think we had a good
11 relationship and a good rapport with them. And that's
12 true of, you know, for example, the women and children's
13 lead I have a really good relationship and I had back
14 then a really good relationship with the lead
15 obstetrician.
16 **Q.** Who was that? Dr McCormack?
17 **A.** Yes, and then it became Dr Sara Brigham.
18 The worst of our relationships was actually with
19 the board, with the people that we have mentioned, with
20 Alison Kelly, Stephen Cross, Ian Harvey, Tony Chambers.
21 **Q.** So was this more about people than roles for
22 you or a combination? You say there were other
23 managers, senior managers, you got on really well with.
24 So how would you --
25 **A.** Yes, it's really difficult because there are

1 different pockets of people. The way in which the
2 structures work is really complex and so, for example,
3 you have got a risk manager, you have got an HR manager.
4 Individually I got on well with many of the individuals
5 within our institution. The sum of it, the sum of the
6 problem, I still to this day don't quite know what we
7 could have done differently to have had a different
8 outcome because I think the layers of NHS management are
9 part of what makes this so difficult. Whose
10 responsibility was it to do what at what time and whose
11 responsibility is it to challenge when someone in
12 a position of senior leadership is so dismissive of
13 an issue?
14 And I think it is difficult but I also know then
15 that we had some very direct conversations with these
16 people. So it wasn't that things were getting lost in
17 translation.
18 **Q.** From the doctors' or paediatricians'
19 perspective, going to external bodies earlier themselves
20 was obviously a matter that you could have considered or
21 could have done. So we have spoken earlier about
22 phoning the police. What would have stopped you as
23 a group doing that at the time, or earlier, and for
24 those who were there before you in 2015?
25 **A.** I can't answer that question. I don't know

1 why we didn't and it is a huge regret and -- yes,
2 I don't know. But I am -- and I live with knowing that
3 we have to learn from these events and that is
4 personally, as well as organisations and institutions.
5 And, yes, I wish I had done something differently back
6 in 2016.
7 **Q.** Dr Issac, of course, Howie Isaac, and
8 Dr Mittal will be giving evidence too but they are
9 safeguarders and you say you were sharing an office with
10 one. Again, referrals via safeguarding to local
11 authorities, just getting out of the Trust, that was
12 a route and an option, not canvassed at the time between
13 you?
14 **A.** I am assuming you are thinking about LADO
15 referral in that statement. I have been, I have been
16 part of situations where we have done a referral to
17 LADO.
18 **Q.** About a member of staff or is it always
19 parents? We do it for parents, don't we?
20 **A.** No, about members of staff on more than one
21 occasion we have done LADO referrals. This situation is
22 subtly different and if we'd had -- you know, if we'd
23 had or if I'd had had significant concern about
24 something that I had seen or witnessed, it was the
25 nature of the sort of circumstantial evidence that made

1 that feel like a difficult step to take.
2 In order to make a LADO referral, it is about
3 an allegation about a member of staff; admittedly, that
4 they might have caused harm. There is no high bar of
5 they have to have caused harm. But certainly from
6 a personal point of view, it was the overall situation,
7 it was the body of the number of unexplained incidents
8 that was such a concern and there wasn't ever one
9 individual case where I thought: that needs referral.
10 **Q.** The actual structure of Working Together 2015
11 is about everybody being responsible for child safety,
12 child protection, child safety. So, in a sense, looking
13 for an allegation isn't the test, is it? The test is
14 being concerned for children or babies and you were all
15 obviously very concerned about babies on the unit?
16 **A.** And you are absolutely right. It is -- you
17 know, we talk about safeguarding a lot. I regularly am
18 involved in safeguarding meetings. Like I say, it does
19 tend to refer to one child. You do a referral about
20 a situation. But, again, I wouldn't -- I'm not sitting
21 here completely discounting it as a possibility.
22 I would say, though, that if you had enough
23 evidence to go to a LADO, then, you know, they are not
24 an organisation that will do an investigation. They are
25 part of the threads that pull together and the police

1 would be involved.
2 **Q.** They work with the police, though, don't they?
3 **A.** Yes. Again, would they have suggested
4 referral to the police? I can't rewrite history.
5 **MS LANGDALE:** Thank you very much, Dr Holt. Is
6 there anything you would like to add or say that
7 I haven't asked you? You have been giving evidence for
8 some time but I would hate for you to leave and you
9 wished you had said something else as well.
10 **A.** No, thank you.
11 **MS LANGDALE:** Thank you very much.
12 **LADY JUSTICE THIRLWALL:** Dr Holt, thank you very
13 much indeed for the care that you have taken, both at
14 the time and in giving your evidence today. You are
15 free to go now. Thank you.
16 Ms Langdale, tomorrow morning at 10 o'clock.
17 **MS LANGDALE:** It's Friday tomorrow. I think.
18 **LADY JUSTICE THIRLWALL:** Oh, yes. Sorry, I will be
19 the only one here. So Monday morning, 10 o'clock.
20 Thank you all very much.
21 (4.42 pm)
22 (The Inquiry adjourned until 10.00 am,
23 on Monday, 7 October 2024)
24
25

1 INDEX
2 DR ELIZABETH NEWBY (affirmed) 1
3 Questioned by MR DE LA POER 1
4 Questioned by LADY JUSTICE THIRLWALL 47
5 DR SATYANARAYANA MURTHY SALADI 49
(sworn)
6
7 Questioned by MR DE LA POER 49
8 Questioned by MR BAKER 119
9 Questioned by LADY JUSTICE THIRLWALL 126
10 DR SUSIE HOLT (affirmed) 129
11 Questioned MS LANGDALE 129
12
13
14
15
16
17
18
19
20
21
22
23
24
25

LADY JUSTICE THIRLWALL: [57] 1/3 1/6 1/9 7/1 7/4 7/9 47/14 47/20 48/4 48/7 48/14 48/22 49/4 49/7 49/11 82/4 82/7 82/18 82/23 82/25 83/4 100/4 100/15 101/21 102/2 102/7 102/11 102/20 103/2 103/8 103/17 103/21 104/4 104/9 104/13 104/16 104/19 105/5 110/5 110/8 117/19 117/21 118/1 119/6 126/11 127/12 127/18 128/2 128/6 128/18 128/23 129/8 129/12 133/20 186/9 199/12 199/18
MR BAKER: [2] 119/8 126/8
MR DE LA POER: [26] 1/4 1/13 7/10 47/11 48/17 49/5 49/12 82/6 83/5 100/5 100/16 101/19 103/4 103/10 103/18 103/20 103/22 104/7 104/11 104/14 104/17 105/6 110/10 118/5 119/1 128/21
MS LANGDALE: [7] 129/9 129/14 133/21 186/10 199/5 199/11 199/17

'

'Position [1] 163/6
'real [1] 173/21
'We [1] 132/19

0

00018 [1] 101/23
00031870001 [1] 169/6
0003297 [1] 25/5
0014414 [1] 146/7
003112 [1] 133/12

1

1 September [2] 108/16 116/13
1 September 2016 [1] 106/9
1.05 pm [1] 105/2
1.12 [1] 105/23
10 [3] 109/7 119/3 161/2
10 February 2017 [1] 176/23
10 June [1] 59/25
10 o'clock [2] 199/16 199/19
10 October 2016 [1] 114/22
10.00 [2] 1/2 199/22
11 [2] 30/7 175/14
11 May [1] 77/20
11.10 am [1] 49/1
11.30 [1] 48/25
11.30 am [1] 49/3
110 [1] 187/6
12 [8] 41/8 58/12 105/23 132/18 133/4 134/9 134/12 161/22
12 April [4] 113/7 180/13 183/4 186/10
12 October [1] 29/4
13 [3] 30/13 58/13 137/22
13 July 1 [1] 105/15
13 July 2016 [1] 105/8
13 October [1] 30/8
13th [1] 32/6
14 [2] 59/23 140/6
15 June [1] 79/8
15th [1] 79/20
16 [2] 11/8 135/9
16 April [1] 183/5
16 April 2018 [1] 186/7
17 February 2016 [1] 40/16
17 June [1] 49/17
1991 [1] 49/25
1996 [1] 50/2
1998 [2] 1/21 50/6

2

2 March [1] 75/5
2 pm [1] 146/11
2.05 pm [1] 105/4
2.42 pm [1] 129/5
20 [2] 69/5 108/12
2005 [2] 2/5 2/8
2006 [1] 2/9
2008 [1] 50/12
2009 [1] 50/9
2010 [1] 151/12
2014 [1] 153/3
2015 [26] 2/13 13/14 25/10 28/17 31/16 32/4 34/20 36/19 37/7 50/21 52/7 52/16 53/16 55/9 57/21 59/22 67/10 71/9 125/3 132/3 146/20 153/3 165/14 176/6 196/24 198/10
2016 [42] 3/23 4/11 34/12 34/20 36/16 36/23 38/21 39/16 40/16 44/22 51/22 53/25 73/19 73/21 74/3 74/4 76/19 77/3 77/20 78/12 83/7 87/9 97/10 105/8 106/9 114/22 123/12 129/21 129/22 129/23 130/14 132/9 135/3 139/6 141/9 143/9 146/20 150/7 165/14 175/3 176/7 197/6
2017 [10] 50/22 52/7 109/4 113/7 139/7 160/14 168/24 175/14 176/23 192/13
2018 [3] 186/7 186/18 187/5
2019 [1] 165/3
2020 [1] 187/22
2023 [1] 50/16
2024 [5] 1/1 1/15 49/17 130/2 199/23
22 [1] 69/6
23 June [1] 21/21
23 October 2015 [1] 31/16
23rd [3] 30/9 32/8 37/15
24 [1] 56/12
24 hours [3] 17/3 17/6 107/22
24/48 hours [1] 67/17
26 January 2017 [2] 109/4 168/24
26 October 2015 [1] 37/7
27 [1] 16/21
27 June [3] 73/8 83/7 115/18
27th [3] 85/17 86/2 86/22
28 [1] 16/25
28 June [1] 86/8
29 July [1] 24/21
29 June [4] 23/21 94/3 133/12 133/17
29 June 2016 [1] 87/9
29th [1] 83/13

3

3 June [1] 79/11
3 o'clock [1] 129/2
3 October 2024 [1] 1/1
3.00 pm [1] 129/7
30 January [1] 175/14
30 June [1] 97/10
30s [1] 155/20
30th [3] 99/6 99/7 99/18
32 [1] 146/16
33 [2] 18/24 83/9
35 [1] 150/9
37 [3] 24/20 106/10 106/11
38 [1] 24/24
39 [2] 152/19 154/18

4

4 August [1] 26/7
4 June 2024 [2] 1/15 130/2
4.42 [1] 199/21
47 [2] 15/10 163/4
48 [2] 28/3 56/12
48 hours [1] 107/22

5

5 August [1] 26/9
5 past 2 [1] 105/1
51 [1] 30/6
53 [1] 164/9
54 [2] 31/23 33/25
55 [1] 109/5
59 [1] 41/9

6

61 [1] 43/18
62 [2] 113/10 114/5
63 [1] 44/1

7

7 February [1] 111/10
7 July [1] 146/10
7 October 2024 [1] 199/23
76 [1] 173/15
7th [1] 110/23

8

8 February [1] 74/17
8 February 2016 [1] 39/16
82 [1] 45/13

9

9 June [1] 59/22
9 June 2016 [1] 44/22
95 [1] 1/23

A

A's [5] 25/11 25/21 59/7 115/6 119/23
A,B,C [1] 22/6
aback [1] 145/23
abdomen [1] 18/22
abdominal [1] 71/19
abhorrent [1] 158/19
ability [1] 8/20
able [19] 24/9 25/19 28/25 35/13 36/19 80/10 82/9 82/14 82/15 85/23 92/4 122/16 123/21 128/14 168/25 170/13 179/1 181/25 194/20
abnormal [1] 68/22
abnormalities [1] 17/11
abnormality [1] 89/20
about [307]
absolute [1] 177/12
absolutely [4] 45/20 48/19 125/25 198/16
absorbing [1] 88/5
abuse [1] 14/13
abusive [1] 54/22
accept [2] 69/3 81/18
acceptance [1] 126/4
accepted [1] 162/20
access [8] 84/18 84/19 85/12 87/4 108/8 110/24 167/6 168/4
accessed [5] 85/3 85/4 85/9 104/2 148/16
accordance [1] 131/20
according [1] 63/8
account [2] 188/11 192/16
accountable [2] 194/18 194/20
accuracy [1] 160/7
accurate [5] 130/5 178/4 192/15 192/17 193/21
accusing [1] 46/21
achieved [1] 183/2
acknowledge [1] 162/20
across [8] 82/19 95/10 106/24 128/1 157/3 162/9 171/5 172/4
acted [1] 44/12
acting [1] 188/14
action [4] 16/7 77/5 93/12 136/1
actioning [1] 100/1
actions [6] 99/24 136/1 176/7 183/9 184/12 192/12
activity [2] 105/18 152/22
acts [1] 182/5
actual [3] 107/24 164/11 198/10
actually [33] 35/15 42/21 52/14 65/15 66/20 66/21 72/17 80/3 88/15 101/21 107/22 113/22 136/25 137/1 140/24 142/7 144/8 148/9 158/22 160/10 163/21 164/2 166/19 171/2 171/16 172/25 177/19 182/21

A

actually... [5] 183/1 185/2 187/19 195/8 195/18
acuity [8] 105/19 150/24 151/13 152/22 152/23 153/1 153/4 179/22
add [2] 191/22 199/6
added [3] 152/17 165/19 191/25
address [3] 98/7 157/16 157/18
addressed [1] 97/25
adequate [1] 81/19
adhered [1] 163/12
adjourned [1] 199/22
adjournment [1] 105/3
administered [1] 68/7
administering [1] 3/2
administration [2] 3/13 8/18
admission [1] 146/14
admittedly [1] 198/3
adult [1] 12/22
adults [1] 140/7
advantage [1] 25/23
adversarial [2] 46/20 47/1
advice [8] 14/10 70/2 117/5 121/19 121/21 126/5 127/1 136/9
advise [2] 161/3 193/2
advocating [4] 172/4 172/7 172/11 174/5
aetiology [1] 21/14
affected [2] 177/10 177/15
affirmed [4] 1/7 129/10 200/2 200/9
afraid [2] 130/20 131/21
after [54] 4/16 8/2 8/3 10/12 10/12 19/19 26/15 28/16 32/11 35/1 42/20 43/5 43/7 44/18 62/16 68/3 70/6 73/12 75/17 78/9 78/15 80/17 85/25 86/3 86/21 87/1 87/2 89/2 90/5 90/19 92/9 99/7 99/15 99/19 100/11 104/25 106/3 110/13 111/12 111/14 130/22 135/4 141/11 146/16 147/23 150/6 157/9 158/24 158/24 158/25 166/17 177/17 187/17 188/19
aftermath [1] 10/14
afternoon [3] 104/10 104/12 128/25
afterwards [7] 21/15 40/11 42/22 68/5 154/11 156/17 181/16
again [32] 12/3 16/2 38/9 48/10 60/19 62/21 64/5 64/18 65/1 65/9 65/20 75/19 77/4 78/16 84/12 84/23 89/22 100/13 103/23 104/24 113/23 117/3 131/21 138/8 141/20 153/3 154/18 186/3 189/15 197/10 198/20 199/3
against [2] 3/2 193/12
agencies [3] 134/2 142/8 186/16
agency [5] 15/5 55/20 87/21 134/4 142/8
ago [3] 102/8 166/13 188/24
agree [16] 18/19 23/1 68/11 68/12 76/6 77/7 77/18 82/18 95/15 98/16 114/10 117/12 126/3 126/7 153/13 178/3
agreed [4] 112/17 135/22 179/21 180/15
agreeing [1] 44/23
agreement [2] 177/2 177/18
ahead [1] 48/17
air [3] 36/4 99/14 116/2
airway [1] 80/5
airways [1] 88/17
AK [1] 94/8
alarms [1] 88/3
albeit [1] 168/19
Alder [2] 1/25 80/21
Alder Hey [2] 1/25 80/21
Alex [2] 149/22 149/23
Alex Mancini [2] 149/22 149/23
align [1] 19/14
Alison [7] 86/14 94/8 151/19 173/3 173/4 180/7 195/20
Alison Kelly [1] 195/20
all [150] 6/12 11/20 12/1 13/20 17/13 22/2 22/5 23/1 24/5 24/6 24/10 24/16 25/18 25/24 26/1 33/19 33/23 36/7 37/2 38/11 39/12 39/13 40/2 44/3 47/12 51/10 52/3 54/12 56/24 56/24 59/17 61/20 65/12 65/13 66/8 66/9 68/10 68/14 70/4 70/15 70/23 72/6 75/5 75/10 75/16 77/9 77/10 81/20 83/4 83/21 83/21 84/5 86/2 87/3 88/8 90/11 91/8 91/13 91/16 93/10 93/13 93/21 95/22 95/25 96/21 96/21 96/22 96/23 100/20 101/2 101/8 103/2 103/8 103/23 107/10 107/12 108/13 109/22 110/13 110/24 112/9 112/23 113/20 114/3 114/12 116/17 117/22 122/2 123/5 127/8 127/14 128/2 128/10 128/13 130/24 132/21 133/1 133/2 134/4 134/5 134/24 135/1 135/1 135/8 135/23 136/17 138/13 139/16 140/22 141/7 145/23 148/11 148/17 155/3 157/3 157/4 158/4 165/25 168/4 168/17 170/7 170/10 170/12 170/18 170/19 171/18 173/19 174/14 174/17 176/23 177/2 178/8 178/9 180/3 180/23 183/5 183/8 183/11 190/1 190/25 191/1 191/4 191/7 191/11 191/24 194/2 194/6 195/6 198/14 199/20
allegation [3] 14/13 198/3 198/13
allegations [2] 161/4 193/12
Allitt [3] 57/22 135/2 136/18
allocated [2] 38/25 73/23
allowed [3] 46/19 46/25 148/16
allows [3] 9/23 19/18 19/21
alluding [1] 179/18
almost [6] 26/15 46/12 46/20 60/12 189/19 194/2
alone [1] 123/22
along [4] 70/9 97/15 105/24 180/18
already [18] 4/9 6/2 28/2 54/14 73/20 83/11 83/17 90/23 93/12 97/3 97/8 97/13 111/21 116/17 166/3 170/24 181/4 186/8
also [43] 12/6 18/11 19/22 20/2 23/10 23/10 23/11 23/25 25/4 25/20 33/6 40/9 46/8 60/7 70/13 76/10 77/7 85/4 91/15 94/7 95/24 97/14 107/14 114/24 142/10 147/5 149/7 154/13 157/8 161/5 161/9 163/24 164/6 164/9 167/8 167/19 168/18 170/3 171/3 171/24 176/10 184/19 196/14
alternative [1] 11/18
although [14] 4/13 16/9 16/12 16/12 17/1 27/22 28/8 39/24 44/24 48/9 109/8 175/17 184/8 192/20
always [18] 9/3 12/17 33/5 33/15 42/16 43/17 48/8 61/24 71/17 124/15 124/21 145/9 152/13 154/10 168/5 184/23 184/25 197/18
am [82] 1/2 4/5 11/25 16/24 30/5 34/25 41/8 43/7 46/4 49/1 49/3 50/18 51/19 56/4 57/3 57/4 58/9 58/14 59/11 59/12 67/19 71/2 71/4 73/11 73/17 74/7 74/12 75/7 75/24 77/17 78/3 83/5 84/8 86/5 86/8 90/24 92/3 100/13 103/7 105/8 106/23 107/2 110/10 111/5 117/17 118/17 120/12 126/23 127/3 127/4 128/16 129/1 129/16 131/4 135/8 139/17 139/23 145/22 146/2 147/3 150/11 151/17 152/6 152/17 158/24 160/6 164/16 167/3 167/24 169/9 172/9 178/22 178/24 178/25 185/9 190/12 191/13 192/6 197/2 197/14 198/17 199/22
amazing [1] 170/15
among [2] 4/23 35/4
amongst [3] 120/17 123/4 172/6
amount [2] 181/18 189/11
amplify [1] 13/5
analysis [1] 74/1
anchor [1] 134/8
anger [1] 188/5
angry [8] 80/20 110/3 110/5 110/8 190/7 193/22 193/22 193/22
annual [1] 167/6
anomalies [1] 90/13
anomaly [2] 90/13 144/12
another [11] 21/1 21/6 23/15 43/24 45/23 66/19 75/17 76/5 176/22 180/20 182/12
answer [17] 35/1 38/10 45/13 57/5 75/25 76/1 76/4 76/5 78/7 81/25 82/15 93/24 117/6 117/6 118/8 127/1 196/25
answered [3] 73/20 107/10 113/6
answering [7] 71/2 84/15 118/11 118/18 118/19 119/19 158/11
answers [6] 80/12 81/21 82/16 82/20 118/12 148/17
antagonistic [1] 51/18
antenatally [1] 89/19
antibiotics [1] 61/16
anticipate [1] 131/16
anticipated [1] 12/25
anxious [2] 171/7 171/9
any [118] 3/11 4/25 6/18 7/11 8/24 9/15 10/15 12/7 13/25 15/20 19/23 24/5 25/1 25/19 25/23 26/21 26/22 29/9 29/23 35/6 35/14 36/20 36/24 37/20 40/22 42/2 43/8 46/5 47/6 47/10 51/21 51/22 51/23 52/9 52/13 52/20 53/7 53/24 54/8 55/6 57/7 58/21 58/23 58/25 59/2 59/16 61/25 63/3 63/3 64/12 64/12 64/14 65/9 65/16 66/6 69/9 71/15 72/11 74/20 76/15 77/25 78/8 78/20 78/23 80/12 82/20 83/24 86/18 96/18 97/16 98/6 101/7 106/1 108/8 109/15 112/17 112/25 114/7 114/25 115/5 116/25 118/12 118/16 121/13 124/15 130/10 131/11 131/13 131/15 135/25 138/2 139/1 140/1 143/1 143/11 143/14 144/23

A

any... [21] 145/3 148/1 152/18 153/22 158/17 158/21 160/7 164/18 166/16 169/2 169/25 170/12 172/7 173/5 177/8 179/12 181/14 185/23 185/24 189/7 194/1
anybody [5] 30/1 35/15 39/6 73/25 74/12
anyone [3] 33/10 40/10 173/2
anything [31] 9/4 36/7 36/8 40/21 42/11 43/16 64/6 64/7 70/9 71/21 72/1 74/13 77/25 81/11 95/4 95/19 95/21 122/17 127/10 127/11 128/19 131/24 136/3 141/3 143/21 149/9 154/12 163/20 175/7 194/2 199/6
anyway [2] 9/4 97/15
anywhere [1] 75/22
apart [3] 53/2 55/1 58/23
apologies [1] 190/11
apologise [4] 39/12 109/3 128/13 190/13
apologised [2] 190/9 190/10
apology [10] 110/2 164/25 169/1 169/2 169/5 169/22 175/2 175/16 188/22 188/25
apparent [3] 9/4 9/5 188/3
apparently [2] 75/17 100/8
appear [2] 25/13 47/10
appearance [1] 117/4
appeared [7] 22/17 73/2 73/24 96/17 109/14 113/24 133/23
appearing [3] 45/22 100/25 105/16
appears [5] 25/4 25/21 97/14 156/9 157/9
applied [3] 55/9 55/11 140/15
applies [1] 52/3
apply [4] 15/17 16/3 55/23 137/16
appreciate [2] 28/21 176/10
approach [1] 86/13
approachable [1] 12/13
approached [1] 150/2
appropriate [8] 8/13 29/15 46/2 51/18 148/8 156/21 169/8 185/7
April [15] 50/9 77/3 113/7 113/7 129/23 130/12 130/14 143/22 144/21 180/13 183/4 183/5 185/22 186/7 186/10
April 2016 [1] 130/14
arbitrary [1] 152/16
are [231]
area [2] 9/13 15/12
areas [4] 13/15 44/24 60/23 114/16
aren't [2] 36/24 132/3
arguing [1] 194/8
argument [2] 106/22 106/23
arguments [2] 33/6 38/12
arise [1] 93/23
arisen [1] 53/16
arising [1] 128/19
around [20] 3/12 5/7 21/1 23/25 33/4 41/1 42/19 43/5 44/17 110/23 125/8 137/5 144/16 148/18 152/15 164/5 174/2 177/3 187/20 194/23
around February [2] 43/5 144/16
arrange [2] 18/25 19/12
arranged [1] 180/12
arrangements [3] 5/23 135/25 146/14
arrested [2] 26/16 162/13
arrived [3] 4/15 4/23 184/25
articulated [2] 35/15 155/10
articulation [1] 42/13
as [245]
ascribe [1] 47/6
ask [38] 1/5 7/4 8/9 13/5 13/15 24/13 26/12 45/6 60/13 71/6 74/21 78/8 79/17 82/4 90/14 92/15 94/11 98/24 99/22 105/9 106/13 114/4 114/8 114/15 119/4 120/12 125/1 126/13 128/19 132/24 139/23 140/9 150/14 160/15 175/13 177/22 183/7 190/15
asked [36] 12/6 33/1 42/24 45/9 47/17 74/17 74/20 75/1 75/3 81/2 107/7 115/11 117/6 117/7 117/9 117/10 118/13 118/24 119/19 126/14 126/15 126/16 126/19 126/20 127/2 130/22 132/6 135/12 146/21 151/20 159/23 165/12 165/19 166/18 182/2 199/7
asking [6] 57/5 82/1 86/9 104/17 118/18 168/21
aspect [2] 55/22 112/2
aspects [1] 113/11
aspirational [1] 163/12
asserted [1] 58/8
assessment [2] 25/9 25/20
assessors [1] 108/21
associate [1] 45/3
associated [4] 61/11 83/21 83/25 91/15
association [3] 158/6 163/11 164/14
assume [1] 42/23
assumed [1] 10/21
assuming [1] 197/14
assumption [1] 7/7
assure [1] 176/15
assured [1] 177/10
astonishing [1] 170/9
at [397]
attempt [1] 98/1
attempted [1] 162/15
attend [8] 40/20 40/23 74/18 74/19 131/20 143/15 168/25 170/5
attendance [1] 176/2
attended [16] 39/15 40/18 58/25 59/9 59/10 64/23 94/7 97/18 115/18 116/5 116/12 125/11 131/24 138/6 143/5 150/7
attending [3] 84/5 95/6 97/16
attention [4] 22/6 46/6 103/11 136/23
attest [1] 144/15
attitude [2] 12/9 109/20
attributed [1] 102/13
August [4] 26/7 26/9 67/10 146/25
August 2015 [1] 67/10
authorities [2] 136/24 197/11
authority [3] 15/8 52/12 55/21
automatically [1] 141/22
available [4] 57/14 68/4 91/6 123/9
aware [52] 2/24 13/22 15/5 20/3 20/21 26/13 26/15 31/2 39/21 44/11 57/21 57/24 58/2 60/15 62/25 67/9 72/24 73/11 73/11 76/15 77/19 79/11 112/8 116/8 117/17 117/17 117/22 121/18 122/1 122/4 126/25 127/7 130/8 130/17 130/21 131/5 143/18 148/24 149/8 158/6 161/15 161/18 168/22 170/3 172/21 173/3 174/20 178/25 182/19 188/10 190/20 192/6
away [4] 5/8 54/4 56/8 101/11
awful [5] 34/21 45/24 46/3 148/1 169/13

B

B's [2] 62/1 64/3
babies [54] 15/17 34/3 38/25 40/7 54/13 54/17 64/14 65/16 67/18 68/12 68/13 68/15 68/17 70/12 70/23 72/15 73/23 75/2 75/10 75/17 79/4 88/15 94/15 94/16 107/3 115/20 116/3 116/20 121/1 121/3 121/9 121/10 121/13 127/19 127/20 131/13 131/15 131/25 145/5 146/16 146/18 147/23 153/23 156/15 157/5 159/6 159/10 162/14 165/14 167/22 167/23 173/18 198/14 198/15
babies' [2] 88/23 192/18
baby [34] 22/17 23/13 33/21 61/16 67/12 67/13 67/15 67/16 68/18 68/19 68/24 69/1 71/18 71/19 71/24 72/16 77/8 77/17 78/20 79/14 80/6 80/17 80/20 81/19 82/12 88/1 88/4 88/6 118/11 122/10 148/4 152/8 158/18 158/19
Baby A [2] 67/15 118/11
Bachelor [3] 129/17 129/18 129/18
back [32] 10/21 14/4 47/2 47/15 67/3 67/20 69/14 71/14 71/20 72/1 84/20 94/15 101/23 108/15 110/14 112/7 112/9 112/10 112/19 113/4 113/5 114/16 134/11 136/9 144/8 153/20 172/5 174/21 187/6 192/2 195/13 197/5
backed [1] 44/9
background [3] 37/17 125/4 165/4
backward [1] 88/13
bad [4] 66/11 76/14 108/9 128/9
bad faith [1] 66/11
bag [1] 125/7
Baker [7] 73/18 104/14 104/17 119/3 119/6 119/7 200/7
balance [3] 38/14 174/9 174/14
balanced [1] 162/23
bang [1] 13/10
banged [1] 109/25
banking [1] 109/12
BAPM [3] 163/20 164/7 166/4
bar [1] 198/4
barrister [2] 177/21 180/17
base [1] 154/11
based [6] 18/14 27/19 60/19 64/10 138/14 138/16
basis [3] 86/17 154/1 192/15
be [210]
Bearing [1] 37/19
became [11] 2/8 36/12 46/20 77/19 120/14 130/8 130/17 174/20 182/6 188/3 195/17
because [130] 6/13 9/4 9/22 10/13 10/24 11/21 19/9 19/20 22/23 32/19 33/22 42/5 46/13 46/16 47/8 51/10 52/3 53/10 54/12 55/25 56/2 56/6 56/13 57/12 61/1 61/6 61/13 63/20 63/24 64/9 65/9 65/10 65/13 65/20 65/22 67/15 68/12 68/23 70/22 71/4 71/18 71/21 73/11 73/12 73/18 75/25 77/12 80/5

B

because... [82] 80/19 80/22 81/10 81/18 81/19 81/22 82/9 82/16 82/19 83/24 84/3 84/6 84/7 84/16 85/9 86/9 87/22 88/13 88/23 89/19 90/2 90/12 91/5 91/12 91/19 91/24 93/16 93/23 99/8 99/8 100/21 101/1 105/11 108/6 108/16 113/1 114/16 117/10 117/10 117/23 118/15 119/17 119/17 122/6 124/10 125/8 126/20 127/3 127/7 127/16 133/15 136/10 137/9 143/11 143/14 143/23 144/17 145/10 149/15 149/25 150/3 151/10 153/14 155/5 155/24 156/6 159/17 161/17 168/7 171/15 174/1 174/21 176/24 177/12 184/17 186/19 191/10 191/18 193/23 195/8 195/25 196/8
become [4] 9/5 122/13 178/23 188/10
becomes [1] 42/20
becoming [2] 61/3 61/22
bed [1] 157/2
been [104] 4/16 4/21 5/4 16/12 18/15 19/15 21/4 23/2 24/2 24/2 25/13 25/17 25/25 27/21 31/5 31/9 31/12 31/12 31/21 32/15 32/15 32/16 32/18 32/20 32/21 32/21 33/1 33/18 33/23 36/1 37/21 39/7 41/6 41/10 41/24 42/9 43/22 46/3 46/25 57/2 57/25 63/9 63/24 65/2 66/2 68/7 68/12 76/3 86/13 93/1 93/12 116/1 116/3 116/8 116/9 119/14 119/25 120/4 121/13 121/16 124/1 130/15 131/7 138/3 139/21 141/25 143/10 143/17 143/23 144/3 148/5 150/2 151/11 151/12 152/10 155/6 162/9 162/25 163/19 164/4 164/17 166/20 166/21 171/20 171/23 172/23 177/7 178/10 179/21 183/14 184/3 185/1 188/17 188/19 189/18 190/20 191/1 192/10 193/4 194/3 195/5 197/15 197/15 199/7
before [49] 2/12 5/19 28/16 28/18 29/18 30/1 32/10 32/15 32/19 37/16 43/6 50/11 59/21 62/25 73/10 73/16 74/6 77/8 83/12 86/4 91/6 91/24 101/21 102/3 102/4 102/16 102/19 102/24 105/11 108/17 111/8 111/13 111/13 112/10 113/16 116/13 122/17 132/20 147/1 148/5 148/10 148/13 148/25 163/19 175/2 177/23 180/23 184/24 196/24
beforehand [2] 40/6 74/21
beg [1] 94/21
began [3] 105/21 106/3 165/17
begin [1] 1/20
beginning [3] 36/23 67/9 181/18
begins [2] 86/22 87/11
behalf [1] 119/4
behaved [1] 125/21
behaviour [5] 54/22 55/2 55/3 55/3 189/18
behaviours [1] 190/9
behind [3] 24/3 47/23 138/17
being [68] 2/20 5/12 6/5 6/15 8/22 10/18 11/4 14/17 15/3 15/24 18/18 23/18 24/13 25/24 26/1 26/1 26/4 29/1 35/22 35/25 37/7 45/1 46/8 46/14 46/15 47/17 63/4 65/5 65/6 67/25 68/13 73/25 75/2 75/17 77/6 77/25 83/14 93/12 97/12 98/4 98/21 98/25 100/19 112/23 116/7 118/20 131/11 131/16 135/9 137/20 144/4 146/4 146/4 148/3 150/17 151/4 151/10 151/13 156/13 168/21 168/23 171/24 172/7 176/13 189/17 193/11 198/11 198/14
beings [1] 41/18
belief [3] 1/18 29/12 49/22
believe [13] 5/4 5/16 6/21 15/16 134/2 134/5 138/10 147/15 161/25 172/25 173/19 174/23 187/9
below [1] 105/22
benchmark [1] 155/21
bereaved [1] 177/14
best [11] 1/18 27/12 28/15 32/22 49/21 59/1 66/14 83/13 159/3 177/9 177/14
better [5] 19/24 23/7 149/5 163/24 170/19
between [26] 6/14 10/16 23/12 23/17 24/6 43/8 50/19 50/24 51/24 51/24 51/25 66/17 75/22 111/15 112/17 132/16 151/16 152/17 169/14 176/6 184/4 184/12 188/4 194/9 195/4 197/12
between June 2015 [1] 176/6
Beverley [3] 57/22 135/1 136/18
Beverley Allitt [2] 57/22 136/18
beyond [2] 55/5 191/8
bias [3] 140/17 185/1 193/14
biased [1] 185/3
bigger [2] 70/20 138/21
birth [4] 59/13 59/15 59/16 89/2
bit [19] 9/12 12/15 13/11 16/18 19/20 37/5 42/21 44/5 46/12 79/17 127/14 135/13 138/8 142/3 145/23 161/15 182/3 182/21 191/17
blame [1] 84/7
blaming [1] 84/8
blank [1] 142/20
blanket [1] 164/3
blinkered [1] 168/23
blood [3] 27/22 27/24 168/16
blue [1] 7/5
blur [1] 138/9
board [10] 97/17 140/2 149/25 163/8 170/18 175/17 176/7 183/6 192/12 195/19
board's [1] 176/4
boardroom [1] 150/8
boards [2] 141/2 185/13
bodies [2] 184/16 196/19
body [11] 12/9 51/1 51/3 52/2 95/11 111/11 177/11 178/6 189/12 191/16 198/7
bold [5] 78/19 108/10 108/11 108/13 108/14
bookend [1] 36/19
born [1] 59/11
both [8] 15/6 17/2 23/7 63/25 154/12 157/7 179/3 199/13
bottom [5] 22/23 23/24 105/14 134/18 148/15
bowels [1] 88/7
box [2] 115/14 193/6
boxes [2] 9/23 191/24
brand [1] 137/13
break [4] 48/18 49/2 104/23 129/6
breakdown [1] 184/3
Brearey [32] 18/12 31/24 33/18 33/23 36/25 39/15 39/25 42/10 42/23 44/11 53/22 72/10 72/15 73/1 74/21 77/20 78/9 78/19 79/23 80/3 83/16 85/24 91/9 93/4 100/10 130/13 138/10 159/18 164/23 165/6 170/4 178/1
Brearey's [1] 18/14
Brearley [1] 78/14
breaths [1] 88/17
brief [4] 88/18 117/7 118/12 127/1
briefly [5] 1/20 7/23 115/17 125/1 125/4
Brigham [1] 195/17
bring [6] 19/22 25/4 50/15 86/7 102/21 106/6
bringing [1] 63/14
British [1] 163/11
broader [1] 131/7
broken [1] 111/17
brought [2] 21/22 130/16
Broviac [2] 125/9 125/22
bruise [2] 61/4 61/18
Brunton [3] 21/17 21/19 21/20
bug [4] 22/18 65/16 66/10 66/25
bugs [2] 121/5 121/8
building [5] 52/25 53/5 53/7 110/16 138/17
bullying [1] 55/2
bundle [1] 108/7
busier [1] 153/2
business [3] 52/10 139/9 139/13
busy [4] 10/14 52/4 153/7 154/23
busyness [1] 151/13
but [262]
by16 [1] 185/22
by16 April [1] 185/22

C

C's [1] 25/7
C-peptide [3] 26/13 68/6 77/5
call [6] 21/13 68/17 88/7 129/9 142/7 187/1
called [13] 30/13 33/2 56/11 95/23 100/19 107/14 107/14 115/24 132/23 133/2 160/20 165/12 165/15
calling [4] 34/10 101/1 132/19 134/17
came [24] 6/3 19/14 26/14 28/3 56/22 62/25 67/2 80/17 84/3 84/4 86/6 108/12 121/9 123/2 127/22 132/10 139/20 139/20 139/21 159/4 180/24 181/2 181/6 186/25
cameras [1] 157/2
can [148] 1/13 3/5 9/21 10/2 12/19 15/15 15/24 17/4 21/21 21/23 22/25 23/5 23/14 23/17 24/18 25/4 25/7 25/9 25/23 26/4 27/12 28/15 31/23 32/22 38/1 38/18 40/23 47/15 48/20 49/20 50/18 51/13 55/15 58/7 59/1 59/6 60/5 61/7 61/24 62/10 62/18 62/20 64/22 66/6 66/7 66/18 72/17 74/13 75/7 76/23 76/24 79/16 81/18 82/10 83/13 83/13 83/23 85/22 87/10 87/22 89/1 89/8 91/18 92/16 92/18 92/24 93/10 94/1 94/6 94/18 96/10 96/11 97/1 97/12 97/14 98/3 98/20 99/24 100/10 101/22 101/23 105/21 105/22 106/1 106/6 106/16 108/15 109/18 110/11 112/10 115/9 115/13 122/23 124/6 124/15 124/20 124/22 126/13 127/12 128/11 129/14 129/20 130/4 133/11 134/5 134/12 134/13 134/23 140/9

C

can... [39] 145/11 146/2 147/19 147/21 148/20 150/14 151/4 151/5 151/7 151/21 155/14 155/16 156/12 156/19 157/21 158/10 159/13 159/23 160/15 161/1 161/21 162/4 162/7 162/17 163/3 165/22 169/18 169/21 171/13 171/22 175/13 177/22 177/24 178/18 183/6 183/11 186/1 192/7 192/14
can't [36] 17/24 24/17 29/3 32/12 32/12 32/13 32/15 32/15 32/16 32/18 32/21 32/25 35/11 40/4 40/9 41/3 62/9 86/6 100/21 102/25 103/1 131/3 131/8 131/9 131/10 132/2 136/4 141/24 143/14 144/14 160/6 173/1 186/5 186/17 196/25 199/4
candour [1] 147/15
cannot [21] 58/2 60/3 63/19 63/22 68/2 70/13 74/15 77/2 78/6 79/2 79/12 79/18 89/6 89/10 93/6 101/17 107/21 139/16 173/16 188/7 192/18
canvassed [1] 197/12
capacity [1] 114/7
capture [1] 45/20
card [1] 85/4
cardiac [3] 76/2 89/13 90/13
cardio [4] 72/16 72/17 88/21 88/25
cardiologist [1] 72/19
cards [5] 103/19 103/20 103/21 104/3 104/5
care [55] 6/4 6/8 7/20 8/15 8/25 9/10 9/11 15/1 15/1 16/20 26/11 28/11 28/22 30/19 31/7 34/2 40/7 41/25 44/7 45/25 48/12 58/17 59/2 59/8 63/24 67/15 71/10 71/12 72/22 79/7 80/21 81/2 81/5 81/6 81/12 81/19 81/20 87/24 88/2 90/8 92/22 92/23 93/2 116/23 137/2 145/25 149/15 153/20 154/15 155/23 156/1 156/6 174/23 191/10 199/13
cared [2] 148/5 183/18
career [6] 1/21 3/22 4/14 49/24 90/23 140/18
careers [1] 140/23
caring [1] 158/21
carried [1] 165/25
carry [3] 108/25 128/15 128/16
case [29] 2/19 3/5 5/3 8/5 8/5 8/6 9/6 14/22 17/1 18/2 18/11 27/25 29/6 30/22 31/5 37/19 44/19 48/4 61/21 63/17 77/7 113/16 113/23 123/24 132/9 135/1 136/17 152/13 198/9
Casenote [4] 161/6 161/17 165/24 176/12
cases [7] 22/5 22/13 63/15 166/1 178/15 179/7 179/10
casual [1] 173/16
category [3] 9/24 9/25 90/18
causally [1] 83/25
cause [13] 41/12 60/12 71/13 72/16 72/17 76/2 90/17 119/22 122/21 137/10 178/14 179/25 192/17
caused [12] 15/3 18/15 60/1 83/11 116/8 124/1 141/19 141/25 159/5 173/12 198/4 198/5
causes [5] 60/1 61/7 62/12 71/18 145/10
causing [9] 23/5 42/6 98/22 99/3 99/3 108/23 120/18 122/19 124/3
caveat [1] 143/19
cc'ing [1] 178/1
CCTV [6] 45/10 45/17 46/1 46/2 156/25 157/1
CDOP [5] 182/9 186/2 186/4 186/11 186/12
cease [1] 93/13
centre [1] 90/6
centres [1] 89/11
certain [2] 9/2 83/17
certainly [13] 20/17 38/18 48/22 76/22 139/15 153/17 164/6 172/9 173/13 179/23 185/16 186/15 198/5
certainty [2] 174/2 174/3
Certificate [1] 50/8
cetera [10] 3/11 3/13 5/6 5/8 33/22 36/11 145/21 171/25 178/17 180/4
chain [1] 41/25
Chair [2] 97/17 183/6
challenge [6] 51/16 51/17 149/17 170/10 184/7 196/11
challenged [1] 194/4
challenges [1] 45/17
challenging [2] 11/22 51/12
Chambers [11] 52/17 94/8 109/11 109/23 110/15 151/6 155/13 175/15 176/1 179/1 195/20
Champion [4] 185/6 185/8 185/12 185/19
championing [1] 185/24
chance [3] 138/22 165/8 177/1
change [11] 6/11 7/11 20/24 47/17 51/21 51/22 52/12 60/9 132/20 132/22 148/3
changed [2] 52/14 139/14
changes [3] 52/14 171/17 179/22
changing [1] 146/14
character [1] 77/18
characterisation [1] 11/24
characterised [2] 26/17 77/4
charge [1] 10/12
chart [6] 38/22 38/25 39/3 39/6 73/21 73/24
chart's [1] 39/7
charts [3] 152/21 168/10 168/11
chasm [2] 192/22 192/23
chat [1] 111/7
check [4] 61/15 150/15 166/10 175/4
checked [1] 157/4
Cheshire [3] 15/22 180/21 184/8
Cheshire Constabulary [1] 180/21
Chester [26] 2/4 2/16 3/23 5/2 5/13 5/24 12/23 13/19 38/4 39/4 47/24 50/12 50/20 55/18 129/21 131/13 146/10 147/24 147/25 153/17 155/18 155/19 157/7 162/11 162/22 165/3
Chief [3] 52/16 137/15 139/4
Chief Executive [2] 52/16 137/15
child [155] 16/5 16/18 16/20 17/2 17/9 17/16 18/22 19/25 20/1 20/2 20/3 20/7 24/22 25/2 25/5 25/7 25/11 25/13 25/19 25/21 25/24 26/7 26/9 26/11 26/24 26/25 28/17 28/20 28/21 29/2 29/6 29/11 29/18 30/1 30/5 30/9 30/9 30/18 30/24 30/24 31/7 31/7 31/8 31/16 32/4 32/8 32/10 32/11 32/20 37/9 37/14 37/19 44/25 45/4 50/6 54/18 58/13 58/13 58/14 58/18 58/22 58/23 59/2 59/7 59/9 59/13 59/14 59/14 59/15 59/17 59/20 59/21 59/24 60/20 61/12 62/1 62/16 63/9 63/9 63/9 63/10 63/25 63/25 64/3 67/9 68/3 68/3 69/5 69/6 69/7 69/10 69/17 69/19 70/17 71/8 71/10 71/10 71/12 71/13 72/11 72/13 73/18 73/19 77/3 77/7 79/7 79/8 79/11 79/20 80/1 80/7 82/3 114/21 115/6 116/18 116/19 116/22 116/23 117/17 118/9 119/10 119/23 120/2 121/17 121/17 122/7 123/24 124/2 125/3 125/6 125/9 125/21 140/8 140/11 141/2 141/5 141/7 141/8 141/11 141/13 142/25 145/3 146/23 150/5 167/25 181/9 182/10 182/11 182/15 182/18 182/25 198/11 198/12 198/12 198/19
Child A [27] 20/1 25/13 25/19 28/20 29/2 58/13 58/14 58/18 58/22 58/23 59/2 59/9 59/14 59/14 59/17 59/20 63/9 63/25 114/21 116/18 116/19 116/22 116/23 118/9 119/10 120/2 121/17
Child A's [5] 25/11 25/21 59/7 115/6 119/23
Child B [13] 20/3 25/24 58/13 59/13 59/15 59/21 59/24 61/12 63/9 63/25 69/17 121/17 122/7
Child B's [2] 62/1 64/3
Child C [2] 20/2 63/10
Child C's [1] 25/7
Child D [14] 16/5 16/18 17/2 17/16 25/2 25/5 26/24 26/25 29/6 45/4 62/16 63/9 123/24 124/2
Child D's [9] 16/20 18/22 19/25 20/7 24/22 29/11 37/9 37/19 44/25
Child E [3] 26/7 67/9 68/3
Child F [3] 26/9 26/11 68/3
Child H [3] 69/5 69/6 69/7
Child I [10] 28/17 29/18 30/1 30/5 30/9 32/4 32/20 71/8 72/11 72/13
Child I collapsed [1] 30/24
Child I died [5] 31/16 32/8 32/10 32/11 71/10
Child I for [1] 31/7
Child I over [1] 30/24
Child I responded [1] 30/18
Child I's [7] 30/9 31/7 31/8 37/14 71/10 71/12 71/13
Child J [5] 73/18 73/19 125/3 125/6 125/9
Child L [2] 77/3 77/7
Child N [6] 79/7 79/8 79/11 80/1 80/7 82/3
Child N's [1] 79/20
Childhood [4] 15/13 55/8 55/23 140/15
children [11] 7/17 14/11 38/11 48/9 52/5 84/5 123/3 123/21 155/18 191/11 198/14
children's [11] 2/1 15/1 71/1 138/17 184/8 185/5 185/8 185/12 185/18 194/7 195/12
choice [3] 169/9

C

choice... [2] 169/21 171/19
choose [1] 135/24
chooses [1] 183/8
chose [1] 193/2
Chris [3] 188/2 188/4 188/12
Christmas [2] 173/1 174/6
chronology [5] 26/7 105/7 106/8 109/1 120/13
ciphers [1] 159/16
circulate [1] 183/8
circulated [3] 75/5 191/21 191/25
circulation [1] 178/20
circumstances [2] 17/16 20/12
circumstantial [1] 197/25
cited [1] 193/18
clarification [1] 176/4
clarify [1] 113/21
clause [1] 165/19
clear [13] 36/14 38/1 44/23 69/7 88/17 100/11 113/19 115/9 124/2 175/1 175/17 178/5 193/8
clearly [3] 34/5 171/5 173/24
clinical [9] 4/6 12/16 46/8 57/20 77/24 101/15 139/8 157/10 171/11
clinicians [2] 23/18 109/17
close [2] 173/18 186/6
closely [1] 87/12
clumping [1] 100/20
clunky [1] 9/20
cluster [4] 28/9 67/6 71/14 91/10
co [2] 10/16 139/12
co-ordination [2] 10/16 139/12
coalesce [1] 42/19
coalesced [2] 35/2 36/21
cohesive [1] 51/19
cohesively [2] 11/20 51/10
cohort [2] 153/25 158/3
collapse [9] 9/8 32/3 45/1 62/1 66/3 80/1 80/11 94/17 124/3
collapsed [4] 20/3 30/24 70/12 123/22
collapses [13] 8/3 30/10 44/3 88/22 120/15 120/18 123/2 123/4 123/12 123/20 124/14 124/17 177/3
colleague [3] 51/6 54/10 54/23
colleagues [36] 6/19 9/18 23/1 35/5 36/25 37/22 40/22 42/22 43/5 53/11 57/7 59/14 64/13 70/8 72/12 72/20 72/22 78/18 81/13 81/15 91/1 108/21 111/7 111/19 114/9 115/19 116/6 116/14 123/4 123/11 127/20 133/1 168/19 168/19 168/25 174/22
colleagues' [1] 37/25
collective [4] 26/18 68/9 69/3 77/6
College [20] 50/6 95/14 146/23 146/24 149/8 149/9 149/14 149/24 150/2 150/4 164/16 165/8 165/16 166/13 166/17 166/21 167/2 167/3 167/9 167/10
College's [1] 165/5
colour [1] 20/24
column [1] 193/1
combination [2] 124/23 195/22
come [54] 1/5 5/18 7/1 16/3 16/17 20/2 20/13 20/17 20/20 22/4 24/15 24/18 35/14 38/3 41/7 46/13 46/13 49/7 52/25 54/2 59/19 72/12 73/8 75/21 85/15 97/11 101/15 104/10 104/11 105/9 108/22 112/7 112/9 112/10 113/4 113/5 118/21 128/1 136/23 141/14 146/8 147/20 151/21 160/16 161/20 165/8 174/4 174/11 174/21 174/24 183/25 185/10 190/18 194/24
comes [4] 57/19 88/3 156/25 171/5
comfortable [1] 100/7
coming [22] 26/16 54/13 54/17 54/23 62/22 67/20 70/19 71/20 72/1 80/23 80/25 93/3 95/10 101/3 101/12 106/24 107/2 112/19 126/22 126/22 133/14 172/5
comment [8] 11/18 11/23 12/6 51/14 102/12 167/19 191/14 191/15
commenting [1] 192/7
comments [2] 192/9 193/3
commissioned [1] 157/13
commissioning [1] 109/16
committee [4] 2/17 3/4 3/8 137/25
Committee representative [1] 137/25
committee's [1] 3/15
committees [2] 167/9 167/10
common [10] 73/3 75/9 75/18 88/8 88/14 88/22 89/3 122/8 123/22 145/15
commonly [1] 124/17
comms [1] 100/1
communicate [1] 53/3
communicated [1] 179/17
communication [8] 52/20 111/15 146/9 149/2 149/6 150/6 184/12 191/15
communications [2] 184/18 184/22
community [3] 54/19 140/16 140/20
compared [2] 12/21 146/20
comparison [1] 153/14
compassion [1] 194/12
competent [3] 36/10 46/17 96/17
complained [1] 125/5
complaint [4] 81/17 81/21 125/17 126/5
complaints [1] 81/8
complete [2] 56/11 114/5
completed [5] 31/21 50/11 109/15 146/25 188/19
completely [8] 15/9 16/15 34/23 45/18 80/22 82/13 95/11 198/21
completes [1] 48/23
Completion [1] 50/8
complex [1] 196/2
compounded [1] 20/7
comprehend [2] 34/2 44/6
comprehensive [2] 166/2 177/13
concern [29] 6/24 10/9 23/5 34/16 36/22 37/22 37/25 61/6 62/2 65/11 67/25 71/13 71/15 76/9 76/10 77/14 77/17 91/2 91/10 96/1 98/8 98/22 120/17 120/19 120/20 136/7 193/1 197/23 198/8
concern/upset [1] 23/5
concerned [37] 6/12 8/15 22/5 22/15 22/16 22/18 22/20 23/11 28/20 29/20 41/11 44/2 51/22 55/8 72/22 76/7 107/2 116/19 120/6 120/9 120/14 122/6 125/8 125/24 130/5 137/20 141/14 155/25 157/24 158/5 160/8 162/5 164/14 178/14 189/4 198/14 198/15
concerns [79] 34/7 35/2 39/25 42/19 43/13 43/19 44/10 44/10 55/5 55/13 58/23 60/6 62/23 63/1 65/6 65/12 68/25 72/2 72/13 96/8 97/7 101/6 106/20 110/18 111/24 112/23 113/6 113/19 114/3 115/11 116/6 118/15 119/10 119/15 122/25 123/3 123/10 126/18 130/18 132/8 136/15 137/16 143/8 143/18 144/22 152/1 156/8 156/13 157/18 157/21 157/23 157/25 159/8 159/8 159/24 159/25 162/12 162/19 164/12 165/9 165/11 165/13 166/15 166/17 168/20 168/22 173/17 173/17 173/25 177/8 178/8 180/23 180/25 181/22 181/24 188/11 188/16 189/4 190/1
conclude [2] 104/9 141/17
concluded [2] 154/24 177/6
concludes [3] 119/1 128/3 178/11
conclusion [5] 18/19 86/2 87/3 87/15 155/9
conclusions [3] 148/8 154/19 154/21
condition [9] 58/24 59/7 60/2 60/6 62/3 69/22 70/1 72/5 90/12
conditions [4] 72/3 76/12 88/20 89/21
conduct [2] 44/19 189/24
conducted [1] 96/7
confident [1] 153/18
confidential [2] 160/20 160/21
confirm [4] 1/13 49/20 130/4 179/2
confirmed [1] 29/12
conflating [1] 144/1
conflicting [1] 174/14
confusing [1] 191/17
congenital [2] 17/10 29/13
connected [2] 53/8 72/6
consensus [5] 24/25 85/25 86/11 86/16 169/20
consequence [1] 141/24
consequences [1] 120/7
consider [10] 45/9 88/21 120/4 145/14 153/19 155/3 156/2 156/22 177/8 179/12
consideration [3] 96/8 111/24 155/5
considered [7] 25/18 34/6 44/9 141/12 173/21 176/25 196/20
considering [1] 69/20
Constabulary [1] 180/21
constituted [1] 41/13
consultant [37] 2/8 2/13 3/25 6/19 12/9 24/14 35/4 36/25 40/22 50/13 51/1 51/3 54/23 72/11 78/17 109/6 111/11 111/19 123/10 129/23 129/24 137/13 137/23 143/4 143/5 152/1 154/5 154/7 154/9 159/1 167/8 176/16 177/11 178/6 189/11 191/12 191/16
Consultant-led [2] 154/5 154/7
consultants [50] 11/13 11/20 11/22 26/18 35/7 40/15

C

consultants... [44] 40/18 44/4 44/13 50/24 51/9 51/12 51/24 51/24 51/25 52/2 53/13 68/11 75/5 78/3 81/10 85/25 87/3 93/11 93/21 96/22 105/19 106/8 109/21 110/15 110/17 110/24 111/16 112/18 132/16 143/9 145/7 147/1 152/2 154/3 159/21 172/10 175/15 178/2 181/23 183/14 186/20 189/4 190/22 193/10
Consultants' [1] 130/16
consultation [2] 80/16 80/18
contact [14] 17/17 52/23 53/4 53/14 53/24 56/7 62/6 62/8 62/10 86/19 112/15 112/22 147/11 192/21
contacted [2] 43/9 54/1
contacting [4] 37/21 55/17 69/12 121/19
contacts [1] 52/9
contamination [2] 22/19 121/13
contemporaneous [1] 59/20
content [3] 1/17 49/20 135/17
contents [3] 105/20 109/9 130/4
context [6] 19/25 57/12 124/12 135/7 144/9 151/5
continue [7] 50/15 136/9 168/2 170/14 174/22 193/17 193/25
continues [2] 165/23 166/8
continuing [3] 68/25 106/7 113/1
continuously [1] 153/4
contribute [1] 75/3
contributing [3] 153/5 155/6 163/13
controlled [1] 84/21
convenient [4] 16/19 101/19 104/8 129/1
convening [1] 55/20
conversation [23] 4/19 10/20 17/23 17/25 18/10 21/3 33/1 33/4 36/18 37/16 72/9 73/4 73/5 80/15 82/3 112/5 130/20 130/24 144/6 178/25 179/3 187/2 188/15
conversations [9] 20/18 35/1 35/5 35/23 138/23 143/25 144/15 173/16 196/15
convicted [1] 2/20
convince [1] 180/9
cooperative [1] 51/15
coping [1] 170/8
copy [10] 86/8 108/7 132/9 132/11 160/20 160/21 160/23 166/19 166/25 176/20
copying [1] 23/1
Coroner [48] 16/7 16/8 16/14 17/2 17/17 17/20 18/10 37/6 37/16 37/20 37/21 44/18 55/14 56/1 56/6 56/18 56/18 57/18 75/20 90/11 110/17 114/18 115/6 115/15 116/25 117/9 117/14 117/17 117/22 117/25 118/6 118/22 118/24 120/1 126/16 126/17 127/14 127/17 127/20 127/22 127/25 178/25 179/3 179/6 179/8 179/9 179/11 184/24
Coroner's [5] 17/21 75/24 90/14 118/17 179/6
Coroners [1] 56/13
Coronial [1] 56/14
corporate [2] 161/3 161/16
correct [24] 2/3 2/6 2/14 16/6 49/15 49/18 49/23 50/1 50/3 50/7 50/14 50/17 57/7 57/8 67/4 67/7 87/20 110/19 121/2 121/11 123/14 123/23 124/25 191/13
correctly [3] 56/4 83/23 101/11
correlate [1] 192/11
correspondence [2] 19/2 116/2
corridor [6] 138/13 138/13 138/19 138/22 140/2 143/6
corroborate [1] 151/10
COT [1] 125/6
cots [1] 157/2
could [60] 9/9 19/23 21/14 26/21 34/3 34/21 36/5 42/17 45/18 45/18 45/20 45/20 46/23 47/22 49/12 51/16 53/12 57/3 64/2 64/15 68/20 68/23 69/2 79/6 80/24 82/15 85/2 85/12 85/13 87/21 88/4 91/12 93/19 99/9 99/15 102/18 103/11 105/12 108/3 121/24 132/20 132/22 133/2 135/20 136/1 141/17 144/3 144/23 148/19 151/1 157/6 160/1 164/11 176/19 182/4 192/22 193/14 196/7 196/20 196/21
couldn't [19] 18/2 18/3 27/9 32/21 46/16 80/23 122/5 130/20 131/3 131/22 132/13 148/1 151/10 153/24 166/22 174/23 179/24 187/2 189/13
Counsel [1] 119/3
counter [3] 33/6 46/15 167/24
counterarguments [1] 36/9
Countess [29] 2/4 2/8 2/15 2/24 3/22 5/2 5/13 5/19 5/24 13/2 13/19 38/4 39/4 48/13 50/12 50/20 55/18 129/20 131/13 146/10 147/12 147/24 147/24 155/19 157/7 162/10 162/22 165/3 188/2
country [1] 157/3
couple [9] 38/20 57/14 77/13 86/3 90/23 101/12 106/13 177/22 187/7
course [20] 5/3 15/7 15/9 15/9 16/1 16/1 16/7 17/1 19/25 26/5 82/6 104/16 116/18 132/3 136/1 137/10 140/18 151/21 193/17 197/7
court [1] 171/20
cover [1] 140/8
covered [3] 61/16 91/13 125/22
covert [2] 156/10 157/5
CQC [1] 40/14
create [1] 164/11
creature [1] 158/17
crimes [1] 57/21
criminal [1] 182/5
criteria [1] 164/7
critical [1] 127/25
criticise [1] 12/3
Cross [6] 94/10 95/4 95/20 151/7 179/2 195/20
cruel [1] 149/4
culture [4] 9/17 13/2 27/22 195/2
cultures [1] 27/24
current [2] 156/7 168/1
cusp [2] 39/17 40/13
cut [2] 82/19 172/4

D

D's [9] 16/20 18/22 19/25 20/7 24/22 29/11 37/9 37/19 44/25
daily [4] 154/2 154/4 154/7 154/7
damage [1] 137/11
dark [1] 136/21
data [1] 105/19
date [14] 4/3 25/21 32/2 36/20 37/7 41/4 43/19 50/15 99/5 105/15 132/13 175/4 186/1 186/4
date-stamped [1] 37/7
dated [6] 1/14 44/22 49/16 130/2 146/10 192/6
dateline [1] 105/16
dates [1] 143/14
Datix [16] 8/10 8/14 9/1 9/3 9/10 9/20 9/21 10/5 10/8 10/17 10/18 10/25 31/21 42/3 97/4 126/2
Datixes [1] 9/16
Dave [1] 23/2
day [28] 9/20 10/8 26/20 37/24 41/6 62/16 67/20 68/3 69/25 85/25 86/21 87/2 92/10 92/22 93/1 100/21 129/3 132/23 139/11 139/11 154/1 154/1 154/12 154/25 171/25 171/25 174/20 196/6
days [12] 23/23 37/15 64/19 77/13 79/23 86/3 90/5 101/10 115/22 151/16 152/17 154/8
days' [1] 57/15
daytime [1] 56/8
De [10] 1/3 1/8 49/4 49/10 103/9 105/5 126/15 128/19 200/3 200/6
deal [19] 5/20 5/22 5/25 11/8 15/14 16/20 24/20 29/4 50/18 54/9 58/12 91/18 92/25 106/9 109/4 113/10 113/12 114/18 159/7
dealing [9] 4/14 7/23 10/14 11/7 17/13 91/20 161/21 171/21 171/22
dealings [2] 116/21 143/1
dealt [3] 53/19 120/20 192/5
Dear [1] 165/1
death [87] 8/2 8/23 10/12 15/13 16/5 16/8 16/16 17/9 17/21 18/8 18/15 19/25 20/7 24/22 25/7 25/11 25/21 28/10 28/17 28/23 29/1 29/18 30/1 30/9 31/17 37/9 37/14 44/25 47/5 55/8 55/23 57/13 57/17 58/18 67/9 67/11 67/13 67/15 67/20 67/23 71/13 72/11 72/13 72/17 72/18 86/20 89/16 114/21 115/7 118/8 119/23 123/25 130/15 130/18 130/21 130/23 137/1 140/11 140/14 140/24 141/2 141/4 141/5 141/7 141/8 141/11 141/16 141/22 141/23 141/25 142/5 142/25 144/5 147/11 152/7 155/2 158/1 163/16 167/25 174/2 178/14 181/9 182/10 182/11 182/15 182/18 182/25
deaths [114] 10/10 23/11 24/1 24/10 25/18 25/24 28/9 29/20 29/24 30/2 33/19 33/24 34/24 40/2 41/11 44/3 55/10 55/12 56/23 56/24 63/4 66/2 66/6 66/8 66/22 67/21 69/16 70/4 70/11 70/12 72/7 74/24 75/19 76/10 76/16 79/4 83/22 86/15 89/17 89/18 89/24 90/1 90/10 90/12 90/18 90/21 90/25 91/11 91/16 93/17 93/20 96/15 106/16 107/3 107/5 108/12 111/25 112/11 112/13 112/16 113/2 116/15 117/18 117/22 117/24 118/3 120/15 120/18 123/3 123/12 123/20 127/23 128/10 128/14 130/9 130/25

D
deaths... [38] 130/25 131/1 131/2 131/6 131/8 131/15 131/19 132/4 136/8 140/6 140/8 140/20 141/7 144/1 144/2 144/4 144/11 145/4 148/19 151/14 151/16 152/3 152/17 153/1 158/3 160/1 161/6 161/8 163/14 164/13 164/15 165/13 165/20 176/6 177/3 190/2 192/18 194/8
debrief [8] 7/23 8/2 18/25 19/7 19/15 19/18 20/13 58/25
debriefs [3] 24/4 131/11 131/17
decade [1] 2/11
December [4] 125/3 174/7 175/1 175/3
decide [1] 102/22
decided [4] 101/14 101/16 112/9 165/15
decipher [1] 98/1
decision [7] 24/13 56/14 90/6 100/18 101/17 181/9 188/9
decision-making [1] 188/9
decisions [2] 111/23 137/9
decompress [1] 20/15
decrease [2] 61/24 88/25
deep [3] 99/25 100/18 103/6
deeply [1] 46/8
defence [5] 134/25 135/20 135/23 135/24 135/24
defenceless [1] 158/18
deficiencies [1] 28/11
definitely [9] 19/17 22/14 27/14 62/9 62/9 72/14 85/1 85/11 186/21
definitive [1] 84/15
degree [2] 4/21 171/2
deliberate [3] 33/13 108/23 116/8
deliberately [2] 34/3 99/3
delivered [2] 153/23 166/20
delivering [3] 154/15 155/23 191/10
delivery [1] 59/10
department [13] 2/12 6/4 11/8 14/8 26/21 53/4 53/7 81/9 107/10 128/9 128/11 143/17 157/11
departments [3] 85/10 139/2 185/14
departure [1] 40/14
depend [1] 168/7
dependency [1] 146/19
depending [2] 135/25 147/14
depends [1] 68/18
deputy [2] 96/23 179/4
describe [7] 13/1 18/21 109/7 130/8 131/5 135/8 195/3
described [2] 44/25 68/9
describes [3] 22/7 72/10 85/24
describing [1] 65/8
description [5] 45/3 84/13 135/11 151/2 165/18
deserve [1] 148/16
deserved [2] 148/12 148/18
designated [3] 142/16 142/23 142/24
designation [1] 148/4
designed [1] 165/21
desk [2] 49/8 132/9
desperately [1] 174/21
detached [1] 13/11
detail [8] 5/18 13/22 16/18 22/2 40/2 131/4 160/6 179/2
detailed [5] 85/19 123/8 161/5 178/16 179/3
details [4] 17/25 130/19 186/22 188/23
detected [1] 89/20
deteriorate [3] 90/4 94/16 94/17
deteriorated [6] 59/22 69/7 79/8 79/11 89/6 122/10
deteriorates [1] 78/21
deteriorating [2] 71/24 80/20
deterioration [15] 26/10 58/18 60/1 61/12 62/11 68/4 69/9 69/14 69/16 70/7 75/10 79/13 79/20 80/4 121/21
deteriorations [2] 30/10 178/14
determination [1] 118/7
Devastated [1] 169/8
devastating [4] 145/2 145/3 145/4 159/5
developed [3] 9/17 47/1 47/1
Diagnostics [1] 48/10
diary [1] 186/13
did [173] 2/7 2/16 2/18 3/4 4/25 5/12 7/1 9/18 9/19 10/4 10/20 11/21 14/7 14/8 14/15 18/11 18/13 18/20 18/21 19/3 21/15 27/5 27/23 30/1 31/14 35/14 38/3 38/7 38/7 38/13 40/14 40/19 40/21 42/11 44/6 44/10 44/19 49/24 50/4 50/12 50/15 51/11 51/16 51/22 52/9 54/19 55/22 56/20 58/23 59/16 60/15 61/25 63/3 63/7 63/13 64/5 64/8 64/11 65/5 67/6 67/23 69/14 71/13 71/15 72/11 73/3 73/25 74/21 74/24 75/13 76/1 77/5 77/22 79/24 81/3 81/19 81/20 82/16 91/3 91/7 93/23 93/24 96/18 97/7 100/23 100/24 101/7 102/24 110/5 113/13 114/25 115/5 116/24 117/13 117/15 117/21 118/16 119/9 119/25 120/3 120/7 120/9 122/11 124/2 127/9 127/10 127/10 130/10 130/13 131/20 136/2 136/21 136/21 136/22 136/23 136/24 138/3 138/14 138/25 140/5 142/15 143/1 144/20 144/25 145/7 148/12 148/25 149/1 151/25 152/5 153/6 154/5 155/3 155/4 157/15 160/1 160/4 160/4 160/7 160/11 160/23 160/23 161/16 163/2 164/9 164/10 166/14 167/18 169/14 170/7 170/7 171/6 173/24 176/17 179/5 180/11 181/15 181/21 181/23 183/15 185/11 185/15 185/18 186/17 187/11 187/24 188/16 188/21 189/1 189/6 189/6 189/8 191/10
didn't [80] 3/14 5/16 5/16 12/7 12/18 13/8 13/8 14/18 14/23 15/17 16/3 19/9 19/14 20/16 27/9 37/3 40/20 43/16 47/8 47/10 52/12 52/25 53/11 53/14 53/23 56/17 61/9 63/10 64/7 65/21 65/22 70/7 74/18 74/19 76/6 80/12 81/10 82/20 84/10 85/8 87/20 98/7 108/3 117/11 117/12 117/12 117/12 117/18 120/4 122/17 140/8 141/1 143/21 148/25 153/14 153/24 154/8 156/2 156/7 161/10 161/14 161/15 165/25 169/3 169/8 169/9 169/20 170/21 170/25 173/5 173/6 174/24 175/8 177/2 178/22 188/7 188/8 189/3 189/17 197/1
die [3] 59/17 90/5 116/22
died [18] 15/18 17/16 20/1 20/2 25/2 30/9 31/16 32/8 32/10 32/11 32/20 62/16 66/4 68/3 71/10 72/16 132/1 147/24
dies [1] 145/3
difference [3] 53/8 66/17 158/22
different [43] 6/16 12/23 26/2 38/6 46/9 47/24 50/20 52/25 53/5 53/7 60/8 60/14 60/24 62/10 65/19 65/19 78/1 84/4 84/6 85/10 93/17 103/16 135/24 135/25 136/1 136/25 142/3 142/8 142/13 153/10 153/16 156/22 165/22 168/7 174/15 191/5 191/5 191/18 191/20 191/22 196/1 196/7 197/22
differently [5] 27/20 57/3 180/9 196/7 197/5
difficult [30] 6/16 7/21 9/22 10/2 17/3 17/12 17/16 33/11 36/4 36/13 38/9 43/15 45/13 46/13 84/9 107/13 108/9 143/14 145/18 148/15 156/23 158/13 171/15 178/7 181/8 189/10 195/25 196/9 196/14 198/1
difficulties [1] 53/11
difficulty [1] 80/5
digging [1] 46/22
digital [2] 84/22 84/23
diligence [1] 137/17
diligent [1] 194/25
direct [7] 48/21 52/9 52/20 52/23 96/18 115/11 196/15
directed [1] 81/8
directly [13] 4/24 20/4 28/21 38/10 52/21 53/15 53/20 53/23 54/1 67/12 67/18 159/23 172/17
director [12] 4/6 12/16 46/9 52/22 77/21 77/22 78/4 137/15 139/4 165/15 187/11 193/2
Directors [1] 185/10
dirty [1] 125/10
disappeared [1] 122/6
disappears [1] 61/5
disappointed [2] 106/15 180/19
disbelief [3] 36/4 37/5 182/3
discharged [1] 80/17
disclosed [1] 176/16
disclosure [1] 188/18
discolouration [2] 58/22 60/12
discounting [1] 198/21
discredit [1] 163/6
discuss [27] 3/5 3/11 14/11 16/7 18/11 24/5 24/10 42/25 43/13 43/13 55/13 56/5 56/10 56/15 57/13 69/24 74/24 75/20 78/4 89/5 90/11 91/5 97/25 100/23 177/1 180/15 189/3
discussed [24] 16/13 18/1 18/2 23/20 25/7 25/14 25/20 25/25 26/1 33/23 34/18 56/24 57/17 60/18 65/23 78/10 81/10 86/24 93/12 158/8 174/19 174/20 179/8 186/11
discussing [20] 21/12 21/14 57/10 67/21 70/10 70/16 70/17 70/18 70/22 70/23 72/14 72/20

D

discussing... [8] 81/13 84/8 91/9 95/7 99/8 112/20 117/16 132/17
discussion [32] 17/19 18/21 24/6 24/23 31/24 32/10 32/24 43/8 65/4 65/4 71/6 72/19 73/1 90/7 93/16 96/13 98/3 115/5 130/25 138/2 138/4 138/6 138/11 156/10 156/12 163/19 169/14 169/17 169/19 177/9 177/18 181/18
discussions [13] 41/14 43/10 58/21 72/21 72/21 74/25 95/18 102/10 121/23 122/2 122/24 131/11 131/23
dismissed [1] 155/4
dismissive [1] 196/12
disorder [1] 170/16
disposal [1] 168/18
dispute [1] 179/23
dissatisfaction [1] 178/6
disseminate [1] 107/21
disseminated [1] 160/21
distension [1] 71/19
distinct [1] 131/1
distress [1] 20/8
distressed [2] 105/25 106/3
district [11] 12/20 87/24 89/8 89/17 89/25 90/1 90/9 90/10 90/21 90/22 144/9
disturbing [1] 45/1
dithering [1] 173/13
dive [3] 99/25 100/19 103/7
division [6] 6/4 6/23 7/16 7/18 41/25 139/10
divisional [6] 6/1 6/6 7/11 47/17 48/11 48/13
divisions [1] 6/16
DN [2] 97/14 97/14
do [181] 1/11 5/20 6/22 6/23 7/10 8/2 9/22 11/2 11/21 14/1 14/4 14/22 14/23 16/3 16/19 21/3 21/16 23/8 24/13 24/13 27/12 27/14 27/17 27/19 28/15 29/9 31/8 31/11 34/7 37/2 37/20 40/21 43/15 44/13 46/11 49/11 51/11 53/6 54/12 54/14 56/10 57/13 58/7 58/21 58/25 59/1 59/4 59/21 60/17 62/19 64/12 65/9 65/15 68/11 68/12 69/25 73/5 76/5 76/20 77/7 77/18 78/2 78/8 78/13 78/14 78/23 79/12 80/25 81/14 81/14 81/16 81/18 82/8 82/10 83/22 83/22 84/9 84/9 84/11 88/23 89/4 89/17 91/5 92/4 95/3 95/8 96/16 96/25 97/16 97/19 98/25 99/11 101/22 102/14 103/9 106/5 108/7 109/11 110/2 112/18 112/21 112/21 113/15 115/8 117/7 117/19 122/1 124/3 125/11 125/13 127/9 127/10 128/19 129/2 130/2 130/3 131/6 131/24 133/6 133/17 136/18 136/19 136/21 136/22 137/12 138/7 142/15 143/8 143/10 143/17 143/25 147/12 147/19 148/9 149/2 149/4 149/11 150/11 150/20 153/4 153/24 154/8 154/21 155/13 155/14 156/23 157/19 159/3 159/16 164/18 165/15 165/16 165/21 166/14 167/4 167/22 167/23 167/25 168/2 168/20 169/16 171/23 171/25 174/12 175/7 177/8 177/16 180/22 180/24 183/18 187/4 190/4 190/19 190/25 193/15 193/20 194/14 196/10 197/19 198/19 198/24
doctor [7] 21/18 60/8 140/22 142/23 142/25 149/18 159/2
doctors [29] 12/2 22/9 46/19 46/21 51/1 51/25 65/5 65/8 65/11 84/19 84/24 85/6 85/7 95/10 98/6 98/13 100/25 102/21 106/24 107/1 142/16 165/2 165/6 165/12 166/1 166/3 170/17 172/6 195/4
doctors' [1] 196/18
document [17] 23/15 62/14 74/9 75/11 94/2 96/11 101/23 107/25 108/1 108/2 133/12 151/1 161/22 190/15 190/17 191/18 192/25
documentation [1] 142/11
documented [5] 60/22 64/10 69/9 94/20 94/22
documents [3] 146/2 150/15 150/18
does [17] 2/10 27/18 34/25 44/15 44/23 48/2 61/12 70/8 81/25 103/23 104/9 118/21 119/20 125/17 182/21 192/11 198/18
doesn't [6] 9/25 25/13 61/23 158/21 163/1 163/1
doing [19] 27/12 28/15 33/11 35/16 38/8 42/12 59/1 66/13 71/25 99/9 113/1 133/11 136/18 154/2 154/3 154/4 155/13 169/7 196/23
don't [133] 6/25 7/3 7/25 8/5 18/25 19/6 19/8 19/9 21/5 21/5 22/1 24/12 24/12 24/12 24/17 25/6 25/22 25/22 26/10 28/18 37/4 38/14 38/15 38/16 39/12 40/10 41/5 43/18 45/23 46/24 46/24 53/1 53/1 54/24 55/5 58/8 65/7 66/20 66/21 69/18 69/23 70/2 71/2 72/6 73/10 73/11 73/15 74/7 75/1 75/2 76/20 76/21 77/15 77/16 79/1 80/2 81/7 81/16 81/16 81/21 83/1 88/24 92/3 93/4 93/24 94/16 94/24 97/19 97/20 103/7 103/9 103/10 107/14 107/16 107/25 108/6 108/6 108/8 109/8 111/20 112/2 112/8 112/25 113/4 117/6 124/6 125/14 126/25 127/2 127/25 132/10 136/5 137/16 137/18 139/20 145/6 145/22 145/25 148/20 159/16 160/25 161/13 163/18 164/18 166/16 168/20 168/23 169/11 170/12 172/9 172/18 173/12 178/3 179/14 179/16 183/15 183/20 185/17 189/2 190/5 193/18 193/23 194/1 194/1 194/8 194/9 194/10 195/1 196/6 196/25 197/2 197/19 199/2
done [34] 8/16 19/24 22/10 22/13 24/2 31/15 36/1 39/7 47/4 56/12 57/3 73/25 85/20 90/6 99/12 101/8 102/24 113/3 128/12 128/15 132/22 140/10 144/17 155/24 156/16 157/7 166/3 168/11 191/12 196/7 196/21 197/5 197/16 197/21
door [2] 13/10 138/17
doubt [3] 19/17 41/4 159/8
down [32] 1/11 9/23 23/14 24/18 26/6 44/5 44/5 49/11 79/6 86/23 88/3 94/2 94/13 96/11 98/20 102/13 103/13 105/23 106/6 111/17 113/5 129/13 134/12 138/25 147/20 151/21 158/18 162/17 167/13 169/18 182/5 186/25
downgrade [1] 100/2
downgraded [2] 98/5 146/13
downgrading [1] 98/7
Dr [168] 1/5 1/7 1/10 1/13 12/16 18/12 18/14 20/21 21/17 21/24 22/4 23/3 23/8 24/14 24/25 26/12 26/17 28/2 28/13 30/15 31/24 31/24 31/25 33/18 33/23 36/25 36/25 37/1 39/15 39/15 39/15 39/24 39/25 39/25 42/10 42/10 42/10 42/23 42/23 44/11 44/12 44/19 44/20 44/23 44/25 45/7 47/11 47/14 48/23 49/6 49/8 49/9 49/15 50/21 51/6 53/22 53/22 55/18 56/10 57/10 58/4 60/11 60/15 60/16 60/18 62/16 62/21 62/22 63/8 63/11 63/14 64/15 64/24 68/9 72/8 72/9 72/10 72/10 72/15 73/1 73/20 74/21 77/4 77/20 78/9 78/14 78/19 78/23 79/16 79/23 80/3 83/5 83/16 85/24 87/12 91/9 92/2 93/4 97/22 98/5 98/24 100/10 103/13 104/22 105/7 105/14 106/1 108/19 114/14 115/5 116/24 119/1 119/8 119/22 120/16 126/14 128/3 128/18 128/24 129/9 129/10 129/13 129/16 130/1 130/13 130/13 132/25 133/12 133/21 137/25 139/9 142/22 142/24 144/1 146/8 147/4 147/6 151/6 151/6 151/7 153/10 153/13 159/15 159/15 159/18 159/18 161/23 164/23 170/4 170/4 173/10 175/22 177/1 177/25 178/1 183/8 187/8 187/10 190/17 195/16 195/17 197/7 197/8 199/5 199/12 200/2 200/5 200/9
Dr Brearey [30] 18/12 31/24 33/18 33/23 36/25 39/15 39/25 42/10 42/23 44/11 53/22 72/10 72/15 73/1 74/21 77/20 78/9 78/19 79/23 80/3 83/16 85/24 91/9 93/4 100/10 130/13 159/18 164/23 170/4 178/1
Dr Brearey's [1] 18/14
Dr Brearley [1] 78/14
Dr Brunton [1] 21/17
Dr Gibbs [20] 21/24 26/12 26/17 31/24 36/25 39/24 42/10 62/16 62/21 63/8 63/11 63/14 64/15 68/9 72/9 77/4 147/4 151/6 173/10 183/8
Dr Gibbs' [1] 147/6
Dr Green [2] 187/8 187/10
Dr Harkness [2] 23/3 23/8
Dr Hawdon [1] 177/1
Dr Holt [9] 129/9 129/13 130/1 146/8 161/23 177/25 190/17 199/5 199/12
Dr Howie [1] 142/22
Dr Issac [2] 144/1 197/7
Dr Jayaram [17] 12/16 31/25 37/1

D

Dr Jayaram... [14] 39/25 42/10 42/23 44/12 53/22 72/10 97/22 98/5 115/5 130/13 139/9 151/7 159/18 170/4
Dr Lambie [3] 20/21 22/4 62/22
Dr McCormack [1] 195/16
Dr Mecrow [2] 44/19 44/23
Dr Mecrow's [1] 44/20
Dr Mittal [4] 55/18 56/10 57/10 197/8
Dr Neame [3] 30/15 153/10 153/13
Dr Newby [10] 1/5 1/10 1/13 45/7 47/11 47/14 48/23 51/6 72/8 120/16
Dr Saladi [30] 49/6 49/8 49/15 50/21 58/4 64/24 73/20 78/23 79/16 83/5 87/12 92/2 98/24 103/13 104/22 105/7 105/14 106/1 108/19 114/14 116/24 119/1 119/8 119/22 126/14 128/3 128/18 128/24 132/25 133/21
Dr Saladi's [1] 133/12
Dr Sara [1] 195/17
DR SATYANARAYANA [2] 49/9 200/5
Dr Sean Tighe [1] 137/25
Dr Subhedar [4] 24/14 28/2 28/13 39/15
Dr Subhedar's [1] 24/25
DR SUSIE HOLT [2] 129/10 200/9
Dr V [4] 39/15 60/15 60/16 60/18
Dr V's [1] 60/11
Dr ZA [2] 151/6 159/15
draft [1] 147/2
draw [4] 46/6 103/11 153/14 175/20
drawing [3] 22/6 110/1 175/20
drawn [1] 175/18
dread [1] 159/1
drop [1] 9/23
drug [2] 5/7 8/18
drugs [3] 3/2 3/11 3/12
drunk [1] 54/23
drunken [1] 55/3
dry [2] 80/22 82/13
due [7] 45/1 91/12 116/9 128/10 137/16 151/20 178/10
Duncan [13] 97/17 139/19 183/6 183/9 183/16 183/18 183/24 184/5 185/5 185/18 186/7 186/18 187/4
duplicate [1] 191/21
during [12] 8/19 52/4 67/12 71/12 90/24 112/4 115/19 132/14 139/6 165/6 165/14 195/4
duties [1] 157/10
duty [7] 33/5 33/9 33/22 38/24 73/23 147/15 147/19
dying [1] 148/5

E

each [14] 5/19 22/17 23/13 28/10 28/23 33/21 51/16 68/6 144/4 152/7 152/15 153/19 176/10 179/1
earlier [17] 20/1 25/17 25/25 60/9 115/19 127/14 127/15 132/4 144/15 151/11 161/14 171/6 176/18 192/10 196/19 196/21 196/23
early [7] 47/16 55/16 73/19 76/19 110/22 120/13 160/13
earth [1] 31/13
easier [2] 46/25 155/8
easily [4] 51/16 53/12 85/9 168/5
easy [9] 1/10 54/24 55/4 55/5 108/10 152/11 152/12 171/18 171/19
eating [1] 170/16
ed [1] 145/19
effect [1] 71/15
effects [1] 145/15
eight [3] 162/14 165/14 177/7
eight months [1] 177/7
Eirian [9] 11/19 33/19 38/21 51/6 78/20 79/25 172/23 172/24 173/11
Eirian Powell [7] 33/19 38/21 51/6 78/20 79/25 172/24 173/11
Eirian's [1] 174/11
either [9] 65/3 92/10 121/4 143/2 143/25 145/7 148/24 179/22 192/22
elaborate [1] 137/12
electronically [1] 168/12
eliminate [2] 141/25 145/18
eliminated [1] 145/17
ELIZABETH [2] 1/7 200/2
else [11] 30/1 35/11 66/10 71/23 71/24 91/14 128/4 158/5 173/2 182/13 199/9
email [58] 19/1 21/21 21/23 22/3 22/24 53/23 62/16 62/19 62/25 63/7 63/20 63/21 64/8 64/8 65/3 73/6 73/14 74/11 78/14 78/17 78/24 79/24 83/13 85/14 85/15 85/22 86/4 86/5 86/6 86/22 86/24 87/8 87/11 87/11 87/14 87/16 91/21 92/2 93/8 93/10 93/14 99/7 99/15 99/16 99/16 115/22 116/1 123/11 132/20 132/24 133/6 133/12 133/13 135/5 178/1 179/18 179/20 183/8
emails [7] 26/1 53/2 93/13 147/2 177/23 188/4 191/6
embarrassed [1] 169/10
embolism [2] 99/14 116/2
Emily [1] 165/2
Emma [1] 139/17
emotional [2] 19/22 135/13
emphasising [1] 144/7
employ [1] 194/22
employed [3] 120/10 129/22 129/23
employment [1] 167/8
end [21] 4/13 10/8 19/10 19/12 26/20 34/11 36/18 36/19 37/24 41/4 44/16 44/23 66/1 81/19 100/17 106/20 129/3 134/20 146/25 155/12 183/10
ending [1] 170/20
energy [1] 114/3
engaged [1] 12/11
engaging [1] 184/18
enough [6] 97/4 114/1 155/14 156/2 157/6 198/22
enquiries [1] 92/5
ensure [1] 188/13
ensuring [1] 86/17
entering [1] 84/17
entire [1] 67/12
entirely [2] 119/14 125/23
entitled [2] 161/14 167/1
entrance [1] 84/17
episode [2] 79/19 82/9
episodes [1] 86/15
equal [1] 7/17
equipment [3] 8/19 22/19 33/21
error [4] 8/18 8/18 9/10 9/11
errors [3] 8/24 12/3 163/7
escalated [2] 177/7 178/8
especially [2] 178/21 184/6
essential [1] 173/25
essentially [3] 138/18 148/21 192/3
et [10] 3/11 3/13 5/6 5/8 33/22 36/11 145/21 171/25 178/17 180/4
et cetera [10] 3/11 3/13 5/6 5/8 33/22 36/11 145/21 171/25 178/17 180/4
even [24] 9/10 20/4 41/2 65/15 76/1 84/10 88/16 88/18 90/19 91/16 121/7 123/20 139/15 139/16 145/2 157/6 158/10 159/3 159/4 170/11 173/18 181/20 186/17 188/7
evening [3] 92/10 174/11 187/1
event [13] 8/25 9/9 10/5 17/13 18/3 19/19 60/19 114/19 124/15 143/11 169/2 174/16 181/14
events [26] 4/25 5/19 7/12 9/3 13/14 19/20 20/4 20/9 21/12 27/17 30/8 33/5 33/9 34/8 34/10 38/20 46/3 58/5 69/15 73/3 84/1 110/11 120/14 167/7 177/15 197/3
eventually [2] 160/11 183/1
ever [11] 3/4 36/7 38/3 43/16 44/19 46/18 115/11 138/25 149/9 169/10 198/8
every [5] 9/20 69/25 145/4 152/7 157/2
everybody [9] 18/5 18/6 19/10 19/13 20/8 20/13 26/2 112/21 198/11
everybody's [2] 10/7 19/13
everyone [3] 36/10 46/21 100/7
everything [2] 44/9 45/21
evidence [36] 5/5 15/20 16/11 26/25 27/2 29/13 47/10 47/15 48/23 80/8 92/25 114/20 115/1 115/10 115/14 119/8 119/18 120/15 121/12 121/18 124/2 128/4 128/7 128/8 129/2 147/6 148/23 151/24 152/18 153/9 173/10 197/8 197/25 198/23 199/7 199/14
evidenced [2] 154/20 189/17
exact [4] 43/19 81/1 109/8 130/19
exactly [8] 11/21 34/7 51/11 87/2 99/20 114/13 131/22 135/9
examination [1] 123/8
example [13] 8/17 14/13 17/10 22/20 40/5 45/21 71/5 144/16 151/12 156/5 184/23 195/12 196/2
excellent [1] 174/23
except [1] 53/24
exchange [1] 188/3
exclude [1] 100/2
excluded [2] 86/1 116/9
Exec [2] 42/1 176/20
executive [10] 52/16 109/6 137/15 139/5 185/5 185/8 185/10 185/11 185/18 194/9
Executives [6] 94/19 106/3 106/19 116/6 171/10 193/9
exhausted [1] 186/14
exist [1] 9/25
expand [1] 171/13
expect [4] 118/2 131/16 144/10 176/8

E

expectation [3] 43/23 53/18 169/16
expected [12] 10/23 11/1 41/10 89/18 89/19 124/15 124/18 124/21 127/6 146/24 158/1 167/7
expecting [1] 17/22
experience [23] 2/11 5/1 5/14 10/15 12/4 12/23 12/24 13/1 46/8 47/23 47/24 47/25 51/13 64/14 69/23 70/1 88/14 89/3 118/16 126/24 154/14 163/6 180/3
experienced [6] 26/9 88/10 127/4 127/5 127/5 147/10
experts [1] 165/22
explain [15] 18/3 27/10 62/11 72/17 87/22 88/11 89/6 93/19 113/18 121/25 122/5 122/16 125/3 128/11 147/21
explainable [1] 124/22
explained [11] 5/14 77/8 82/14 123/21 124/15 124/20 145/11 148/19 155/10 160/1 181/21
explaining [4] 27/21 83/16 93/19 155/1
explanation [10] 14/23 16/4 28/10 28/23 29/1 67/5 89/7 112/12 112/15 158/2
exploring [2] 97/6 99/25
express [1] 188/17
expressed [5] 107/12 156/14 159/25 166/17 185/21
expressing [2] 34/4 173/23
expressly [1] 34/17
extent [1] 184/9
external [9] 68/7 95/11 146/9 149/6 176/12 177/13 186/15 193/5 196/19
extra [3] 88/16 88/17 95/8
extra way [1] 95/8
extrapolation [2] 154/20 179/23
extremely [8] 22/20 41/11 44/2 89/16 89/22 90/10 90/20 176/14

F

face [2] 25/10 109/11
faced [1] 174/25
Facere [1] 171/7
Facere Melius [1] 171/7
facing [1] 53/12
fact [25] 20/20 22/4 23/22 23/25 33/4 33/6 35/22 37/8 53/6 60/13 61/18 62/7 63/8 66/2 67/2 67/23 73/1 77/4 106/21 116/7 116/10 124/1 173/22 174/2 182/24
factor [4] 73/3 153/5 155/6 163/14
factors [1] 155/3
facts [3] 27/19 174/3 189/6
factually [1] 164/10
faeces [3] 125/7 125/22 125/23
failing [1] 193/10
failure [6] 26/18 57/8 68/10 69/3 77/6 77/18
fair [4] 20/7 20/11 146/5 193/24
fairly [1] 23/6
faith [3] 66/11 137/8 137/13
false [1] 188/14
families [14] 46/1 46/4 119/4 147/7 147/10 147/16 148/10 153/21 158/19 169/11 177/10 177/14 184/18 190/14
family [9] 18/5 125/2 125/12 125/15 148/1 155/22 156/2 173/18 183/19
Family J [2] 125/12 125/15
far [22] 28/20 51/21 55/7 58/10 69/19 76/22 76/24 84/22 94/9 107/2 116/18 117/17 130/5 149/8 157/23 165/22 172/20 173/3 173/19 182/19 190/19 192/6
far-fetched [1] 173/19
fatal [2] 8/3 9/8
Father [3] 80/7 82/3 125/5
Father J [1] 125/5
fault [1] 79/16
faulty [1] 8/19
February [19] 3/23 34/12 36/16 39/16 40/15 40/16 41/1 41/2 41/4 43/5 44/17 74/17 110/23 111/10 144/16 144/18 160/14 176/23 192/13
February 2016 [2] 34/12 36/16
February 2017 [2] 160/14 192/13
fed [1] 41/25
feed [3] 40/21 153/20 168/10
feedback [1] 166/12
feeding [1] 9/17
feeds [1] 88/5
feel [22] 13/8 13/9 46/1 46/4 114/9 119/9 120/9 153/6 153/24 155/7 156/7 169/8 169/9 169/11 169/20 170/10 171/24 173/6 178/9 190/7 193/20 198/1
feeling [12] 20/8 22/12 43/17 46/11 80/25 88/4 96/5 111/9 111/22 128/15 136/10 166/3
feelings [1] 162/16
feels [2] 152/11 159/3
fellow [5] 106/8 143/9 152/2 153/9 178/2
felt [42] 11/13 16/6 16/8 24/2 24/3 27/22 28/8 33/10 43/12 65/25 86/17 100/12 114/9 134/17 137/18 153/18 153/25 155/25 159/4 162/22 164/7 166/1 167/13 169/7 169/9 169/23 169/24 170/12 170/18 170/20 171/13 171/17 178/20 179/11 180/8 182/6 182/22 182/23 185/1 185/6 188/22 192/4
ferociously [1] 134/24
fetched [1] 173/19
few [20] 8/9 64/19 66/22 68/13 69/15 77/9 79/23 81/2 81/22 86/5 90/5 101/10 101/13 102/7 104/15 107/19 111/25 182/2 182/8 184/10
fight [2] 111/3 111/18
fill [6] 8/13 10/5 10/8 10/19 10/22 57/19
filled [1] 10/19
filling [3] 9/16 9/21 126/1
filters [4] 65/14 91/13 121/6 121/7
final [4] 2/7 24/24 45/6 99/22
Finally [2] 125/1 195/2
find [6] 44/6 90/17 119/22 123/21 151/25 191/9
finding [2] 71/21 72/1
findings [5] 28/4 29/7 29/10 160/22 189/8
fine [1] 104/13
finished [2] 101/23 109/24
firm [2] 18/19 112/25
first [34] 1/4 5/25 13/16 28/15 33/24 35/2 36/18 47/6 56/7 56/9 63/11 75/8 79/10 80/17 83/19 84/4 101/10 102/5 107/4 114/7 117/3 117/4 120/14 130/7 130/24 132/19 135/5 143/4 144/20 144/25 145/9 147/18 181/13 192/8
firstly [3] 6/11 106/14 113/13
fit [1] 122/17
five [2] 104/24 138/18
five past 2 [1] 104/24
fixed [1] 180/8
flagged [1] 10/9
flawed [1] 156/23
floor [1] 138/16
floundering [1] 148/7
fobbed [1] 138/17
focus [7] 50/21 69/18 72/3 146/15 166/4 166/6 186/15
focusing [1] 165/5
follow [5] 2/10 57/8 78/7 161/3 166/16
follow-up [1] 166/16
followed [5] 15/20 56/21 131/17 164/20 190/5
following [14] 11/9 29/6 32/3 42/13 55/12 55/17 57/1 57/4 72/11 72/13 130/17 151/18 165/13 165/24
follows [1] 117/2
forceful [1] 109/12
foremost [1] 147/18
forensic [2] 167/23 167/24
forensically [1] 167/25
foresight [1] 171/16
forgive [3] 100/5 106/11 163/19
forgot [1] 153/6
form [6] 8/14 10/22 57/19 109/18 126/2 193/14
formal [3] 8/8 9/15 24/4
formally [2] 26/1 74/22
formed [1] 72/25
forms [1] 56/11
formulate [1] 113/18
forth [4] 110/14 126/22 126/22 192/2
forthcoming [1] 184/7
forthwith [1] 93/13
forward [28] 1/5 21/21 23/16 23/22 23/22 24/19 26/6 26/23 30/5 46/14 46/15 67/8 71/4 71/8 73/17 77/3 83/6 88/12 94/2 94/15 97/1 105/7 105/13 106/7 108/17 145/20 168/24 188/9
found [9] 5/5 28/11 30/15 34/2 125/6 137/3 137/6 171/21 181/7
Foundation [2] 4/1 4/10
four [7] 22/5 22/13 63/14 64/14 87/25 105/22 192/16
fourth [1] 67/23
framed [1] 180/17
framework [1] 41/23
framing [1] 56/4
free [4] 48/24 119/14 128/24 199/15
frequently [2] 152/23 195/10
Friday [1] 199/17
friend [1] 119/3
friends [5] 155/20 155/22 156/1 156/6 173/8
Frog [1] 175/23
front [4] 58/16 61/3 64/20 182/22
frustrating [1] 180/2
full [9] 22/23 49/12 88/25 161/5 166/19 166/25 176/21 188/18 192/14
fully [1] 18/3
functioning [1] 107/9
fundamental [1] 158/22
fundamentally [1] 157/1
further [15] 3/6 44/5 64/15 86/18 105/24 114/14 126/9 138/19 161/17 166/16 170/3

F

further... [4] 177/8 178/16 182/12 193/4
future [3] 153/20 184/6 194/13

G

gained [1] 48/10
gardening [1] 170/20
gastroenterology [1] 129/25
gather [1] 96/20
gathering [1] 79/5
gave [7] 7/14 93/7 114/20 119/8 121/18 166/25 173/10
general [15] 2/5 7/10 7/22 12/20 41/7 87/24 89/17 90/22 120/13 129/24 143/6 144/9 148/21 156/3 178/5
generalised [1] 115/11
generality [1] 13/23
generally [2] 132/8 190/10
generate [1] 93/15
generation [1] 170/17
gestation [1] 163/15
get [24] 14/20 15/6 17/8 19/12 37/3 52/13 72/18 82/21 96/21 96/23 98/14 101/4 106/25 107/13 107/19 109/1 136/24 140/1 148/25 149/1 166/14 167/5 176/17 194/8
gets [2] 186/22 191/16
getting [7] 61/2 70/2 79/5 88/24 194/7 196/16 197/11
Gibbs [20] 21/24 26/12 26/17 31/24 36/25 39/24 42/10 62/16 62/21 63/8 63/11 63/14 64/15 68/9 72/9 77/4 147/4 151/6 173/10 183/8
Gibbs' [1] 147/6
gift [1] 107/17
give [24] 8/1 11/17 14/10 45/22 49/12 60/5 74/20 75/25 76/1 76/4 80/10 88/17 109/19 112/22 115/14 119/18 129/14 133/7 151/5 160/6 177/23 179/2 180/10 180/18
given [20] 1/14 18/1 25/25 26/25 28/13 35/25 80/8 93/6 110/24 127/1 151/10 151/24 159/2 178/10 178/20 180/2 184/6 184/10 188/11 188/17
giving [9] 45/22 56/17 93/20 115/1 127/5 156/5 197/8 199/7 199/14
GMC [5] 81/11 81/14 81/17 134/24 135/19
go [62] 10/21 14/11 21/23 22/1 22/25 23/17 23/19 36/13 40/19 43/14 48/24 68/20 70/7 75/20 80/21 87/10 88/3 90/16 92/2 95/16 97/21 99/23 101/5 101/23 102/22 108/14 125/16 126/5 128/24 133/17 133/25 134/11 134/12 134/12 134/20 134/21 142/2 142/6 146/7 150/9 150/25 152/19 154/18 155/2 161/2 162/17 163/3 165/10 169/5 169/18 176/19 176/22 177/4 177/20 177/23 177/24 178/11 178/18 191/17 192/25 198/23 199/15
goes [7] 22/9 27/9 45/25 71/25 88/3 99/21 127/11
going [82] 1/20 5/22 10/18 13/5 13/13 16/17 20/19 21/20 22/24 23/15 23/15 24/3 31/14 32/17 37/23 50/18 56/18 58/4 58/9 58/15 59/19 62/14 69/18 71/4 71/5 76/14 76/23 76/25 78/3 81/13 83/5 84/5 85/17 87/8 87/10 88/24 91/14 92/11 92/13 92/17 94/2 97/25 98/17 101/8 101/15 104/23 105/9 105/10 110/10 111/5 111/21 112/8 113/17 114/4 114/15 116/22 120/12 122/2 127/7 136/2 139/23 145/20 146/2 147/3 149/17 151/17 153/17 157/16 162/1 162/19 167/21 170/19 180/16 181/7 182/7 185/14 185/20 185/22 187/6 188/9 189/9 196/19
gone [5] 8/15 70/4 142/20 144/15 174/7
good [26] 6/11 11/14 19/17 24/10 26/4 36/10 50/25 51/2 51/4 51/4 82/10 91/19 112/11 119/6 154/15 154/15 155/21 156/2 157/6 162/21 173/7 194/21 195/10 195/11 195/13 195/14
goodness [1] 147/3
Gosh [1] 28/18
got [25] 1/10 7/18 13/10 58/15 82/2 107/20 117/5 118/8 125/10 132/13 133/8 136/9 137/19 163/22 171/15 175/22 177/16 184/17 188/12 189/15 190/11 195/23 196/3 196/3 196/4
governance [3] 6/15 41/23 41/25
grade [1] 153/17
graphs [4] 150/23 151/2 152/21 154/23
grateful [2] 158/25 176/3
great [1] 92/25
Green [5] 187/8 187/8 187/8 187/9 187/10
grew [1] 65/15
grey [1] 9/13
grief [2] 147/14 192/19
grievance [10] 111/20 187/11 187/25 188/6 188/15 189/7 189/16 189/19 189/23 190/5
grieving [1] 149/3
grilled [1] 23/2
ground [2] 138/16 153/12
grounds [1] 95/25
group [20] 11/13 20/17 21/15 44/4 44/13 53/19 72/21 88/20 105/19 107/4 137/23 157/23 158/3 159/12 159/14 159/15 159/25 176/16 177/1 196/23
grouped [2] 66/22 130/25
grouping [1] 66/7
groups [3] 52/3 87/25 188/1
growing [1] 65/14
guess [1] 145/10
guidance [7] 3/9 15/22 55/15 134/25 135/19 145/20 147/17
guide [1] 43/14
guilty [2] 128/15 171/21

H

had [264]
hadn't [7] 8/15 27/24 151/11 151/12 155/24 188/17 192/20
half [1] 48/21
halfway [2] 44/5 98/20
hand [6] 98/4 98/5 172/15 172/18 193/1 193/6
handled [1] 178/7
happen [12] 10/20 17/22 43/16 47/2 61/8 66/6 83/25 89/25 97/7 107/9 124/22 148/25
happened [28] 10/24 18/6 25/16 31/3 33/5 34/8 36/6 36/6 40/11 42/22 56/8 69/15 77/23 82/11 97/2 100/22 125/5 137/18 138/9 141/15 145/9 152/15 171/16 186/6 187/1 187/3 190/7 194/6
happening [15] 29/17 34/5 34/21 42/25 44/8 57/18 61/21 66/10 70/8 76/7 77/23 148/24 158/5 171/4 171/23
happens [2] 167/4 173/21
happy [3] 100/17 112/14 154/12
hard [7] 34/2 44/6 135/14 145/2 174/9 174/13 194/16
Harkness [3] 23/2 23/3 23/8
harm [19] 15/3 33/14 54/13 54/17 98/22 99/3 99/4 108/23 116/8 128/15 141/14 141/17 141/19 141/21 141/24 141/25 158/20 198/4 198/5
harmed [1] 54/13
harming [5] 34/3 38/11 157/5 159/10 173/18
Harvey [17] 52/22 77/21 93/9 94/9 105/21 154/22 154/25 155/11 166/25 178/1 178/19 179/10 179/13 179/19 184/10 192/12 195/20
Harvey's [1] 166/24
has [39] 11/19 15/21 26/12 26/17 26/25 27/1 51/6 61/24 68/9 68/19 73/18 77/4 86/13 92/24 93/10 93/12 97/2 100/22 112/9 113/4 115/10 117/9 119/3 119/17 122/13 126/23 145/8 148/23 162/9 163/19 171/20 175/18 178/7 185/21 190/20 192/10 194/2 194/6 194/17
hasn't [1] 141/25
hate [1] 199/8
have [389]
haven't [3] 100/9 102/24 199/7
having [32] 18/10 19/1 27/16 30/23 38/11 46/7 46/13 52/4 54/14 55/12 60/15 66/11 66/22 70/12 72/19 73/5 74/25 78/24 91/3 91/10 94/7 96/13 96/14 101/9 107/8 117/23 121/5 123/11 125/11 144/12 165/8 174/19
Hawdon [6] 161/18 165/25 166/2 166/9 177/1 184/24
Hawdon's [2] 161/20 167/20
hazy [1] 42/21
HDU [2] 92/22 93/2
HDU/SCBU [2] 92/22 93/2
he [88] 22/1 22/4 22/7 22/9 23/10 23/10 23/11 28/3 52/18 63/9 72/18 72/20 73/3 74/24 75/1 77/24 78/18 79/24 80/4 85/24 85/24 86/11 86/22 87/2 95/6 97/23 99/13 110/3 110/6 110/7 110/8 113/8 113/16 113/17 113/23 113/24 113/25 114/3 114/7 118/2 118/7 118/13 119/4 126/16 126/18 126/20 126/21 126/23 126/24 126/25 127/3 127/5 127/6 138/6 139/20 139/21 164/25 173/10 178/13 179/11 179/11 180/1 180/22 180/24 181/2 181/6 181/16 181/16 182/2 182/2 182/5 182/6 183/16 183/25 184/1 184/2 184/9 184/10 185/7 185/21 186/25 186/25 187/10 188/13 188/16 188/17

H

he... [2] 189/1 189/2
he's [2] 118/8 184/17
head [4] 15/2 39/9 71/22 139/5
heading [1] 99/24
health [10] 34/2 44/6 50/6 58/20 58/24 60/2 60/6 62/3 146/23 150/5
healthier [1] 116/20
hear [6] 148/2 155/14 155/16 158/11 175/19 189/7
heard [11] 2/19 6/1 27/16 36/7 38/11 72/8 73/15 114/3 136/11 143/11 148/23
hearing [4] 38/2 51/5 90/24 180/5
heart [1] 168/12
hearts [1] 88/23
held [1] 109/9
help [20] 17/4 17/19 18/6 24/9 28/25 42/5 43/14 58/9 59/6 64/20 69/8 87/21 92/16 92/18 92/24 103/23 113/17 134/2 134/14 190/21
helpful [7] 12/11 48/11 86/23 120/1 151/25 164/4 185/17
helpfully [1] 161/23
helping [1] 80/3
hence [1] 69/8
her [36] 1/5 27/2 27/8 27/16 33/3 39/8 45/1 51/7 51/14 96/19 96/25 112/14 113/5 129/2 142/21 149/15 160/10 170/24 171/10 171/24 172/7 172/11 172/20 173/2 173/11 173/11 173/23 174/5 174/10 174/10 174/16 175/6 175/10 189/3 190/1 190/1
here [21] 4/14 5/20 8/22 16/25 25/23 30/6 41/8 50/21 54/11 70/22 71/24 73/18 86/6 137/7 151/17 164/24 177/4 185/21 192/9 198/21 199/19
Hey [2] 1/25 80/21
hide [1] 148/20
high [2] 146/19 198/4
higher [8] 6/24 6/25 7/15 13/7 42/8 52/13 144/3 157/25
highlight [5] 8/17 164/8 182/16 192/4 194/5
highlighted [1] 39/1
highly [1] 184/2
Hill [5] 2/21 4/9 4/15 4/20 57/25
him [35] 18/1 18/15 22/5 52/20 52/21 52/23 74/22 78/2 78/20 79/25 95/21 109/12 110/15 113/22 134/1 138/2 138/4 138/6 138/7 138/11 139/24 155/14 155/16 173/12 180/6 182/3 183/16 183/21 185/6 186/23 187/2 187/13 187/24 188/13 188/15
hindsight [1] 36/3
his [7] 28/4 109/11 173/14 181/15 181/15 183/19 184/2
history [2] 18/2 199/4
hm [29] 3/3 8/11 11/11 13/17 17/18 21/25 22/11 23/4 24/8 25/3 25/8 27/7 28/5 29/19 30/20 39/2 41/15 58/6 60/10 62/24 64/25 68/8 75/6 75/12 79/9 79/22 87/18 110/9 114/23
hmm [1] 2/22
hold [1] 174/13
holding [2] 38/6 41/22
Holt [14] 129/9 129/10 129/13 129/16 130/1 146/8 161/23 165/7 175/22 177/25 190/17 199/5 199/12 200/9
home [2] 125/17 126/5
homes [1] 92/6
honest [10] 7/3 12/1 17/25 21/5 25/22 28/19 29/3 145/22 164/16 172/9
honesty [2] 140/23 148/16
hope [4] 22/2 85/23 177/13 193/25
hoping [1] 93/15
horrendous [1] 172/3
hospital [58] 2/1 2/2 2/4 3/10 4/10 4/10 12/21 14/8 15/18 24/15 34/7 34/10 34/17 39/17 41/10 41/16 42/13 43/21 46/9 47/22 50/13 52/8 53/1 53/9 54/21 55/25 56/1 56/16 56/20 57/25 76/16 87/25 89/8 89/17 89/25 90/2 90/9 90/10 90/16 90/22 129/21 137/2 137/21 138/15 140/11 140/16 140/19 140/24 141/4 142/16 144/9 146/10 150/7 155/19 162/4 185/13 185/15 195/3
Hospital's [3] 153/16 162/11 165/14
hospitals [5] 1/25 12/20 153/11 168/7 180/4
hot [3] 68/15 131/17 154/5
hour's [1] 56/12
hours [9] 17/3 17/6 67/17 107/22 107/22 191/7 191/7 191/7 191/8
how [73] 3/5 7/12 12/10 12/11 12/11 12/13 14/7 16/2 19/15 26/3 45/23 45/23 50/23 51/21 53/8 53/18 54/8 65/25 68/18 70/14 84/6 95/8 96/16 111/9 111/10 113/15 113/24 125/21 128/12 132/7 134/16 135/13 136/21 136/23 136/24 137/16 141/17 145/8 146/4 147/14 148/1 151/8 151/25 152/17 153/2 154/23 155/22 159/1 159/24 159/25 163/18 168/7 169/7 169/11 169/22 170/7 171/13 171/17 171/23 173/9 173/24 173/24 174/3 180/2 180/17 183/1 191/3 192/4 192/5 193/20 193/20 195/3 195/24
However [3] 34/4 86/14 96/5
Howie [6] 142/21 142/22 143/3 143/5 143/10 197/7
Howie Isaac [1] 197/7
HR [1] 196/3
huge [2] 189/10 197/1
huh [1] 39/20
human [4] 41/18 158/16 158/16 158/23
humble [1] 190/13
hurry [1] 104/20
hurt [4] 158/17 158/18 158/18 158/19
hushed [1] 112/23

I

I accept [1] 69/3
I actually [1] 42/21
I agree [4] 23/1 77/18 114/10 117/12
I already [2] 83/17 90/23
I also [4] 107/14 167/8 168/18 196/14
I am [73] 4/5 11/25 16/24 30/5 41/8 43/7 46/4 50/18 51/19 56/4 57/3 57/4 58/9 58/14 59/11 59/12 67/19 71/2 71/4 73/11 73/17 74/7 74/12 75/7 75/24 77/17 78/3 83/5 84/8 86/5 86/8 90/24 92/3 100/13 103/7 105/8 106/23 107/2 110/10 111/5 117/17 118/17 120/12 126/23 127/3 127/4 128/16 129/1 135/8 139/23 145/22 146/2 147/3 150/11 151/17 152/6 152/17 158/24 160/6 164/16 167/3 167/24 169/9 172/9 178/22 178/24 178/25 185/9 190/12 191/13 192/6 197/2 197/14
I answer [1] 93/24
I appreciate [1] 28/21
I ask [7] 1/5 82/4 140/9 150/14 160/15 175/13 183/7
I asked [1] 130/22
I assume [1] 42/23
I attended [2] 58/25 59/10
I backed [1] 44/9
I became [3] 2/8 77/19 130/17
I beg [1] 94/21
I believe [9] 5/4 6/21 15/16 134/2 134/5 138/10 147/15 161/25 187/9
I call [1] 129/9
I came [1] 84/3
I can [11] 62/20 66/18 76/24 85/22 87/22 126/13 128/11 151/5 155/16 158/10 165/22
I can't [23] 17/24 24/17 29/3 32/12 32/12 32/13 32/25 35/11 40/4 41/3 62/9 86/6 100/21 103/1 131/3 131/9 132/2 143/14 160/6 173/1 186/5 196/25 199/4
I cannot [16] 58/2 60/3 63/19 63/22 68/2 70/13 74/15 77/2 78/6 79/2 79/12 79/18 93/6 101/17 139/16 188/7
I carry [1] 128/15
I certainly [2] 20/17 179/23
I come [1] 174/21
I completely [1] 15/9
I considered [1] 173/21
I could [8] 45/18 45/18 53/12 80/24 82/15 103/11 132/20 144/23
I couldn't [12] 18/2 18/3 80/23 130/20 131/3 131/22 132/13 148/1 151/10 153/24 174/23 187/2
I did [21] 2/7 2/18 18/13 18/20 38/7 38/7 38/13 44/6 44/10 52/9 58/23 64/5 64/8 81/20 82/16 96/18 120/3 131/20 140/5 161/16 167/18
I didn't [34] 5/16 5/16 14/18 40/20 52/12 53/11 53/14 53/23 56/17 65/21 65/22 74/19 84/10 85/8 87/20 108/3 117/11 117/12 117/12 117/12 117/18 120/4 153/14 153/24 156/2 161/14 161/15 169/8 169/9 173/5 173/6 174/24 175/8 178/22
I discussed [2] 16/13 81/10
I do [35] 24/13 24/13 27/14 34/7 44/13 58/7 58/21 58/25 60/17 65/9 65/15 68/12 73/5 76/20 77/18 78/13 79/12 80/25 81/14 97/19 106/5 108/7 109/11 115/8 122/1 125/13 127/10 130/3 136/19 138/7 143/17 150/20 153/4 167/25 183/18
I don't [97] 6/25 7/3 8/5 19/8 19/9 21/5 21/5 24/12 24/12 24/12 24/17 25/22 26/10 28/18 37/4 38/14 38/15 41/5 45/23 46/24 46/24 54/24 55/5 65/7 66/20

I

I don't... [72] 66/21 69/18 70/2 71/2 72/6 73/10 73/11 73/15 74/7 75/1 75/2 76/20 76/21 77/15 77/16 79/1 80/2 81/7 81/21 83/1 93/4 93/24 94/24 97/19 97/20 103/7 103/10 107/14 107/16 107/25 108/6 108/6 108/8 111/20 112/2 112/8 112/25 113/4 125/14 126/25 127/25 132/10 136/5 137/16 137/18 139/20 145/6 145/22 148/20 160/25 161/13 163/18 164/18 166/16 169/11 170/12 172/9 173/12 178/3 179/14 185/17 189/2 190/5 193/23 194/1 194/1 194/8 194/9 194/10 195/1 196/25 197/2
I dread [1] 159/1
I explained [2] 77/8 82/14
I feel [2] 114/9 190/7
I felt [10] 11/13 16/6 16/8 33/10 137/18 153/18 155/25 162/22 169/9 178/20
I first [1] 84/4
I for [1] 179/24
I found [3] 34/2 137/6 181/7
I go [1] 191/17
I got [4] 132/13 137/19 188/12 196/4
I guess [1] 145/10
I had [29] 12/1 33/3 43/5 79/14 79/15 80/16 81/22 81/25 118/12 132/11 132/12 132/14 139/3 139/8 139/19 153/14 153/15 153/18 155/18 155/20 169/9 174/7 179/3 183/18 187/1 188/14 195/13 197/5 197/24
I hadn't [2] 151/11 151/12
I happened [1] 187/1
I have [33] 1/16 4/9 13/10 23/2 31/13 32/12 47/12 51/23 60/17 60/17 60/22 64/5 64/9 81/12 82/2 97/13 102/1 102/4 119/2 126/8 132/21 133/8 138/13 140/13 156/16 156/24 158/25 172/15 181/4 195/5 195/13 197/15 197/15
I haven't [2] 100/9 199/7
I hope [3] 22/2 85/23 193/25
I invite [1] 48/20
I just [25] 26/11 26/25 38/16 45/12 45/15 47/15 47/25 79/16 87/14 92/15 94/11 98/24 102/23 108/15 108/16 114/15 125/3 132/14 132/24 133/3 134/8 157/21 174/23 177/22 188/13
I knew [6] 22/14 33/20 82/15 84/12 149/15 188/2
I know [15] 42/19 59/14 60/20 67/11 85/3 87/11 93/16 127/19 138/10 144/16 150/3 156/25 173/7 179/7 179/8
I left [3] 34/11 42/20 43/7
I live [2] 155/18 197/2
I look [1] 192/8
I made [1] 100/11
I make [1] 115/9
I may [2] 161/21 187/7
I mean [5] 19/15 66/2 164/16 180/7 184/20
I meant [1] 188/25
I mention [1] 127/24
I mentioned [2] 76/10 91/24
I met [1] 165/2
I might [7] 94/20 94/22 97/19 103/6 104/3 125/13 175/4
I miss [1] 127/11
I move [1] 73/17
I must [1] 19/11
I never [1] 145/6
I no [1] 41/4
I obviously [1] 43/4
I perceived [1] 15/2
I probably [6] 53/20 54/1 81/7 91/3 91/7 122/11
I provided [1] 81/5
I put [1] 137/13
I qualified [1] 1/23
I read [2] 51/5 133/22
I realised [1] 83/20
I really [3] 25/22 143/21 145/22
I received [3] 63/21 81/21 133/13
I refer [1] 141/10
I regularly [1] 198/17
I remember [23] 28/8 34/4 71/18 80/16 80/19 80/22 81/3 81/9 83/23 86/4 95/9 95/17 101/10 109/22 133/13 145/12 150/23 151/9 154/22 156/5 159/17 181/16 187/20
I remembered [1] 79/18
I repeat [1] 163/20
I replied [1] 33/3
I respected [1] 188/13
I rightly [1] 41/23
I said [7] 53/10 64/5 74/24 91/22 122/8 123/8 143/21
I sat [1] 188/1
I saw [4] 63/20 122/13 144/17 160/25
I say [8] 43/6 43/15 58/7 96/21 143/15 144/13 170/11 198/18
I see [3] 52/10 104/4 121/23
I seem [1] 96/5
I sent [3] 86/4 99/7 127/17
I shared [2] 142/20 143/3
I should [1] 91/23
I sought [1] 69/8
I spoke [1] 127/17
I still [1] 196/6
I suppose [20] 3/8 5/10 8/4 10/10 12/14 13/7 14/18 14/25 15/19 29/12 34/20 36/12 36/23 37/4 38/7 42/2 42/15 42/18 43/12 48/2
I supposed [1] 15/2
I suspect [17] 52/3 54/19 55/24 56/2 56/24 65/9 65/10 65/22 66/8 68/24 70/11 70/13 71/17 72/2 72/4 72/20 75/24
I take [3] 131/6 141/1 143/8
I think [137] 7/6 7/14 7/14 7/20 8/6 9/12 9/20 12/19 12/23 16/18 19/8 19/8 19/8 19/11 23/6 23/21 27/21 28/18 34/19 39/16 44/16 46/10 46/10 46/11 48/11 51/15 52/24 54/11 54/15 56/2 59/11 59/12 60/18 60/22 61/17 72/3 75/15 81/1 82/19 82/22 82/24 83/16 85/16 87/5 90/20 92/9 94/13 95/24 97/9 98/12 99/7 99/12 101/14 102/14 104/1 104/5 104/6 106/20 107/14 110/22 113/15 117/3 118/16 121/7 123/24 128/7 128/16 134/10 135/6 136/6 136/10 137/10 140/12 140/17 145/12 147/5 148/14 148/14 148/15 149/4 149/4 150/8 150/17 150/22 151/19 152/14 153/10 154/5 154/25 156/16 156/22 157/17 159/2 159/17 159/18 160/13 162/19 163/18 164/4 164/18 164/19 167/11 168/1 168/22 169/2 169/12 169/12 169/20 170/18 170/23 174/11 175/3 175/3 177/17 179/18 180/5 180/19 181/6 181/13 182/5 182/20 182/20 186/6 186/8 186/12 186/19 188/10 190/6 190/11 194/1 194/16 194/16 194/17 194/24 195/10 196/8 196/14
I this [1] 7/6
I thought [31] 16/14 57/2 63/22 79/1 79/2 79/4 81/3 81/11 81/24 84/14 86/23 91/18 93/3 93/18 96/20 97/7 101/9 112/3 113/21 148/6 148/8 152/4 157/18 157/18 157/19 162/6 162/24 163/5 163/14 187/10 198/9
I to [1] 34/25
I trained [1] 84/3
I understand [6] 47/21 57/6 71/9 84/22 102/11 118/1
I understood [4] 55/11 98/18 179/14 179/15
I want [6] 71/6 106/13 125/1 128/5 128/13 190/15
I wanted [3] 18/4 45/6 84/6
I was [91] 12/15 13/5 16/5 16/9 16/10 16/14 32/17 33/1 33/2 38/18 41/14 42/22 44/2 44/11 53/10 56/17 58/2 58/17 59/11 59/25 60/3 60/4 63/20 63/20 65/17 66/9 66/19 67/11 67/12 67/14 67/15 67/16 67/18 72/14 72/15 73/11 73/11 73/12 74/25 76/1 76/13 79/13 79/14 81/12 82/14 82/15 84/2 84/4 84/5 93/15 93/19 97/5 98/12 104/20 112/8 114/4 117/4 118/10 118/11 118/19 119/11 119/11 119/16 119/18 119/19 119/19 122/1 122/18 127/7 127/25 129/22 129/23 129/24 130/20 131/23 137/13 139/15 143/19 144/13 144/21 145/23 155/19 155/25 157/17 159/14 161/15 161/18 186/19 186/21 187/20 188/6
I wasn't [14] 12/14 26/15 52/15 72/24 73/10 81/4 104/19 127/24 131/14 138/5 157/6 172/11 172/16 176/1
I will [15] 8/1 51/9 57/18 60/13 64/19 78/7 78/16 96/3 98/3 104/14 124/5 128/16 133/8 186/9 199/18
I wish [1] 197/5
I won't [2] 98/1 190/16
I wonder [3] 5/12 21/21 126/13
I wondered [1] 102/17
I worked [2] 96/17 139/16
I worried [1] 173/18
I would [40] 8/9 11/17 17/24 18/1 18/1 18/4 27/21 31/13 41/10 53/21 61/15 66/22 67/19 70/3 73/15 88/20 113/11 114/18 117/9 118/2 126/3 126/7 127/6 132/22 135/8 140/19 143/19 144/8 153/13 155/2 167/24 178/2 185/15 186/13 190/17 190/21 194/5 194/12 198/22 199/8
I wouldn't [7] 77/25 131/15 160/8 168/20 181/25 188/23 198/20
I wrote [1] 91/21
I'd [1] 197/23
I'm [8] 7/4 101/22 130/20 131/21 132/2 181/25 188/23 198/20

I

I'm afraid [2] 130/20 131/21
I's [7] 30/9 31/7 31/8 37/14 71/10 71/12 71/13
Ian [13] 86/14 94/9 105/21 154/22 154/25 155/11 166/24 166/25 179/10 180/7 184/10 192/12 195/20
Ian Harvey [8] 94/9 105/21 154/22 154/25 155/11 166/25 179/10 195/20
Ian Harvey's [1] 166/24
idea [5] 7/1 24/10 33/10 38/8 130/10
ideas [1] 156/17
identified [7] 8/24 9/11 55/16 75/9 94/7 96/15 97/12
identify [1] 42/6
identifying [1] 192/20
ie [1] 29/14
if [211]
IH [1] 94/8
image [1] 108/1
imagine [1] 148/1
imaging [1] 168/17
immediate [7] 18/25 19/23 56/13 57/13 77/5 142/7 195/9
immediately [2] 36/1 56/7
impact [8] 7/11 98/2 147/14 147/22 173/24 188/7 188/8 192/18
impacted [2] 8/20 153/7
impersonal [1] 13/3
implication [2] 33/16 33/17
implied [1] 162/24
importance [2] 56/17 93/21
important [19] 19/16 42/4 42/5 54/11 124/8 124/24 145/14 152/15 155/3 168/1 168/11 170/23 178/20 190/12 194/6 194/14 194/18 194/19 195/6
impossible [1] 19/12
impression [8] 12/1 12/8 12/17 82/21 109/19 125/20 164/11 172/19
impressions [1] 26/3
improve [2] 156/19 184/13
inaccurate [1] 162/6
inaudible [1] 100/15
inbox [1] 63/1
incident [6] 5/9 9/24 10/1 42/2 47/3 125/12
incidents [5] 8/9 10/11 42/3 127/15 198/7
include [6] 3/11 3/14 18/21 25/11 25/21 142/9
including [4] 1/25 55/17 104/14 156/11
incomplete [1] 91/23
inconceivable [1] 33/8
inconsistencies [1] 44/24
incorrect [2] 164/10 188/11
increase [3] 67/24 76/16 146/19
increased [9] 76/9 83/18 118/3 130/9 130/18 131/6 151/14 155/2 176/5
increasing [1] 153/4
incredibly [2] 172/23 194/16
incubators [1] 33/21
indeed [12] 2/12 48/15 48/24 49/19 100/6 104/7 108/19 120/16 126/12 128/3 128/22 199/13
independent [10] 16/25 95/11 98/14 98/15 101/1 101/4 106/25 146/22 149/7 161/6
index [3] 36/21 42/11 199/24
India [2] 49/25 84/3
indicated [3] 23/18 68/7 109/25
indictment [1] 67/14
indirectly [1] 67/14
individual [11] 20/18 42/3 152/14 159/9 160/1 160/2 160/7 160/8 160/22 192/15 198/9
individually [2] 159/13 196/4
individuals [3] 139/1 147/23 196/4
inevitable [1] 151/15
inevitably [1] 147/14
inexperience [1] 118/15
Infancy [3] 15/13 55/8 55/23
infant [2] 21/1 147/11
infected [2] 22/17 121/13
infection [20] 27/6 27/23 29/14 61/14 61/15 61/17 61/23 62/13 66/7 91/12 120/18 120/21 120/25 121/1 121/10 122/19 124/1 124/2 125/10 145/11
infections [3] 61/1 65/20 122/21
inflicting [1] 158/20
inform [3] 89/23 147/12 147/16
informal [1] 138/22
information [40] 57/16 64/2 70/15 72/18 79/5 79/5 85/9 91/5 91/8 91/23 91/24 92/1 93/3 93/6 93/7 96/20 96/24 97/6 111/18 114/17 117/13 118/6 118/23 120/1 123/7 126/23 127/23 130/22 137/5 144/24 148/21 150/21 167/14 168/5 172/15 180/18 180/23 191/22 192/15 192/17
informing [1] 56/18
infrequent [1] 185/16
initial [3] 62/4 97/15 138/5
initially [1] 128/9
initials [1] 94/9
innocent [2] 170/1 193/12
input [5] 74/20 98/14 101/1 101/4 109/15
inputted [1] 191/20
inputting [1] 191/19
INQ [1] 25/4
INQ0002693 [1] 147/6
INQ0003095 [1] 175/14
INQ0003112 [2] 87/9 133/18
INQ0003116 [1] 86/7
INQ0003117 [1] 176/22
INQ0003362 [1] 97/11
INQ0003365 [1] 105/12
INQ0003371 [1] 94/5
INQ0003395 [1] 177/24
INQ0003492 [1] 150/16
INQ0005721 [1] 78/15
INQ00066821 [1] 183/7
INQ00067250001 [1] 190/18
INQ0009618 [1] 160/16
INQ00127440001 [1] 164/23
INQ0025743 [2] 21/22 62/15
INQ0036166 [2] 23/16 64/19
INQ0101112 [1] 134/14
INQ0101113 [1] 161/22
Inquest [5] 114/21 117/4 119/9 119/21 127/8
Inquests [2] 127/5 127/6
inquiries [1] 179/12
Inquiry [22] 1/14 6/2 15/20 22/3 30/21 45/9 49/16 63/22 64/9 80/8 92/24 102/5 105/12 105/17 110/12 114/17 115/10 127/22 148/23 161/23 190/20 199/22
Inquiry's [1] 46/6
inquisitive [2] 145/8 194/25
inside [1] 55/25
insinuation [1] 170/21
insist [2] 101/16 113/1
insisted [1] 112/19
inspection [1] 40/14
instance [2] 10/17 47/6
instantly [1] 155/4
instead [1] 165/15
institution [1] 196/5
institutions [1] 197/4
instructed [1] 44/18
instrumental [1] 162/25
insulin [9] 5/5 5/5 5/12 5/17 26/13 57/25 68/6 68/7 77/5
intensive [4] 30/19 80/21 81/20 137/2
intentionally [1] 158/20
interact [2] 53/12 195/10
interacted [1] 116/22
interaction [7] 116/19 125/2 125/4 139/3 139/19 175/10 188/2
interactions [2] 139/5 139/8
interest [2] 129/25 181/24
interested [5] 20/24 21/8 21/10 22/24 90/16
interesting [1] 140/12
Interestingly [1] 166/18
interests [2] 177/9 177/14
internal [1] 182/13
interpret [1] 147/15
interpreted [1] 193/14
interrogation [1] 161/9
intervention [3] 89/13 89/13 155/8
interview [4] 135/7 135/12 150/21 171/6
interviewed [3] 159/12 159/14 189/21
interviewing [1] 130/10
intimate [1] 45/25
into [24] 7/20 9/24 34/9 34/20 40/21 61/18 62/25 83/1 92/5 96/8 101/15 105/23 108/2 111/23 114/21 115/14 123/2 137/17 151/25 165/20 189/25 191/19 191/20 194/7
investigate [5] 34/11 61/25 87/17 113/2 134/5
investigated [4] 121/10 136/24 145/17 145/18
investigating [5] 30/22 66/25 108/11 114/17 187/12
investigation [21] 14/25 15/11 25/1 43/21 85/19 89/7 96/7 98/2 109/15 155/24 161/5 161/9 162/13 162/25 165/5 171/1 177/13 189/25 193/4 194/7 198/24
investigations [6] 67/2 71/25 90/19 109/24 120/21 120/24
invite [2] 48/20 48/20
invited [5] 162/10 165/4 165/16 176/11 177/20
inviting [1] 174/10
involve [5] 55/21 95/11 142/7 181/9 184/14
involved [42] 2/20 10/16 15/10 16/6 20/5 26/10 28/22 35/4 35/7 35/11 37/1 58/17

I

involved... [30] 63/24 67/11 67/12 67/14 67/16 67/19 72/15 72/22 74/25 76/1 79/7 79/13 79/14 111/19 123/25 131/11 131/14 131/16 131/23 138/2 138/5 138/10 158/12 159/10 165/21 172/11 172/16 185/1 198/18 199/1
involvement [7] 16/20 32/3 32/6 71/10 118/11 127/10 179/6
involves [2] 107/1 114/15
involving [1] 184/15
IR [1] 165/21
irrelevant [1] 117/14
irrespective [1] 41/12
is [469]
Isaac [4] 142/22 143/3 143/10 197/7
isn't [7] 38/17 46/23 102/8 102/14 124/8 143/14 198/13
isolating [1] 121/8
Issac [2] 144/1 197/7
issue [12] 14/17 23/25 42/6 121/9 130/8 164/12 164/13 166/6 175/18 180/3 188/7 196/13
issues [6] 3/11 70/25 107/11 132/17 162/12 194/17
it [622]
It appeared [1] 109/14
it's [44] 7/6 10/2 10/7 12/20 17/8 19/17 19/20 52/24 66/23 83/9 83/23 99/1 99/2 106/24 108/1 113/19 120/4 124/6 133/16 133/18 133/23 135/5 140/13 142/12 145/2 145/3 148/14 155/2 158/19 164/2 167/6 169/12 169/12 170/23 171/15 171/18 177/7 185/13 194/2 194/3 194/18 195/6 195/25 199/17
items [1] 192/7
its [1] 25/10
itself [3] 8/25 54/21 102/17
ITU [2] 92/22 93/2

J

Jane [7] 139/17 161/18 161/20 165/25 166/9 167/20 184/24
Jane Hawdon's [1] 167/20
January [11] 38/21 39/1 73/21 74/4 74/5 109/4 160/13 168/24 170/21 175/14 176/1
January 2016 [1] 74/4
January/early [1] 160/13
Jayaram [17] 12/16 31/25 37/1 39/25 42/10 42/23 44/12 53/22 72/10 97/22 98/5 115/5 130/13 139/9 151/7 159/18 170/4
Jo [1] 164/24
job [4] 120/10 171/8 171/25 194/16
jobs [1] 170/22
John [4] 174/7 174/19 186/19 186/22
join [1] 50/12
joined [1] 2/4
joint [2] 142/8 174/12
July [10] 24/21 53/25 73/7 105/8 105/15 143/22 146/10 150/7 165/2 176/7
July 2016 [1] 176/7
jumping [3] 4/13 148/7 148/7
June [36] 1/15 2/13 21/21 23/21 25/10 44/22 49/17 50/16 53/25 59/22 59/25 66/1 71/15 73/7 73/8 74/3 79/8 79/11 83/7 86/8 87/9 94/3 97/10 97/10 106/20 115/18 123/12 130/2 133/12 133/15 133/17 134/9 135/3 135/9 135/18 176/6
June 2015 [2] 2/13 25/10
June 2016 [2] 123/12 135/3
junior [6] 22/9 51/1 60/8 65/5 65/7 65/11
just [171] 5/1 5/14 5/20 5/22 6/10 6/23 7/23 8/9 9/17 10/20 10/23 11/17 13/5 13/5 13/9 13/14 14/20 16/2 17/4 17/19 20/1 20/22 23/2 25/6 25/16 26/11 26/25 27/16 29/16 32/14 32/17 32/22 35/5 36/12 36/14 37/4 38/1 38/14 38/16 38/20 41/7 42/16 42/20 43/6 43/6 43/17 45/12 45/15 45/15 46/10 47/2 47/15 47/25 50/11 50/18 51/9 51/23 58/15 62/21 64/20 64/23 69/15 70/25 71/4 74/12 78/16 79/16 79/23 83/14 83/24 84/7 84/14 87/14 92/1 92/15 92/15 92/17 92/18 92/24 94/11 96/3 96/10 97/9 97/21 98/3 98/19 98/24 99/1 99/23 99/23 101/21 102/12 102/23 102/25 103/4 103/10 105/8 105/9 105/16 105/22 106/16 108/13 108/15 108/16 109/18 109/19 110/11 111/8 111/9 111/13 111/13 111/14 111/25 113/4 113/11 114/4 114/15 114/15 114/18 115/13 115/17 116/13 117/14 118/18 118/19 118/24 121/3 125/3 125/16 126/13 126/18 127/9 127/25 131/8 132/14 132/24 133/3 133/7 133/8 133/14 134/8 136/21 148/6 150/15 150/17 151/1 157/21 157/21 158/11 158/16 159/3 159/4 161/1 166/10 171/13 174/8 174/19 174/23 175/1 175/19 177/22 177/23 180/5 186/1 187/6 188/13 189/3 191/21 192/22 193/22 197/11
JUSTICE [4] 47/13 126/10 200/4 200/8

K

keen [1] 188/6
keep [6] 70/8 88/24 117/7 153/25 166/6 171/3
Kelly [6] 77/21 94/8 151/19 173/3 173/4 195/20
kept [2] 43/4 168/5
key [1] 75/8
kill [1] 58/1
killing [2] 115/20 116/3
Killingback [6] 101/22 133/18 134/22 146/7 177/5 178/19
kind [15] 9/24 34/21 46/14 90/13 131/3 135/7 139/12 140/20 154/24 156/23 174/14 181/17 181/19 188/5 194/5
kindest [1] 148/9
Kingdom [1] 50/5
Kings [1] 119/3
knew [20] 22/14 33/20 80/4 82/15 83/17 84/12 115/13 119/21 127/14 132/7 145/22 149/15 159/9 166/21 173/10 174/2 174/3 180/6 188/2 189/2
know [171] 3/1 5/7 6/22 6/23 6/25 7/3 7/17 8/5 13/9 13/11 16/11 17/8 19/20 20/2 21/16 24/12 24/17 25/22 28/16 29/4 32/6 32/8 34/7 34/22 35/13 36/13 36/15 37/4 37/14 38/15 38/16 38/21 40/14 41/5 42/17 42/17 42/19 43/13 43/19 44/13 45/21 45/23 45/24 46/17 46/24 46/25 52/23 53/11 54/14 54/16 55/4 57/19 59/14 60/20 66/5 67/11 68/4 71/2 73/21 75/4 75/23 76/20 77/22 78/14 79/3 79/12 79/24 84/6 84/11 84/23 85/2 85/3 87/11 87/20 89/20 89/22 91/5 93/4 93/16 93/24 97/19 103/7 103/10 106/8 107/14 107/16 108/3 111/20 112/4 114/20 114/24 117/11 118/2 118/7 126/25 127/19 131/24 132/10 132/14 132/25 137/10 137/15 137/16 137/17 138/10 140/23 141/1 142/15 142/15 143/21 144/16 145/11 145/13 147/1 148/3 148/18 150/3 151/5 151/6 152/12 155/1 155/5 156/17 156/18 156/25 157/1 158/18 159/16 160/9 160/19 161/15 161/16 163/18 164/5 164/20 168/20 168/23 169/11 171/18 171/20 172/7 172/9 172/14 173/7 173/12 174/8 175/5 175/7 177/16 178/3 179/7 179/8 179/14 179/16 180/12 182/12 183/15 183/15 183/18 188/23 189/1 189/2 189/8 195/12 196/6 196/14 196/25 197/2 197/22 198/17 198/23
knowing [7] 46/11 68/16 168/23 171/9 171/14 180/25 197/2
knowledge [4] 1/18 6/19 49/22 163/6
known [5] 17/10 52/18 67/19 129/16 183/16
knows [4] 6/2 126/21 126/24 147/3

L

La [10] 1/3 1/8 49/4 49/10 103/9 105/5 126/15 128/19 200/3 200/6
label [1] 195/6
laboratory [1] 26/14
labour [1] 101/3
LADO [5] 197/14 197/17 197/21 198/2 198/23
Lady [21] 1/4 47/12 47/13 48/17 48/20 49/5 82/6 100/16 101/19 103/4 104/8 105/6 119/2 126/8 126/10 129/9 146/8 175/14 190/16 200/4 200/8
Lambie [3] 20/21 22/4 62/22
Langdale [4] 129/8 129/11 199/16 200/10
large [1] 48/12
larger [1] 12/22
last [14] 17/5 41/5 69/15 77/13 78/7 86/14 86/15 86/20 91/22 97/10 100/11 126/14 153/15 165/3
late [4] 28/17 41/1 160/13 191/9
late February [1] 41/1
late October 2015 [1] 28/17
later [14] 18/11 20/23 26/14 39/19 64/19 68/5 79/23 115/22 139/21 139/24 150/10 154/6 156/25 187/13
latter [1] 144/14
law [1] 171/20
layers [2] 7/8 196/8

L

lead [6] 43/24 77/5 83/1 139/8 195/13 195/14
leader [1] 10/11
leaders [1] 137/14
leadership [4] 12/15 41/21 194/11 196/12
leading [2] 88/21 89/16
leads [2] 53/21 77/24
leans [1] 140/20
learn [2] 106/15 197/3
learned [3] 43/3 119/2 137/4
learning [3] 140/22 162/21 168/3
least [23] 4/3 20/12 37/22 61/6 66/8 68/15 68/19 75/25 76/13 85/5 89/3 93/6 95/17 96/22 97/6 98/18 101/12 106/21 114/3 127/17 175/5 175/6 192/23
leave [6] 41/5 101/11 131/21 148/6 170/20 199/8
leaving [6] 39/17 41/4 56/15 106/2 184/10 187/20
led [11] 15/1 34/8 34/10 46/14 109/9 126/1 126/4 154/5 154/7 154/9 162/12
left [15] 3/22 34/11 36/15 39/19 41/2 42/20 43/5 43/7 44/18 105/24 125/22 187/17 191/14 191/17 193/1
left-hand [1] 193/1
legal [2] 118/7 126/25
lesions [2] 18/22 21/6
less [6] 4/15 7/15 88/22 89/3 122/13 166/2
let [3] 113/5 123/22 167/13
let's [5] 5/20 44/23 67/8 86/7 101/4
Letby [25] 26/16 30/23 31/6 33/1 38/11 86/1 87/3 93/1 93/18 101/7 112/5 112/6 112/19 115/20 116/9 155/23 156/12 157/9 158/8 158/12 170/5 172/5 173/17 189/1 189/25
Letby's [4] 31/8 39/1 73/15 73/23
letter [17] 110/2 147/12 169/1 169/2 169/5 169/10 169/21 175/2 175/13 175/15 175/16 176/23 177/6 179/1 183/23 188/21 188/25
letters [4] 110/13 110/14 191/5 192/2
level [9] 42/8 52/13 67/24 144/10 149/2 164/3 164/4 180/25 195/9
levels [4] 68/6 88/3 163/12 166/6
liaise [1] 135/22
life [4] 128/16 132/21 132/22 158/23
life' [1] 173/21
light [6] 13/1 25/19 42/9 106/2 146/21 156/13
lightly [1] 81/16
like [64] 7/15 8/9 10/10 11/17 12/21 13/9 27/18 33/20 45/15 46/6 47/4 49/7 53/14 54/24 61/3 61/4 62/12 65/18 65/24 66/25 74/13 89/12 89/14 89/21 95/25 100/25 107/12 109/25 110/2 110/2 113/11 114/18 119/18 127/11 128/1 132/17 136/3 141/3 143/15 144/13 145/13 152/11 152/16 153/6 153/24 155/7 156/16 163/21 164/17 168/13 170/20 173/20 174/18 178/2 180/8 182/6 182/22 182/23 190/17 190/21 194/24 198/1 198/18 199/6
likely [3] 18/15 25/2 131/7
limit [1] 179/24
limited [3] 30/8 139/5 163/25
line [10] 105/10 105/24 110/1 125/9 125/22 148/15 170/22 175/18 175/20 175/20
lines [3] 70/9 105/22 180/19
link [3] 6/13 23/12 190/1
list [2] 23/19 178/20
listen [2] 110/12 183/25
listening [2] 38/5 114/11
literature [1] 62/5
little [8] 9/12 12/15 16/18 19/19 44/5 46/12 139/3 191/16
live [2] 155/18 197/2
lived [1] 136/20
Liverpool [3] 2/2 24/15 26/14
lives [1] 92/5
living [1] 158/17
local [4] 15/8 55/21 137/24 197/10
localised [2] 60/23 61/22
lock [3] 5/7 84/22 84/23
locked [1] 5/8
locum [1] 129/22
London [2] 62/8 62/9
long [5] 68/18 88/23 183/1 188/19 188/24
longer [1] 190/16
look [46] 3/9 5/18 13/13 16/17 20/19 23/24 40/2 58/5 62/14 75/7 77/10 85/5 86/12 87/8 92/3 92/11 92/13 92/18 97/9 97/21 104/25 105/10 107/3 112/11 115/13 132/18 135/17 137/17 144/23 152/11 158/24 158/24 160/15 160/24 162/3 164/2 165/19 167/21 177/22 178/4 179/19 183/7 183/23 186/9 187/15 192/8
looked [14] 19/1 25/16 26/22 61/15 62/15 64/18 68/24 87/12 97/5 133/20 145/1 147/23 158/4 158/25
looking [39] 14/4 16/25 22/7 22/10 33/20 41/8 59/25 60/20 68/22 70/21 71/17 72/3 77/12 77/12 77/14 77/16 84/13 84/14 92/1 92/5 97/6 98/13 103/15 103/25 104/2 104/2 106/16 106/18 107/5 108/25 112/2 113/25 123/2 123/15 123/19 131/7 133/25 179/25 198/12
looks [4] 183/5 187/17 190/20 191/13
lose [1] 171/8
lost [4] 48/10 145/6 194/8 196/16
lot [21] 5/4 5/6 6/14 12/20 21/11 23/5 45/24 62/2 136/8 139/8 140/13 164/5 167/25 169/17 169/19 175/20 181/21 190/11 190/24 190/25 198/17
lots [5] 36/9 60/24 61/7 90/25 138/12
loud [2] 33/14 35/15
loved [1] 145/5
lovely [1] 46/16
lower [1] 146/15
Lucy [11] 73/15 73/23 93/18 96/17 101/11 106/21 112/10 155/23 172/23 173/8 174/6
Lucy Letby [2] 93/18 155/23
Lucy Letby's [2] 73/15 73/23
luncheon [1] 105/3
lunchtime [3] 28/7 86/25 105/1

M

madam [2] 102/1 128/5
made [18] 7/11 7/21 12/3 15/24 46/12 53/7 96/6 97/8 98/11 100/11 101/17 102/12 104/3 175/17 182/8 192/10 192/12 197/25
main [1] 84/17
mainly [5] 35/8 35/9 54/18 57/16 150/20
major [2] 28/11 163/13
make [27] 6/16 10/19 58/14 61/12 76/6 81/17 88/18 113/18 115/9 119/20 137/9 144/25 153/20 154/11 154/14 157/3 158/21 165/23 168/2 168/9 170/7 185/15 188/6 189/6 190/4 190/12 198/2
makes [6] 78/19 118/7 142/14 169/11 186/19 196/9
making [8] 52/14 56/14 56/21 111/23 177/11 178/5 188/9 193/11
manage [4] 8/20 20/16 90/2 153/22
managed [4] 7/13 26/4 89/8 89/10
management [37] 2/16 3/4 3/14 3/17 7/8 12/7 12/13 13/8 42/13 42/24 43/11 43/20 52/8 52/10 53/9 53/10 53/15 53/17 76/16 77/1 96/6 101/14 109/14 114/8 136/13 136/15 137/9 138/25 139/4 150/8 172/6 181/5 191/15 192/3 194/10 194/10 196/8
manager [8] 11/19 52/11 93/16 96/23 139/18 172/23 196/3 196/3
managerial [1] 12/8
managers [26] 11/2 12/10 52/10 53/24 92/10 95/9 96/22 98/11 105/18 109/21 111/10 111/16 112/19 139/10 139/13 184/4 184/13 194/12 194/15 194/18 195/4 195/7 195/7 195/9 195/23 195/23
managing [1] 69/23
Manchester [1] 2/1
Mancini [2] 149/22 149/23
mandatory [2] 10/24 13/20
many [12] 4/24 34/24 138/8 144/12 151/8 159/1 163/12 172/12 173/7 185/14 194/17 196/4
March [5] 75/5 86/14 129/21 129/22 143/20
mark [1] 87/22
marked [1] 73/24
marks [1] 70/24
massive [1] 192/23
maternal [5] 58/20 58/24 60/2 60/5 62/3
matter [7] 5/25 15/3 15/4 45/6 103/11 114/14 196/20
matters [9] 5/22 7/22 14/10 23/20 30/21 41/7 46/5 152/15 192/5
may [47] 1/5 3/6 5/11 9/5 10/22 16/2 35/19 37/15 40/1 41/13 42/6 43/1 43/2 51/21 57/14 68/21 71/4 73/18 73/19 77/11 77/20 78/7 78/12 79/16 88/2 95/20 102/17 116/2 116/8 120/2 120/17 124/1 124/21 126/22 129/9 131/17 133/3 144/15 147/20 148/4 159/9 161/21 172/5 181/13 183/14 187/7 190/16
maybe [23] 22/19 35/16 46/22 46/24

M

maybe... [19] 46/24 53/1 53/4 56/4 57/3 65/17 65/23 70/15 70/16 70/18 70/18 70/21 91/23 93/18 93/22 96/23 117/4 127/3 127/8
MBBS [1] 49/25
McCormack [1] 195/16
MD [1] 50/2
me [40] 60/7 61/10 64/9 65/21 75/1 75/2 75/8 80/3 80/18 81/5 81/22 82/1 84/10 100/5 102/4 106/11 113/3 117/9 118/14 118/20 118/25 119/17 119/18 126/19 133/7 139/20 139/21 157/22 158/17 161/14 161/19 163/19 172/22 173/19 177/23 180/10 182/21 186/1 186/21 191/13
mean [17] 13/6 19/15 43/4 45/21 61/23 66/2 78/25 79/2 83/2 136/22 149/11 154/21 163/22 164/16 174/1 180/7 184/20
meaning [2] 41/20 173/17
means [8] 48/19 61/2 85/4 91/14 137/1 145/19 157/5 192/13
meant [3] 106/17 137/12 188/25
meantime [1] 111/19
measures [1] 156/22
Mecrow [3] 44/19 44/23 44/25
Mecrow's [1] 44/20
media [4] 95/25 96/1 101/2 112/22
mediation [1] 170/5
medical [32] 1/21 1/23 7/18 10/13 12/22 16/10 21/8 28/10 28/23 28/25 29/14 49/25 52/22 59/21 60/1 71/17 72/3 72/5 76/12 77/21 78/4 129/17 137/14 139/4 145/10 158/2 165/15 168/10 172/10 174/8 174/17 193/2
medication [1] 168/11
medications [1] 145/15
medicine [6] 3/4 45/22 129/18 148/20 152/13 163/11
medicines [5] 2/16 3/7 3/19 4/17 5/8
Medland [6] 113/8 114/11 180/11 180/22 183/4 186/11
meet [7] 23/7 52/11 53/13 78/3 164/24 180/16 185/16
meeting [140] 23/17 23/21 24/5 24/21 25/14 25/16 25/19 26/23 27/13 27/14 29/5 34/18 39/15 39/21 40/1 40/6 42/24 55/21 64/19 64/22 65/9 65/21 65/23 70/20 73/6 73/9 73/13 74/6 74/8 74/17 74/21 74/23 77/23 77/24 78/9 78/10 78/15 78/18 81/9 82/13 83/6 83/8 83/11 83/14 83/17 83/21 85/25 86/2 86/14 86/16 86/21 86/25 90/24 94/3 94/4 94/6 94/19 95/3 95/5 96/4 97/10 97/16 98/21 99/23 100/14 100/17 100/22 102/18 105/8 105/17 105/20 105/23 106/2 106/14 108/16 108/20 109/4 109/6 109/9 109/10 109/19 109/22 110/4 110/13 113/11 113/14 113/17 115/18 116/12 125/11 125/13 125/15 130/12 130/16 130/23 138/7 138/7 150/7 150/11 150/19 151/5 154/17 154/19 155/10 155/12 156/4 156/9 157/9 158/8 164/20 166/18 168/25 170/4 170/21 176/1 177/20 178/3 178/13 180/11 180/20 181/2 181/7 181/10 181/15 181/17 181/19 182/7 183/4 183/5 183/10 183/11 185/25 186/2 186/4 186/10 186/12 186/15 186/18 186/22 193/8
meetings [25] 41/23 52/11 53/13 56/25 57/7 67/22 86/5 91/4 95/5 99/10 100/20 101/10 101/13 116/5 131/23 138/8 138/12 138/23 143/5 143/16 172/12 172/16 172/17 184/15 198/18
Melius [1] 171/7
member [23] 14/1 14/15 15/3 51/20 73/2 83/20 83/24 86/18 92/21 93/5 96/15 97/25 98/22 99/2 99/3 158/7 161/25 167/1 167/3 167/4 167/11 197/18 198/3
members [6] 11/20 51/10 150/4 163/8 183/19 197/20
membership [2] 50/5 167/7
memorable [1] 17/4
memory [10] 17/5 58/9 64/12 66/14 78/2 82/10 111/6 125/18 149/17 172/22
mental [3] 69/18 127/11 127/13
mention [5] 108/11 127/24 160/7 182/14 193/4
mentioned [11] 4/9 23/12 28/2 76/10 83/6 91/24 94/3 97/13 127/13 181/4 195/19
mentioning [1] 65/2
mentions [1] 186/20
message [2] 111/14 151/9
met [14] 77/20 92/9 97/20 106/9 106/19 107/3 113/7 113/22 125/13 139/23 140/21 164/6 165/2 186/23
mid [2] 41/2 155/20
mid-30s [1] 155/20
mid-February [1] 41/2
middle [3] 34/1 40/15 147/5
midwives [1] 85/7
might [67] 5/13 9/13 9/14 10/17 14/22 21/4 22/22 27/18 30/3 33/9 35/9 38/11 38/13 38/14 40/23 44/7 59/17 69/25 76/4 76/7 78/25 79/1 82/8 86/23 88/6 88/15 88/16 88/18 89/9 89/12 90/4 90/5 90/6 90/14 90/15 90/22 94/20 94/22 97/19 100/2 100/13 100/20 101/7 103/5 103/6 104/3 104/5 112/18 115/6 116/10 116/15 117/15 118/6 119/25 120/3 120/10 125/13 141/16 141/23 141/24 156/22 158/12 175/4 178/23 179/21 185/2 198/4
Mike [1] 165/1
Millward [1] 151/20
mind [11] 10/18 37/12 37/19 70/4 70/14 79/15 82/4 85/17 96/7 97/8 174/13
mind's [1] 142/20
minds [2] 34/22 113/20
minimum [1] 85/5
minuted [1] 26/2
minutes [3] 105/23 151/6 181/15
misconduct [2] 161/4 161/9
misinformation [1] 192/19
miss [1] 127/11
missed [1] 70/21
missing [4] 5/5 66/10 71/22 71/23
mistake [3] 106/11 118/14 120/4
misusing [1] 108/4
Mittal [5] 55/18 56/10 57/10 142/24 197/8
mm [32] 3/3 8/11 11/11 13/17 16/22 17/18 21/25 22/11 23/4 24/8 25/3 25/8 27/4 27/7 28/5 29/19 30/20 39/2 41/15 58/6 60/10 62/24 64/25 68/8 75/6 75/12 79/9 79/22 87/18 110/9 113/9 114/23
Mm-hm [29] 3/3 8/11 11/11 13/17 17/18 21/25 22/11 23/4 24/8 25/3 25/8 27/7 28/5 29/19 30/20 39/2 41/15 58/6 60/10 62/24 64/25 68/8 75/6 75/12 79/9 79/22 87/18 110/9 114/23
Mmm [14] 2/22 16/22 25/12 25/15 27/4 28/24 35/21 38/23 41/17 45/8 45/11 45/14 47/19 113/9
Mmm hmm [1] 2/22
Mmm mm [3] 16/22 27/4 113/9
mode [1] 163/16
model [5] 16/10 16/14 29/14 99/25 100/1
modifying [1] 145/20
moment [15] 13/13 20/3 20/20 29/16 59/19 71/6 85/15 101/20 104/8 161/21 166/13 177/23 177/25 180/10 190/18
Monday [7] 52/11 73/7 83/8 130/17 143/16 199/19 199/23
month [6] 20/1 23/16 23/22 25/17 39/19 116/13
months [10] 68/14 68/19 69/15 74/6 75/22 102/8 107/19 132/20 177/7 184/11
morals [1] 194/11
morbidity [6] 56/25 56/25 67/22 70/19 70/25 91/4
more [68] 2/10 5/6 7/17 9/13 10/22 16/18 31/15 33/15 35/1 36/20 38/20 42/5 42/16 46/12 46/12 48/2 48/11 52/5 55/24 56/1 56/10 56/17 59/13 59/15 61/3 61/13 61/22 66/12 68/24 71/16 76/6 79/4 79/4 79/5 82/2 85/19 90/25 91/16 91/25 98/19 104/10 104/11 104/15 104/25 108/8 108/12 118/17 127/23 128/25 129/1 130/22 131/7 135/11 135/13 136/6 140/20 140/21 143/23 162/15 163/22 163/23 164/4 164/18 170/12 179/2 195/10 195/21 197/20
morning [12] 18/11 56/9 62/15 64/18 72/8 87/9 99/17 99/17 122/14 162/10 199/16 199/19
mortality [16] 24/21 39/14 41/22 56/25 67/22 70/20 74/16 78/5 83/18 91/4 131/18 144/3 144/18 146/20 148/2 151/2
most [10] 2/13 18/15 67/18 93/3 146/18 148/8 181/23 190/12 194/5 194/19
Mother [5] 26/24 27/13 80/7 82/3 125/5
motion [1] 142/8
mouth [2] 80/22 82/13
move [20] 21/20 23/16 23/21 24/19 26/6 26/23 30/5 47/20 67/8 71/4 71/8 73/17 77/3 83/5 93/8 94/2 105/12 106/7 108/17

M

move... [1] 151/1
moved [8] 4/11 23/22 30/23 31/6 92/21 93/1 99/16 143/23
movement [2] 92/25 185/24
movie [1] 173/20
moving [4] 54/4 73/17 105/7 168/24
Mr [32] 1/3 1/8 49/4 49/10 52/22 73/18 77/21 93/9 103/9 104/14 104/17 105/5 109/23 110/15 114/11 119/3 119/6 119/7 126/15 128/19 175/15 178/1 178/19 179/13 179/19 180/22 187/8 187/8 187/9 200/3 200/6 200/7
Mr Baker [7] 73/18 104/14 104/17 119/3 119/6 119/7 200/7
Mr Chambers [2] 110/15 175/15
Mr De La Poer [6] 1/3 49/4 103/9 105/5 126/15 128/19
Mr Green [2] 187/8 187/9
Mr Harvey [7] 52/22 77/21 93/9 178/1 178/19 179/13 179/19
Mr Medland [2] 114/11 180/22
Mr Tony Chambers [1] 109/23
Ms [11] 77/21 101/22 129/8 129/11 133/18 134/22 146/7 177/5 178/19 199/16 200/10
Ms Kelly [1] 77/21
Ms Killingback [6] 101/22 133/18 134/22 146/7 177/5 178/19
Ms Langdale [4] 129/8 129/11 199/16 200/10
much [52] 1/9 3/21 12/18 47/11 48/14 48/24 49/19 52/12 53/14 59/15 60/8 61/3 61/10 62/17 82/14 88/22 91/25 92/8 96/12 100/6 104/7 104/22 106/7 108/19 118/17 119/13 126/11 128/3 128/21 128/23 129/12 139/21 140/16 143/16 153/7 155/8 156/16 163/18 169/14 171/18 174/6 175/24 185/3 187/4 187/13 189/13 190/16 191/3 199/5 199/11 199/13 199/20
multi [2] 15/5 55/20
multiple [1] 168/6
murder [1] 162/15
murdered [3] 26/7 120/2 159/6
murdering [2] 2/20 162/14
MURTHY [3] 49/9 49/14 200/5
Murthy Saladi [1] 49/14
must [2] 19/11 191/1
my [116] 1/4 2/7 12/23 12/24 12/25 15/2 17/25 29/12 32/3 37/22 41/4 41/5 42/22 43/4 47/12 47/23 47/24 48/17 48/20 49/5 49/14 53/11 53/21 55/13 55/24 56/5 57/4 59/13 70/14 76/3 79/2 79/10 79/16 80/22 80/23 81/10 81/13 81/15 82/6 82/13 84/2 87/22 89/3 90/20 93/5 95/19 99/7 100/11 100/16 100/23 101/19 103/4 104/8 105/6 106/1 106/11 108/7 110/12 111/19 111/22 113/15 114/8 114/9 116/24 117/3 118/5 118/11 118/12 118/15 119/2 119/2 119/16 120/4 126/8 127/10 127/19 129/9 129/16 129/17 131/21 132/21 132/22 135/7 139/8 142/20 143/4 145/10 146/8 149/17 150/1 150/20 150/21 153/8 154/19 155/18 155/19 155/21 155/22 156/1 156/1 156/5 157/1 158/25 162/16 163/1 168/1 173/4 173/5 173/7 175/14 175/23 179/10 181/2 186/14 190/13 190/16
my Lady [17] 1/4 47/12 48/17 48/20 49/5 82/6 100/16 101/19 103/4 104/8 105/6 119/2 126/8 129/9 146/8 175/14 190/16
myself [7] 18/5 21/12 53/21 82/16 127/19 174/19 179/25

N

N's [1] 79/20
nagging [1] 100/11
naive [1] 157/17
name [18] 35/13 39/1 39/8 46/13 46/14 49/13 49/14 73/16 73/23 100/9 102/14 103/14 105/16 105/24 129/14 129/16 160/4 185/9
named [3] 35/6 35/8 160/10
names [1] 139/16
nappy [1] 125/6
narrative [1] 46/15
natural [3] 30/3 116/15 148/19
nature [3] 158/16 163/15 197/25
Neame [3] 30/15 153/10 153/13
necessarily [3] 61/20 95/5 122/23
necessary [1] 153/25
need [50] 6/14 7/25 10/18 22/1 22/22 23/6 25/6 31/15 35/19 39/12 43/10 53/17 53/23 54/16 54/25 75/7 76/23 76/25 85/2 85/12 88/15 88/16 88/18 89/12 91/25 92/3 92/15 101/1 103/9 109/3 110/1 112/10 112/11 114/15 117/18 133/7 134/2 147/12 155/4 163/23 163/25 168/4 168/9 171/2 175/4 180/9 190/12 194/20 194/21 194/22
needed [11] 10/17 43/12 43/13 44/9 52/13 85/19 101/8 152/8 161/8 167/21 167/22
needing [3] 80/20 88/25 122/10
needs [6] 56/12 78/21 85/5 89/11 146/19 198/9
negative [4] 7/12 137/21 162/23 193/3
Negotiating [1] 137/24
neonatal [71] 2/12 7/12 8/23 11/14 17/9 24/1 24/20 28/9 29/18 31/6 34/9 39/14 42/25 44/3 44/8 45/17 45/25 55/10 65/13 65/18 66/1 66/5 68/1 70/25 71/16 74/16 76/7 76/17 78/4 84/17 84/19 84/20 84/24 87/24 88/2 88/9 88/10 88/12 89/18 96/23 101/3 124/12 124/17 130/9 130/15 130/19 130/24 131/19 144/10 146/15 146/19 146/22 149/20 152/21 153/15 155/24 157/2 157/8 158/1 162/11 162/13 163/5 170/16 170/25 172/13 173/6 174/18 175/6 176/6 177/10 193/9
neonate [1] 14/16
neonates [4] 6/14 28/1 55/10 184/15
neonatologists [2] 24/14 176/13
neonatology [2] 2/5 69/25
never [6] 19/14 102/1 108/10 145/6 190/9 190/10
new [5] 3/9 99/25 100/1 119/17 137/13
newborn [1] 61/8
Newby [12] 1/5 1/7 1/10 1/13 45/7 47/11 47/14 48/23 51/6 72/8 120/16 200/2
newly [1] 153/23
news [1] 161/24
next [22] 12/25 43/15 49/5 57/14 67/20 81/22 83/22 84/9 88/20 89/15 90/18 92/10 98/20 110/11 118/4 133/24 134/21 161/1 170/17 177/4 178/11 186/15
NHS [10] 3/25 132/7 132/11 148/16 152/24 194/10 194/12 194/15 194/17 196/8
Nichol [2] 97/17 183/6
Nigel [1] 182/25
night [10] 17/13 21/12 33/2 60/21 92/22 92/25 100/11 122/12 174/6 191/10
nights [2] 73/12 83/12
nighttime [1] 56/9
Nim [1] 178/13
nine [1] 131/22
nine years [1] 131/22
NNU [3] 37/23 86/17 86/19
no [105] 3/8 3/8 3/16 3/18 3/20 5/17 6/12 7/6 7/6 9/10 9/14 10/23 12/5 14/3 15/9 15/19 15/19 15/19 15/19 20/13 21/6 21/11 22/14 22/14 24/12 24/17 27/8 28/11 29/25 30/4 31/4 33/15 35/17 36/7 37/13 38/13 39/5 39/11 39/23 40/4 40/8 40/12 40/25 41/4 43/12 43/16 44/21 44/21 46/17 47/8 47/9 51/15 59/18 63/2 63/6 64/17 74/11 82/2 102/11 102/11 103/8 107/6 109/3 109/3 115/9 116/21 117/1 119/11 119/12 120/8 120/11 120/11 120/24 121/1 121/21 124/2 125/19 126/8 128/2 130/11 132/5 138/5 140/3 149/19 151/9 153/10 158/1 159/8 160/25 172/16 176/18 178/24 179/11 185/21 186/10 186/25 188/25 189/22 189/25 191/10 192/16 192/17 197/20 198/4 199/10
nobody [3] 76/22 101/3 121/24
nod [1] 191/3
Nods [37] 4/12 4/18 11/16 15/23 18/17 22/8 26/8 28/14 29/8 30/17 31/1 31/19 31/22 37/18 40/17 43/25 51/8 55/19 80/9 80/13 110/21 111/1 116/11 116/16 124/19 136/14 144/19 146/6 151/23 157/14 169/4 171/12 175/12 181/11 188/20 190/3 190/23
non [4] 8/3 9/8 185/8 185/10
Non-Executive [2] 185/8 185/10
non-fatal [2] 8/3 9/8
none [5] 37/11 67/2 172/9 172/10 194/3
normal [2] 34/5 44/8
normality [1] 34/23
normally [2] 48/18 89/25
not [240]
note [4] 63/7 63/13 99/24 164/24
noted [1] 33/18
notes [21] 24/7 59/12 59/21 60/11 60/20 60/22 68/20 69/9

N

notes... [13] 81/22 94/4 98/20 102/3 105/9 105/10 124/5 168/6 168/10 168/10 178/21 186/19 186/21
nothing [2] 24/2 128/21
notice [1] 75/13
noticed [3] 42/16 122/12 137/1
notifying [2] 42/12 78/20
Nottingham [1] 129/19
November [1] 50/12
November 2008 [1] 50/12
now [84] 1/10 2/19 8/5 11/17 12/7 13/18 14/4 16/18 20/20 25/23 26/10 27/12 28/2 30/8 31/5 31/16 31/23 35/18 37/6 39/14 40/13 44/18 44/22 58/2 58/4 60/11 61/15 67/23 68/4 70/10 72/8 73/17 77/2 78/6 78/16 78/23 79/12 80/7 80/25 81/7 81/17 83/7 85/22 87/8 96/3 97/20 100/3 102/16 102/19 103/7 104/23 105/14 106/6 110/10 111/5 114/19 114/20 115/9 118/18 128/25 130/20 134/11 146/3 155/14 155/15 158/10 159/4 159/25 162/17 163/1 166/14 169/18 171/15 171/16 171/18 171/20 176/7 178/9 183/17 186/5 190/4 192/14 193/25 199/15
number [33] 1/25 2/1 7/8 9/23 23/20 30/10 33/9 41/11 44/2 55/16 58/8 58/14 83/6 106/11 116/5 130/9 131/6 134/16 136/7 139/14 144/11 150/15 150/17 150/22 150/22 151/2 151/14 152/16 153/1 176/5 183/14 185/4 198/7
Number 3 [1] 185/4
nurse [26] 2/20 3/1 4/16 10/12 36/10 46/17 57/25 83/24 95/13 96/18 99/25 100/18 108/22 125/12 125/15 149/13 149/18 149/19 149/20 160/5 160/9 160/22 161/14 162/13 172/22 193/12
nurses [25] 12/3 38/24 38/24 46/21 51/3 51/25 84/19 84/25 84/25 85/6 88/9 95/10 98/13 98/16 100/25 102/21 106/25 107/1 156/11 172/12 172/19 172/20 173/6 174/9 174/18
nursing [22] 10/13 11/1 11/2 11/15 11/19 19/10 33/7 73/22 77/22 95/14 103/6 139/5 146/24 149/8 149/10 149/15 149/25 150/2 163/20 168/10 172/6 174/17

O

o'clock [3] 129/2 199/16 199/19
oath [1] 1/10
objectives [1] 164/2
obligated [1] 147/16
obs [1] 100/12
observation [2] 128/20 168/12
observations [2] 100/12 134/16
observed [3] 20/25 36/10 104/23
obstetrician [1] 195/15
obstetrics [2] 6/6 6/14
obtain [1] 50/5
obtained [2] 121/12 149/9
obtaining [1] 49/25
obvious [3] 6/13 55/1 77/11
obviously [21] 14/19 19/3 23/10 37/14 38/2 43/4 52/1 65/12 81/18 83/17 84/22 96/16 107/11 110/3 145/14 165/20 174/1 176/14 192/7 196/20 198/15
occasion [1] 197/21
occasions [2] 2/1 58/8
occur [2] 89/1 124/14
occurred [6] 5/11 10/6 29/21 32/19 39/16 70/7
occurring [1] 33/14
October [13] 1/1 28/17 29/4 30/8 30/13 31/16 32/4 36/19 37/7 42/15 71/9 114/22 199/23
October 2015 [1] 71/9
odds [1] 181/20
off [10] 9/17 31/6 88/4 125/7 125/7 138/18 138/20 138/20 143/23 157/10
offer [1] 170/14
offered [1] 185/5
office [7] 17/21 138/19 142/20 143/3 143/12 176/21 197/9
officer [1] 17/21
offices [7] 138/14 138/18 138/20 139/19 143/6 186/25 191/9
offload [2] 19/19 135/13
offloading [1] 19/21
often [3] 27/25 53/2 168/6
Oh [2] 21/11 199/18
okay [16] 7/6 58/11 71/7 74/10 84/1 86/10 87/25 92/12 111/17 117/18 124/6 133/9 139/25 172/18 179/16 182/1
omit [1] 193/4
on [266]
on-call [3] 21/13 68/17 187/1
once [1] 17/16
one [102] 5/10 10/5 10/18 10/19 18/7 20/20 22/19 24/14 25/5 30/21 30/25 35/2 36/7 40/18 43/16 43/23 45/12 45/22 46/17 47/6 48/9 59/9 60/6 62/18 66/3 66/18 66/21 67/11 67/13 72/25 73/2 75/8 75/17 82/5 83/20 84/17 87/25 90/23 91/15 91/18 91/22 92/15 92/19 94/11 94/15 96/15 98/4 99/10 103/11 105/10 108/16 114/14 114/16 122/15 126/5 126/13 127/13 128/7 128/25 132/21 132/22 132/25 133/14 133/21 133/25 134/6 134/9 134/10 135/22 137/19 137/19 139/17 139/17 142/5 145/5 145/5 147/11 150/15 150/23 155/20 156/11 156/11 158/7 164/14 167/9 167/9 168/5 175/6 179/24 180/10 182/8 183/19 186/20 187/1 188/1 190/15 190/16 197/10 197/20 198/8 198/19 199/19
ones [2] 56/6 56/13
ongoing [2] 25/1 165/5
only [25] 9/22 23/22 36/5 36/5 37/15 60/23 63/21 68/17 70/10 70/22 84/23 85/12 90/23 119/19 127/2 134/4 139/18 143/19 144/14 159/19 178/23 186/23 187/3 193/3 199/19
open [4] 114/11 118/17 143/23 165/7
opening [1] 161/4
opens [1] 88/7
operation [1] 7/22
opinion [14] 12/12 26/19 38/2 38/6 90/20 93/17 153/8 154/19 162/23 163/2 180/8 190/13 191/23 191/24
opinions [2] 174/15 178/9
opportunity [7] 46/7 68/20 77/10 93/23 111/6 140/22 176/10
opposed [2] 100/19 135/16
opposite [1] 61/21
option [1] 197/12
or [185] 6/18 6/23 7/12 7/18 8/18 8/18 9/10 9/16 10/12 10/19 10/20 10/22 11/2 11/23 17/20 19/7 19/24 21/10 27/19 28/6 28/16 30/10 30/22 31/25 32/10 34/8 34/9 35/6 36/22 38/4 38/13 38/14 39/25 40/19 40/23 41/23 42/6 42/20 43/6 45/17 48/20 51/25 53/23 53/25 54/23 55/2 55/3 56/4 56/8 56/15 57/4 60/24 61/3 61/5 61/18 62/7 63/4 65/4 66/8 66/14 66/25 67/21 68/25 69/23 70/8 70/18 71/23 72/10 72/21 72/23 73/7 73/22 73/23 74/13 75/2 75/9 76/13 78/21 78/21 79/25 81/5 83/24 84/15 85/13 88/4 88/5 88/6 89/10 89/10 89/21 90/5 90/15 91/8 92/10 95/22 95/23 96/18 97/14 98/6 101/3 101/16 102/12 104/10 105/22 107/17 107/18 107/22 109/9 109/16 110/6 110/23 111/21 116/13 117/4 117/14 118/10 125/20 125/22 130/25 131/8 131/11 132/6 136/3 136/3 137/3 138/3 138/14 139/1 140/8 140/11 141/2 141/3 142/15 143/10 144/1 144/3 145/11 148/2 148/13 148/20 149/10 153/23 156/11 159/13 159/13 160/4 160/4 160/9 160/12 168/21 169/1 169/15 172/6 172/6 172/19 173/3 173/24 177/10 178/14 179/16 179/23 180/18 180/24 180/24 182/14 182/17 183/12 184/18 187/8 187/11 187/13 187/25 189/2 189/21 190/10 191/24 195/22 196/18 196/20 196/23 197/18 197/23 197/24 198/14 199/6
or July [1] 73/7
or July 2016 [1] 53/25
order [6] 18/4 114/4 138/9 167/11 194/20 198/2
ordered [1] 165/24
ordering [1] 56/14
ordination [2] 10/16 139/12
organisation [2] 137/14 198/24
organisations [1] 197/4
other [43] 25/1 35/7 36/18 36/24 36/25 46/5 51/16 53/12 56/19 62/12 67/18 68/6 68/15 70/13 70/23 72/7 75/2 78/17 87/21 91/1 93/5 98/5 98/6 103/11 122/25 124/7 126/17 131/1 131/21 139/1 139/1 144/2 145/6 150/4 153/11 173/22 180/3 180/20 182/8 184/16 186/20 191/11 195/22
others [8] 35/12 38/6 97/13 134/14 136/21 144/1 148/25 151/8
ought [1] 87/3
our [94] 1/4 4/14 9/19 14/11 26/7 48/18 48/19 49/5 56/25 57/11 57/19 62/4 67/8

O

our... [81] 68/15 69/18 71/22 72/3 84/24 86/14 95/18 95/25 96/8 97/1 97/6 101/3 102/9 105/7 106/20 107/7 107/11 108/17 111/15 111/23 111/24 112/23 113/5 113/17 113/19 113/19 114/3 114/16 127/11 128/9 134/25 135/22 136/9 137/16 137/17 138/19 139/9 139/10 139/18 140/17 142/23 142/24 143/15 143/16 146/15 146/18 146/22 148/21 154/5 157/18 157/25 159/3 159/7 163/10 165/4 165/20 165/24 166/5 167/8 170/11 170/13 170/18 170/22 171/3 176/16 177/7 177/12 178/13 184/16 185/5 185/8 185/18 186/14 188/8 189/18 191/8 192/3 194/19 195/8 195/18 196/5
ours [1] 163/22
ourselves [1] 184/4
out [40] 1/11 7/5 17/5 33/14 34/23 35/15 45/12 47/4 51/5 58/15 61/10 73/2 80/23 87/15 90/17 96/3 98/6 104/20 108/12 119/22 128/20 133/22 134/16 137/3 137/6 147/17 159/4 163/3 163/7 163/21 164/17 165/10 165/25 173/20 174/6 180/1 181/24 191/4 194/6 197/11
outbreak [1] 66/7
outcome [3] 95/18 182/7 196/8
outline [1] 105/21
outset [2] 58/7 181/20
outside [3] 55/25 134/2 176/16
over [20] 22/2 23/20 25/6 30/24 64/23 73/17 92/17 97/21 99/16 99/23 105/1 121/6 125/16 139/14 139/15 140/18 144/11 156/25 157/2 165/10
over-tired [1] 125/16
overall [1] 198/6
overview [12] 70/20 141/3 141/6 141/7 143/1 162/23 181/10 182/10 182/11 182/15 182/18 182/25
own [5] 8/12 84/2 119/16 137/20 191/24
oxygen [3] 88/3 88/16 88/24

P

paediatric [23] 1/24 2/11 6/3 11/14 12/9 50/13 52/17 84/24 84/24 84/25 85/6 85/6 109/6 109/21 110/16 110/23 138/6 139/18 154/10 170/15 176/16 177/11 190/22
paediatrician [4] 87/1 90/22 129/24 167/8
paediatrician's [1] 192/8
paediatricians [10] 60/24 88/9 137/24 138/20 143/7 156/14 157/23 176/8 178/8 184/13
paediatricians' [3] 86/16 86/25 196/18
paediatrics [9] 2/5 4/7 12/18 47/18 48/2 50/2 50/6 146/23 150/4
page [67] 11/10 16/23 21/23 22/23 22/23 23/20 25/6 30/7 41/8 58/12 62/17 64/23 69/5 83/10 86/7 87/10 92/17 93/9 94/12 97/21 98/19 99/23 101/24 101/24 102/14 103/12 105/13 105/14 106/10 106/11 106/12 109/7 133/12 133/17 133/19 133/24 133/24 133/25 134/13 134/14 134/14 134/17 134/20 134/21 146/8 147/7 147/9 150/16 150/25 160/16 160/16 160/19 161/1 161/2 161/13 161/15 161/22 165/10 175/14 176/22 177/4 177/24 178/11 178/11 178/18 192/8 192/25
page 1 [6] 133/24 146/8 150/16 175/14 176/22 178/18
page 10 [2] 109/7 161/2
page 11 [1] 30/7
page 12 [2] 41/8 161/22
page 2 [7] 21/23 58/12 86/7 93/9 94/12 150/25 177/24
page 3 [7] 87/10 133/12 133/19 134/14 134/14 134/17 178/11
page 37 [1] 106/10
page 4 [7] 11/10 69/5 98/19 105/13 133/17 133/25 134/20
page 6 [2] 16/23 83/10
page 7 [2] 147/7 147/9
page 8 [1] 106/12
page 9 [2] 160/16 192/25
pages [1] 108/2
pains [2] 179/20 180/1
palliative [2] 145/25 149/15
PALS [3] 81/8 81/17 81/21
Pan [1] 15/22
Pan Cheshire [1] 15/22
panel [16] 141/3 141/6 141/7 143/1 149/13 150/3 181/10 182/10 182/11 182/15 182/19 182/25 186/2 186/4 186/11 186/12
paper [5] 132/8 132/11 150/10 151/19 151/22
Paper' [1] 163/7
papers [2] 22/3 162/9
paperwork [1] 194/3
paragraph [50] 5/20 16/21 16/25 18/24 24/20 24/24 28/3 30/6 31/23 33/25 41/9 43/18 44/1 45/13 58/12 58/13 59/23 63/11 65/1 69/5 69/6 83/9 86/12 91/22 106/11 109/5 113/10 114/5 130/7 131/10 132/18 133/3 133/4 134/9 134/12 137/22 140/6 146/13 146/17 150/9 152/19 154/18 162/3 163/4 164/9 173/15 178/4 179/19 183/24 193/7
paragraph 1 [1] 146/13
paragraph 12 [5] 58/12 132/18 133/4 134/9 134/12
paragraph 13 [2] 58/13 137/22
paragraph 14 [2] 59/23 140/6
paragraph 2 [2] 162/3 178/4
paragraph 20 [1] 69/5
paragraph 22 [1] 69/6
paragraph 27 [1] 16/21
paragraph 28 [1] 16/25
paragraph 3 [2] 146/17 183/24
paragraph 33 [2] 18/24 83/9
paragraph 35 [1] 150/9
paragraph 37 [2] 24/20 106/11
paragraph 38 [1] 24/24
paragraph 39 [2] 152/19 154/18
paragraph 4 [1] 130/7
paragraph 47 [1] 163/4
paragraph 48 [1] 28/3
paragraph 5 [1] 5/20
paragraph 51 [1] 30/6
paragraph 53 [1] 164/9
paragraph 54 [2] 31/23 33/25
paragraph 55 [1] 109/5
paragraph 59 [1] 41/9
paragraph 61 [1] 43/18
paragraph 62 [2] 113/10 114/5
paragraph 63 [1] 44/1
paragraph 76 [1] 173/15
paragraph 8 [1] 131/10
paragraph 82 [1] 45/13
paragraphs [2] 11/8 23/24
paraphrasing [1] 20/22
pardon [1] 94/21
parental [1] 60/6
parents [22] 26/24 27/15 56/16 80/19 81/13 81/15 81/16 88/11 89/24 90/7 90/15 125/24 128/14 146/3 148/23 149/3 184/18 192/14 192/16 192/21 197/19 197/19
part [27] 5/1 12/21 47/22 56/11 64/20 72/25 81/5 92/19 116/1 120/13 124/16 141/8 143/16 144/14 144/22 151/11 152/10 158/2 167/7 168/2 179/24 189/14 189/21 193/17 196/9 197/16 198/25
participate [1] 114/25
particular [16] 3/1 5/22 8/8 8/17 40/19 53/18 58/13 69/16 70/17 78/3 92/21 109/20 117/16 155/20 158/7 178/22
particularly [9] 14/16 17/9 66/6 72/16 87/24 89/5 93/18 95/19 111/24
parts [3] 98/19 161/18 162/20
party [3] 35/23 41/14 175/6
passionately [2] 170/11 170/13
past [4] 48/21 94/4 104/24 105/1
patch [1] 76/14
pathologist [1] 44/24
pathology [1] 91/6
patience [1] 154/13
patient [13] 8/21 14/16 21/1 21/6 76/1 86/18 112/14 153/7 154/15 156/14 163/24 168/6 177/12
patients [18] 2/20 3/2 14/2 54/10 58/1 70/13 70/19 70/24 87/4 152/14 153/19 153/25 154/8 158/24 158/25 163/23 170/15 194/19
pattern [2] 33/18 181/3
patterns [2] 19/13 58/22
pause [3] 133/5 157/21 173/14
pausing [2] 175/19 190/24
pay [1] 135/23
pdf [2] 107/24 108/2
pending [1] 24/25
penultimate [1] 128/20
people [43] 4/24 9/13 9/14 10/16 10/21 19/18 19/22 20/18 35/6 50/20 52/14

P

people... [32] 53/19 84/18 84/23 87/17 99/10 100/8 108/13 120/14 121/18 125/21 139/10 148/15 156/17 156/20 158/20 159/13 173/22 174/4 181/3 184/25 188/10 191/11 191/18 191/20 191/22 194/19 194/22 194/23 195/19 195/21 196/1 196/16
people's [3] 34/22 92/5 122/25
peptide [3] 26/13 68/6 77/5
perceive [1] 51/22
perceived [3] 15/2 98/10 109/20
perception [2] 50/19 51/7
perfectly [1] 7/3
performing [1] 30/15
perhaps [19] 7/14 9/8 13/11 14/12 38/9 46/19 47/2 110/11 125/21 133/11 134/13 140/17 151/14 152/11 153/22 163/24 171/17 181/20 188/17
perinatal [5] 56/25 67/21 70/19 91/4 163/11
period [22] 17/6 25/9 25/20 30/24 36/15 44/17 50/21 50/23 52/7 61/8 67/12 67/24 83/19 95/7 110/22 112/4 143/20 144/11 144/13 165/6 187/4 195/4
periods [2] 52/4 153/3
permission [1] 119/3
permitted [2] 112/7 172/8
persist [1] 122/21
person [13] 33/9 46/14 47/7 53/3 53/3 56/5 65/4 91/15 114/7 148/11 149/16 164/14 190/12
personal [2] 38/1 198/6
personally [2] 44/11 197/4
perspective [4] 6/10 11/18 164/12 196/19
pertained [1] 3/10
pharmacist [1] 187/10
pharmacy [3] 3/12 187/11 188/1
phone [2] 16/7 142/7
phoning [2] 136/3 196/22
phrase [3] 45/12 94/13 175/19
physical [1] 14/13
pick [3] 45/12 122/11 176/19
picked [2] 68/21 191/3
picking [1] 30/6
picture [1] 114/5
piece [1] 8/18
pinpoint [1] 143/14
place [15] 3/7 5/6 7/24 19/7 19/9 24/4 24/24 39/21 51/22 74/17 95/6 168/6 171/1 180/12 194/21
places [1] 10/21
plan [6] 48/20 76/15 100/1 112/17 112/25 153/20
Planned [3] 6/8 7/20 48/12
planning [1] 100/1
plans [3] 26/3 145/21 154/12
play [4] 152/7 179/11 179/24 182/5
please [43] 1/5 13/6 21/23 25/5 26/23 30/5 40/23 45/15 49/12 49/20 50/21 50/23 58/4 59/6 71/8 79/6 87/10 93/8 94/12 98/19 101/23 105/13 107/6 108/15 109/18 113/12 129/15 133/18 146/7 150/14 151/1 160/15 161/21 163/4 175/13 177/5 177/10 177/24 183/7 183/7 190/17 193/1 193/2
plenty [1] 138/22
plus [2] 31/24 66/3
pm [7] 105/2 105/4 105/15 129/5 129/7 146/11 199/21
pneumonia [1] 29/13
pockets [1] 196/1
Poer [10] 1/3 1/8 49/4 49/10 103/9 105/5 126/15 128/19 200/3 200/6
point [45] 3/12 6/3 12/19 12/24 15/24 21/8 25/5 35/14 36/15 37/20 44/14 54/11 66/13 86/5 97/24 98/11 106/22 109/1 118/13 120/5 122/15 123/19 127/24 132/15 135/16 135/18 135/21 138/7 140/12 154/13 154/14 156/13 157/22 163/7 170/23 175/11 175/16 179/6 184/17 185/20 185/23 186/13 191/10 192/22 198/6
pointed [2] 15/21 27/3
pointing [3] 73/2 81/4 98/6
points [1] 44/24
police [57] 15/4 15/8 15/10 17/2 34/10 43/9 43/21 55/21 85/13 87/16 87/20 91/19 92/4 95/4 95/16 95/20 95/22 97/25 98/17 100/3 100/19 100/24 101/2 101/5 102/22 113/16 113/19 114/1 114/2 115/23 132/19 132/23 133/1 133/2 134/5 134/17 135/7 136/3 136/3 142/9 162/12 162/25 165/12 174/21 177/19 180/15 180/18 182/17 182/17 182/22 183/2 185/20 185/22 196/22 198/25 199/2 199/4
policies [1] 132/7
policy [4] 13/15 15/12 132/11 140/15
pool [1] 33/7
poor [5] 33/8 107/23 107/24 108/1 171/19
poorly [2] 128/11 146/18
popping [1] 138/25
population [1] 170/19
portray [1] 193/9
pose [2] 35/19 101/7
posing [3] 14/2 14/15 54/10
position [19] 15/16 38/5 38/12 38/17 44/15 46/22 47/1 110/16 112/6 118/21 126/16 150/10 153/12 158/23 172/20 179/5 180/2 190/7 196/12
positive [4] 7/11 66/15 173/11 173/23
possibility [5] 33/13 35/12 47/5 115/20 198/21
possible [5] 58/10 60/7 62/12 148/11 184/9
possibly [6] 21/14 25/24 41/1 46/16 47/22 171/23
post [3] 2/7 3/25 168/1
postmortem [12] 18/4 29/6 29/10 29/13 56/15 56/16 75/21 75/25 76/4 90/14 90/16 123/8
postmortems [1] 179/9
postnatal [7] 84/21 85/3 85/3 85/7 85/8 131/18 153/23
potential [5] 9/11 67/25 120/21 125/9 156/18
potentially [6] 61/13 98/22 108/23 148/4 157/5 182/4
Powell [9] 11/19 33/19 38/21 51/6 78/20 79/25 172/24 172/25 173/11
practice [6] 7/23 9/20 19/18 36/11 84/4 125/20
preceded [1] 30/10
preceding [2] 130/21 130/23
precisely [3] 12/25 32/25 41/3
predominantly [1] 146/15
preferred [1] 166/20
pregnant [1] 155/21
preparation [2] 114/25 115/1
prepare [1] 89/24
prepared [2] 151/19 191/25
presence [3] 35/15 70/3 79/15
present [7] 23/19 28/3 94/7 97/12 98/6 113/15 153/21
presentation [3] 28/13 28/16 69/22
presented [10] 27/24 105/18 106/20 150/11 150/16 150/18 150/22 151/17 154/23 162/22
press [5] 100/1 147/22 148/2 161/25 184/14
pressure [5] 119/9 119/12 119/12 119/16 119/19
pressurised [1] 119/17
presumably [2] 40/9 192/21
pretences [1] 188/14
preterm [2] 89/22 94/15
pretty [1] 170/9
prevent [3] 128/14 128/14 171/3
previous [7] 60/21 67/17 72/7 79/19 101/24 146/20 172/22
print [1] 108/9
printed [1] 107/20
prior [3] 124/3 176/13 184/14
prioritising [1] 161/7
priority [2] 177/12 182/23
private [1] 45/25
privilege [1] 158/23
probably [35] 7/21 9/12 23/7 24/4 53/20 53/25 54/1 56/7 60/4 61/9 62/5 64/6 64/7 66/19 68/2 70/21 76/11 81/7 81/17 89/4 91/3 91/7 93/17 95/13 113/18 117/3 117/10 118/14 120/4 122/11 122/19 125/16 135/13 159/16 188/5
problem [5] 13/10 42/7 53/16 68/1 196/6
problems [1] 88/8
procedure [8] 13/15 15/12 15/14 55/17 57/8 187/11 189/20 189/24
procedures [3] 5/6 56/22 190/6
proceed [3] 95/8 96/16 142/10
process [31] 4/25 5/10 5/15 7/24 15/17 55/7 87/23 101/8 111/20 118/17 127/11 127/13 137/16 141/6 141/8 141/13 142/2 142/6 142/12 144/7 145/24 162/21 163/2 165/21 185/17 187/24 188/6 188/15 189/7 189/14 190/5
processes [5] 140/6 140/8 161/3 161/16 194/21
procurement [1] 3/13
produce [2] 9/3 9/3
produced [6] 3/9 38/22 38/25 73/22 74/9 91/8
profession [1] 158/21
professional [3] 34/3 44/7 178/9
profoundly [1] 128/17
progress [2] 61/18 61/24

P

progressive [2] 61/2 122/9
projection [1] 171/14
prominent [1] 122/13
prompt [2] 8/25 9/10
proof [2] 113/25 114/1
properly [4] 71/3 80/24 113/2 113/6
property [2] 107/15 166/23
proposed [1] 183/9
prospectively [1] 123/7
protecting [1] 137/20
protection [4] 31/7 31/8 54/18 198/12
protections [1] 3/7
protocols [1] 107/8
proud [1] 51/19
prove [1] 113/24
proven [1] 27/24
provide [5] 64/2 107/17 174/22 177/2 193/25
provided [14] 17/1 22/3 49/16 59/7 81/1 81/5 81/6 81/12 105/11 114/18 116/23 130/1 161/23 167/14
providing [4] 59/1 87/23 170/14 193/24
provoke [1] 4/25
pseudomonas [1] 65/14
psychological [1] 189/11
public [3] 148/21 156/3 192/13
publicity [1] 137/21
publicly [2] 167/15 176/14
published [1] 107/22
pull [2] 23/6 198/25
Purple [1] 60/12
purpose [5] 3/15 35/16 113/13 119/21 182/14
purpuric [1] 22/7
pursue [1] 136/9
put [32] 3/6 6/4 9/24 23/15 42/7 46/14 46/15 75/17 76/5 86/23 87/13 96/9 97/1 101/22 111/5 118/20 120/10 121/6 124/7 135/6 137/8 137/13 142/8 148/10 148/13 157/1 182/21 189/10 189/24 190/17 190/21 191/24
putting [1] 70/15

Q

QC [2] 113/8 180/11
qualifications [2] 129/15 129/17
qualified [2] 1/21 1/23
qualities [1] 194/15
quality [3] 107/23 107/24 108/1
quantify [1] 192/18
quarter [1] 94/12
question [33] 12/25 38/9 45/19 57/4 60/14 63/12 63/13 70/24 73/20 79/10 83/22 84/16 87/22 92/15 93/25 95/19 96/14 100/9 103/24 106/1 108/16 115/11 116/24 117/2 118/4 118/5 126/13 126/14 136/6 141/17 147/7 158/11 196/25
questioned [13] 1/8 47/13 49/10 119/7 126/10 129/11 189/24 200/3 200/4 200/6 200/7 200/8 200/10
questions [18] 8/9 47/12 73/19 81/3 82/2 82/16 104/15 104/18 104/25 106/13 117/6 118/8 119/2 119/4 120/12 126/9 135/12 182/2
quick [2] 12/2 66/3
quickly [1] 157/7
quite [22] 6/12 9/22 10/2 11/25 12/19 12/20 24/2 33/11 47/16 60/22 65/2 81/2 86/4 89/2 101/13 107/19 111/24 121/24 156/23 157/5 169/9 196/6
quote [1] 134/21
quoted [1] 193/18

R

Rachel [2] 185/7 185/16
racist [1] 55/2
radio [1] 148/2
raise [11] 34/6 34/16 43/10 44/10 44/12 47/5 55/5 76/25 132/8 141/17 147/5
raised [20] 6/19 6/22 6/23 23/25 43/19 44/14 45/19 53/21 72/2 74/22 115/19 136/7 136/15 144/12 156/13 159/24 162/11 181/10 181/13 181/14
raising [7] 22/4 44/10 166/14 168/20 188/12 188/16 190/1
Rajiv [2] 142/24 143/4
Rajiv Mittal [1] 142/24
ramblings [1] 135/8
range [1] 36/20
ranging [1] 194/17
rank [1] 160/4
rapport [1] 195/11
rare [8] 66/23 89/16 90/1 90/10 90/20 140/25 140/25 145/15
rarely [1] 140/18
rash [31] 21/7 22/7 60/7 60/8 60/15 60/16 60/18 60/20 61/7 61/11 61/18 61/22 61/23 62/12 63/9 63/10 63/18 64/3 64/5 64/9 65/11 65/19 99/11 121/17 121/20 121/22 121/23 122/4 122/12 122/15 122/20
rashes [18] 23/12 60/5 60/9 60/25 60/25 60/25 61/1 61/7 63/5 64/14 99/11 99/13 121/16 122/3 122/8 122/9 122/21 122/25
rate [8] 130/18 137/1 144/3 155/2 158/1 168/12 168/13 174/3
rates [3] 146/20 148/3 151/3
rather [15] 11/4 16/15 24/4 47/3 56/18 60/5 65/18 70/17 70/20 118/18 152/16 154/20 162/23 164/3 169/25
ratio [1] 77/5
Ravi [5] 98/21 99/12 144/22 189/12 189/15
ray [3] 168/14 168/15 168/17
RCPCH [34] 34/9 41/13 95/12 98/14 102/21 106/9 106/16 106/18 107/2 107/14 107/25 108/3 108/21 110/24 111/12 116/12 116/14 128/7 128/8 149/7 157/13 157/15 159/7 159/12 160/11 160/19 161/21 161/24 162/9 163/5 163/10 176/11 176/25 184/21
reached [2] 87/15 154/20
reaction [5] 11/23 31/11 75/16 93/14 98/10
read [24] 51/5 58/15 63/14 96/3 108/9 108/10 132/6 132/12 132/14 133/3 133/8 133/22 134/24 134/24 135/1 135/19 136/17 148/2 160/24 162/4 162/5 169/12 176/11 176/24
reading [2] 29/10 62/4
reads [1] 103/14
reaffirm [1] 163/14
real [3] 47/1 164/12 164/12
realise [1] 159/5
realised [3] 83/20 108/4 182/6
really [49] 6/17 7/19 18/5 25/22 31/14 34/22 36/21 37/4 37/5 42/4 44/15 46/3 48/19 140/12 140/24 140/24 140/25 143/13 143/21 143/22 145/22 145/24 148/14 148/14 155/3 155/25 157/7 158/3 160/6 168/1 168/11 173/5 173/8 174/13 174/13 180/24 181/8 181/8 185/17 187/3 189/10 189/12 189/14 194/18 195/13 195/14 195/23 195/25 196/2
reason [13] 69/24 75/23 80/11 89/7 91/21 91/24 100/23 100/24 112/13 116/21 126/20 155/1 176/4
reasonable [4] 29/15 82/21 125/23 126/5
reasonably [1] 15/15
reasons [2] 62/1 87/16
reassurance [1] 177/3
reassure [1] 156/19
reassured [1] 46/4
recall [26] 3/5 16/25 19/1 19/8 19/9 21/5 24/12 24/13 24/17 31/24 32/12 32/13 58/21 60/3 94/18 102/18 106/2 124/3 124/6 125/11 125/13 130/20 131/3 137/23 155/13 166/16
recalled [1] 102/23
receive [1] 160/23
received [17] 9/15 13/18 37/7 37/16 54/5 54/8 63/7 63/21 74/12 75/14 78/24 81/21 92/24 133/13 135/4 135/5 161/25
receiving [2] 88/1 93/14
recent [3] 4/22 24/1 73/3
recently [1] 87/12
receptive [1] 12/10
recipients [1] 62/18
recognise [5] 91/3 91/7 92/4 183/20 189/17
recognised [1] 142/4
recollect [11] 22/2 23/8 65/22 74/14 74/15 75/2 76/20 79/2 80/14 97/19 98/3
recollection [26] 19/6 21/3 27/8 27/13 27/16 27/17 28/12 29/9 30/8 30/12 32/23 40/10 59/7 60/19 65/10 66/15 78/8 78/23 81/25 93/5 95/21 97/16 98/25 100/23 103/23 110/4
recommendation [1] 161/8
recommendations [1] 108/13
recommended [4] 161/5 161/17 190/6 193/5
reconstruct [1] 66/14
reconverted [1] 108/2
record [2] 60/11 168/8
recorded [6] 24/7 94/12 97/22 97/23 100/8 102/15
records [2] 59/20 114/20
Recurring [1] 98/23
red [5] 39/1 73/24 95/24 109/11 110/3
redacted [3] 149/1 166/21 189/15
redesignated [1] 170/16
reduce [1] 97/24
refer [14] 81/14 81/16 83/24 133/6 141/2 141/5 141/10 141/11 141/13 141/22 142/1 150/8 150/10 198/19
reference [8] 8/1 149/24 165/17 165/23 173/13 173/14 178/24 185/21
referenced [1] 162/9
references [1]

R

references... [1] 138/13
referral [9] 142/5 142/13 183/2 197/15 197/16 198/2 198/9 198/19 199/4
referrals [2] 197/10 197/21
referred [1] 127/20
referring [4] 81/24 117/24 166/10 192/9
refers [2] 44/16 149/6
reflection [1] 193/24
reflections [1] 45/7
refresh [2] 111/6 125/18
refresher [1] 9/16
regard [2] 149/11 178/10
regarding [9] 119/10 121/19 121/21 122/25 125/12 125/20 162/19 184/16 192/17
regards [1] 131/18
region [1] 164/6
regional [7] 71/20 89/5 89/11 89/12 90/3 90/5 90/6
Registrar [3] 21/13 21/16 63/3
Registrars [5] 24/1 62/23 63/1 65/2 153/9
regret [1] 197/1
regrettable [1] 184/3
regular [2] 41/22 144/6
regularly [2] 143/5 198/17
reinforce [1] 163/10
reintroduce [1] 175/6
related [13] 54/12 54/18 55/25 58/19 58/24 60/2 60/4 60/5 62/3 62/7 65/17 65/24 66/9
relates [1] 134/10
relating [1] 5/23
relation [11] 3/19 13/25 30/25 45/4 59/24 69/6 118/11 121/16 131/13 131/25 132/12
relations [3] 52/1 52/6 111/15
relationship [8] 11/14 11/24 12/7 51/7 184/4 195/11 195/13 195/14
relationships [8] 11/7 50/19 50/24 51/23 54/4 184/6 195/3 195/18
relative [1] 68/6
relatively [3] 4/22 94/16 144/13
release [1] 100/2
released [2] 111/8 176/13
releases [1] 184/14
relegation [1] 47/18
relevant [4] 117/15 118/6 144/23 168/4
Reliable [1] 121/12
relied [1] 57/6
rely [1] 150/20
remain [4] 90/21 185/8 194/10 194/18
remained [8] 48/8 91/7 111/22 111/25 112/1 157/3 178/15 194/2
remaining [1] 170/22
remediate [1] 155/7
remember [96] 17/24 27/14 27/19 28/8 29/3 32/25 34/4 35/11 40/4 40/9 41/3 58/2 58/25 59/1 60/17 63/19 63/22 64/8 65/15 66/18 66/20 66/21 68/2 71/18 73/5 76/23 76/24 77/2 77/19 78/6 78/13 79/12 79/18 80/2 80/16 80/19 80/22 80/25 81/3 81/7 81/9 82/9 82/11 83/23 85/23 86/4 92/3 94/24 95/3 95/9 95/17 96/5 97/20 99/11 100/21 101/10 101/17 102/25 103/1 106/5 109/8 109/11 109/22 115/8 125/14 131/8 131/9 131/10 132/2 133/13 136/4 136/18 138/7 139/16 145/12 150/11 150/23 151/7 151/9 151/18 154/22 155/14 156/5 159/13 159/17 159/23 161/13 170/23 173/1 181/16 183/12 185/17 186/5 186/17 187/20 188/7
remembered [1] 79/18
remembering [1] 84/12
remind [5] 51/9 64/23 78/16 178/2 186/1
reminded [1] 63/21
remit [3] 3/8 107/16 173/7
removed [1] 12/16
reopening [1] 179/12
reorganisation [1] 184/7
repair [1] 184/5
repeat [1] 163/20
repeated [2] 116/7 183/25
replied [2] 27/8 33/3
reply [2] 22/25 191/15
replying [1] 110/16
report [38] 44/20 44/22 75/14 102/5 107/13 107/17 107/20 107/20 107/23 108/4 109/16 110/25 111/8 111/12 112/22 145/12 148/25 149/1 149/1 154/24 155/9 157/13 157/15 160/11 160/19 166/1 166/2 166/5 166/9 166/19 167/20 167/20 176/11 176/11 176/17 176/20 176/20 176/21
reportable [1] 10/25
reported [6] 47/3 47/3 136/8 136/12 136/12 175/25
reporting [2] 42/2 42/3
reports [11] 91/6 97/4 135/1 136/17 168/14 176/13 176/14 176/25 193/3 193/13 193/17
represent [1] 174/7
representation [3] 95/12 95/13 98/15
representative [4] 137/25 150/3 180/21 182/16
represented [1] 193/23
representing [1] 149/14
represents [1] 119/5
reputation [2] 137/10 137/20
request [6] 43/21 78/19 170/8 177/12 179/9 180/14
requested [2] 149/10 169/1
required [2] 161/6 169/1
requirement [1] 170/3
requiring [2] 9/8 10/5
research [1] 99/12
resigning [1] 173/21
resolved [3] 7/13 25/17 60/12
resolving [1] 61/22
resource [2] 163/25 163/25
respect [2] 158/22 159/3
respected [2] 174/5 188/13
respiratory [4] 88/19 88/22 89/1 168/13
respond [3] 89/4 178/21 178/22
responded [1] 30/18
responding [1] 161/4
response [14] 8/8 15/5 17/15 28/12 35/19 100/9 125/17 142/9 155/17 166/14 167/14 177/16 178/18 180/6
responsibility [8] 10/4 10/7 11/4 30/23 56/21 190/8 196/10 196/11
responsible [4] 44/7 116/10 139/11 198/11
rest [4] 125/17 126/6 128/16 157/4
result [5] 5/8 17/22 26/13 26/21 68/22
resulted [1] 6/5
results [7] 27/5 27/22 68/21 75/21 77/11 77/13 168/16
resume [2] 48/21 48/24
resus [1] 8/19
resuscitating [3] 59/11 59/12 59/14
resuscitation [12] 9/8 30/16 30/18 33/2 67/13 67/16 72/23 78/22 80/4 89/1 122/11 131/14
retired [1] 172/25
retirement [1] 174/12
retrospect [3] 118/14 123/16 123/17
retrospectively [2] 123/20 140/7
return [2] 171/10 172/11
returned [1] 171/24
returning [4] 3/22 69/4 112/5 170/24
reveal [3] 119/9 119/12 120/7
revealed [1] 120/24
revenue [1] 164/25
review [60] 24/15 24/22 25/1 28/4 29/6 34/9 38/20 39/14 41/13 41/13 41/14 44/19 68/20 74/16 75/3 75/4 99/25 100/18 102/16 102/19 103/22 106/25 109/16 131/18 140/6 141/8 144/17 144/18 146/22 149/7 149/11 149/13 149/25 151/25 152/10 157/19 161/6 161/17 161/18 161/20 162/10 162/21 163/2 165/4 165/16 165/17 165/18 165/24 165/24 165/25 167/17 167/23 168/21 176/11 176/12 176/25 178/16 182/13 184/21 184/24
reviewed [4] 9/6 33/23 131/20 141/7
reviewer [1] 193/5
reviewers [1] 166/4
reviewing [4] 1/20 33/18 33/19 49/24
reviews [3] 24/3 75/11 167/25
Revill [1] 164/24
rewrite [1] 199/4
right [40] 1/22 3/23 7/19 9/21 30/13 40/13 41/2 46/23 56/5 56/22 64/4 71/11 79/21 83/4 87/16 87/19 94/9 103/2 103/8 105/16 106/23 107/16 108/23 110/12 110/20 128/2 134/11 134/18 137/9 147/18 149/16 150/25 172/22 185/9 186/22 191/16 193/6 194/22 194/22 198/16
right-hand [1] 193/6
rightly [8] 41/23 80/19 80/20 118/10 145/12 154/22 159/17 187/21
ring [1] 100/2
rise [4] 60/5 78/5 151/13 152/2
risk [10] 3/17 6/15 14/16 35/20 54/10 101/7 146/16 157/11 168/22 196/3
role [13] 4/6 12/8 12/15 14/7 50/16 53/11 129/20 135/20 152/6 165/6 179/11 184/2 185/11
roles [2] 191/12 195/21
room [4] 51/5 105/24 138/21 183/17
rota [3] 84/13 84/14 139/11
rotas [5] 85/5 92/1 106/22 107/11 154/7
rotated [1] 150/17
roughly [1] 187/13
round [3] 59/25

R

round... [2] 109/23 154/9
rounds [7] 64/11 153/18 154/2 154/4 154/5 154/7 154/8
route [4] 55/13 56/19 182/17 197/12
routine [1] 140/1
Royal [18] 50/5 95/14 146/23 146/24 149/7 149/9 149/14 149/24 150/2 150/4 164/16 166/12 166/17 166/20 167/1 167/3 167/9 167/10
Rule [1] 119/3
run [5] 115/17 117/14 128/11 129/3 145/4
running [1] 127/6
Russell [2] 164/25 165/1
Ruth [1] 151/20
Ruth Millward [1] 151/20

S

sad [1] 177/15
saddened [1] 189/15
safe [6] 19/19 97/24 153/25 156/7 164/3 174/23
safeguarders [1] 197/9
safeguarding [27] 13/16 13/18 13/21 14/7 14/10 14/11 14/14 14/17 14/24 14/25 15/6 54/5 54/6 54/12 57/11 57/12 141/2 141/10 141/12 141/14 142/12 142/13 142/16 142/24 197/10 198/17 198/18
safety [11] 5/7 77/22 86/17 153/8 154/13 156/15 156/19 163/24 177/12 198/11 198/12
said [80] 20/22 20/25 23/21 25/25 26/12 27/1 27/2 27/5 27/18 29/1 32/23 33/14 35/22 35/25 36/2 38/10 39/7 40/6 47/16 47/21 47/23 51/6 53/10 57/9 64/5 65/10 74/24 81/1 81/15 81/15 82/19 83/14 91/22 91/23 94/20 94/22 95/4 95/20 96/10 98/21 98/25 99/13 102/18 102/23 103/24 106/24 107/4 107/15 107/21 107/24 108/21 109/24 109/25 110/1 110/17 115/23 117/10 120/15 120/16 122/8 123/8 123/11 125/15 126/18 132/8 141/21 143/3 143/21 144/22 147/10 153/10 155/13 156/4 160/9 165/7 166/13 176/18 184/23 184/24 199/9
Saladi [34] 49/6 49/8 49/9 49/14 49/15 50/21 58/4 64/24 73/20 78/23 79/16 83/5 87/12 92/2 98/24 102/15 103/13 104/22 105/7 105/14 106/1 108/19 114/14 116/24 119/1 119/8 119/22 126/14 128/3 128/18 128/24 132/25 133/21 200/5
Saladi's [1] 133/12
same [12] 21/2 25/18 33/8 35/6 97/1 111/22 114/9 135/10 143/6 178/19 192/25 195/7
Sara [1] 195/17
sat [2] 113/5 188/1
SATYANARAYANA [3] 49/9 49/14 200/5
saw [10] 39/3 63/20 111/12 121/17 122/13 122/16 144/17 144/18 151/22 160/25
say [124] 9/13 9/14 10/17 11/12 12/14 13/10 17/3 18/7 18/25 19/22 20/8 20/11 22/9 23/1 24/24 27/9 28/6 28/7 28/22 32/2 33/25 34/14 35/9 36/5 37/21 38/18 40/21 41/9 41/16 43/6 43/15 43/18 44/1 45/13 46/23 58/5 58/7 59/22 62/9 67/5 69/6 70/8 74/22 80/10 80/23 81/11 84/14 85/1 85/11 90/15 92/2 92/20 93/6 95/14 96/4 96/21 98/16 100/24 102/24 106/14 109/8 109/10 109/13 110/5 113/3 114/5 114/12 115/6 124/16 128/4 128/5 128/10 131/22 132/18 136/12 136/17 136/20 137/7 137/22 138/12 140/4 141/20 143/15 144/13 145/2 147/9 147/18 149/2 152/19 154/18 155/2 155/12 158/13 159/7 160/1 160/5 161/10 163/4 164/9 165/11 167/13 167/22 170/11 172/5 173/15 174/18 175/16 176/9 177/4 179/20 185/15 186/3 186/13 187/12 187/24 188/21 188/22 192/9 192/23 195/22 197/9 198/18 198/22 199/6
saying [39] 23/8 27/17 38/3 38/12 57/6 57/16 63/11 63/17 66/19 71/25 73/12 79/24 84/8 87/2 91/15 93/11 94/12 94/18 95/9 95/15 95/21 97/22 97/23 98/12 102/15 103/24 114/1 119/11 126/23 127/3 155/15 155/16 158/12 172/14 175/9 178/12 184/1 185/23 192/13
says [10] 20/21 20/23 63/9 87/14 162/3 162/4 162/7 164/5 181/16 183/23
SCBU [2] 92/22 93/2
scenes [1] 24/3
school [1] 1/23
Sciences [1] 129/17
scores [1] 168/12
scratching [1] 71/22
screen [9] 21/22 78/16 92/17 97/11 111/5 133/14 134/14 150/14 160/17
scroll [1] 22/22
scrutinise [1] 137/17
scrutinised [1] 152/8
Sean [1] 137/25
searched [1] 108/3
searching [1] 92/6
second [11] 15/12 23/19 62/17 66/21 97/15 117/4 124/16 128/13 133/7 172/15 172/18
second-hand [2] 172/15 172/18
secretarial [1] 138/21
secretary's [1] 138/19
section [3] 15/10 110/11 160/23
securing [1] 80/5
security [1] 103/22
see [89] 15/24 22/5 22/24 22/25 23/17 25/7 25/9 25/23 26/4 44/20 44/25 52/10 53/1 54/22 54/23 55/15 62/18 62/19 62/20 64/15 64/22 65/7 65/20 70/7 70/14 86/3 86/3 86/6 87/10 87/25 88/8 90/23 92/16 92/18 93/9 94/6 97/12 97/14 98/20 99/24 100/10 100/20 101/9 102/14 104/4 105/15 105/15 105/21 105/22 105/23 108/6 117/16 121/23 124/5 126/23 133/6 133/17 133/25 134/1 134/20 134/23 139/1 139/20 139/21 144/20 144/23 146/2 146/13 147/9 151/17 153/19 160/11 160/22 161/1 161/10 161/14 164/24 169/11 169/21 177/3 178/18 180/1 181/15 185/10 190/19 192/7 192/22 193/15 194/12
seeing [17] 9/18 21/5 22/3 55/2 59/12 65/8 69/19 69/21 69/23 70/1 70/11 71/18 75/16 76/6 96/15 151/19 161/13
seek [1] 46/4
seeking [1] 109/15
seem [4] 82/10 96/5 96/6 188/16
seemed [8] 6/16 13/11 29/15 80/11 82/19 173/19 174/9 189/16
seems [2] 25/17 63/8
seen [37] 14/12 23/13 33/3 36/7 39/6 43/16 46/18 60/7 60/8 60/15 60/17 64/3 64/5 64/9 65/11 68/14 68/21 68/23 69/2 77/9 90/23 99/13 100/9 102/1 102/2 102/4 102/9 105/11 110/13 115/10 121/17 122/17 138/13 146/18 154/9 185/3 197/24
select [1] 193/3
selected [1] 193/13
selection [1] 193/14
Selections [1] 193/12
send [3] 89/11 169/1 188/21
sending [2] 71/19 164/17
sends [1] 85/24
senior [45] 12/10 12/13 23/18 41/21 42/12 42/24 43/11 43/20 52/8 52/10 53/15 53/17 53/24 76/16 77/1 86/16 86/24 87/1 92/9 93/16 94/18 95/9 96/6 98/11 105/18 106/3 106/19 109/14 109/17 109/21 111/10 111/16 111/16 112/18 139/3 149/13 154/10 172/12 172/19 181/5 184/4 184/13 194/15 195/23 196/12
seniors [2] 73/6 73/13
sense [12] 4/13 59/17 66/5 119/20 142/14 153/12 154/17 180/25 181/2 182/3 185/14 198/12
senses [1] 137/19
sensitive [2] 146/3 176/15
sent [26] 21/24 64/8 65/20 78/14 78/17 79/23 83/13 86/4 86/8 87/9 90/3 93/10 99/7 99/17 99/17 102/4 102/5 108/1 112/22 127/17 132/20 132/25 169/10 175/15 176/24 188/25
sentence [1] 24/24
sentenced [1] 4/16
separate [3] 7/16 159/18 182/20
separated [2] 6/5 154/6
separately [3] 23/7 147/13 182/18
sepsis [6] 16/11 18/16 25/2 27/3 29/14 60/4
September [3] 106/9 108/16 116/13
septic [2] 22/17 27/23
sequence [2] 34/8 34/9
series [1] 178/19
serious [10] 8/25 9/2 9/7 9/9 10/10 61/1 64/6 64/11 68/10 77/6
seriously [1] 43/22
serves [1] 172/22
service [14] 97/24 139/18 146/22 157/19 165/4 165/18 170/11 170/13 170/14 170/15 170/17 193/10 193/24 195/8
services [3] 142/9 184/8 184/16
session [1] 28/7
sessions [2] 114/25

S

sessions... [1] 115/1
set [10] 45/20 87/15 134/16 147/17 163/3 163/21 164/2 165/10 180/1 184/25
setback [1] 88/1
setbacks [7] 87/25 88/7 88/11 88/13 88/15 88/21 89/15
sets [1] 192/16
setting [3] 46/2 185/2 191/4
settle [1] 88/18
seven [4] 37/2 110/15 159/19 172/10
several [2] 178/15 183/25
Shakes [1] 39/9
shall [2] 164/21 169/5
share [3] 96/24 118/15 192/14
shared [4] 6/15 12/12 142/20 143/3
sharing [7] 26/2 97/6 109/16 111/17 143/11 147/1 197/9
she [51] 12/2 16/12 20/21 20/22 20/23 27/1 27/2 27/5 27/6 27/8 27/9 27/22 27/23 27/23 33/4 33/15 36/6 36/6 36/9 38/13 38/14 42/16 43/17 46/16 46/17 72/9 72/10 96/17 99/9 101/11 101/14 112/8 113/4 116/10 143/10 143/23 149/25 150/1 157/11 160/9 165/25 167/21 169/23 169/24 169/25 171/20 172/5 172/25 173/2 174/24 174/24
she's [1] 35/16
shed [2] 25/19 106/1
sheet [1] 107/21
shift [2] 10/11 30/25
shifts [7] 19/10 19/13 36/7 92/22 92/22 92/25 93/1
shocked [1] 148/6
shocking [1] 46/3
short [6] 49/2 67/24 109/18 129/6 143/20 144/13
shortcomings [1] 192/4
shortly [3] 15/15 68/5 106/3
should [50] 8/16 14/5 19/15 22/13 26/3 31/6 31/9 31/20 34/23 36/1 37/21 42/7 43/9 43/20 43/22 54/9 57/3 69/2 72/2 86/1 86/18 91/23 95/22 97/11 112/7 115/23 118/22 118/24 125/16 125/21 126/1 126/4 126/15 126/17 126/18 126/20 127/9 133/2 133/21 140/10 140/15 141/2 146/8 148/13 149/4 152/12 178/15 185/6 190/6 194/10
shouldn't [3] 95/23 126/2 164/17
showed [5] 89/7 108/9 128/9 153/2 161/13
showing [1] 73/22
shown [5] 77/15 152/21 161/19 177/25 194/11
shows [1] 101/5
sick [2] 69/19 84/5
sicker [1] 59/13
side [3] 114/8 145/15 193/6
side-effects [1] 145/15
sides [1] 184/2
sight [1] 145/6
sighted [2] 60/13 173/24
signed [1] 169/2
significance [1] 122/12
significant [4] 17/10 61/13 153/5 197/23
significantly [1] 191/8
signpost [1] 147/13
silenced [1] 171/3
similar [2] 21/1 181/3
Simon [4] 113/8 180/11 183/4 186/11
Simon Medland [2] 113/8 180/11
simply [1] 171/8
since [7] 86/13 86/15 140/14 177/7 178/7 178/21 194/4
single [3] 145/5 157/2 179/25
Sir [13] 97/17 139/19 183/6 183/9 183/16 183/18 183/24 184/5 185/5 185/18 186/7 186/18 187/4
Sir Duncan [2] 183/16 183/24
Sir Duncan Nichol [1] 97/17
sit [9] 1/11 2/16 49/11 129/13 163/1 163/1 167/9 167/11 189/23
sitting [3] 25/23 109/22 198/20
situation [19] 5/23 8/19 11/5 36/13 54/9 57/24 66/1 70/3 89/23 127/4 136/7 152/7 168/19 178/7 186/24 188/18 197/21 198/6 198/20
situations [5] 54/16 54/25 55/1 89/4 197/16
six [3] 74/6 75/22 162/15
six months [2] 74/6 75/22
slant [1] 178/22
sleepless [4] 73/12 73/13 83/12 83/12
slightly [5] 48/17 114/16 136/20 182/20 186/14
small [8] 12/20 33/7 33/7 47/21 53/4 53/7 92/19 179/22
so [329]
so-called [1] 160/20
soaked [2] 125/7 125/23
social [6] 15/1 15/1 142/9 174/11 174/16 175/10
society [1] 158/19
solicitors [2] 115/2 117/5
solidified [1] 34/22
some [84] 4/21 5/4 5/22 9/13 9/13 10/22 14/5 16/24 19/21 19/21 20/19 20/22 21/13 22/18 22/19 30/8 33/6 36/15 41/1 41/5 41/7 54/1 59/19 60/9 60/23 61/7 65/10 66/10 66/25 71/9 73/18 87/21 87/21 88/16 88/17 89/21 90/13 93/4 94/4 96/1 97/13 99/12 100/8 101/14 104/3 104/11 104/17 104/24 107/11 112/22 114/9 114/24 120/12 120/17 122/19 127/20 130/18 130/21 132/12 132/15 132/20 135/18 138/7 143/4 143/15 144/14 146/18 148/18 157/5 158/2 158/2 162/20 163/7 167/7 172/15 175/22 175/23 179/7 179/9 185/1 191/14 193/3 196/15 199/8
somebody [14] 31/5 35/19 38/8 38/10 84/7 84/14 85/1 85/5 85/11 88/25 91/15 119/17 181/14 182/13
somebody's [1] 145/5
someone [10] 33/11 45/22 46/24 104/25 120/2 159/5 159/6 180/20 191/9 196/11
something [53] 2/19 2/23 6/1 6/18 8/16 9/19 10/9 14/5 21/1 21/7 22/10 22/13 23/6 26/12 27/18 27/25 31/2 31/9 34/17 34/21 36/1 40/3 43/1 43/2 47/16 56/3 56/8 56/11 61/4 66/10 66/15 66/25 69/20 71/23 71/23 72/4 89/10 89/11 91/14 94/25 97/22 121/24 122/5 123/7 128/4 140/13 142/4 158/5 173/20 180/18 197/5 197/24 199/9
sometimes [3] 9/24 10/3 88/16
soon [2] 23/6 150/6
sorry [37] 7/4 31/22 39/10 39/11 60/13 63/12 82/18 101/22 102/1 103/3 103/9 106/10 107/6 109/2 117/20 124/16 128/17 131/4 132/2 133/7 133/16 138/18 139/17 141/20 142/3 142/21 160/6 162/7 162/8 172/2 172/4 181/25 182/11 183/13 186/3 188/23 199/18
sort [48] 7/7 10/20 12/12 42/20 46/20 46/22 47/18 53/3 54/16 54/19 54/20 54/20 55/2 55/3 55/6 56/6 56/12 61/5 62/11 66/24 66/25 72/6 74/1 91/17 92/6 99/13 107/10 109/24 113/18 122/19 136/20 138/21 139/9 142/13 145/20 152/10 153/22 161/25 163/21 164/7 181/18 187/4 188/8 189/19 194/2 194/3 195/9 197/25
sought [2] 40/5 69/8
sound [3] 27/18 64/11 162/21
soundbites [1] 164/17
source [5] 120/17 120/24 123/21 123/22 125/9
sources [2] 120/21 168/6
SPA [1] 107/8
space [1] 19/19
SPC [1] 94/9
speak [14] 45/15 63/3 69/5 76/15 79/17 79/25 82/14 83/8 107/6 127/12 173/5 187/7 187/12 192/14
speaking [5] 7/10 64/12 78/9 80/2 80/8
speaks [2] 86/11 102/17
specialist [2] 50/8 121/19
specialists [1] 62/7
specialties [1] 12/22
specific [11] 5/10 8/22 13/25 24/5 30/25 36/20 78/19 98/7 131/11 135/16 144/4
specifically [7] 75/1 80/2 136/5 139/20 184/14 189/3 189/12
speculate [2] 117/8 127/2
speculating [1] 103/7
speculation [3] 113/3 117/11 127/16
spend [1] 114/2
spent [2] 21/11 21/13
spoke [9] 20/21 40/15 74/13 93/5 127/17 137/24 179/11 182/3 193/9
spoken [6] 39/24 40/3 148/9 148/11 154/25 196/21
spokesperson [1] 44/12
spotlight [2] 96/2 101/2
spotted [1] 69/3
spring [1] 4/11
stabilise [1] 90/2
stable [2] 59/15 94/17
staff [34] 10/13 10/13 11/1 11/20 11/21 14/1 14/15 15/4 17/13 19/10 33/8 33/22 51/10 51/11 73/2 73/22 73/22 83/20 83/24 86/18 92/21 96/15 97/25 98/22 99/2 99/3 111/16 163/22 163/24 174/17 177/10 197/18 197/20

S

staff... [1] 198/3
staffing [8] 74/1 162/12 162/19 163/11 164/3 164/7 166/6 180/4
stage [31] 37/2 38/3 48/9 53/24 55/16 61/6 62/2 65/7 65/13 70/11 77/19 79/3 84/9 84/10 84/16 87/23 91/9 99/8 101/14 101/18 112/20 117/11 118/19 122/1 122/18 123/1 123/9 135/22 139/17 180/6 182/15
stairs [1] 84/21
stakeholders [1] 148/22
stamped [1] 37/7
stand [1] 94/10
standard [3] 131/20 141/6 141/12
standardised [1] 142/10
standards [2] 163/20 166/4
standing [1] 109/23
start [5] 49/24 50/23 88/6 104/24 129/2
started [3] 32/25 42/19 111/21
starting [3] 13/14 30/6 97/24
state [1] 106/4
stated [4] 146/13 178/13 179/21 193/18
statement [52] 1/14 1/17 4/4 5/21 7/25 15/15 16/23 24/19 29/5 30/7 33/25 34/14 37/6 37/8 37/9 37/17 41/8 49/16 49/21 58/5 69/4 83/9 96/4 96/9 96/11 106/10 106/14 106/22 109/5 111/3 130/1 132/16 132/18 134/11 134/13 147/22 150/9 151/24 152/20 154/18 157/1 163/3 164/10 167/19 171/6 176/24 187/6 187/15 192/10 192/11 192/13 197/15
statements [5] 17/2 58/14 168/21 189/16 192/12
statistic [1] 152/16
statistical [1] 147/2
statistics [1] 152/6
stay [4] 22/22 71/12 88/12 89/9
stayed [2] 68/18 68/19
Staying [2] 7/22 8/8
steeped [1] 188/5
step [6] 31/12 47/2 88/13 89/15 94/15 198/1
Stephen [7] 94/10 95/4 95/20 151/7 179/2 180/7 195/20
Stephen Cross [6] 94/10 95/4 95/20 151/7 179/2 195/20
Stepping [5] 2/21 4/9 4/15 4/20 57/24
steps [8] 3/6 55/16 61/25 88/12 94/15 136/11 155/7 171/10
Steve [8] 85/8 100/10 138/10 144/22 165/6 188/4 189/12 189/13
stick [2] 61/9 61/9
still [21] 4/4 4/5 4/21 17/6 72/3 72/4 76/11 77/14 77/17 96/25 121/7 124/22 154/9 155/23 163/17 170/25 171/21 171/22 174/10 175/10 196/6
stock [1] 29/16
Stockport [8] 3/25 5/4 5/7 12/24 13/2 47/24 48/1 48/9
stoma [1] 125/7
stood [1] 17/5
stop [4] 88/5 88/23 93/10 191/10
stopped [1] 196/22
story [1] 114/8
storyline [1] 173/20
straight [1] 56/8
straightforward [1] 165/18
strange [2] 22/6 180/14
streamline [1] 7/7
stress [4] 52/2 126/21 126/24 189/11
stressed [2] 117/5 171/9
stressful [1] 80/18
stretched [1] 193/10
string [2] 162/11 162/18
strongly [2] 96/25 174/5
structure [8] 6/1 6/6 47/18 48/11 48/13 53/9 192/3 198/10
structures [1] 196/2
struggle [1] 38/7
struggled [1] 189/13
struggling [1] 180/8
stuff [3] 81/3 132/21 139/12
Subhedar [5] 24/14 28/2 28/13 39/15 178/13
Subhedar's [1] 24/25
subjected [1] 190/8
submit [1] 10/8
subscribe [1] 26/19
subscription [1] 167/6
subsequently [6] 1/24 43/3 50/4 79/14 111/21 137/4
subsided [1] 60/21
substandard [3] 81/2 81/5 81/6
substantiated [1] 189/19
substantive [1] 129/24
subtly [1] 197/22
succession [1] 66/3
such [16] 10/22 28/9 31/12 46/17 71/5 73/4 73/5 92/5 108/1 108/5 113/21 128/8 141/25 168/18 192/19 198/8
sudden [20] 8/23 15/13 20/24 31/17 45/1 55/7 55/22 56/22 61/11 69/16 75/9 79/21 79/25 94/17 140/14 140/23 141/4 141/23 142/4 152/9
suddenly [6] 59/21 71/24 78/21 88/5 88/6 94/16
SUDiC [1] 15/17
sufficient [2] 155/25 170/25
sufficiently [1] 9/9
suggest [5] 30/2 32/17 35/9 90/15 140/20
suggested [5] 11/19 98/4 116/2 181/16 199/3
suggesting [2] 33/11 182/4
suggestion [2] 169/25 181/12
suggestions [1] 182/8
suggests [2] 12/2 74/11
sum [2] 196/5 196/5
summarise [5] 44/15 87/14 110/10 111/9 157/22
summary [8] 6/2 62/21 65/21 109/18 110/12 178/3 178/3 183/9
superbugs [1] 145/13
superimposed [1] 153/2
supervision [1] 156/11
supply [1] 3/13
support [3] 19/22 88/19 193/13
supported [1] 173/11
supporting [1] 96/25
supportive [5] 172/20 172/23 173/2 173/5 174/10
suppose [21] 3/8 5/10 8/4 8/4 10/10 12/14 13/7 14/18 14/25 15/19 29/12 34/20 36/12 36/23 37/4 38/7 42/2 42/15 42/18 43/12 48/2
supposed [3] 15/2 101/12 107/9
sure [32] 10/19 36/24 43/7 46/4 52/15 56/21 57/4 59/11 74/7 75/7 75/23 78/8 81/4 82/25 86/5 92/3 99/9 100/13 106/23 120/6 135/8 152/6 152/17 154/11 154/15 157/3 157/6 168/2 168/9 184/9 185/9 188/6
surgeons [1] 71/23
Surgery [1] 129/18
surgical [3] 7/18 12/22 89/13
surprise [3] 175/9 178/24 188/17
surprised [2] 11/25 189/14
surveillance [1] 156/10
survivable [2] 89/20 89/23
Susannah [1] 129/16
SUSIE [3] 129/10 129/16 200/9
suspect [22] 52/3 54/13 54/17 54/19 54/20 55/1 55/4 55/24 56/2 56/24 65/9 65/10 65/22 66/8 68/24 70/11 70/13 71/17 72/2 72/4 72/20 75/24
suspected [4] 14/1 38/4 54/9 77/25
suspecting [1] 91/25
suspects [1] 133/2
suspicion [17] 36/22 42/11 42/14 54/11 54/14 56/2 56/3 91/17 91/18 91/19 91/20 96/18 118/12 123/25 134/4 162/14 162/14
suspicions [4] 38/5 40/1 120/2 148/18
suspicious [4] 29/23 30/2 38/18 163/15
Suzy [1] 165/7
swallow [1] 84/10
swallowed [2] 7/19 7/20
swipe [6] 84/18 84/19 85/4 85/12 104/3 104/5
swirling [1] 171/18
sworn [2] 49/9 200/5
symptoms [1] 124/3
system [11] 8/10 9/20 9/22 10/2 42/3 42/3 42/6 45/20 68/23 137/9 163/25

T

tab [2] 146/9 175/14
tab 11 [1] 175/14
tab 5 [1] 146/9
table [9] 7/15 12/18 19/23 29/5 47/21 109/12 109/23 109/25 190/19
take [35] 15/15 19/9 23/14 24/4 26/6 29/16 47/15 52/13 53/17 53/23 61/25 75/8 75/22 79/6 85/22 94/1 96/11 100/12 104/23 108/15 114/2 131/6 136/1 141/1 143/8 144/8 146/3 147/3 151/17 155/7 160/24 164/21 176/8 184/2 198/1
taken [17] 3/6 24/13 31/12 43/22 47/2 51/21 53/20 90/6 93/13 145/23 147/4 147/6 157/10 171/1 180/3 191/1 199/13
takes [1] 123/8
taking [14] 25/10 39/21 67/15 70/20 95/6 96/8 111/23 136/11 158/17 171/10 183/9 186/21 191/4 195/5
talk [18] 3/5 5/25 24/23 37/3 60/16 62/22 72/9 72/12 73/25 95/24 136/2 147/19 156/12 162/18 165/3 165/8 170/24 198/17
talked [5] 37/25 39/7 51/23 134/25 135/19
talking [20] 21/4 62/22 64/16 78/15 97/3 99/11 103/6 104/1 132/24 135/3

T

talking... [10] 135/6 143/9 143/10 144/3 150/12 156/24 175/24 181/21 181/23 182/18
talks [3] 22/1 35/18 78/18
tape [1] 95/24
taps [9] 65/13 65/15 65/18 65/24 76/11 91/13 91/13 121/5 121/6
target [1] 48/19
TC [1] 94/8
tea [1] 175/6
teaching [2] 28/7 153/16
team [13] 14/11 41/21 42/1 42/25 51/19 51/19 51/20 57/11 93/5 98/14 100/1 131/12 158/7
teams [5] 11/15 62/8 62/10 91/18 121/19
teams' [1] 8/20
tell [38] 5/11 6/10 7/24 16/24 17/15 17/20 18/24 26/25 28/3 30/7 30/12 31/23 32/22 37/8 40/23 50/19 51/13 69/13 83/14 96/10 106/17 116/24 117/18 129/20 130/7 130/12 130/13 131/10 131/22 132/13 132/15 135/18 151/4 162/7 169/7 176/23 181/25 187/2
telling [4] 40/10 78/2 78/10 116/14
Temporarily [1] 146/14
ten [2] 94/4 159/1
ten years [1] 159/1
tend [2] 10/11 198/19
tended [1] 18/19
terminology [2] 142/3 195/8
terms [34] 6/5 7/10 12/10 14/24 17/5 18/7 20/8 32/2 35/18 36/21 38/1 41/18 42/10 46/6 52/1 52/6 54/8 56/1 65/25 68/10 70/2 98/21 99/1 101/6 110/14 132/13 139/4 140/4 147/22 165/17 185/2 193/20 194/14 195/2
tertiary [4] 69/8 69/13 69/24 137/2
test [3] 27/5 198/13 198/13
tested [1] 171/20
text [1] 169/21
than [32] 2/11 4/15 6/24 11/4 16/15 24/5 31/15 36/20 36/25 47/3 48/12 48/12 56/18 59/15 60/5 65/18 70/18 70/20 92/1 108/12 118/18 152/16 154/20 157/25 162/23 163/22 164/3 169/25 170/19 180/20 195/21 197/20
thank [54] 1/6 1/9 1/12 3/21 7/9 21/20 23/14 24/18 47/11 47/14 48/14 48/16 48/23 49/19 62/17 79/6 82/2 83/4 92/8 93/8 94/1 96/12 100/5 100/16 101/24 104/7 104/19 104/22 105/6 106/6 106/6 108/19 126/8 126/11 128/2 128/18 128/21 128/23 128/24 129/3 129/12 133/10 134/21 149/23 151/21 160/18 162/17 175/23 199/5 199/10 199/11 199/12 199/15 199/20
thanks [1] 169/18
that [1311]
that February [1] 144/18
that January [1] 170/21
that's [74] 2/3 2/14 4/10 7/19 10/9 11/9 15/24 17/9 24/6 28/12 34/14 37/17 53/4 53/25 54/18 56/10 57/16 61/9 63/10 64/6 64/7 65/3 65/22 66/11 66/19 69/23 70/21 73/8 73/13 75/9 75/23 78/17 80/18 85/13 90/9 90/11 90/14 91/17 95/17 96/9 97/7 98/12 102/7 102/14 103/8 103/15 103/25 104/13 105/19 109/10 110/3 112/3 117/12 133/14 133/15 133/24 134/18 141/8 145/10 149/24 150/17 150/25 152/13 161/22 171/19 175/19 179/14 179/15 185/9 185/22 185/23 187/22 191/3 195/11
their [54] 10/21 13/10 26/2 34/6 34/16 42/10 43/19 46/22 64/13 72/12 82/12 82/15 88/3 88/17 90/23 92/6 96/7 97/8 106/22 106/22 107/16 107/16 107/17 108/4 109/16 110/18 114/2 123/25 124/3 125/6 125/7 125/17 125/24 126/4 136/10 137/20 138/20 139/16 147/14 147/23 148/4 150/3 153/20 163/5 163/15 165/9 166/5 167/13 167/17 168/22 178/9 190/9 192/18 192/19
them [67] 4/24 10/22 11/22 20/5 24/16 40/23 41/12 44/9 44/12 44/14 48/10 51/12 53/2 53/23 54/1 58/15 63/4 63/17 67/19 71/20 80/11 80/15 80/16 81/8 82/11 82/20 82/21 88/18 89/12 89/24 90/2 90/11 91/6 105/11 107/3 107/10 107/12 111/5 116/21 117/18 117/24 125/8 135/8 136/2 139/6 139/17 143/2 145/17 145/18 145/19 147/12 147/13 148/6 148/11 149/10 151/18 152/16 154/11 156/6 159/25 165/4 168/21 169/3 173/7 177/1 180/9 195/11
thematic [5] 39/14 74/16 75/3 75/4 152/10
theme [4] 75/8 75/9 75/18 98/23
themselves [3] 42/4 173/9 196/19
then [89] 2/8 7/18 15/4 27/9 32/19 33/4 33/6 38/17 41/1 42/18 42/21 43/14 44/5 46/2 48/10 56/9 57/18 73/14 77/13 77/14 83/12 84/20 88/5 88/20 89/15 90/18 95/15 98/16 98/17 99/12 99/13 99/21 100/8 101/2 101/5 101/9 102/21 102/22 104/17 104/24 105/22 105/24 107/7 110/15 113/8 129/3 129/23 130/17 134/20 138/6 138/19 140/9 142/10 145/19 147/19 150/16 153/21 154/6 156/9 157/4 158/6 158/17 163/1 165/19 166/18 170/22 174/25 177/19 177/20 178/18 180/16 180/22 180/23 181/20 182/2 182/2 182/6 182/6 182/8 185/2 186/20 187/2 187/25 193/6 193/25 195/14 195/17 196/14 198/23
there [272]
thereafter [2] 135/18 183/1
therefore [9] 16/13 17/4 29/14 42/1 46/19 131/15 154/24 156/2 163/13
these [61] 19/20 22/13 33/5 35/22 44/10 46/2 55/1 64/14 66/11 70/22 73/3 83/21 85/16 88/8 88/10 88/13 88/15 89/16 89/23 91/4 91/7 91/16 93/19 93/19 94/16 98/19 99/11 99/13 101/10 102/1 102/2 110/13 112/12 112/13 112/15 117/23 123/4 123/12 123/19 127/14 127/19 128/10 132/12 143/8 152/9 159/6 163/14 173/16 174/14 174/22 176/13 176/14 177/15 178/21 182/4 184/5 185/2 186/6 191/4 196/15 197/3
they [220]
they've [1] 190/11
thing [21] 6/11 26/4 28/15 36/5 43/23 46/20 54/21 56/9 92/6 94/11 95/8 97/1 99/22 107/4 112/3 128/13 132/21 132/22 147/18 148/9 194/6
things [41] 7/21 9/5 10/10 12/12 18/7 27/19 33/20 36/21 52/12 52/13 53/13 54/23 55/3 61/4 65/18 65/24 66/24 72/25 83/18 84/6 89/13 107/11 108/8 108/9 110/2 127/8 127/13 128/5 131/21 132/21 145/13 146/4 157/20 168/8 168/13 168/18 174/8 187/7 191/4 194/24 196/16
think [241]
thinking [41] 14/14 29/17 31/20 38/13 47/23 56/1 56/5 57/20 58/19 60/3 60/4 61/14 63/20 65/17 65/23 66/8 66/9 66/16 66/18 66/20 72/4 73/14 75/24 76/3 76/11 76/13 76/13 84/2 94/25 97/5 118/10 122/18 127/8 127/9 140/17 163/7 171/2 173/14 181/3 185/3 197/14
third [5] 65/1 86/12 102/13 179/19 193/6
thirds [1] 103/13
THIRLWALL [4] 47/13 126/10 200/4 200/8
this [227]
thorough [1] 194/25
those [54] 3/12 4/24 12/12 17/15 20/4 20/4 20/9 20/11 20/19 35/5 39/25 41/14 41/24 42/7 42/18 47/12 56/22 57/7 58/15 61/1 63/14 66/4 66/17 68/14 68/16 70/9 75/16 86/3 88/22 89/24 98/25 99/10 101/10 101/13 101/18 105/10 120/9 120/24 121/12 131/20 145/5 146/19 161/7 164/15 166/15 167/12 168/17 172/16 177/14 180/19 190/7 193/17 194/9 196/24
though [16] 62/4 65/15 77/11 84/10 119/22 132/14 135/17 170/12 182/22 183/5 187/5 187/18 190/20 191/14 198/22 199/2
thought [68] 4/25 5/10 5/15 6/11 11/20 16/14 24/10 29/10 31/6 31/17 34/20 40/22 41/24 51/10 51/17 53/17 57/1 57/2 62/11 63/22 66/22 78/24 79/1 79/2 79/4 81/3 81/11 81/24 82/8 84/14 86/23 87/23 91/18 93/3 93/18 96/20 97/7 101/9 112/3 113/21 113/25 115/23 116/7 118/6 140/13 145/13 145/15 145/19 148/6 148/8 152/4 155/4 156/25 157/18 157/18 157/19 158/12 162/6 162/24 163/5 163/9 163/14 180/15 181/7 181/13

T

thought... [3] 184/2 187/10 198/9
thoughtful [1] 47/15
thoughts [8] 19/23 26/3 45/16 79/3 85/16 87/13 113/21 145/9
thread [1] 93/9
threads [1] 198/25
threat [2] 14/2 120/10
three [18] 23/11 23/23 23/24 24/1 24/5 24/10 25/18 25/24 33/24 35/6 35/8 37/15 63/17 66/2 75/22 105/22 131/25 138/20
three days [2] 23/23 37/15
throat [1] 175/23
through [22] 53/21 63/21 64/9 76/14 85/17 106/7 115/17 117/14 129/3 136/25 139/6 142/2 142/6 149/15 151/1 154/25 156/12 182/24 185/17 188/2 191/17 195/5
throughout [1] 140/23
throwing [1] 156/17
Thursday [3] 1/1 28/6 146/10
tiers [2] 7/8 13/8
Tighe [1] 137/25
time [163] 2/13 4/20 5/16 6/3 6/13 6/20 8/6 8/13 8/24 9/5 12/15 12/17 14/15 14/19 15/17 16/6 16/9 18/18 20/23 21/2 21/7 21/11 21/13 22/12 23/16 24/25 26/11 26/22 29/1 29/17 29/23 31/3 31/18 34/4 34/19 35/14 36/5 36/14 37/9 39/22 41/1 41/24 42/15 42/18 42/18 42/19 43/6 44/21 47/9 52/5 56/12 57/15 58/3 58/17 58/18 59/13 59/15 59/16 60/3 60/7 60/9 60/21 61/20 63/3 63/23 66/16 67/24 69/12 70/17 71/16 72/23 75/13 75/21 75/22 76/18 77/23 79/4 79/19 83/19 84/2 85/2 89/2 91/11 93/21 95/1 95/6 95/22 96/6 97/2 97/9 102/5 102/9 107/8 111/8 111/9 112/4 112/6 114/2 116/9 122/13 127/22 132/14 134/8 135/3 135/5 135/10 135/14 135/16 137/3 137/5 137/25 139/15 141/3 142/17 143/7 143/20 144/4 144/11 144/16 145/24 146/12 148/17 151/18 153/19 154/2 154/4 155/21 157/22 158/13 159/20 160/24 169/15 170/9 171/14 171/17 171/21 172/5 172/21 173/23 174/17 176/17 178/9 179/8 179/15 186/23 187/20 188/18 188/24 189/7 189/8 189/10 189/18 190/9 190/25 191/4 191/7 194/3 194/6 196/10 196/23 197/12 199/8 199/14
time of [1] 58/17
timeline [5] 4/14 13/14 108/17 114/16 187/3
times [5] 68/16 83/7 139/14 163/22 183/25
timescale [1] 139/6
timescales [1] 156/24
timing [1] 163/15
timings [1] 67/8
tired [1] 125/16
today [6] 1/4 17/7 48/20 118/21 149/17 199/14
toe [1] 170/22
together [25] 13/23 15/21 19/13 19/14 20/13 20/17 23/6 24/11 26/1 35/18 37/3 42/7 63/14 66/23 70/16 87/13 96/21 96/24 100/21 158/4 159/21 189/25 190/21 198/10 198/25
toiled [1] 156/24
told [46] 11/21 18/14 27/2 31/9 31/12 42/9 42/22 43/2 51/11 54/22 61/17 65/6 71/14 73/1 74/1 76/22 82/7 82/11 83/11 93/1 95/1 102/20 110/17 111/2 115/18 116/1 116/17 116/18 118/22 126/16 126/17 129/1 144/21 146/4 146/4 147/7 148/12 148/13 151/4 151/13 166/22 166/23 176/19 177/20 179/16 180/16
tomorrow [2] 199/16 199/17
Tony [10] 52/17 94/8 109/11 109/23 151/6 155/13 176/1 179/1 180/7 195/20
Tony Chambers [7] 52/17 94/8 109/11 151/6 155/13 176/1 195/20
too [4] 26/19 175/24 178/13 197/8
took [11] 3/25 7/24 19/7 24/23 33/16 41/5 74/17 107/19 145/23 180/12 192/16
Tool [1] 131/19
top [10] 23/19 25/9 29/5 47/20 64/22 65/1 92/18 94/7 97/23 191/12
topic [2] 4/19 54/4
torn [1] 173/9
touch [2] 43/4 154/10
towards [3] 27/3 109/21 140/20
towel [2] 125/7 125/23
train [1] 50/4
trained [2] 84/3 167/25
trainee [3] 140/22 154/10 154/14
trainees [2] 19/11 22/15
training [23] 1/24 2/7 9/15 9/16 13/16 13/18 13/21 13/25 14/5 49/25 50/9 54/5 54/8 54/12 54/17 54/20 55/6 140/4 140/5 145/10 154/16 167/10 170/17
transferred [2] 30/19 157/10
transient [2] 122/22 122/23
translation [1] 196/17
transpired [3] 113/22 136/25 177/19
traumatic [2] 17/12 19/21
traumatised [1] 173/8
treated [3] 62/12 155/22 192/5
treating [1] 111/11
treatment [2] 145/21 155/21
treatments [1] 3/10
trend [1] 153/4
trends [7] 42/4 42/7 68/22 77/12 77/14 77/15 77/16
trial [1] 26/16
tried [2] 18/25 19/11
trigger [1] 64/7
triggered [1] 43/20
triplets [1] 131/25
troubleshooting [1] 153/22
troubling [1] 174/14
true [6] 1/17 12/19 49/21 130/4 171/23 195/12
trust [35] 4/1 4/11 34/11 41/2 81/6 85/12 107/15 107/21 107/23 108/4 108/7 112/24 113/2 114/8 128/8 136/10 136/10 136/13 140/5 147/15 159/2 161/3 163/8 165/19 166/5 171/9 175/17 177/9 177/18 178/7 184/12 186/14 187/17 187/20 197/11
Trust's [1] 115/2
truth [1] 178/23
try [8] 58/9 61/25 64/13 87/12 166/5 184/5 191/21 191/23
trying [20] 14/20 16/2 47/4 62/6 62/8 62/10 72/18 73/14 104/20 104/20 113/16 113/23 113/24 127/24 171/25 174/21 182/5 185/13 192/3 193/9
turn [8] 5/21 7/25 11/9 13/13 25/6 58/4 61/18 83/9
turned [2] 174/6 174/24
TV [1] 100/2
twice [3] 65/3 68/15 127/17
twin [1] 66/3
twins [2] 59/10 59/10
two [31] 6/15 13/14 48/12 66/17 68/14 68/19 73/12 83/12 84/16 85/10 88/12 94/15 98/19 101/13 101/18 103/13 111/19 113/11 115/22 116/20 127/17 128/5 131/25 154/5 155/18 157/20 160/20 165/2 165/6 174/8 186/20
two days [1] 115/22
two months [2] 68/14 68/19
two weeks [2] 101/13 101/18
two-thirds [1] 103/13
tying [1] 135/18
type [2] 60/25 65/19
types [2] 60/24 173/17
typically [1] 140/21

U

Uh [1] 39/20
Uh-huh [1] 39/20
UK [3] 84/3 84/3 84/5
unaware [1] 122/24
uncertainty [1] 171/22
uncomfortable [1] 158/6
uncomfortableness [1] 158/10
uncommon [3] 69/21 69/22 191/9
under [15] 14/20 41/23 52/2 74/2 110/1 119/9 119/11 119/12 119/16 119/18 126/21 126/24 134/4 175/18 188/14
undergo [1] 178/16
understaffed [1] 52/4
understand [34] 10/4 15/10 16/2 16/3 17/4 18/6 21/10 34/25 45/18 47/21 47/22 54/24 55/22 56/20 57/6 58/7 64/13 64/15 71/9 80/24 84/22 94/10 102/11 113/13 118/1 135/15 137/15 138/3 152/8 157/15 165/22 179/5 180/12 185/11
understanding [15] 8/12 15/16 55/9 55/13 55/24 113/15 113/17 140/9 141/9 150/1 173/4 176/4 179/10 180/24 181/19
understands [1] 105/18
understood [9] 55/11 72/5 98/18 106/17 132/7 179/13 179/14 179/15 184/1
undertaken [2] 41/12 176/12
undertaking [1] 153/18
undertook [1] 1/24
underwent [1] 13/20
unexpected [71] 8/23 15/13 16/8 16/10 16/12 16/15 18/3 18/8 31/17 45/2 45/5 55/7 55/12 55/22 56/22 57/12 57/17 58/19 61/12 69/9 69/14 70/6 75/10 75/19 75/20 79/21 80/1 88/1 88/13

U

unexpected... [42] 88/21 89/15 90/1 90/9 90/12 90/18 90/21 90/25 91/11 93/20 96/14 112/1 112/12 112/16 117/24 123/5 123/6 123/13 124/7 124/21 124/23 131/1 140/10 140/14 140/24 141/4 141/16 141/18 141/23 142/4 144/2 144/5 144/8 152/2 152/9 152/12 161/7 161/8 164/13 164/15 176/5 190/2
unexpectedly [1] 78/21
unexplained [35] 16/16 70/6 90/19 90/21 91/1 91/8 91/11 93/20 96/14 111/25 112/1 112/13 112/15 123/5 123/6 123/13 124/8 124/24 131/1 140/11 140/14 141/16 141/18 141/23 142/5 144/2 144/5 144/7 152/3 152/13 165/13 165/20 176/5 178/15 198/7
unfair [2] 162/18 164/7
unfolding [1] 181/17
unforgiveable [1] 142/21
unfortunate [1] 20/12
Unfortunately [1] 97/2
unfounded [1] 193/11
unhappy [1] 81/11
unhelpful [3] 152/4 152/5 164/18
uninvestigated [1] 156/7
union [3] 135/1 135/24 135/24
unions [2] 135/20 135/23
unit [86] 2/12 7/12 8/23 17/9 22/18 28/10 29/18 31/6 33/7 34/5 34/9 34/24 42/25 44/3 44/8 45/17 46/1 51/15 52/17 55/10 65/13 65/18 66/1 68/1 68/13 68/14 69/8 69/13 70/25 71/16 76/8 76/17 77/9 78/4 80/21 84/17 84/20 85/2 86/1 88/2 88/10 88/12 90/5 96/23 98/5 98/7 101/4 104/2 108/22 112/10 113/5 121/24 123/3 124/12 124/17 127/24 130/9 130/15 130/19 131/6 137/2 143/24 144/10 146/12 146/15 147/11 148/4 151/14 153/15 153/17 154/23 155/24 156/10 156/19 158/1 162/11 163/21 170/16 170/25 171/24 172/13 173/6 175/7 176/6 193/10 198/15
United [1] 50/5
United Kingdom [1] 50/5
units [9] 66/6 69/24 71/20 89/5 89/12 89/18 90/3 163/13 164/5
University [2] 129/19 153/16
unknown [1] 163/16
unless [4] 7/25 77/17 141/21 166/25
unlikely [1] 163/13
unmanageable [1] 153/6
unnatural [2] 29/24 47/5
unprofessional [1] 193/11
unrecognised [1] 90/13
unredacted [2] 166/19 176/21
unreliable [1] 91/22
until [12] 26/15 50/16 64/8 65/20 73/6 73/6 88/4 91/8 143/21 143/22 191/9 199/22
until June [1] 50/16
untoward [1] 154/12
unusual [7] 17/8 28/9 56/3 58/21 66/23 66/24 69/20
unwell [5] 16/13 52/5 68/25 79/4 90/4
up [58] 3/25 5/21 7/15 7/20 7/25 10/9 11/9 12/19 13/9 22/22 23/15 23/24 25/4 26/16 30/6 34/10 41/25 44/23 45/20 46/13 46/13 50/15 52/13 53/23 68/21 77/15 78/16 79/17 81/20 83/10 86/7 89/15 93/8 96/6 97/8 97/11 105/9 111/5 112/23 122/11 130/16 146/8 153/20 156/17 156/25 160/16 164/20 166/16 169/2 170/20 174/6 174/24 176/19 185/15 186/9 190/18 191/3 194/24
update [1] 161/24
upheld [1] 189/18
upon [6] 27/19 29/10 51/14 57/7 112/19 173/24
upset [3] 23/5 80/19 184/17
urged [1] 184/5
urgent [5] 6/4 7/20 41/25 48/12 142/7
urgently [1] 30/13
us [109] 5/11 6/10 7/14 7/24 16/19 16/24 17/4 17/15 17/19 18/24 24/9 26/21 28/3 28/25 30/7 30/12 31/23 32/22 37/8 43/14 44/13 48/20 49/12 49/20 50/15 50/19 51/13 51/17 52/2 53/3 56/15 59/6 61/17 65/12 68/14 69/13 71/14 77/9 77/10 82/7 83/11 83/14 89/9 92/16 92/18 92/24 94/14 95/1 96/10 96/21 96/21 96/24 98/15 98/16 101/2 102/20 103/15 103/25 106/17 107/7 107/18 107/19 109/19 111/2 111/9 113/17 113/25 114/15 115/18 116/1 116/17 116/18 129/14 129/20 130/1 130/7 131/10 132/15 134/5 135/18 147/11 147/21 151/4 155/10 156/12 159/19 162/4 162/7 164/5 164/8 165/7 165/19 169/7 170/10 170/19 171/18 172/10 172/11 176/8 176/10 176/23 180/14 182/21 184/5 184/14 188/11 190/8 193/2 194/9
use [7] 13/2 94/13 111/2 140/18 163/5 163/25 185/6
used [14] 5/12 33/22 53/2 53/13 53/22 94/14 116/3 128/8 128/10 140/6 152/23 166/5 176/1 180/5
useful [1] 152/18
uses [1] 130/12
using [4] 4/16 57/25 103/15 156/10
usual [3] 8/2 90/12 125/20
usually [23] 53/22 57/11 57/13 60/23 61/1 61/5 61/5 66/24 81/15 81/16 88/23 89/3 89/18 89/23 90/2 90/3 90/11 91/6 123/6 124/14 124/20 124/22 141/11
utility [1] 45/16

V

V's [1] 60/11
value [2] 45/17 167/20
valued [1] 165/8
vans [1] 95/25
variations [1] 147/2
various [7] 62/6 88/7 121/19 135/23 147/2 151/16 165/10
ventilator [1] 88/2
ventilators [1] 22/20
verbal [1] 177/17
verdicts [1] 159/4
versed [1] 181/6
version [5] 160/12 160/25 161/12 178/23 189/15
versions [2] 160/20 191/5
versus [5] 46/20 95/10 98/13 100/25 106/24
very [99] 1/9 3/21 7/23 9/7 16/9 17/8 17/12 17/15 19/20 20/12 20/23 21/8 22/5 22/15 22/15 23/11 29/22 33/7 33/7 36/3 36/10 36/10 36/12 43/22 45/5 45/13 45/24 46/7 47/11 47/15 48/14 48/23 49/19 50/25 51/2 51/4 62/17 64/11 67/24 80/18 88/18 89/21 90/1 90/4 90/4 92/3 92/8 92/19 96/12 97/23 100/5 104/7 104/22 106/7 107/13 108/9 108/19 115/17 119/6 125/1 126/11 128/3 128/6 128/21 128/23 129/12 139/3 139/5 140/18 143/16 143/20 143/22 145/14 145/23 146/3 156/21 156/23 157/17 158/4 163/21 165/7 170/10 171/5 171/9 173/4 173/23 174/5 180/8 180/19 186/6 188/12 191/9 193/8 196/15 198/15 199/5 199/11 199/12 199/20
via [1] 197/10
view [28] 3/12 12/24 14/7 14/15 14/24 18/14 18/18 21/8 22/23 31/20 40/5 51/14 52/7 66/13 87/6 106/22 120/5 154/13 154/14 163/10 163/17 166/5 168/9 181/12 185/22 191/24 193/13 198/6
viewed [1] 42/8
views [3] 100/11 111/23 173/23
Viner [1] 164/25
visible [2] 13/12 194/21
visits [1] 140/1
voice [5] 7/15 12/18 48/3 109/12 171/3
voiced [1] 178/8
volition [1] 119/16
volunteer [1] 119/15
vomiting [1] 88/6
vulnerable [1] 14/16

W

waiting [1] 86/13
walk [1] 13/9
walked [2] 52/17 183/16
want [28] 5/21 8/1 11/9 26/11 26/25 56/16 71/6 83/1 83/9 94/11 106/13 125/1 127/25 128/4 128/5 128/11 128/13 128/19 132/24 137/12 154/14 155/6 155/22 168/17 168/20 190/15 194/8 194/12
wanted [17] 8/17 17/20 18/4 34/6 34/16 40/6 45/6 74/22 79/24 84/6 98/24 110/17 134/8 156/1 166/4 185/24 188/13
wanting [2] 156/6 170/13
wants [1] 158/16
ward [32] 7/24 14/12 59/25 64/10 71/1 84/21 85/3 85/4 85/7 85/8 93/16 96/22 101/3 112/5 112/7 112/9 112/19 120/15 120/18 121/3 121/14 122/25 153/5 153/18 153/24 154/2 154/4 154/5 154/7 154/8 154/9 166/7
wary [1] 178/22
was [709]

W

was December 2016 [1] 175/3
wasn't [35] 12/1 12/14 24/9 25/20 26/15 40/2 40/5 52/15 72/24 73/10 81/4 104/19 117/10 120/22 127/24 131/14 138/5 141/18 150/18 152/11 155/4 157/6 157/11 171/7 172/11 172/16 176/1 181/10 182/7 182/24 184/9 188/14 190/25 196/16 198/8
watchful [1] 86/13
water [1] 175/22
way [41] 1/11 7/17 14/14 14/19 27/24 42/5 42/12 42/23 46/12 62/21 74/2 76/5 80/14 84/15 94/13 95/8 98/18 102/13 103/13 108/5 112/21 112/21 112/22 113/22 116/3 120/3 120/8 128/8 128/9 131/19 135/11 140/19 155/1 162/24 178/6 181/16 182/24 185/6 185/13 193/23 196/1
ways [4] 84/16 145/19 156/18 191/5
we [633]
We talked [1] 134/25
we'd [2] 197/22 197/22
we'll [1] 102/21
weapon [2] 3/2 4/17
website [3] 107/23 148/10 148/13
Wednesday [2] 28/6 105/15
week [6] 26/14 65/3 68/5 86/15 86/20 165/3
weeks [9] 68/13 68/15 77/9 81/23 101/12 101/13 101/18 146/16 154/6
welcoming [1] 13/8
welfare [1] 31/8
well [72] 9/25 19/24 21/15 22/16 25/24 32/14 41/21 42/24 46/15 59/9 61/8 61/24 66/18 66/19 70/13 71/1 75/19 76/9 76/19 79/20 81/22 82/14 82/16 84/11 85/3 87/6 88/4 88/6 88/11 88/19 89/2 90/15 91/1 92/4 95/13 97/1 97/4 98/12 100/2 100/25 106/23 107/1 107/9 112/3 113/25 114/4 117/23 118/3 118/5 120/9 121/5 122/8 122/18 124/6 127/12 127/21 128/6 138/23 148/7 150/10 151/11 156/18 157/19 167/12 170/15 177/4 181/6 188/12 195/23 196/4 197/4 199/9
well-being [1] 25/24
Wenham [1] 182/25
went [14] 6/24 6/25 19/24 34/20 42/18 48/5 97/3 107/17 115/14 164/23 174/19 179/9 187/7 187/12
were [398]
weren't [15] 8/24 20/4 70/15 70/16 80/23 99/9 99/9 120/6 122/5 148/24 154/3 154/3 167/1 168/24 171/7
what [298]
what's [3] 162/1 171/23 185/14
whatever [2] 42/6 185/6
WhatsApp [1] 111/7
when [118] 4/15 4/23 6/3 7/16 8/13 9/5 10/5 12/3 33/5 33/23 34/7 35/9 35/15 36/20 37/11 37/20 39/16 41/3 41/5 41/16 43/2 47/16 48/4 51/5 53/25 54/12 54/14 54/20 55/11 55/16 56/22 57/10 57/14 57/19 59/7 59/10 63/7 63/13 63/20 63/21 66/24 67/19 67/21 68/17 68/22 69/19 71/10 75/19 75/23 77/11 79/7 84/2 84/4 87/23 90/24 91/3 91/25 95/7 96/13 96/21 98/11 99/10 101/9 102/5 103/24 105/8 106/19 106/20 107/13 107/20 107/24 113/22 115/13 116/20 116/22 117/23 118/7 119/8 120/14 121/9 123/2 124/14 127/7 130/7 130/9 133/13 136/12 139/19 139/23 141/3 143/8 143/22 144/16 144/20 144/21 144/25 145/3 145/4 146/12 148/24 149/1 158/4 159/4 159/7 160/11 162/5 174/19 174/24 179/10 182/6 184/15 185/10 187/13 189/15 191/17 192/14 194/24 196/11
where [49] 7/1 9/7 10/17 14/12 24/20 25/17 25/20 36/13 38/4 48/18 51/17 54/9 54/25 55/1 56/3 56/3 57/2 57/25 69/24 70/24 70/24 74/25 79/14 80/24 89/4 90/14 98/3 104/20 110/16 132/10 136/7 138/14 140/10 140/21 145/8 147/13 148/4 152/11 153/19 157/17 168/19 168/25 179/14 186/11 187/3 189/24 192/4 197/16 198/9
whereas [6] 15/2 46/22 56/13 61/4 113/22 118/19
wherever [1] 141/15
whether [68] 5/11 5/13 6/10 6/23 9/4 19/6 22/13 28/16 30/22 42/20 43/6 43/9 45/19 46/1 46/1 55/9 56/14 56/16 57/4 57/4 58/2 61/15 61/16 62/3 62/7 62/10 63/19 63/19 71/2 72/16 74/7 74/12 75/2 76/14 79/13 79/14 79/15 79/18 81/4 93/4 93/24 95/3 95/21 95/22 101/16 101/16 103/10 106/1 106/2 107/8 107/17 108/3 111/20 112/6 118/5 118/10 126/25 132/6 144/4 148/19 152/8 152/9 160/9 160/9 171/8 178/4 184/25 185/21
which [115] 2/13 3/10 6/8 8/19 10/10 16/23 21/24 24/20 24/23 29/20 30/7 33/20 33/21 33/22 37/15 37/22 38/24 38/24 47/21 52/11 53/21 54/24 55/13 55/21 56/12 57/11 57/14 60/1 60/4 60/6 60/21 61/4 62/15 65/19 66/10 66/24 67/13 69/15 69/20 70/4 72/5 73/9 73/22 77/6 78/18 82/10 83/7 83/8 84/18 84/21 85/24 87/21 88/8 89/10 89/11 89/12 89/20 89/25 90/18 90/21 90/25 93/21 95/12 99/5 100/21 100/21 105/17 106/25 107/21 107/23 108/2 108/2 108/8 108/10 108/13 109/6 115/19 115/23 116/2 116/6 116/13 117/2 122/2 122/12 122/13 122/19 123/8 125/9 131/19 131/19 131/22 131/23 135/12 140/19 140/21 142/6 145/13 146/24 149/16 151/10 153/16 162/11 162/24 163/23 165/19 170/20 172/19 175/1 175/1 180/19 181/23 182/9 182/12 195/9 196/1
which December [1] 175/1
while [4] 88/17 101/8 133/11 150/16
whilst [6] 2/15 2/23 7/13 13/19 38/3 39/3
whistleblower [1] 112/21
whistleblowing [5] 132/7 132/11 132/17 134/25 135/19
who [76] 4/24 10/16 15/17 21/16 24/14 28/21 32/25 35/4 35/11 39/6 40/18 40/22 41/20 47/4 52/14 52/15 52/15 52/18 56/6 56/20 59/13 66/4 70/12 70/19 72/16 72/22 78/21 83/16 83/20 84/18 84/23 85/2 88/1 88/4 88/6 88/9 88/25 91/18 93/1 93/7 98/15 104/2 108/21 109/9 120/9 123/24 132/1 134/5 139/9 139/10 139/13 139/17 142/15 142/19 147/10 147/23 148/15 149/14 149/16 153/23 154/22 155/20 158/8 160/5 172/4 172/7 179/16 179/17 185/7 187/11 189/12 190/8 193/9 193/11 195/16 196/24
Who's [1] 175/20
whole [6] 53/8 131/12 142/6 184/22 189/11 191/17
whom [4] 6/22 32/23 83/15 192/16
whose [7] 10/4 16/5 16/5 154/21 166/23 196/9 196/10
why [49] 14/22 14/22 14/23 17/6 24/9 25/19 37/2 45/19 61/9 64/7 64/7 66/11 69/7 69/8 70/8 70/21 71/24 80/18 85/13 89/6 90/11 93/20 95/10 96/10 96/24 97/7 102/16 102/18 102/19 102/23 102/23 109/9 112/12 117/2 117/12 117/19 117/21 118/17 122/10 123/21 127/3 128/12 152/5 158/15 162/5 175/20 181/21 193/2 197/1
wide [1] 194/17
wide-ranging [1] 194/17
widely [1] 71/16
wider [3] 92/5 143/17 157/8
will [92] 5/18 8/1 10/19 20/2 20/20 22/24 26/6 26/23 48/24 51/9 54/2 57/18 60/13 61/18 64/19 71/8 72/8 73/8 75/8 75/21 75/23 75/25 77/14 77/24 78/7 78/16 81/17 85/15 85/23 93/9 93/15 95/11 95/12 95/13 95/16 95/25 96/1 96/3 96/20 96/21 97/9 98/3 100/12 101/2 101/3 101/5 102/22 102/22 104/14 104/17 104/22 104/23 104/24 104/25 105/15 105/15 106/25 108/25 109/1 115/17 124/5 126/21 126/24 126/25 127/1 128/16 129/1 129/2 129/3 133/7 133/8 147/7 147/10 147/13 147/13 151/20 159/3 160/16 160/22 161/20 164/25 168/7 176/15 177/13 177/25 185/7 185/9 186/9 190/18 197/8 198/24 199/18
Wirral [2] 153/15 184/8
wisdom [1] 169/15
wisely [1] 164/1
wish [1] 197/5
wished [1] 199/9
withdraw [1] 90/7
within [23] 3/9 4/10 4/19 6/23 11/7 14/8 16/9 16/10 16/14 56/7 56/20 105/10 107/22

W

within... [10] 136/9 136/13 137/14 139/10 145/12 164/6 173/7 177/9 195/2 196/5
without [12] 11/22 19/17 51/12 59/12 96/8 109/15 111/23 112/15 113/5 144/4 168/21 174/3
witness [32] 1/4 1/14 1/17 4/3 4/24 5/21 7/25 15/14 16/23 24/19 29/5 30/6 34/14 37/8 41/8 49/5 49/16 49/21 69/4 83/8 96/4 96/9 96/11 104/10 106/10 106/14 109/5 111/3 114/24 114/25 115/14 128/25
witnessed [2] 20/25 197/24
witnesses [1] 124/7
women [1] 195/12
Women's [6] 2/2 7/16 24/15 48/9 138/17 184/7
won't [2] 98/1 190/16
wonder [4] 5/12 21/21 103/4 126/13
wondered [7] 31/13 47/25 102/17 102/23 132/19 184/23 184/25
wondering [1] 74/12
word [11] 7/19 9/21 13/3 98/1 98/20 100/13 106/23 107/16 111/2 152/23 171/20
words [7] 8/12 80/23 81/1 103/17 103/18 144/2 175/25
work [20] 10/3 10/21 47/4 67/20 73/25 88/9 101/15 104/20 145/25 153/24 157/10 166/2 170/12 171/11 173/1 174/22 185/7 186/23 196/2 199/2
worked [10] 11/20 19/10 51/10 51/18 96/17 139/16 153/15 153/15 174/4 191/8
workforce [1] 174/8
working [19] 2/11 2/15 13/23 15/21 16/9 16/10 16/14 35/18 41/5 50/20 70/14 85/9 131/12 139/11 144/9 149/8 157/4 170/18 198/10
workload [1] 153/6
world [2] 136/21 157/8
worried [15] 24/2 63/4 65/2 65/5 66/4 69/13 82/8 99/1 99/2 108/22 116/15 122/10 147/21 172/18 173/18
worries [2] 132/12 137/18
worry [5] 20/9 91/12 96/18 122/9 183/20
worrying [4] 60/25 69/10 81/9 91/16
worse [2] 61/2 147/24
worst [1] 195/18
would [193] 3/10 8/4 8/5 8/9 8/20 8/25 9/2 9/3 9/3 9/12 10/11 10/18 10/21 10/23 10/23 11/1 11/17 11/23 13/9 13/9 14/11 15/1 15/10 16/19 17/24 18/1 18/1 18/4 20/17 23/7 24/4 25/10 26/19 27/21 31/11 31/13 32/20 41/6 41/10 41/22 41/24 43/14 43/23 44/12 45/3 45/15 45/19 45/21 45/23 46/1 46/5 46/25 48/18 49/7 52/18 53/17 53/19 53/21 55/21 57/2 57/2 61/14 61/15 66/22 67/19 68/14 68/16 68/16 68/19 68/24 69/18 69/19 70/3 73/15 76/3 77/9 77/10 77/12 77/15 77/16 81/7 82/4 85/8 88/20 93/22 96/25 98/14 98/17 99/21 101/19 107/25 113/1 113/3 113/4 113/11 114/18 117/9 118/2 118/2 118/2 119/14 122/9 125/23 126/3 126/7 127/6 127/16 127/22 132/22 135/8 137/10 137/15 139/21 140/16 140/18 140/19 140/21 141/6 141/10 141/13 142/1 142/2 142/6 142/6 142/9 142/10 143/9 143/10 143/13 143/15 143/17 143/19 144/8 144/12 148/6 148/9 150/1 153/13 154/9 154/10 155/2 155/6 155/7 155/22 157/6 157/18 157/19 157/19 159/7 163/5 163/10 163/14 163/22 164/4 164/6 165/21 166/14 166/19 167/24 168/9 168/10 168/17 171/8 173/19 174/1 174/10 174/24 176/3 176/10 177/18 178/2 179/23 179/24 183/16 183/20 184/9 185/7 185/15 186/13 190/13 190/17 190/21 191/22 194/5 194/12 195/3 195/24 196/22 198/22 199/1 199/3 199/6 199/8
wouldn't [30] 20/16 25/18 35/13 53/20 77/25 114/2 114/2 125/24 131/15 131/16 140/1 141/5 141/11 141/12 141/21 141/22 144/6 144/10 156/1 160/8 166/13 166/21 168/20 170/22 172/14 175/9 179/12 181/25 188/23 198/20
wrapped [2] 125/8 125/22
write [1] 73/14
writing [3] 110/2 135/6 190/24
written [4] 115/22 140/19 162/24 176/3
wrong [5] 55/4 127/10 137/8 164/11 191/13
wrongdoing [1] 15/3
wrongly [2] 41/24 118/10
wrote [4] 37/8 37/11 91/21 169/10

X

X-ray [3] 168/14 168/15 168/17

Y

year [7] 4/16 70/5 90/24 115/19 132/15 143/4 175/1
years [4] 131/22 146/21 159/1 159/2
yes [290]
yesterday [4] 86/25 147/4 153/10 162/13
yet [2] 72/5 115/10
you [1134]
you that [1] 176/15
young [1] 191/11
your [195] 1/18 1/21 3/22 4/3 4/6 4/14 4/25 5/21 6/10 6/18 6/19 7/24 8/12 8/12 9/18 9/24 10/15 11/4 11/8 11/18 11/23 12/4 12/8 13/1 13/3 15/14 15/16 16/20 16/23 17/5 17/15 17/19 18/10 22/12 23/1 24/19 28/3 28/12 28/12 29/5 30/6 30/12 31/11 31/20 32/6 32/22 33/25 34/14 35/4 35/14 36/24 37/6 37/8 37/11 37/25 38/1 40/5 40/13 40/22 41/8 43/23 44/1 44/15 45/7 45/16 47/15 47/25 48/23 49/12 49/21 49/24 49/24 50/19 51/6 51/13 51/14 52/7 53/18 55/9 57/4 57/7 58/5 59/6 59/22 63/1 64/13 66/13 66/14 66/14 69/4 70/7 72/11 75/16 78/7 82/3 83/8 85/17 87/6 87/8 87/13 87/16 92/2 93/14 93/24 94/21 96/4 96/9 96/10 97/11 100/9 102/14 103/13 103/23 105/16 105/24 106/8 106/10 108/7 108/21 109/5 109/10 109/19 111/3 111/6 111/7 112/6 116/6 116/14 116/18 118/3 118/21 119/9 119/15 120/10 123/4 123/10 123/11 125/18 125/20 126/16 127/13 128/3 129/14 129/20 132/9 132/16 132/18 134/8 134/11 134/13 135/23 139/13 140/9 140/23 141/9 143/9 145/9 150/9 151/24 152/1 152/19 153/12 154/17 154/18 155/17 157/22 159/24 160/24 163/3 163/17 164/12 165/10 167/19 168/18 168/19 168/25 171/5 171/8 171/25 172/19 173/17 175/2 175/16 176/24 180/3 180/23 180/25 187/6 187/15 189/4 189/24 190/21 191/15 191/24 199/14
yourself [6] 12/8 20/5 38/6 45/3 151/7 164/23
yourselves [3] 43/8 169/15 192/21

Z

ZA [2] 151/6 159/15