**Monday, 14 October 2024**

**(10.00 am)**

**(Proceedings delayed)**

**(10.06 am)**

**LADY JUSTICE THIRLWALL:** I'm sorry to have kept you all waiting, there was a technical glitch which I understand has now been fixed.

Yes.

**MS LYONS:** Good morning, my Lady. May Nurse T be called, please.

**LADY JUSTICE THIRLWALL:** Nurse T, would you like to come and sit down. I think you have to stand up to take the oath and then sit down.

**NURSE T (affirmed)**

**Questions by MS LYONS**

**LADY JUSTICE THIRLWALL:** Do sit down.

Yes, Ms Lyons.

**MS LYONS:** Nurse T, you've provided a witness statement for the Inquiry dated 18 April 2024. Are the contents of that statement true to the best of your knowledge and belief?

**A.** They are.

**Q.** The Inquiry understands that you were Letby's mentor on two occasions, is that correct?

**A.** That's correct, yes.



**Q.** The first period of mentorship was during Letby's second year of training and you mentored her during 31 May 2010 until 4th July 2010.

What was your impression of Letby during this mentorship?

**A.** So in, in that period of time I found Lucy to be a conscientious, capable nurse. She's obviously quite intelligent -- very intelligent. She had good knowledge and was, was keen to expand that. She was keen to gain and practise the skills that she had. She was always appropriate in her communication.

She's quite a quiet person, quite contained, but friendly, approachable, and I found her quite easy to support and mentor during her placement.

**LADY JUSTICE THIRLWALL:** Can I just ask at what stage was she at then?

**A.** She was coming towards the end of her second year.

**LADY JUSTICE THIRLWALL:** So she was a student?

**A.** So she was a student. So she started training in September '08, so this was towards the end of her second year. So I felt that for that stage in her place -- in her training and her first placement on the neonatal unit she was, you know, appropriate knowledge and skills.



**MS LYONS:** And you mentored her again and this would have been in her third year, the first place -- the first placement of her third year and the dates for that placement or mentorship were 25 October 2010 until 19 November 2010, so she's now a third-year nursing student in her final year.

**A.** Yes.

**Q.** And what was your impression of her in this period of mentorship?

**A.** So it was, it was about six months later and I'm not sure what other practical placements she had had in between, but she --

**Q.** If you go to paragraph 16 of your Inquiry witness statement, you comment there on the period of mentoring Letby.

**A.** Yes, I am just sorry I'm just ...

**LADY JUSTICE THIRLWALL:** Don't worry, just take a few moments. There's no hurry.

**A.** My Inquiry statement.

**LADY JUSTICE THIRLWALL:** Paragraph 16 she was suggesting you might want to have a look at.

**A.** Yes. Yes. Those are the words I was looking for. She was intelligent and engaged. Her, her skills and knowledge were continuing to increase. She was quite clear that being a neonatal nurse was where she



saw her career going. She, she could seem quite aloof and quiet but she was quite a contained person, but I didn't see, have any issues with her communication.

Because we didn't work with our students every single shift necessarily, I always got feedback from other people that had worked with her and nobody else on the unit raised concerns. In fact, the general impression was that she was a good student that, you know, would -- would be a good future member of the team if she got offered a job.

**Q.** And when you look back to that period, when you mentored her in her second and third year, and you look at the --

**A.** Sorry, I'm just struggling to hear you a little bit.

**Q.** Sorry, I'll speak up.

When you look back on the period that -- when you were Letby's mentor in her second and third year of study, you obviously had a very positive impression of her and looking back now, does that remain your view of her period as a student?

**A.** Yes, certainly she was -- she always seemed engaged and, and keen and proactive about her learning. She always appeared caring and -- towards the babies and the families and supportive of them in a manner that was

appropriate for the stage of training she was at, and certainly nobody else on the unit raised any concerns that they felt differently from that.

**Q.** I'd like to ask you now about something you said in one of your statements to the police. It was your statement to the police dated 2 May 2018 and in that statement, you described the staffing levels on the neonatal unit and what you said there was that:

"The staffing levels were: predominantly good."

Do you agree with that, that that was applicable for the period that this Inquiry is concerned with, 2015 to 2016?

**A.** Predominantly good? There were times when we were short-staffed in terms of meeting the BAPM recommended levels but it wasn't all the time. So I would agree that most of the time we had adequate staff.

At times we were short-staffed but I wouldn't say that was the majority of the time. I would say that majority of the time the staffing levels were okay, yes.

**Q.** And how many nurses were on duty during a shift in the NNU?

**A.** There was often only four nurses on duty. So that would usually be three registered nurses, often two Band 6s and a Band 5 and then a nursery nurse who would



be a Band 4. Sometimes you might have two Band 5s on.

Sometimes there might be five -- five on shift and you might have three registered and two nursery nurses, it varied a little bit, but four or five.

**Q.** So in your statement to the police you said:

"They would aim for five members of staff on duty during each shift, two members of staff at Band 6."

**A.** Yes.

**Q.** Does that sound right?

**A.** Mm-hm.

**Q.** "If possible", you added, "and three members of staff at QIS."

Can you explain what QIS means?

**A.** So QIS is Qualified In Speciality, so those people who have undertaken the neonatal nursing course.

**Q.** And who -- which of the nurses in 2015 to 2016 had that additional qualification?

**A.** So all the Band 6s had it and some of -- quite a lot of the Band 6s had another additional course on top. And then of the Band 5s in that time period, I think we had three Band 5s that had the QIS, one of which was Lucy, but she had only completed the course in the March, I think, of 2015.

**Q.** And are you aware of any other Band 5 nurses? Do you know them by name?



**A.** There were other nurses but they hadn't undertaken the course at that point.

**Q.** Were you aware whether Bernadette Butterworth was a Band 5 nurse with the QIS?

**A.** Yes, she was, and I can't remember whether it was only her and Lucy or whether there was one other person with the --

**Q.** We might --

**A.** -- the band -- with the QIS at that point.

**Q.** -- come back to that.

In that same statement to the police, you said, and you were talking about the nursing staff on the NNU, you said:

"You could always do with more staff but when it really matters such as when a baby collapses there is sufficient qualified staff to react."

When you said that, "sufficient qualified staff to react", were you referring to nursing staff?

**A.** Yes. I -- because I think I believe that's what I was being asked about, nursing staff, not medical staff.

**Q.** You also comment in that statement on some differences between the day and the night shift. Can you tell us what, what was the sort of difference between day and night shifts at that time?



**A.** I can't remember what I said back then.

**Q.** You said that night shifts tended to be a bit quieter.

**A.** They, they are quieter in terms of there is not as many people around so you wouldn't have as many extra people on the unit so parents didn't tend to be there all night.

Nursing ratios were -- nursing levels were often very similar day and night though you were more likely just to have four nurses on a night shift, we didn't often have five nurses on a night shift from memory but I'm going back a long time now.

Medical staff wise, there was a lot less medical staff around at night so in the day, there would be all the, all the doctors in but at night there was a Consultant on call who would be at home, could be called in if need be, and then there was one Registrar and one SHO covering the neonatal unit, the paediatric ward and anything that any children that came into the A&E department.

**Q.** And during the day shifts, how frequently were the -- how frequently did doctors conduct ward round visits?

**A.** So there would be a ward round daily but that with consist -- that would be led by a Registrar. We

only had a Consultant-led ward round on Wednesdays and one day at the weekend.

So the Consultant on call for the weekend would do one day of ward round on the paediatric ward and one day a ward round on the neonatal unit but that could vary, but if they did Saturday on the neonates they would do Sunday on paeds, and the other way round.

Wednesday was what we called "grand round" day because we had a Consultant there, but otherwise they were conducted by the Registrar that had been allocated to neonates and an SHO usually.

**Q.** At paragraph 20 of your statement, halfway down paragraph 20, you say:

"... it was sometimes difficult to contact a doctor when needed."

**A.** Yes.

**Q.** Can you expand on what you meant by that there?

**A.** So I think I'm -- I'm particularly thinking of night shifts because on the day shift there would be enough doctors for there to be doctors on paediatrics and on neonates. But at nights, after the doctors had had handover they invariably went to paediatrics first before they came to the neonatal unit and we often didn't see a doctor for, for many hours.



So yes, you could call them if, if you needed them urgently for something in particular, but they weren't there, you know, they didn't appear just to say, "How is everything?" You know, so unless you had a particular query, you know, so they weren't easily visible if you just wanted to have a discussion about a baby but you maybe weren't actually raising something that needed attending to. Does that make sense?

**LADY JUSTICE THIRLWALL:** But if there was something that needed --

**A.** Then you would have to bleep them but ...

**LADY JUSTICE THIRLWALL:** But they weren't generally around?

**A.** Sometimes we could go most of a shift without seeing a doctor.

**LADY JUSTICE THIRLWALL:** Seeing one. Yes, thank you.

**MS LYONS:** But if you called for help, called a doctor for help --

**A.** Yeah, but at that point --

**Q.** -- would they come?

**A.** Yes, if you needed them but they weren't visible, you couldn't just have a discussion with them about a baby. It had to be you were raising a particular concern, so you would actually bleep them.



**Q.** I'd like to move now to a different topic. We asked you about the culture and atmosphere on the neonatal unit in 2015 and 2016 and you start to set that out from paragraph 18 of your statement.

I'd like to ask you about sort of the relationship between the nurses on the NNU.

So in your statement at paragraph 18, you said the nurses worked well together and supported each other?

**A.** Yes.

**Q.** Is that correct?

**A.** Yes.

**Q.** Were you friends with your nursing colleagues?

**A.** I -- I got on -- I felt I got on with all my nursing colleagues. I -- I have a good social group of friends out of work anyway so I maybe didn't socialise with colleagues as much as other people did, but I had one or two friends that I worked with that I did see out of work.

But in work, yes, I had a good relationship --

**Q.** And who was that? Who from the NNU did you socialise with outside of work?

You should have your cipher list there.

**A.** Yes, so Nurse X.

**Q.** Nurse X.

**A.** And Lucy Letby were really the main two that



I -- I saw out of work. I mean, I would go on a ward night out and, you know, if the whole ward was -- say, a Christmas party or a leaving do, but I didn't routinely meet up with other people.

**Q.** So the Inquiry has heard evidence that Letby had a preference to be allocated babies in Nursery 1?

**A.** Pardon? Sorry?

**Q.** The Inquiry has heard evidence that Letby had a preference?

**A.** Yes.

**Q.** She preferred to be allocated babies in Nursery 1.

**A.** Yes, I agree with that.

**Q.** And did that preference cause any tension or a little bit of upset with the more senior nurses in the unit, so the Band 6 nurses?

**A.** Yes, at times. And I know -- though obviously me and Lucy were friends, I've said that -- I know that on occasion I myself had said to her, you know, "Lucy, other people also need to get experience in Nursery 1."

I very much saw her keenness to be in there as her wanting to develop her skills as a neonatal nurse and, you know, she is not the only new neonatal nurse I have worked with that is, is keen to do that. It's quite a natural thing for people wanting to increase their

skills, but she could -- she could sort of argue if she felt she should be in there and I know on occasion I did say, you know, sometimes other people need -- want experience too.

**Q.** When you say argue, do you mean argue with the shift leader who was allocating shifts?

**A.** Yes, I know on times she questioned why I hadn't allocated her to a certain baby and that's when I have said, you know, you can't always be in there. I don't know if "argue" is the right word. I was aware that there were times when she felt unhappy with allocation because she wasn't in there.

**Q.** And what gave you that impression?

**A.** She may have told me verbally or via a message or I have picked it up from other people on the unit. I can't, I can't remember exactly.

**Q.** And what did other nurses on the unit say about this?

**A.** I don't remember it being a big topic of discussion. I -- I -- I can't recall exactly it ever being discussed at me -- with me in any great detail. Just that, oh, you know, Lucy wasn't happy she wasn't in there or ...

**Q.** But it was generally known that she preferred to work in Nursery 1?



**A.** It was known that she preferred to be ...

**Q.** The Inquiry has also heard evidence that the relationship between nurses and midwives could be strained at times. Do you agree with that?

**A.** Yes. We -- we didn't have a great deal to do with, with each other. You know, even though they were just through the doors, we didn't see a lot of each other than at deliveries and things.

**Q.** So you operated separately?

**A.** Yes.

**Q.** You tell us at your paragraph 20 that the relationship between nurses and doctors on the unit was generally good.

**A.** Yes.

**Q.** Did you feel able to -- did you feel you could express your views or challenge a doctor if you disagreed with their management of a baby?

**A.** I felt I could but you weren't always listened to. Sometimes you felt you hadn't been listened to.

**Q.** Can you think of an occasion when you did challenge or --

**A.** I can, but it's not a baby --

**Q.** -- and what the response was?

**A.** -- it's not a baby on the indictment.

**Q.** No, but what was the response of the doctor?



**A.** The baby I'm thinking of, it was during --

**Q.** We don't need the details of the baby.

**A.** No, no, it was during the induction period so it was changeover day when the doctors rotate round.

**LADY JUSTICE THIRLWALL:** So it was a new doctor?

**A.** No, it was -- it was one the Consultants that I was speaking to, but he was like, "Oh, we're busy doing this today", which was showing the new doctors round in the induction so I -- I felt -- and that was a baby that for two days myself and another colleague raised issues about and felt we weren't listened to.

**MS LYONS:** And in that situation when you felt the doctor wasn't listening to you, what would you do? Would you escalate it to your manager or contact a different doctor?

**A.** I -- yes, I -- yes, if the manager was there to escalate to.

**Q.** Who within this -- the hospital senior management, if anyone, visited the NNU during 2015 and 2016?

**A.** I can't remember any of them particularly visiting, if you are talking -- you're not talking about the --

**Q.** Not the unit manager.

**A.** -- manager, but higher up.



**Q.** Above, yes.

**A.** So there was Ann Murphy who was clinical paediatric nursing lead. So we would see Ann but higher than her, I don't remember anyone particularly visiting the unit before the -- July 16, after the unit was downgraded and then Karen Rees would come daily and she would just walk through the unit quite early on in the shift to see Eirian Powell in the manager's office and then she would leave and she didn't speak to or acknowledge any of the nurses on the -- working.

**Q.** If I understood your evidence correctly, *(redacted)* from April 2016 --

**A.** Yes.

**Q.** *(Redacted)*; is that correct?

**A.** Yes, yes.

**Q.** So your awareness of Karen Rees visiting the NNU in the summer of 2016, was that what you were told?

**A.** Yes, actually, I'm thinking after that, aren't I -- I'm thinking -- I -- I believe it started when the unit was downgraded but actually I'm talking about when I -- I saw her after *(redacted)*, sorry, that was my mistake.

**Q.** Can you roughly remember what month that was? *(Redacted)*.

**A.** *(Redacted)*. So it would be after that -- from

the autumn. But from other colleagues I knew that that's what had been happening for weeks.

**Q.** You were asked to describe the quality of the management, supervision and support of nurses on the NNU between June 2015 and June 2016.

Who were your managers?

**A.** Eirian Powell was the unit manager and Yvonne Griffiths was the deputy unit manager.

**Q.** And how would you describe Eirian Powell's management style?

**A.** Quite dictatorial.

**Q.** What do you mean by that?

**A.** What she said she expected to go. She, I didn't feel that she was necessarily that visible on the unit when she was on duty. She never really helped out on the unit if it was busy.

**Q.** Where would she be?

**A.** In the office. She had clear favourites and clear, you know, clearly people that were her favourites and then a -- sort of another small group that were kind of the opposite of that and then the bulk of the staff in the, in the middle.

She could generally be supportive of the nurses as a, as a group, you know, if, if there was a criticism or something that affected the whole unit, she could be



supportive. But on an individual level her support of staff would depend where you fell in her range of favourites to not.

**Q.** You believed that Letby was one of Eirian Powell's favourites, is that right?

**A.** Yes.

**Q.** Why did you think so?

**A.** The way Eirian spoke about her to me.

**Q.** Why would she be speaking to you about Letby?

**A.** Just, just generally how she liked her as a student, she was very keen to make sure there was a job for her when she qualified. She would pass comment to me about how good she thought Lucy was. I could see that Lucy got sent on courses she wanted to go on.

It's hard to put my finger on exactly.

**Q.** So she was sent on courses that she wanted to go on?

**A.** Just -- yes, I mean, comments that Lucy would go far, that she had a great career, that she had her earmarked for this and, you know, earmarked as being a good nurse. I'm trying to remember -- it's a very long time ago to remember the absolute specifics of what gives me that overall impression.

**Q.** Before you think about the specifics, let's



think about the context.

So this is a general chat. Would this general chat be happening on the NNU or outside the NNU?

**A.** It would be when I was in work but whether I was -- whether it was just me and Eirian -- it wouldn't be a general conversation with the whole group of staff on duty.

**Q.** So she was not just sharing these views with you, she was sharing it with other --

**A.** No, no, it wouldn't be. It would just --

**Q.** It would just be you?

**A.** Yes.

**Q.** And why do you think that was?

**A.** She knew we were friends, I don't know. I don't think I was the only person she indicated that she thought Lucy was a particularly good nurse to.

**Q.** And were there other ways in which you saw or heard about Letby being treated more favourably by Eirian Powell?

**A.** Really hard to try and remember examples from 10 years ago -- you know, nearly 10 years ago.

I can't.

**Q.** We can come back to it. If anything occurs to you we can come back to it.

Did anyone else pick up on the fact that she --



that Letby was in the camp of nurses that she particularly liked?

**A.** I feel that was probably a general feeling throughout the unit.

**Q.** You say at paragraph 19 that had you had any concerns about Letby, when she worked on the unit, you would not have felt able to raise them with anybody.

**A.** No.

**Q.** Can you help us understand why you felt that way?

**A.** So Eirian, Yvonne, and another Yvonne who was a professional development nurse shared an office and I generally felt that anything that you told one person in that office became known to everybody in that office.

Myself and Eirian, I don't feel I had a particularly good working relationship with her. I -- she, I think I have put in my statement she was the main reason I left the unit. Knowing that I knew how much she favoured Lucy, I certainly would not have gone to her if I had had concerns.

I didn't have concerns but I certainly wouldn't have gone to Eirian to raise them had I had them because I don't think I would have been listened to. And I think maybe more than not listened to, I would have just been told I was wrong.

**Q.** Had you had any concerns about Letby, would you have considered raising those concerns with Karen Rees or Ann Murphy?

**A.** I didn't really know who Karen Rees was.

Would I have gone to Ann Murphy? I don't, I don't know because I didn't have concerns so I didn't have to think about -- you know, I have never given that any thought.

**LADY JUSTICE THIRLWALL:** Understood.

**MS LYONS:** Do you think Eirian Powell was supportive of Letby after concerns were raised about her?

**A.** Yes.

**Q.** What makes you say that?

**A.** Conversations I had had with her. So my, my understanding at the time, what I was told by Lucy at the time was that after she had been removed from the unit, they told her not to have contact with people from the unit generally, that they recognised that myself and nurse -- sorry, just let me check the letter.

**Q.** Yes, take your time.

**A.** -- Z, yes, Nurse Z because they knew we were good friends out of work with her she was able to talk to us. So Eirian knew that I knew why Lucy wasn't on the unit and I did have some conversations with Eirian



because I, I didn't understand why this was being said.

So I -- I did have conversations with Eirian and she was very supportive of her and, and said to me on several occasions that yes, there had been more deaths during that year but if you took out the babies that had sadly been born with congenital abnormalities that were incompatible with life, if you took those out of the equation, that the numbers weren't significantly higher than in previous years and were in line with other units and that Lucy was unfortunate that she did extra shifts so she happened to have been there for more of them.

And that was the only thing the doctors had to back up what they were saying. And that was very much what I was told throughout that year and beyond.

**Q.** Do you remember when you were first told that by Eirian Powell?

**A.** I can't remember exact conversations.

**Q.** Were you *(redacted)* at that time?

**A.** No, it would be after *(redacted)*. I do know that in the late autumn of '15, I saw the -- a chart similar to the one that was presented in court. It was more staff groups with lists of names underneath and I -- I saw that and Eirian said, "Oh, we're having to do a thematic review because the doctors feel our death rate has increased, it's all nonsense." I mean, and



I did see it, and I saw Lucy's name on it, but at the time that was all Eirian said about it and we didn't discuss it further because it probably wasn't appropriate. I just happened to have walked into the office when it was on the desk so.

**Q.** And when do you think you saw that document?

**A.** That would be November '15.

**Q.** November 2015?

**A.** Yes, around there.

**Q.** And it was on the desk?

**A.** Yes, she was obviously working on it. I had gone into the office to talk to her.

**Q.** And what did you think when you saw that document?

**A.** I -- I don't think I thought a lot. I just thought, oh, they just reviewing everything. I suppose it seems logical that you would look at what staff were on duty medically and nursing.

I guess, I guess I thought they were looking at, was there a competency issue or was there an interpersonal communication issue that could be contributing, I don't know. It -- it was just lists of names. It didn't ...

**Q.** You say at paragraph 19 that you felt bullied and intimidated --



**A.** Yes.

**Q.** -- by Eirian Powell.

**A.** Yes.

**Q.** Can you tell us -- I know it must be very difficult, but what she did or said that made you feel that way?

**A.** (Pause).

**MS LYONS:** Would you like to have a break?

**LADY JUSTICE THIRLWALL:** Would you like to have a break?

**A.** Yes, I just need to gather my thoughts.

**LADY JUSTICE THIRLWALL:** Yes, all right. We will take 10 minutes. Don't talk about your evidence.

So we will rise for 10 minutes.

**(10.42 am)**

**(A short break)**

**(10.54 am)**

**LADY JUSTICE THIRLWALL:** Are we ready to continue? Good, thank you.

Ms Lyons, we don't need to continue with that particular question, we can just move on.

**MS LYONS:** Yes, my Lady.

**A.** Yes, I can answer it if you want.

**LADY JUSTICE THIRLWALL:** If you want to answer it, that's fine. I don't want you to get upset.

**A.** No, it was I just couldn't quite find the words.

**LADY JUSTICE THIRLWALL:** All right.

**A.** Sorry, can you just repeat the question so that --

**MS LYONS:** I just wanted to understand why you felt bullied by Eirian Powell.

**A.** Okay. So there were certain incidents, certain times where she was very critical, raising concerns about my practice that were unfounded. I don't particularly want to list all the details.

**Q.** You don't need to.

**A.** But there were several, and it got to the point where I wouldn't meet with her alone and Nurse X would actually come with me so that I -- partly for me so that when I was coming out going, "Was that really said?" or, "Did I really -- did I say that?" Because I could have meetings with her about things and describe what had actually happened and it was like she just didn't hear it. She had made her mind up and I was wrong. And it got to the point that coming into work on a day shift when I knew she would be there, I would be anxious and I could feel my anxiety levels rising just turning up for work in the morning.

There was one incident where I felt she had



**Q.** What did you mean by that, that it was a poor working relationship?

**A.** So I -- I feel that there were some very strong personalities in play with the Consultants and with Eirian and that their working relationship was quite adversarial. It would be if one said black, the other would say white, almost, you know, it felt.

**Q.** Which Consultants are you referring to?

**A.** Ravi Jayaram and Steve Brearey, I feel are the two Eirian would make comments about. It being her unit and she would make decisions about things. So I just felt like it wasn't, it didn't feel like a cohesive, co-operative working relationship.

**Q.** And did you form the impression at the time that the difficulties in that working relationship, did you think it had an impact on the quality of care being provided to the babies on the unit?

**A.** Not necessarily, no.

**Q.** I'd like to move on now to some of the babies on the indictment. I'm asking you questions, some of these questions I've been asked to ask you by family, by the family members.

If we turn first to Child A.

**A.** Yes.

**Q.** And if we look at paragraphs 21 to 25 of your



breached my confidentiality and told something -- somebody something about me that she shouldn't have done and at that point I thought I really need to take this further. So I e-mailed Karen Rees. The only upshot of that was a meeting with Karen Rees, myself, and Eirian, no one else present, and all that Karen Rees said was, "Is what she told the person true?" And I said, "Well, yes." And she said, "So, I don't see what your problem is." And I said, "My problem is that was private and that person did not need to know that." "But it is true so what's your problem?" And I just felt completely stonewalled and like I was never going to get anywhere.

*(Redacted)*.

**Q.** Okay.

**A.** And --

**Q.** I'll stop you there.

**A.** Yes. *(Redacted)*.

**Q.** Understood.

Before we move on to the babies that you were involved with, I have one other question about the working relationship between the NNU managers and the Consultants and what you say at paragraph 20 is that you felt the working relationship between them, the unit manager and the Consultants, was poor.

**A.** Yes.



statement to the Inquiry, can you briefly tell us about your involvement in Child A's care on the night shift of 8 to 9 June 2015 when you were working as the shift leader?

**A.** Yes. So we had come on duty at half seven that evening. I was designated as the team leader, the shift leader and I believe I, only from a police interview I have done, that I -- I did actually have a baby I was looking after as well, that night.

So I would have taken handover from the off-going team leader. So that would be about all the babies on the unit and then I would have got a specific handover on the baby I had been allocated as well. And I do remember it was shortly after 8 pm.

I -- so I had got all my handover, checked my baby was fine, and I went through Nursery 1 because I needed to pop off the unit to go to the loo, so I just wanted to check everyone was okay before I did and that if there were any day staff left they were in the process of finishing off so they could go home.

So I remember walking through into Nursery 1 and that Mel was at the computer finishing notes so -- I can't remember exactly but I probably said, "Are you nearly done" and she probably said, "Yes, I'm just finishing this", or whatever. Lucy was standing with

her back to where Mel was writing, at Baby A's incubator, so I said, "Are you okay? Do you need anything before I just nip off the unit?" And she was like, "No, no, we just are getting the fluids started", or words to that effect.

Dr Harkness and *(redacted)* Caroline Bennion were at Baby B's cot side, Dr Harkness was inserting lines, central lines access, and they were fine. So I nipped off the unit. As I came out of the door and turned back towards the unit I could see -- so I was, I wasn't long, a few minutes. I could see that they were lifting the lid off the incubator of Baby A.

So I -- I hurried back in and in the time I had been off the unit he had collapsed, he had no heartbeat, and needed full resuscitation.

**Q.** And you weren't involved in the resuscitation of Child --

**A.** Yes, I was, I was involved.

**Q.** You were involved?

**A.** I -- I gave the chest compressions throughout, so -- and, and I know it was -- the swipe data which I didn't know they had had previous to it being shown to me in trial actually matched up perfectly with my memory of those events and what time I re-entered the unit.

So, yes, I -- I gave the chest compressions



throughout.

**Q.** At paragraph 31 of your statement, you describe the skin discolouration that you observed on Child B when Child B collapsed --

**A.** Yes.

**Q.** -- and you said it was the same colour change you had seen on Child A.

**A.** Yes.

**Q.** So am I right in thinking that at the time of the resuscitation you had noticed a colour change --

**A.** Yes.

**Q.** -- on Child A?

**A.** And we, they had re-intubated, passed a breathing tube down to -- into Child A so we had been able to turn him back straight in his incubator so that people could access his right side to give medications and Dr Harkness was on his left, the baby's left side giving breaths via the breathing tube and I was standing at the foot of the incubator reaching through the dropdown door doing the chest compressions, so I was looking up the baby's body so I had a clear view of his colour.

**Q.** And had you seen anything like that before?

**A.** I had never seen anything like that previously and I had been doing neonates for over 15 years at that



point. And I have never seen anything like it since except on his sister.

**Q.** Do you recall how and when Mother A and B and Father A and B became aware of Child A's collapse?

**A.** I can't remember exactly the point they entered the room. But I know that somebody was sent to get them and bring them to the unit soon after the collapse happened. So I don't know exactly the point at which they entered but at some point earlier on in the resuscitation attempt they entered the room.

**Q.** Do you recall making either of them aware of the skin discolouration that you had seen on Child A?

**A.** I don't remember specifically talking to them about that.

**Q.** Are you aware whether any of the other nurses or doctors spoke to them about that?

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

**Q.** In Mother A and B's oral evidence to the Inquiry, she said that Father A and B had overheard nurses saying that there was something wrong with Child A and discussing whether they should come and get them.

Do you know anything about that?

**A.** No.

**Q.** And Mother A and B says that when she was



called to go and see Child A, she said Child A had already crashed and there was nothing more that could be done.

What is the practice of informing parents -- what is good practice for informing parents when a child, when a child has either collapsed or it looks like the child might collapse?

**A.** So in this situation, where it was completely unexpected, then I would expect that if I was involved in the resus, that somebody else would go and bring the parents if they weren't already on the unit, whether that involved ringing them at home or going to the postnatal ward, you know, wherever the parents were at that stage.

I mean, very few babies in the neonatal unit actually die in a collapsed situation. Most of the deaths I have ever seen is where there is a -- a discussion with the parents that, you know, what we're doing isn't working and it's a compassionate redirection of care rather than a -- in a resus situation. That's actually quite unusual. They are usually much more controlled situations than that.

**Q.** You say at paragraph 22 discussions between the medical and nursing staff about possible causes of Child A's death, that there were such discussions. Do

you remember if those discussions included any talk about the unusual skin discolouration or rash on Child A?

**A.** I can't recall now.

**Q.** And as far as you're aware, there was no debrief following Child A's collapse and death?

**A.** No. After he had sadly died, after, after we stopped resuscitation and we passed him to his parents for a cuddle, we kind of stepped back to give them some, some time with him, and we went into what we all call the treatment room although it was actually more of a store, a storeroom, I think at some point before that it had been a treatment room, and we were all, all in there talking.

At that time the main concern seemed to be was that the line had been in the wrong place or was it something related to Mum's own medical condition?

**Q.** And could I just -- sorry, do you want to continue?

**A.** Sorry, I was going to say also I feel there was a suggestion was it connected to the fluids at that time. But I don't really recall anymore around that than that was maybe mentioned, was there a problem with the fluids.

**Q.** With regard to debriefs you say --



**A.** Yes, so we had kind of that little mini --

**Q.** Yes.

**A.** -- debrief, but it wasn't really a debrief, we were all so shocked at the suddenness of it, it was just and -- and a numbness between us all really, going what, what, you know, we just didn't understand how this baby that was so well had collapsed in such a catastrophic way.

There was no formal debrief, there was nothing arranged at a later date where those of us involved could, could get together and, and discuss that when there would be more time to reflect and maybe answers to some of our questions.

**Q.** So with regard to the formal debriefs --

**A.** Yes.

**Q.** -- that don't happen at the time but happen afterwards, at your paragraph 24, we understand that these sorts of formal debriefs were not, I think you said, the norm --

**A.** No.

**Q.** -- and it was not the usual practice to have a debrief after a death, is that correct?

**A.** No, it -- it just wasn't the norm at the time.

The only debrief I remember attending in that 12-month period that covers the indictment was for



a baby that wasn't on the indictment that there was a debrief at which there was only myself, Nurse X and Dr Saladi, and that was at our insistence that we wanted to discuss what had happened and the management of that baby further so ...

**Q.** In Eirian Powell's statement to the Inquiry, she says that it was Trust policy to conduct an immediate debrief for the staff directly involved in the incident and for any other staff who wished to attend and a further debrief seven to 10 days following the death. What do you say about that?

**A.** It didn't happen. It did not happen on -- for the babies I was involved in, that did not happen.

**Q.** Looking back, do you think a debrief would have been beneficial?

**A.** I -- I really do and I think that the Inquiry sent me some messages between myself and Lucy actually discussing that after Baby D had passed away and there was talk of there being a joint debrief for them all but there was never any, any debrief.

And that might have been useful because things like the rashes may have come up, you know.

**Q.** With regards it Child B --

**A.** Yes.

**Q.** -- you did -- you detail your involvement in



the care of Child B from paragraph 19 of your statement. You were Child B's designated nurse --

**A.** Yes.

**Q.** -- on the night shift of 9 to 10 June 2015 and you say at paragraph 29 that "We were unsure as to why Child A had died the night before and we were being extra cautious --

**A.** Yes.

**Q.** -- with Child B."

Can you expand on that, please?

**A.** So I mean, Child B -- Child A in what's now 25 years of neonatal nursing experience, I have never witnessed a deterioration in that manner that fast.

And we didn't have any explanation for that. So the fact that Child B was his twin sister and we weren't sure and the only thing other than it being a problem with the line maybe, one of the things we didn't know was, *(redacted)*.

But because we didn't know why he had collapsed so suddenly and they were twins it felt prudent to be extra cautious in case whatever had caused his collapse was also there in, in Child B. You know, could, could she have the, if it was, if it was a condition that he had, could she have it, because they were twins.

**Q.** And did you think at the time that Child B had

collapsed in the same way as Child A did, in that it was sudden and unexpected?

**A.** Yes, yes. Yes, it was, it was sudden. She was -- I mean, she was on respiratory support, she was still receiving CPAP at that time, so she was doing all her breathing herself but the CPAP just gives a little bit of pressure which takes some of the work of breathing, some of the effort away for the baby, makes it easier. But they are just little prongs that sit in their noses and, as we know, babies move and things, so the prongs can come out and she did, I think in my statement, police statement that I used for this Inquiry statement, I have described an episode prior to midnight where she had actually knocked her prongs out and her saturation dropped, oxygen saturations dropped a little, I popped the prongs back in and she quickly recovered.

I got her checked out because we were being cautious and Dr Lambie was on the unit, so we were all satisfied that it had just been because the prongs had come out.

When shortly after that she collapsed again, initially it was because what alerted us was the alarm on the CPAP machine saying that the pressure had been lost, so the prongs had come out. So because I was doing antibiotic, we were drawing up antibiotics and



I had the gloves on and was doing the actual preparation, Lucy said, "Oh, shall I go and pop the prongs back in?" And I said, "Yes, please."

But the baby continued to deteriorate quite rapidly and when -- and I think Lucy's words were along the line of --

**Q.** Don't say your own name. Just be careful with your own name.

**A.** Did I say my name?

**Q.** No, no, because in the statement your name is mentioned so I just want you to be careful.

**A.** Right. I think she said, "Nurse T, come over, she's -- she looks like her brother" and I went over and she did have that blotchy rash and had collapsed in a similar manner.

**Q.** And there was a skin discolouration on Child B as well?

**A.** Yes, that looked the same, very similar to her brother.

**Q.** And was there any discussion or comment at the time from the doctors or the nurses?

**A.** I think I made a comment about it of --

**Q.** Do you remember what you said about the rash?

**A.** Something along the lines of "Oh, no, not again, she looks like her brother", something like that,



I can't remember my exact words at the time but I do remember feeling that she looked like him and inside I was worrying that we were going to be in a similar situation that we had been in the night before.

**Q.** In your statement to the police, dated 16 July 2018, you set out within that statement a note you had made in Child B's medical records following her sudden collapse.

**A.** Mm-hm.

**Q.** You documented the skin discolouration on Child B, and you also recorded that:

"Parents had been called to the unit as requested by doctors, had been contacted, kept fully informed throughout. At the cot side."

Do you recall whether on this occasion Mother and Father A and B were made aware of this unusual skin discolouration on Child B?

**A.** I -- I can't remember exactly what we, we said. I have vague recollections of where the incubator was in the nursery and the door they came in and where they were standing and that we were saying to them, "Oh, we've got a heart rate and she's coming round." I can't, I can't recall more specifically what those ...

**Q.** Mother A and B's evidence is that a Consultant was asked, asked that a photograph of Child B's skin



discolouration be taken. Were you present or aware of that being said?

**A.** I -- I can't recall. I -- I have seen it in evidence statements, but it wasn't something that I recalled at the time, you know, that I recall personally.

**Q.** And it's, we understand from paragraph 34 of your statement, that you were concerned about the discolouration you had seen on Child A and B and you were concerned about the suddenness of their collapses.

**A.** Mm-hm.

**Q.** What consideration, if any, did you give to completing a Datix incident form?

**A.** We'd only routinely complete a Datix form if a child died. We wouldn't complete one for a sudden collapse if the -- for a collapse if the, the child recovered.

I don't recall whether I completed the Datix for Child A or whether somebody else did it. I have no recollection of that. I presume there was one done, but I can't remember.

**Q.** Do you recall any discussion about whether one should be completed or not?

**A.** I don't recall any discussion. I think it was practice then that we did them for every death but

I can't recall because it's so many years and now we routinely do them for every death but I can't remember whether that was the case then.

**Q.** You thought a debrief might have been helpful for Child A; am I right in thinking a debrief might have been helpful in the case of Child B too?

**A.** Yes, and I think with them happening on concurrent night shifts, that if we had had a debrief for Child A then Child B would have naturally come up in that discussion because there was a few, there were a few of us that were present at both and that would have been useful.

**Q.** Dr Rachel Lambie recalled in her statement to the Inquiry that a number of junior medical staff and nurses were talking about the collapses of Child A and B following the events of the morning of 10 June.

Were you involved in any of those discussions?

**A.** I can't remember those discussions. I may, I may have been, I may not have been. I mean, it's not unusual for incidents like that to be discussed.

**Q.** How did you become aware of the unexpected death of Child D?

**A.** In a message from Lucy, I believe.

**Q.** Please can we have extract A of INQ0000758 on the screen at page 2. So if we -- thank you.



So if we, you see that Child D died at 4.21 in the morning?

**A.** Okay, yes.

**Q.** And if we go to line 31765 we see a message from Letby to you at 8.36 in the morning?

**A.** Mm-hm.

**Q.** I'm just going to let you read that.

**A.** Yes.

**Q.** If we go to the next page, page 3.

**A.** Yes.

**Q.** So at line 31768 at the top of the page, your reaction:

"What!!!! But she was improving. What happened."

Why did you think that Child C was improving?

**A.** So I was -- although I wasn't there when Child D sadly died, I, I was the admitting nurse, I seem to recall, for Child D, so I knew her and I knew her history of how she had come to be on the unit and she was -- she had, she had improved.

I had seen her and I had seen an improvement in her and she was on her antibiotics and I think my expectation of how she was behaving in herself, you know, how, how she was doing and experience was that she would be fine, that she would continue to improve, finish her course of antibiotics and, and be okay.



**Q.** If we go a bit further down to line 31770.

**A.** Yes.

**Q.** This is where Letby describes what happened. And she says:

"... came out in this weird rash looking like overwhelming sepsis".

When you read that at the time, did it cross your mind that this might have been similar to the rash that Child A and Child B had?

**A.** No, it didn't because I was there for Child A and Child B. That did not look like a sepsis rash to me. I had, by that point in my nursing career, seen sepsis rashes and that's what was so weird about A and B was they didn't look -- I don't even know if "rashes" is the right word, "discolouration" seems more appropriate to me.

But I think we're using "rash" because everyone's being, you know, not knowing what else to call it.

She was there for A and B with me. Had she said "came out in that strange looking rash that A and B had", but because she said "a weird looking -- a weird looking rash -- weird rash looking like sepsis" in my head that's something different.

**Q.** Can we go to the next page, to line 31785, please. So I'll just let you read from the top and then



I'm going to ask you a question about 31785.

(Pause)

**A.** Yes.

**Q.** So when you said, "Yes but you've had it all recently", what did you mean there?

**A.** Well, so I knew she was there for A, I knew she was there for B, because she was with me. I knew she was on duty when Child C died because she told me, and here we are, what, within a fortnight, and she's there for Child D as well.

So that's what I meant by that, was she, she had been there for all these difficult, hard, horrible, emotional episodes, and she was a junior member of staff, you know. Just to me it seemed like a lot for her to have -- to be having it deal with.

**Q.** Thank you.

Can we please take that down.

I'm going to take you to another exchange. Please can extract A of INQ0000101 at page 22 be put on the screen, please.

If you could just read that page, please.

(Pause)

**A.** Okay.

**Q.** I think we might need to scroll down a little bit.

**A.** Sorry, are these from -- I have lost -- I'm not -- sorry, can we just go back up?
**Q.** And if we go down a bit more.
**LADY JUSTICE THIRLWALL:** Just pause a minute.
**A.** So am I asking -- is that, is the purple highlight from Lucy --
**MS LYONS:** That's right.
**A.** -- and the other ones are me?
**Q.** That's right. Purple is Letby and the white are messages that you sent.
**A.** Right.
(Pause).
**Q.** Let us know when you get to 32336 and we can scroll up.
(Pause).
**A.** Okay.
**Q.** And then -- yes. So my first question about this page is there seems to be some talk about allocation and we've heard evidence from other shift leaders that they allocated nurses to babies?
**A.** Yes.
**Q.** But I'd like to know what you think Letby meant at line 32336 --
**A.** Yes.
**Q.** -- when she said:



"But at least you had a voice in old handover. Chance to say what you want."
What is she referring to there?
**A.** So around this time we changed how we gave handover. So the allocation of babies we, we would all go into, like, the resource room and have handover on all the babies from the off-going shift leader and then the on-coming shift leader would allocate who went to each baby, but we switched how we did handover at this time so that we, we got an overview, everybody got an overview and the allocation was done by the off-going shift leader, so you were allocated your babies before you arrived. So you got an overview and then went to the cot side and got a more detailed handover on the babies you had been allocated to.
So what Lucy Letby is referring to there is that when it was done the old way, because you were all, the on-coming shift were sitting with the team leader you could say, "Oh, can I have them, please?" You know.
**Q.** You can express a preference for a baby?
**A.** You can express, whereas this way it was pre-allocated. It was to streamline handovers because everybody hearing about every baby could take a very long time and you maybe get -- not everybody needs to know that level of depth on every baby because they



weren't looking after every baby.
So it was to see if, if there was a better way of handing over, I guess, more efficient.
**Q.** Do you know why there was a change introduced?
**A.** For that reason I have just said, to make it more efficient.
**Q.** More efficient.
Can we please go to line 32359. So you've addressed this in your statement and I'd like to ask you about it. 32359.
So you had been a neonatal nurse for many years by this stage.
**A.** 15 --
**Q.** You have given evidence today and in your statement about the unusualness and suddenness of the collapses of Child A, B, C and D and the unexpectedness of Child A, C and D's deaths.
**A.** (Nods).
**Q.** And you're reflecting with your friend and you're saying:
"There's something odd about that night and the other 3 that went so suddenly."
Can you just help us understand what was going through your mind at this stage, what were you thinking was so odd?



**A.** So "there's something odd about that night" is I'm talking about Baby B because we've mentioned her in, in the previous couple of, of messages, "and the other 3 that went so suddenly" as in I am referring to A, C and D.
By "odd", I am a little bit of a lazy texter so I tend to go for short words, so I mean unusual, rather than odd. Yes. It -- in all my 15 years to then and 25 years to now, I have never seen three babies die so suddenly in such a short space of time.
It was highly unusual. I wasn't speculating by the way I used the word "odd" that I thought there was anything suspicious about it. I was just commenting that it, it was highly unusual for me, you know.
**Q.** So --
**A.** It was ...
**Q.** -- Letby responds to you saying -- this is line 32362:
"Odd that we lost 3 and in different circumstances?"
And your reply was:
"I dunno. Were they that different?"
**A.** Yes.
**Q.** So that seems as if you're not even sure whether they were different --

**A.** Were that different.
**Q.** -- and that perhaps they had something in common?
**A.** And that's difficult because I was only there for Baby A and B, not for C and D when they collapsed, though I -- I had met them both, I had worked whilst they were both on the unit.
Were they that different? I knew from what I had been told that C and D were very rapid and somewhat unexpected.
**Q.** So what were you thinking they had in common?
**A.** Just the rapidness, the suddenness, the unexpectedness.
**Q.** Had you worked out that they had all collapsed at nighttime during a night shift?
**A.** I -- I don't think that I had, I don't think I -- I had taken that. I think I was just thinking that it was so unusual to have three deaths so close together and that they were -- seemed to be so sudden in how they happened. I don't think I had really given much thought to them being all on night.
**Q.** If we go further down to the rest of that message exchange -- I'll just give you a moment to read it. So it ends at 31 -- sorry, 32392, I think, and if you just ...



So we -- sorry, it is a bit small. If we go up a bit. Yes.
So when you said "Ignore me. I'm speculating", why did you say that?
**A.** Because I didn't really, it was a -- it was a feeling that it was unusual but I didn't have a specific reason for saying it other than it was, they were close together and all appeared to be quite sudden.
**Q.** Is there any reason why you didn't say that to Letby at the time, what you have just told us?
**A.** No. Again, that, yes, it's just ...
**Q.** With regard to post-mortems, were nurses on the NNU allowed to see post-mortem results or did you request them?
**A.** They were -- they were very rarely fed back to us at all. I don't ever remember having a debrief meeting or a meeting, you know, where post-mortem results were, were given to us so that we knew what a definitive cause was if there had been a post-mortem carried out.
**Q.** Can you please take the document off the screen, please. Thank you.
We have seen -- the Inquiry has seen minutes of a senior clinicians meeting on 29 June 2016 and heard evidence that the Registrars were worried about the



three neonatal deaths and felt nothing was being done.
Were you concerned about these events? How were you feeling at the time?
**A.** I -- I felt that it was unusual. I -- I know that case notes are reviewed by the Consultants when there is a death so I guess I just presumed that they would be looked into.
**Q.** At your paragraph 46, you say:
"There was something not sitting comfortably with me, but I couldn't work out what was going on."
So was that your feeling after these deaths and Child B's collapse?
**A.** Yes, I -- I -- was there something underlying? And I guess there was that thematic review carried out that I mentioned earlier. Yes, I -- I never suspected there was anything sinister.
I never suspected that there was somebody causing deliberate harm that had caused these four incidents.
**Q.** Did it occur to you at the time that the deaths might be due to some sort of incompetence on the part of the medical or nursing staff?
**A.** No. I think I was more thinking had we -- could it be down to some -- a particular batch of fluids or an equipment problem or, you know, something more physical in, in the unit. I, you know, that sort of



thing.
**Q.** You know, you say you didn't -- you didn't suspect anything sinister. But something was not sitting comfortably with you about these events.
Were you aware of the Allitt case, for example? Were you aware that there were occasions when nurses have caused harm to babies that they were caring for? Did that cross your mind at all?
**A.** I -- I am aware, I am aware of Beverley Allitt.
She actually carried out her crimes towards the end of my nurse training, my initial nurse training, and was convicted shortly after I had qualified by which time I was working in paediatrics, not in neonates but in paediatrics.
So I -- I was very aware of her and I was also very aware that changes were made to training and mentorship, you know, sort of, and I always, I always took that very seriously and I -- if I felt I had concerns about a student would raise them because I was aware that that was one of the things that was highlighted from the Inquiry after Beverley Allitt.
But no, it never crossed my mind that that could be happening on my unit because it's just ...
**Q.** So Kathryn Percival --

**A.** Pardon?
**Q.** Kathryn Percival-Calderbank gave evidence last Thursday.
**A.** Yes.
**Q.** And she said she can remember that after finding out that Letby's name kept coming, kept being mentioned as being involved in some of the deaths, she said at the time that people would start to think that there was something untoward occurring. She said she didn't know who was present when she said that, and she wasn't quite sure when she said it.
But, were you present or aware that Mrs Percival-Calderbank had said that?
**A.** No.
**Q.** Dr Lambie, in her evidence to the Inquiry, she said she left the hospital in September, around September 2015, and she described an incident when she was walking through the intensive care unit, she came upon nursing staff in a small huddle in the corner over the computer. She said she asked them what they were doing and one of the nurses replied that they were going through the rota just to make sure there wasn't somebody who was on for all of them.
Dr Lambie recalled the nurse saying something along the lines of "It's an awful thing to think but we're



just looking."
Were you involved in that incident?
**A.** No.
**Q.** Were you aware of it?
**A.** No.
**Q.** I'd like to ask you now a question about Child I.
**A.** Okay.
**Q.** Please can extract A of INQ0000424 at page 59 be put on the screen and if you can look from the last line, 39387. That's a message from Letby to you:
"I'm awake. How are things?"
Do you see that?
**A.** That's not to me, is it? That's to Ashleigh.
**Q.** It's -- no. "I am awake. How are things?" 39387. The last purple --
**A.** Oh, okay, sorry, yes.
**Q.** -- box there.
**A.** Okay, yes.
**Q.** From Letby to you.
**A.** Yes, got it.
**Q.** So this is 14 October 2015, and then if we turn and go to the next page, I'll give you a moment to read it.
The first message is from you.



(Pause)
**A.** Okay.
**Q.** And if we could just go to the bottom of the document, so the last line is 39414.
**A.** Yes.
**Q.** And Letby's response to this message is on the next page.
So you were on duty at the time these messages were being exchanged, is that right?
**A.** Yes.
**Q.** Can you tell us why and who asked you to reallocate Child I's care?
**A.** I think it was Yvonne Griffiths, deputy manager. So I had -- I was the shift -- I must have been the shift leader for, for that day shift. We often if, if a nurse was on for more than one shift, we often allocated them the same babies for continuity.
So I -- I think I had done that which was Lucy for Baby I, and then I think it was Yvonne and not Eirian, it was definitely one of them and my feeling is it was Yvonne, just came to me when she was leaving and, and said that because Baby I had had recurring episodes of being unwell that we weren't going to allocate her to anybody for more than one shift so that it wasn't too much for anybody.



**Q.** In that conversation, did Yvonne Griffiths mention Letby?
**A.** Not that I recall. Only in, in that I allocated Lucy to that baby. So she asked me to change the allocation.
**Q.** When she, did you take what she said at face value or did you think there was more to it?
**A.** I kind of took it at face value. I mean, I was aware, me and Lucy were friends, I was aware she had been present at those incidents in the summer, and this, this baby had, had been backwards and forwards a few times between us and other hospitals with a distended abdomen and not tolerating feeds. So I -- I didn't really think more deeply about it than that was the decision that they had made in the office.
**Q.** Can we take that document down, please. Thank you.
So that, that message exchange was 14 October and I think you gave evidence earlier this morning that it was in November that you saw a version of the thematic review?
**A.** (Nods).
**Q.** Do you remember which babies from the indictment you had seen on that document or --
**A.** There were no babies's names on it. It was

just lists of -- so there was, like, the different groups, so like Band 4, Band 5, Band 6, Consultant, Registrar, SHO, and just lists of names.

And I can't remember if there were numbers by the sides of them but it was in descending order, so at the top of the list was who had been at more of the incidents. So I didn't see it for long, I didn't take a lot of notice of it because I didn't feel like it was -- I wasn't sure how, how private and confidential it was so I -- I had inadvertently seen it so I didn't study it in detail.

**Q.** *(Redacted)*?

**A.** (Nods).

**Q.** Did you and Letby stay in touch during the period *(redacted)*?

**A.** Yes.

**Q.** Did you continue to see each other outside of work?

**A.** Well, yes, because I was, I wasn't in work so I did see her. She did come and visit me *(redacted)*.

**Q.** Were you aware that she had been moved to the Risk and Patient Safety Office in the summer of 2016?

**A.** Yes, I was made aware of that.

**Q.** And how did you become aware of that?

**A.** So I became aware that something had, had gone



on and the unit had been downgraded when I -- via a message from somebody else.

**Q.** Was that Yvonne Griffiths?

**A.** Pardon?

**Q.** Was that message from Yvonne Griffiths?

**A.** No, no. But then Yvonne Griffiths *(redacted)* she came back to my house.

And then when she was leaving we were standing outside and I can't remember the exact words and how it came about, how Lucy came up, but I remember it, she was the person that told me Lucy had been moved off the unit and that she only named Ravi Jayaram had made accusations that she was harming babies and that was how I became aware of it.

I was, I was very concerned about that. I knew, I knew the unit had been dropped down a level because of the increase in baby deaths, but that was the first time I had heard that. I do think Yvonne probably thought that I already know -- that I already knew from Lucy but I didn't and I was so concerned that I had been told this that I rang the RCN for advice about did I need to flag it to Lucy that I had been told this? How did I handle it?

So I actually had a conversation with the RCN about it.



**Q.** So if we just unpack that. Yvonne Griffiths told you about the allegations that Dr Jayaram had made about Letby?

**A.** Mm-hm.

**Q.** What did you say to Yvonne Griffiths when she told you that?

**A.** I can't remember the exact words. But I did say something along the lines of: I don't know anything about that. Should you be telling me, kind of, something along those lines? And we, we ended the conversation.

**Q.** So you said, "Should you really be telling me about this?"

**A.** Yes.

**Q.** And what was her reaction?

**A.** She, I think, very much that she thought I probably knew. So after Lucy was removed because I -- *(redacted)* I saw Lucy soon after I had come back and she did indeed tell me all about it and she told me that she wasn't allowed to contact anyone on the ward but because Nurse Z and myself were friends that she saw out of work that she had been told she could tell us what was going on for support.

**Q.** And what did Letby tell you was going on?

**A.** That some of the doctors were accusing her of



murdering and harming babies and she had been moved to the office job because of that.

**Q.** Did she say which doctors?

**A.** I think she named Dr Jayaram and Dr Brearey.

**Q.** And when she told you this, what was your reaction?

**A.** Well, so I had had a little bit of time to think about that because I had heard that from Yvonne. I -- I was shocked.

**Q.** Did you tell her you already knew?

**A.** I -- I did at that point tell her and she was okay about it. She -- I do think Yvonne said that to me because she thought I had probably already had a conversation with Lucy. So ...

**Q.** And sorry, if you can just go back to what you said earlier in your evidence. Why did you feel you needed to -- who did you ring for support?

**A.** The RCN.

**Q.** And why did you feel you needed to do that?

**A.** Because that was, I mean, I felt it was a breach of confidentiality, wasn't it? I didn't know whether Yvonne should really be telling me that. I didn't know what to do about that. And just it was such a, a big, big thing to hear and it wasn't something I wanted to go and discuss with a friend or a colleague

because of the nature of what I had been told.
So the RCN seemed like a good place to get some confidential advice about what I should do.
**Q.** And did they help you?
**A.** They just advised me that at that point it sounded like Lucy Letby had enough on her plate and maybe not to tell her there and then that I had been told that.
**Q.** Sorry --
**LADY JUSTICE THIRLWALL:** Sorry, are you --
**MS LYONS:** Yes, I have one more question about this, sorry.
Are you okay?
**A.** Yes.
**Q.** Just -- I know it's a long time ago. But did Letby use the word "murdering" when she described what the allegations were?
**A.** I think so. I can't be 100%.
**Q.** You were asked in your Rule 9 request about a comment that had been attributed to you in minutes of a grievance meeting with Eirian Powell on 28 October 2016.
**A.** Yes.
**Q.** It was recorded in those minutes that Eirian Powell said, and I'm just going to read it out



for you:
"Ravi Jayaram was heard by a nurse, (Nurse T) in outpatients, when asked if anything had come from the review to say 'somebody is causing these deaths on the unit'. Nurse T is now anxious to return to the unit after RJ's statement. EP [Eirian Powell] escalated to KR [Karen Rees]."
Now, you tell us at paragraph 58 of your statement that you did not hear Dr Jayaram say this, so can you tell us what was the conversation you had with Dr Jayaram?
**A.** *(Redacted)* I always felt I had a good working relationship with the Consultants and I -- whilst I was there the preliminary report from the Royal College of Paediatrics and Child Health came back with its findings and I was just having a conversation with Dr Jayaram. I said, "Oh, I believe the preliminary report didn't find anything particularly untoward, you know, that was causing the rise in deaths." I can't remember my exact words, but along those lines, and his reply was along the lines -- well, his reply was "Just because they didn't find something doesn't mean there isn't something to find."
That -- and it was a direct conversation with me and at that point that was the end of that conversation



and I can't remember whether I left the room or whether we changed subject but we didn't discuss it further.
**Q.** Was anyone else present for this conversation?
**A.** I can't remember whether Dr Za was there or not.
**Q.** So did you agree or disagree with what he said or said nothing?
**A.** I don't, I don't think because --
**LADY JUSTICE THIRLWALL:** That name shouldn't be reported, the one that was just mentioned.
**A.** Oh sorry, sorry.
**LADY JUSTICE THIRLWALL:** Don't worry about it, it mustn't be reported.
**A.** I completely forgot.
Sorry, I lost my train of thought.
**MS LYONS:** When Dr Jayaram said what he said, did you say, "No, that's not right"?
**A.** I don't think we discussed it any further because obviously I knew at the time I -- I knew what Lucy and Eirian had said. So I don't think I discussed it further because I wanted to maintain a professional working relationship with Dr Jayaram and it didn't feel appropriate to push that further.
**Q.** At paragraph 60 you say you spoke with Letby about what Dr Jayaram had said.



**A.** Yes, I think I did, yes.
**Q.** You told her?
**A.** Yes.
**Q.** And what was Letby's reaction to what Dr Jayaram had said?
**A.** I can't remember exactly. Probably, "Oh, he's ..."
**Q.** Were you aware of any other comments being made about the possibility of babies on the neonatal unit being deliberately harmed?
**A.** No. And I think that's in my statement when I have said about what Eirian said I had overheard it -- he, he didn't allude that -- when he said it doesn't mean there is something to find, he didn't -- he wasn't -- he didn't say to me that there was, you know, that there was something to find that was deliberate, he just said, "It doesn't mean there wasn't something to find."
It was a very open --
**Q.** But how did you interpret that statement? What do you think -- what did you think he was talking about given the background that you were aware of?
**A.** Well, I did wonder if he was alluding to -- to Lucy Letby. But I didn't know.
**Q.** You state at paragraph 60 that *(redacted)* in September 2016 you recall there was a sign in the NNU

after the police were involved stating that any death was to be reported to the Coroner and to the police under Operation Hummingbird.

Are you sure about the dates, because the evidence before the Inquiry is that the police were not contacted until May --

**A.** Yeah, no, I got the dates wrong.

**Q.** -- 2017.

**A.** I've got my dates wrong there.

**Q.** You weren't given, you say at paragraph 63, any training on how to report any concerns about a fellow member of staff. You say you cannot recall any policy or process on speaking up. What was your understanding in 2015/2016 on reporting concerns about patient care or patient safety?

**A.** Well, that your first line would be to raise it with your manager.

**Q.** But we heard earlier that you wouldn't have felt comfortable doing that. So what might you have done instead, if anything?

**A.** I guess I would have probably gone to Ann Murphy.

**Q.** Can you have a read of your paragraph 70, please.

(Pause).



**A.** Yes.

**Q.** You have already mentioned some of this in your evidence today but can you just expand on what you mean by what you set out there at paragraph 70.

**A.** So --

**Q.** How do you think --

**A.** -- I'm just trying to think how to word it.

So I think that they were very strong personalities and that -- it was -- I felt like it was quite a, it wasn't a cooperative, cohesive working relationship necessarily. That was the impression I had as a ward -- my experience of working on the ward, so I just feel that, especially as it was one of Eirian's favoured, you know, favourite nurses that they were raising concerns about, that it could quite -- could have quite quickly come into an adversarial state, almost, nurses against doctors.

**Q.** What do you think should be done to keep babies safe in hospital from the events that occurred here?

**A.** So it's hard to know. Like I said in my statement, I don't think the answer is CCTV. Even had that been in place on every baby in the Countess, how long is that going to be stored for because I know *(redacted)* we have it on the corridors but it's sort of



a continuous loop so it's not kept long term and stored.

You know, you've got to keep it safe, there's got to be somebody available to monitor it and for a lot of the time neonatal units are dimly lit with covers over incubators, you wouldn't able to see, see the babies.

So I don't know how much practical use that could be.

I do wonder if insulin should be a controlled drug in hospital. This isn't the first case we have seen where insulin has been used to attack patients. We mentioned Beverley Allitt before, she used insulin, the case in Stepping Hill Hospital used insulin and, yet, insulin is still held on units without any stock balance.

So I do wonder whether that should be more controlled.

I think, I think we don't get any specific training. We get annual safeguarding updates, mandatory updates, but they don't cover who or how to raise concerns about a fellow member of staff. It's a rare event but we know it happens, sadly.

We get lots of training on how to spot if a child's being abused at home or domestic violence and things like that, but never had training specifically on if you have concerns about a member of staff.



I don't, I don't know and, and maybe some sort of guidance on the procedures to follow if, if that becomes necessary because obviously when these concerns were first raised it could have been that -- we know in this situation it wasn't, but you don't want a situation like did happen in the Stepping Hill case where the wrong person was initially charged. You know, suspicions were initially against her.

So it has to be careful so that if someone's got some suspicions about somebody that person is protected until those are investigated further. So there needs to be some guidance, some protocol steps to follow so that it's done appropriately. I mean, I don't know that there was that for the Trust to follow.

I -- I don't know because I wasn't at that level.

**Q.** Looking back, do you have any reflections that you want to share with us?

**A.** I mean behind, hindsight is great. When I -- I look back and I look back at the statements that I made prior to me starting to have doubts about her guilt, whether it could be true, I wouldn't have given different statements. They are factual and truthful. The only difference was at the time I believed that they would show that it was an unfortunate period rather than deliberately done by somebody.

I don't know how things could have been more open, but things that have come to light since I think would have maybe flagged things up quicker, sooner. But I don't know how that could have been managed differently.

**MS LYONS:** My Lady, those are my questions.

Questions by LADY JUSTICE THIRLWALL

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

May I just ask two questions, if I may.

You told us about, I think Yvonne Griffiths coming to see you and then telling you about Lucy Letby and you think she probably thought that you knew already and you said, "I phoned the RCN to see if I should inform Lucy."

And then you came back to that a little while later.

Can I just ask you, what was it that you were asking you should inform Lucy about?

**A.** What Yvonne had told me.

**LADY JUSTICE THIRLWALL:** Yes, but what were you thinking? Were you asking whether you should say, "Well, Yvonne has said this in a breach of confidentiality and so what should I do about that" or should I say, "Do you know what's being said about you?"

**A.** I think, I think both.



**LADY JUSTICE THIRLWALL:** Both?

**A.** Yes.

**LADY JUSTICE THIRLWALL:** And the reason that you did that was what?

**A.** Just because it was such a shocking thing to have heard.

**LADY JUSTICE THIRLWALL:** Yes.

**A.** And I didn't know what -- what to do with it. You know, it was really to have someone to talk to that could maybe give me advice where I knew it was confidential and safe. I didn't want to talk to another colleague. I didn't want to talk to a random friend. So yes, it seemed like the RCN as my Union was a safe --

**LADY JUSTICE THIRLWALL:** A good place to go.

**A.** A good place to go.

**LADY JUSTICE THIRLWALL:** Understood. I think you said that they did say not -- that you shouldn't tell Lucy about it.

**A.** Yes.

**LADY JUSTICE THIRLWALL:** I wasn't sure I had heard that correctly.

**A.** Yes.

**LADY JUSTICE THIRLWALL:** Thank you.

And then related, possibly related to your response to what you had heard, you were asked a question about



whether you had any suspicions and you said, "Well, it couldn't be happening on my unit because it's just", and then in fact you were asked another question.

I just wondered what was it you wanted to communicate?

**A.** It's just so unbelievable. It's so out of my sphere of understanding, you know, I find it so difficult to comprehend that anyone could do that, that anyone would deliberately harm or kill somebody else, another person, never mind a baby that you are charged with caring for.

I have always looked at my, my role as one that I am, I am part of a multi-disciplinary team and our aim is to send these babies home with their families, with as little long-term ongoing needs as possible from whatever brought them into our care in the, in the first place.

And that, that was -- we can't do our jobs without trust and we can't do our jobs -- I think if you asked any of my colleagues, medical or nursing, they would describe that in a similar way, that you are part of this team with a common goal to send these babies home with their families, and I -- I still now sometimes wake up going, "How can it be true?"

I know it is. But it -- and there's things that



have come out in the trial and the Inquiry that reaffirm that for me because I couldn't understand how I was so blind to any of it. But I now know that she told me there was only me and Nurse Z that she talked to. I now know that's not true.

There's things, considering that she told me that I was one of her closest friends, there's things I have heard from the Inquiry like her trips to Alder Hey I knew nothing about. Her friendship with, relationship, whatever, with Dr U I knew nothing about.

So she -- it -- I am learning how in hindsight I didn't see what was, was going on. *(Redacted)*. And she didn't, there was only her and Nurse X that I was in touch with and saw regularly during that year and neither of them discussed work with me *(redacted)*.

**LADY JUSTICE THIRLWALL:** Yes, understood.

**A.** So, yes, I think that's what I -- I just left hanging in the air, was it's that -- it's that -- it's that disbelief and I go into work now and I trust my colleagues.

I -- you can't do your job unless you trust each other and I still find it really incomprehensible that we are in this position.

**LADY JUSTICE THIRLWALL:** Thank you.

Do you want to ask anything else, Ms Lyons?

**MS LYONS:** No, my Lady. May we have 15 minutes to reconfigure the room, please.

**LADY JUSTICE THIRLWALL:** Yes.

So thank you very much indeed. That concludes your evidence, you are free to go.

**A.** Thank you.

**LADY JUSTICE THIRLWALL:** We are just going to adjourn for 15 minutes so the room can be sorted out for the next witness. 15 minutes.

**(12.14 pm)**

**(A short break)**

**(12.30 pm)**

**MS LANGDALE:** My Lady, may I call Nurse W.

**LADY JUSTICE THIRLWALL:** Indeed and you are in position. Would you like to take the oath?

NURSE W (sworn)

Questions by MS LANGDALE

**MS LANGDALE:** Nurse W, you have provided a statement to the Inquiry dated 7 August 2024. Can you confirm the contents are true and accurate as far as you are concerned.

**A.** Yes.

**Q.** I am going to take you through that statement, if I may, if you have it in front of you.

You tell us that in 2015 and 2016, at paragraph 8,



you were working as a Band 6 nurse and shift leader on the neonatal unit?

**A.** That's correct.

**Q.** Can you just tell us what the role of the shift leader was and in particular how shifts were allocated and whether that changed or not in the period round June 2015?

**A.** Okay. So the role of the shift leader was ideally to be supernumerary which was as BAPM standards --

**Q.** Can you just say what BAPM is?

**A.** British Association for Perinatal Medicine.

That wasn't always able to happen but that was, that was the ultimate aim on the unit, and the shift leader was responsible for all the nurses and the nursery nurses working on that shift, the Band 6s, the Band 5s, and the Band 4s, to try and ensure the smooth running of the unit.

**Q.** In your time when you were a shift leader, were you ever worried about that skill mix or numbers of nurses in the unit under your shift or generally did it work?

**A.** I think it worked, there were certainly busy days but the work was certainly completed. If it took longer -- if it missed -- if it meant missing breaks,



the work was certainly completed but there was definitely busy days within that time period.

**Q.** And the Inquiry heard from Ms Hudson last week that if there were quieter periods occasionally you might be able to, one of you, leave a bit earlier and reclaim some of that time back but generally you worked shifts when the babies required it and you had to stay late; is that the position?

**A.** That's correct. As a Band 6 you could never leave early. Occasionally the Band 4s and Band 5s may get out half an hour early if they could, but there was only ever two Band 6s working a shift so, as one of those, I was there to the end, if not longer.

**Q.** How many of you were Band 6s, do you know?

**A.** Not at the time, I'm sorry, no.

**Q.** Were there more Band 6s than Band 5s, do you know?

**A.** Yes.

**Q.** So the majority, the most skilled, Band 6s and then the 5s, did many of them do this extra course or qualification in intensive care training?

**A.** Yes. So the -- the unit was very supportive of that, so the first course you did was within six to 12 months of starting on the unit. At the time it was called the North-West induction course but now it is



called the Foundation in Neonatal course, or the acronym is FIN.

And then after one to two years of consolidating that course you then went on to do your qualification in speciality, which is the QIS, which you are referring to, and that was very much encouraged by the managerial team and the in-house managerial team, and then that would then -- you would be then qualified in speciality so you were technically a neonatal nurse once you had those two courses.

**Q.** And trying to understand Letby's level of expertise within the organisation or the structure you have described, she was a Band 5 who had done that course. Did that leave her highly experienced, well qualified, moderately qualified, within the nursing group, if you like, with the Band 6s as you were?

**A.** So she was qualified in speciality which meant she had done the two postgraduate, two neonatal postgraduate courses. She had also done her mentorship course which meant she was allocated students on a frequent basis. But she hadn't completed the QIS by too long. However, she did work full time and she did pick up extra shifts. So when you are working full time and working extra shifts you can become more senior quicker than if you were working part time.

**Q.** Is there a limit to how many hours you could all work a week, or not? Is it around 37, 38? Is it more than that?

**A.** I think full-time contracted hours as a nurse is 37 and a half hours a week but certainly if you did bank shifts you could work over that time.

**Q.** The culture and atmosphere on the NNU in 2015 to 2016, you say at paragraph 9:

"In 2015/2016 the NNU was very busy with a high mortality rate ..."

And you go on to say how that affected you and I'll come to that in a moment, but very busy with a high mortality rate. What did you understand about previous years' mortality rates, that year's mortality rates, or, indeed, was there any discussion at the time about mortality rates?

**A.** So in the previous years to that -- so *(redacted)*. In the previous years to that there was no more than five deaths a year and that would be the higher number of five. And in 2015 to 2016, the frequency appeared to increase.

However, I just want to make it clear at the time when you are working shifts you can have a week off, you can have two weeks off on annual leave, and if I give the instance of Baby K, as she was only there for such



a short period on the unit, you may not have known as a nurse that actually a baby had died, so if you hadn't have been on the night shift when Baby K was born or the day shift where she was transferred out, actually a death could go through the unit and the whole of the nursing team wouldn't be -- wouldn't have that information.

It was the overarching team that would be reviewing these deaths that would know the amount that was happening, but certainly I did notice there were more.

**Q.** And that's not because you sat and looked at the figures, from what you say, or reviewed a document with numbers; it is just how it felt, was it?

**A.** It's how it felt, yes.

**Q.** Was there much discussion between you as nurses or with managers or anyone else about that feeling?

**A.** Not for -- with the nursing team, no.

**Q.** You say that rate ultimately affected morale through fatigue, trauma and bereavement -- those words speak for themselves, but can you expand on that for us when we are talking about the culture of that year?

**A.** Yes. So I believe it was a very supportive peer support that I refer to. So nurse to nurse.

My managers at the time, Eirian and Yvonne,



definitely had an open-door policy. I could go in there if I felt overwhelmed, if I was upset, if I needed any personal support, if I had any questions. They very much had an open-door policy. But ultimately it was an extremely busy year and there was more bereavement than, than previous. So ultimately it's going to take a toll on you.

I don't think there is -- there is no words to describe that feeling but as a team we stuck together and we carried on, we turned in every shift and did the best we could.

**Q.** You indeed say that, Nurse W, that you "prided" yourself on your work and:

"As nurses we turned up for each shift, on time upholding all the Nursing Medical Council's professional values."

**A.** Yes.

**Q.** Did you discuss between you how it felt differently at that time? You have said you were working much earlier, in earlier years you hadn't had that level of bereavement to deal with on the unit. Was that something you discussed with the more established nurses at the time, or not?

**A.** I don't think so. It was just so busy we, we carried on, I guess, is what you would say.



**Q.** And you say:

"... nurses often went above and beyond, from baking ... cakes, celebrating parent birthdays, baby milestones, key calendar dates, Christmas, [et cetera], to entertaining siblings so the parents could have a few minutes peace and quiet with their baby."

You are describing compassionate care to families?

**A.** Very much. Yes. Now it's called Family Integrated Care, or FiCare. Chester have always been exceedingly good at it. *(Redacted)*, it was already embedded in the culture at Chester, but now it's labelled as FiCare.

**Q.** In an article reported in a newspaper somebody apparently who worked on the unit anonymously described how during night shifts nurses on the ward would pull a name out of a hat and whoever got picked would be able to leave early despite still being in charge of a baby and instead of carrying out correct handover they would leave a written note by the infant leaving the baby without oversight for hours at a time.

Do you recognise that?

**A.** No, I never witnessed that at all.

**Q.** No one discuss anything like that amongst themselves or say anything like that?

**A.** No. If someone was going to leave early it

would be a Band 4 or a Band 5 and definitely not a shift leader and that would be on a very, very rare basis that there was low acuity on the ward.

**Q.** So the more junior nursery nurses or nurses might be able to leave early if the safety of the babies meant that that wasn't going to be a problem?

**A.** Very rarely, but literally, I can't even tell you the last time that it happened. It's so infrequent and it's very much done by the safety of the unit.

**Q.** You say in your statement you had always described the neonatal nursing team like your second family, hugely supportive of each other, shoulder to cry on, a person to debrief to, friends not just colleagues; is that how you felt at the time in 2015 to 2016, broadly?

**A.** By the majority of the team, yes, I did.

**Q.** You have already told us that Eirian Powell and Yvonne Griffiths were approachable, kind, and you wouldn't have had any hesitation in approaching them about any -- any professional issues. Does that include if you had concerns about others?

**A.** Yes, I could have gone and spoken to them, yes.

**Q.** You tell us that you had an experience working some non-clinical days in the office which was shared by



Eirian Powell, Yvonne Griffiths and Yvonne Farmer. What did you learn about those -- from those days and that experience?

**A.** Yes. So at that time I was shadowing Yvonne Farmer's role and -- but as my statement says, I would, Yvonne shared the office with Yvonne Griffiths, the deputy manager, and Eirian, the manager at the time, and Eirian was showing me reports one day around staffing levels. So she was showing me the data that she was submitting, who that was submitted to, how frequently that data was submitted.

**Q.** At that time, in 2015 to 2016, did you ever see any of the Executives on the unit come down to see you?

**A.** Very, very infrequently.

**Q.** Would you have known them, would you have recognised them?

**A.** I think I would have recognised the Chief Executive because his face would appear on emails occasionally that were sent to the rest of the Trust, but no, I wouldn't have recognised them.

I think at that time they wore their own clothes as well, so it would be very hard to distinguish someone.

**Q.** I think you describe one New Year's Eve day shift when Mr Chambers and another executive came down



to the ward. Can you tell us about that?

**A.** Yes, so it was a New Year's Day shift, and it was around about lunchtime from recollection, maybe early afternoon, and he came -- I had never met him before in person, came with an older gentleman, he was part of the Exec team but I can't recall who he was. I had not met him before, not seen him before. And they said Happy New Year to us and they said, "Are there any New Year babies been -- here been born here today?"

But then they said a really strange comment around: had we been out, did we celebrate New Year, basically had we been significantly out partying, and we were quite shocked by the comment, we felt it was very inappropriate and we politely said no, we hadn't, we were in bed by 10 o'clock as any nurse would be before a 12-hour shift the next day.

They just didn't seem to be on the same level of understanding of what we were doing at the time.

**Q.** You say that the support on the unit was provided all in house, neonatal nurse to neonatal nurse, and there were no clinical psychologists available.

**A.** That's correct. Yes.

**Q.** What's the role, as far as you're aware, a clinical psychologist can play in terms of support for neonatal nursing?



**A.** So in the past two years, they have been of a great service to us as the neonatal team, they have been brought into the unit to support the staff through group sessions, one to ones, and I don't think we would be standing as strong as a team today without them.

They are, they are very much there on an emotional level to hear us. They have offered kind of talking therapies and more kind of in-depth therapies to people, to nursing teams that have needed it over the past couple of years. But they were only brought in to support us from 2022 which is obviously a few years after the first arrest. So we wish, as a team, that they had been brought in sooner to us.

**Q.** At the time, 2015 to 2016, did you have visits or support from Occupational Health? Did they come down and support staff around bereavements or anything?

**A.** I occasionally remember them calling by, but I don't remember any significance that occupational health played.

**Q.** We heard from Kathryn de Berger that she made visits to the neonatal unit to support nurses but you are not aware of that?

**A.** She could have done but she didn't leave a lasting impression.

**Q.** You say that Yvonne Farmer provided a lot of

the supervision and support to nurses and she would ensure compliance of mandatory training, e-learning and equipment competencies. How did she facilitate the education and training opportunities? How did that work in practice for you all?

**A.** So she ran study days. She did cot side teaching with students, newly-qualified nurses, new members of the team, she ensured that everyone's competencies were up to date, she was a really valued member of the team.

**Q.** In terms of relationships between nurses and doctors, you say they were professional, from your point of view; would you like to elaborate on how they were generally at that time?

**A.** Do you mean Consultants or junior doctors or all?

**Q.** Separate them as you will or not, however you see fit to describe the relationships.

**A.** Yes. So I think on all counts they were professional. The junior doctors, like on any -- on any unit rotated through, some of them you may have met previously because they would come through the unit at least once within their training.

The Consultants at that time were quite an established team and I would say they were respectful



to the nurses, the nurses were respectful to them and at that time there wasn't a neonatal Consultant of the week *(redacted)*, so they were shared with the children's ward as well, so they had a bigger workload, so they weren't quite as visible. But certainly if you had any concerns about a baby on the ward round, they, they would listen to you as a nurse and respect your opinion.

**Q.** So you didn't think you were shut down or put off from saying what you were worried about if you were worried about a baby in any way?

**A.** No.

**Q.** Did you feel that whatever they said went or not?

**A.** I didn't have that impression.

**Q.** What about the relationship between neonatal nurses and midwives? You say in your opinion that was poor at this time, that's 2015 to 2016. Why do you say it was poor?

**A.** So I kind of -- I think I divided them in my statement into two groups of the midwives. The senior midwives I didn't feel were very approachable.

Would you mind if I just referred to my statement for the exact words?

**Q.** Of course, please do. I am. It is 19b.

**A.** Thank you.



So if I could just read, if that's okay. So I have written:

"There were some very senior midwives that did not make the neonatal nurses feel very welcome when attending central labour suite or the antenatal/postnatal ward. Some of the midwifery leadership teams were against change. They were patronising and belittling and it made you feel very uncomfortable and inferior. I would avoid these senior midwives wherever I could."

So that was the senior midwives.

But I have definitely gone on to say:

"However, there were many midwives that were helpful, kind, approachable and trying their best. It is these midwives who we called upon several times to provide parental support and scribing in emergency situations. I will be forever grateful to them".

**Q.** We have heard from parents of the babies named on the indictment that sometimes they were dependent on those midwives to facilitate their visits to their own children in the neonatal unit, they had to be taken down, it wasn't easy and they had to request assistance.

Given what you say, it sounds entirely at one with that, that sometimes they felt they were making difficulties for people to ask for that assistance, or



for midwives if they needed that assistance, I'm not saying in every case, there is other examples, but they may well have, as they have described, felt as you did that you were interrupting something or perhaps an unwelcome request is being made; would that be fair, that's at one with what you are saying sometimes?

**A.** I would agree. As you say, it is not in every case but parents have definitely reported that to the neonatal team since I began in the Trust. I think it *(redacted)* improved over time. But parents have certainly told us, "Oh, we have had, we have had to wait an hour to come down this morning to come and see my baby" or "I have missed the ward round because there was no one to bring me."

*(Redacted)*. That's exactly it.

**Q.** Moving on, please, if I may, to your involvement with some of the babies.

You tell us at paragraph 21 you were involved in the care of Child C at the time of his death on 14 June and we know Child C died six days after the death of Child A and four days after the collapse of Child B.

When you were on that shift, were you aware of the death of A and the collapse of B a few days earlier, can you remember?

**A.** I can't recall at this time, I'm sorry.

**Q.** You were the designated shift leader on the night of 13 and 14th, can you tell us, as you've set out from paragraph 24 onwards, what the difficulties were for you as a shift leader in terms of allocating Letby that night and where she was supposed to be?

**A.** Yes. So I am not sure the -- in terms of allocation, I have said this within my statement and at the trial, that allocation, I don't know happened -- if it happened by the previous day shift and the allocation was already in place for the night shift or if I allocated the babies because it was around that time where we changed that criteria.

**Q.** Just pausing there actually because --

**A.** Yes.

**Q.** -- the previous witness, Nurse T, dealt with that. So around June it became the nurse who had completed the shift role to allocate the babies and a proper handover happened at the cot between the new nurse and the one leaving the shift; is that the position?

**A.** Sorry, when did Nurse T say that happened?

**Q.** Around the same time, around the time of that -- June 2015, I think she said. Is that your understanding, it was changed around then as well?

**A.** Yes, and I think I am actually adding in an



extra little part to that. So around this time, as you say, what happened was everyone met in the handover room for shift coming on and the nurse in charge from the previous shift came into that room and gave a full handover to all of the team coming on to that shift.

What changed was that everyone had then a safety huddle, a no more than five-minute safety huddle kind of at the desk, and then everyone went to the cot side and received their individual handover. So that's part of it.

But I think what I am trying to say is at some point as well it changed that the nurse coming on duty, the nurse in charge coming on duty, allocated there and then based on what the handover was.

**Q.** Right.

**A.** So there was the change of where you received your handover but also of who allocated the babies. But I can say that at any point, as the shift leader coming on to shift, you could change that allocation anyway but who allocated the nurses Mel, Lucy, and Sophie that night to those designated babies, I don't recall.

**Q.** You can't be sure now, but what's clear is who was allocated to which baby so perhaps you can pick it up from there.

**A.** I remember distinctly this night shift.



**Q.** So tell us now what happened.

**A.** Yes. So at the beginning of the shift, the only baby that I was concerned about was in Nursery 3. So that was not Baby C.

Letby -- I refer to her as Letby.

**Q.** However you want to.

**A.** Yes. Letby was that baby's allocated nurse and I had some concerns about this baby. I had met him previously. He was showing some signs of respiratory distress which was not normal for this baby and I made that clear to her and asked her to get this baby reviewed by the Registrar and increase the frequency of the baby's observations.

I believe she did listen and get the baby reviewed, I remember the baby being reviewed but I don't recall whether she increased his observations.

So my concern at the start of the shift was for a baby that is not part of the trial.

The shift was busy. Mel had a ventilated baby in Nursery 1, so that baby was one to one with Mel as the other Band 6, and Baby C was next to that baby with Nurse Sophie and so Sophie was a newer member of the team and my former student so I knew her competence level, so Mel was very much supporting Sophie if she needed it and I was supernumerary this shift as well.



So I didn't have so much input in Nursery 1 to begin with because I had no concerns. Although those were the two ITU babies on the unit, they were stable from a distance and --

**Q.** You say that, indeed, at paragraph 29 in relation to Baby C. You were aware Baby C "was receiving ITU care, that he was small for his gestation and that he was clinically stable."

So you were comfortable with the allocation that had been made?

**A.** That's correct.

**Q.** Sorry, continue.

**A.** So then further into the night, Child C has full resuscitation. I believe it was unexpected. It was a highly traumatic event. However, the rest of the unit was still very busy. So once Baby C had gone into the family room with his parents and grandparents, as a shift leader I had to still consider the safety of the rest the unit which was incredibly challenging in such a high emotive environment.

Sorry.

**Q.** Not at all.

**LADY JUSTICE THIRLWALL:** You don't need to apologise. Just take a moment.

**A.** Thank you.

**MS LANGDALE:** Have you got a drink there?

So once Baby C had moved to palliative care, you, what did you ask Letby to do?

**A.** I asked her to return to the baby in Nursery 3 because I was still really concerned about this baby in Nursery 3. I had a quick chat with Mel, a private chat with Mel, and I said, "I'm not sure why -- she's not listening, I am really concerned about this baby in Nursery 3."

I'm not a loud person, I'm not a confrontational person. I was simply just asking her some really basic-level things and she, she just appeared really consumed with Baby C and wanting to be in the family room with Baby C and that family even though I distinctly asked her to not be in there.

**Q.** You say -- sorry, go on.

**A.** So, so I just carried on making sure the baby in Nursery 3 was supervised whilst Letby was not there and ensuring the safety of the rest of the unit.

**Q.** You say:

"After asking Letby more than once I felt some anger towards her as she was being incredibly selfish, this was a challenging shift and I needed her to listen and follow instructions. I did not outwardly display this anger. That is not [your] personality, and it



certainly would not have been within my nursing professional conduct."

Incredibly selfish. Why did you think it was incredibly selfish what she was doing?

**A.** Because she just wasn't being fair to myself or the rest of the unit. I know they are really strong words and they are really strong words that I have written there and they are not words that I have written lightly but that's, that's the truth.

Baby C was with his family and extended family and Mel was allocated with that family now. We reallocated from Sophie to Mel, which was a very reasonable reallocation, and so Mel could come to me for support, Dr Gibbs was still on the unit from in terms of a medical support and the pain relief that Baby C required.

So it didn't then need Lucy as well because the rest of the busy -- the rest of the unit was still so busy.

That night, actually, one of the children's ward nurses came round to help me do some of the IV infusions because of the busyness of the ward.

**Q.** And we know, we took Melanie Taylor last week to them, that Letby was also messaging Jennifer Jones-Key about:



"I just keep thinking about Monday, feel like I need to be in 1 to overcome it but Nurse W said no."

And there is an exchange between them.

"I just feel I need to be in 1 to get the image out of my head, Mel said the same and Nurse W let her go."

Melanie Taylor had no recollection at all of saying to you she wanted to be in Nursery 1 but that she, having been allocated there as a Band 6 accepted she should be there and got on with it.

**A.** (Nods).

**Q.** Which is right as far as you are concerned, did Mel, Melanie Taylor ask to be there, was she there?

**A.** I don't recall any conversation that I had with Mel but the allocation seemed completely correct because Sophie was a junior Band 5 and Mel was a Band 6. So it would be more unusual for someone to have allocated two Band 5s for the two ITU babies. It makes a lot more sense for one Band 6 and one Band 5 to have the two ITU babies next to each other for that, that support.

**Q.** Melanie Taylor also told the Inquiry how it was in the resuscitation that Letby suggested using a Guedel to open Child C's airway.

Melanie Taylor, of course, was a Band 6. Do you have any observation on that, that it was Letby who was



using that?

**A.** I don't remember anything about the Guedel. I've been asked about the Guedel for the first time in my Rule 9. I don't remember anything about the Guedel. But I was also asked, "Would this be an unusual thing for a Band 5 to suggest so early in a resuscitation?" and I have said -- let me make sure I get my correct wording.

**Q.** It is paragraph 32a.

**A.** I have put:

"... so for Letby to think of using it at a very early stage in the resuscitation would be unusual."

But I do not recall it being used.

**Q.** We also told you or you became aware, perhaps at the criminal trial, what Child C's father stated that had been said to them as parents, "You've said your goodbyes now. Do you want to put him in here?" referring to a basket.

When did you first become aware that had been said to the parents of Child C?

**A.** When I got my Rule 9.

**Q.** How would you describe that comment?

**A.** I was absolutely horrified. Absolutely horrified. I was deeply upset by that comment.

It was no part of mine or Mel's or Dr Gibbs'

palliative care for Baby C and in very, very I'm very, very sorry that these words were used.

**Q.** You obviously weren't there when they were and you have just learnt about them.

**A.** Yes.

**Q.** Had you known that at the time, and spoken or someone had taken feedback or comments from Baby C's parents, would that have raised a red flag for you or concern that that was said or not?

**A.** It, they would not have been appropriate comments, no. They absolutely would not have been appropriate comments and I would have taken them to Eirian, my manager, the next time I saw her, and I would have asked her for advice.

It wouldn't have been the right time to have, kind of, dealt with that situation at the time.

**Q.** Of course.

**A.** But I would -- there's always a nurse on-call within the hospital as well, a bed coordinator, their role is, so that's kind of the highest nurse that's available on-call during the night shift.

So could I have taken it to them? Possibly. But I don't know because I wasn't aware at the time. But certainly if I had been aware I would not have kept that information to myself.



**Q.** But it's clear you didn't keep the information to yourself about Letby repeatedly not following instructions. You tell us at paragraph 37 that you indeed reported that to Eirian Powell at the next available opportunity and informing her that the babies' care in Nursery 3 was compromised as a result.

You didn't, of course, know what had happened to Baby C.

**A.** (Nods).

**Q.** What was Eirian Powell's response to that? What did she ask you to do?

**A.** I -- I don't remember her kind of emotional response to it. I remember that she asked me to put in a Datix, a clinical incident form particularly around the delayed care for the baby I mentioned that was in Nursery 3 and to speak to Lucy directly about that as well, which I completed.

**Q.** Did you tell Eirian Powell in the way you have today that it was selfish and compromised another baby as far as you were concerned?

**A.** I did.

**Q.** It is a real criticism, isn't it?

**A.** Yes.

**Q.** It's not --

**A.** And I don't speak lightly, I don't speak that



way about my colleagues, it is just not in my nature at all. So Eirian will have known for me to come to her and speak about a colleague in that way that I was, I was angry with Lucy on that night.

**Q.** And you say you weren't regularly angry with her, that was, I think you say the only time you were angry with her, but did you expect Eirian Powell was going to speak to Lucy Letby about that?

**A.** I would have presumed so.

**Q.** Did you ever get any feedback or her coming back to you, you having raised that concern, with the conclusion or her conclusion having investigated it further or asked Letby about it?

**A.** Not that I recall.

**Q.** Did you ever want to ask, "Did you speak about it" or did you think that was a question ...

**A.** With hindsight, I should have done.

**LADY JUSTICE THIRLWALL:** Perhaps you will just choose a convenient moment.

**MS LANGDALE:** I think that's it, my Lady.

**LADY JUSTICE THIRLWALL:** We choose the same one.

Thank you. So we will take a break now and if you would be back, please, ready to start at ten past 2.

**A.** Okay, thank you.

**LADY JUSTICE THIRLWALL:** We will rise.



**(1.09 pm)**

**(The luncheon adjournment)**

**(2.09 pm)**

**MS LANGDALE:** We will continue where we left off.

At the top of the statement you refer to your feeling strongly a debrief should be held.

**LADY JUSTICE THIRLWALL:** I just noticed that I think your microphone wasn't working and suddenly you have become very loud, so that's a much better state of affairs.

Sorry, would you ask the question again.

**MS LANGDALE:** Yes.

So you have at the top of the page, paragraph 11 (sic), you say you always felt strongly that a debrief should be held at the closest possible time to the significant event witnessed by neonatal staff.

**A.** Correct.

**Q.** Why's that?

**A.** That's what the research suggests. I think the common term for it now is a "hot debrief". There is a hot debrief and a cold debrief. So with people working shift patterns the chances of that exact team being back together within the vicinity the next few weeks would be highly, highly unlikely.

So it is better to gather as a group together there

and then on the shift where it occurs for everyone to kind of come together just to ensure everyone's well-being really before they go home because it's really difficult to go home with those, that high emotional state.

**Q.** As far as you were aware, was anyone at that debrief present when Child A had died and Child B had collapsed? Less than a week before, both of them?

**A.** I don't know whether I knew at the time. But I do now.

**Q.** So nobody said anything at the time, as far as you remember, about the deaths earlier -- the death earlier on in the week and the collapse of Baby B?

**A.** I don't remember, sorry.

**Q.** Do you think you would have remembered if somebody had said, "There's two in close succession" or any other such comment?

**A.** I probably did at the time but it, it was such, I think you can tell by my emotions and my earlier evidence it was a really, really difficult night and by that time in the morning, this was just beforehand over, I was completely drained so I could well have done at the time but I'm sorry, I don't remember now.

**Q.** You say attendance at such debriefs was not compulsory in 2015 and 2016. Even when it was still



within the shift if you like, it wasn't compulsory, or do you mean if they were booked at another time they weren't compulsory?

**A.** Yes, either. No one had to attend a debrief and they still don't now, it's still not mandatory now to attend a debrief, whether that's the hot debrief or the cold debrief, it's an elective thing to come along.

**Q.** Why is it an elective thing?

**A.** I don't know the answer, I'm sorry. I have always believed that debriefing is, is a good way to come together. Any debrief that is offered to myself I'll always try and attend.

**Q.** And roughly, do you think they are well attended or, you know, or not?

**A.** I think it depends on the person, some people think they are of use to them, some people think otherwise, so I think it depends on the individual.

**Q.** In terms of the matters this Inquiry is investigating, a debrief which might collate concerns that of their own don't seem significant but when you put them together are more significant, do you think it's important where those rare cases where it's abuse on the part of a member of staff is concerned that debriefs can be very productive to see wider issues, behaviour, broader context, and the like?



**A.** I don't think that would be discussed at a debrief. I think a debrief is about the team coming together to talk about the events. But I think concerns, if you are talking about suspicions, anything along those lines would be at their -- the reviews held by the Consultants following the death of a baby on the back of the clinical incident form that would go in about that. That's where you would look to see if there is any other matters of concern. That's not what I see as a debrief.

**Q.** So you wouldn't necessarily expect a nurse to raise any concerns about another nurse's conduct or comments or behaviour in that hot debrief when you are all together; there would be a different route for raising those afterwards, do you think?

**A.** That's what I would believe, yes.

**Q.** What would be that route? What is it and do you think it could be improved upon whatever that route is?

**A.** To raise concerns?

**Q.** Mm-hm.

**A.** So I think your first line would be your manager. That would be always your first line but then the matron would be the person above the manager and now within the Trust, there is a big Speak Up campaign but



only since the -- maybe the past two years since the criminal trial.

So we do now have a Speak Up representative on, on the ward, a nurse representative. So if you didn't want to approach it with your manager or someone in a senior position, you could go to her. Yes.

**Q.** Do you think an anonymous confidential line into a safeguarding unit if you had concerns about the way someone was behaving around children would be a useful tool for people to report items that they were concerned about?

**A.** I think it would be. I think anonymity gives you courage.

**Q.** It may seem obvious, but why does it?

**A.** Because people say that they won't judge but unfortunately that is society today; that they will. And so you will approach the situation differently, I think.

**Q.** And would it be different as well if it was someone independent from a manager or in the unit, so someone who didn't know the personalities involved, reporting a concern about -- it could be a member of staff's absurd comment or a comment that was so off that it raised real concerns?

**A.** Yes. Someone that's not part of the team

I think will be best placed for that because naturally within a working environment there are different groups of friends within a team and ideally all those different groups get on.

But if you had someone independent then they wouldn't be there to judge the personality or the kind hair, the little, you know, tittle tattles that go on naturally within any working environment. They would go in as, I would probably describe it as fresh eyes, that they wouldn't know any of the previous events or anything along that line so --

**Q.** A new perspective?

**A.** Yes, I think the term would be "fresh eyes", I think I have heard that term used around where there may be, I think like on ward rounds on different units, I know they do it on labour ward where a senior midwife will go and have fresh eyes over a situation around maybe a baby's monitoring inside the mum -- I know it's not along the same lines of debriefing whatsoever but the "fresh eyes" term is used within the NHS.

So it's that independent person with the fresh perspective, perspective that's the word I am looking for, a fresh perspective on something without any kind of bias.

**Q.** You say going back to your statement at



paragraph e on page 11, you say:

"... there will have been informal discussions about Child C's collapse and death."

And that would be very normal, you say, for nurses coming in on the shift over the next few days to enquire after Child C if they had previously met him and his family.

**A.** Yes, that that would be correct because that's your natural feeling as a nurse; is ultimately you want to care and if that baby wasn't then there you would naturally enquire as to where that baby was.

You don't necessarily think the worst. You think maybe they have been moved to another hospital, maybe they needed surgery. Your first thought wouldn't be that baby has sadly died. So you would do it at an appropriate time and in a private space as to where that baby had been, and I'm sorry, I don't remember how many days Baby C was before he passed away. So whoever had met him on those previous shifts would naturally be: Where is he now?

**Q.** So a professional and caring curiosity generally you would say --

**A.** Yes.

**Q.** -- if babies died? Would that be the same if they deteriorated or collapsed or when they have



recovered, or appear to have recovered, is that closure on that event as far as routes of enquiry are concerned?

**A.** Sorry, where's the question within that, sorry?

**Q.** When a baby deteriorates or collapses --

**A.** Yes.

**Q.** -- would there be the same informal conversations between people about that or if the baby's recovered does that not trigger the same enquiry that you have described for a baby who's died?

**A.** I think it depends on what you mean by "collapse". In some of the statements I have provided over the years, a collapse to maybe the police is a different way that I would use the termination "collapse". So a baby starting to vomit, in my mind isn't a collapse, but it may have been within the criminal proceedings.

In my mind a collapse is a baby that's needed resuscitation or it's a baby that's become critically unwell whether that's in special high dependency or intensive care and possibly if they were in special care and they had had a collapse and then in ITU you would definitely be curious around that, "Oh, gosh, what events led to that?"

So that's where some questions may be considered.



**Q.** And again informally, was there a nurses' room where you could eat lunch on the occasions you got time for it, or have breaks?

**A.** Yes.

**Q.** Where did you manage to speak together?

**A.** Yes, there is a break room.

**Q.** And how many people can sit in the break room?

**A.** I would say -- it doesn't exist anymore -- probably four, four to five.

**Q.** Four to five. So you could ask each other in breaks or informally. And was that kind of conversation taking place about different babies or patients?

**A.** I think naturally on breaks you try not to speak about the patients to be honest because that's your time to breathe and enquire about other people's personal lives and try to just have that little breathing space.

But you may enquire at that time.

**Q.** You tell us on page 13 of your statement about Child E and you met him on the night of 29 July?

**A.** Yes.

**Q.** Also on 3 August when you say -- well, how was he when you saw him on 3 August?

**A.** How was he when I saw him?

**Q.** Yes, the -- at page 12, b --

**A.** Yes.
**Q.** -- on the night shift.
**A.** So I don't remember now, from recall, but this is -- "the night of the 29th" was from my statement provided to the police a few years ago.
But the day of the 3rd I do remember. He was still in Nursery 1 in an incubator and he was clinically stable. He had a lot of skin to skin that day with his mum and the only concern I had that day was that he recommenced his, his insulin in the afternoon.
**Q.** And when you came in the next day, what was the news that you were given about Baby E?
**A.** That he had died.
**Q.** And who gave you that news?
**A.** I believe it was Lucy.
**Q.** And you say at paragraph d on page 13 where she was and what she told you. Can you tell us that?
**A.** Yes. So in the old unit, as you came in on the left-hand side, that's where the kitchen was where you put your bags and your food in the fridge, so that was naturally the first place you walked in when you entered the unit.
And I believe she came in here to tell me. I'm not 100% certain that it was Baby E but I am highly, you know, a high number that it was.



She appeared. She couldn't wait to tell me and it was not easy news to walk into first thing in the morning.
**Q.** And the way that that was imparted to you, did you think that was appropriate at the time?
**A.** No, I didn't think it was appropriate at all.
**Q.** In what way wasn't it?
**A.** Obviously when I had left only 12 hours previously the baby was clinically well. I should have been allowed to have come into work, received the handover with the rest of the support of the team around me, but I was bombarded with that information in the kitchen within a minute of walking on the unit. It wasn't professional. It wasn't conducted in a fair manner to myself.
**Q.** Did you mention that to anyone at the time? Any of your managers?
**A.** I don't recall, I'm sorry.
**Q.** Did you or any other nurse suggest talking to Mother E about this? About events, or not?
**A.** About how Lucy gave me the information?
**Q.** No, not how Lucy had given you the information but about -- about the death, did any nurse discuss that with Mother E, do you know?
**A.** Sorry, I'm not quite sure what you are saying



to me.
**Q.** Did anyone discuss with the parents, with Mother E and F about the death?
**A.** So the death had occurred in the night shift.
**Q.** Yes.
**A.** So they will have done but I was on the day shift before and the day shift afterwards. Yes, I did meet with the family that next day though because I was allocated to his brother Baby F.
**Q.** And was there any discussion at that point with her about what she had seen or observed the day before or anything, or not?
**A.** I don't recall, sorry.
**Q.** Baby M, if you go to page 17 of your statement, which is at page 18, paragraph e. What do you remember now about Baby M?
**A.** I remember the situation fairly clearly. He was one of a twin, he was in Nursery 1 in the right-hand corner. He was next to his brother, who was in an incubator alongside him. He was stable in terms of his observations on that day.
He did have some bile in his NG, which is an abnormal finding, but I did not think what happened on that day would happen for the morning.
**Q.** You say Letby walked over to his incubator to



check him -- to check on him as the type of monitor being used was quite sensitive and the alert could have been explained by something as simple as him kicking the probe off himself. When Lucy got to the incubator she immediately said that he wasn't breathing.
**A.** (Nods).
**Q.** So from what you have just said, that's nothing you expected to happen to him?
**A.** It's not what I expected at all.
**Q.** You say on page 19 that:
"Dr Jayaram arrived very quickly."
And during the resuscitation you remember thinking it wasn't looking hopeful because you had given him quite a lot of drugs.
And then you say and you told the police, at the bottom the page:
"... we had given him quite a lot of drugs but he wasn't responding until, and I don't really know why, I don't really know what made the difference, but he did respond and we managed to bring him back."
Can you expand upon that?
**A.** Yes. So we are following something here called the newborn life-support algorithm in terms of the management of the situation and the resuscitation and we'd got to the stage where we were administering

drugs and that being adrenaline, sodium bicarb, glucose, everything that is involved within the algorithm and we had given multiple doses of adrenaline.

So when you are at that stage, with experience, if they don't respond to the first or the second adrenaline, normally that baby will go on to die because in effect that baby is dead at that moment in time, they have got no heartbeat and they're not breathing, so if you were to stop the resuscitation that baby would not survive.

So you generally can carry on the resuscitation until the clinical team come to the conclusion that we all agree to stop the resuscitation and we were very close to doing that in this case with Child M, and then his heart started beating again.

The -- after every 30 seconds you listen in with a stethoscope, you'll auscultate and there was a heartbeat. So when I say he came back, that's what I mean; that his heartbeat was himself and not the compressions anymore.

**Q.** You tell us you remember talking generally to Dr Brearey when he was completing an echo scan on Child M within the next few days to see if there was an underlying cardiac condition that caused the collapse. What were you asking Dr Brearey about it?



**A.** So Dr Brearey is our cardiac link within the neonatal unit and that's why he was performing the echo and I guess it was just inquisitive.

I was trying to find an answer because it, it was unexpected and I almost needed an answer for what had happened and the fact that he was scanning the baby's heart made it suggest that there may be an underlying cardiac issue within this baby.

When babies collapse, when neonates collapse, the most common finding is that it's a respiratory cause because the majority of babies have a perfectly formed heart when they are born. Most cardiac conditions are picked up antenatally on scan. So I was really intrigued to know was there going to be something found on, on this echo scan. So I was asking appropriate questions within the situation.

**Q.** Can you remember what Dr Brearey said to you?

**A.** I remember him reporting the scan as normal to me.

**Q.** And then you tell us you remember Eirian Powell calling you into the office and asking what you had said to Dr Brearey about Child M's collapse. When did she do that, after she had seen you speaking with him presumably, or not?

**A.** I don't know whether she witnessed me speaking



with him or whether he went to her and said, "Nurse W has asked this question of me."

The recollection I have is that I was asked to come into the office to speak to her and she asked me, "What did you say to Dr Brearey?" and I just said exactly what I have said to you now.

**Q.** You weren't involved in any further conversations about Child M?

**A.** No.

**Q.** You have no memory of Child N or dealing with Child N at this point. Were you aware that medical staff were being requested at that time to let either Dr Brearey or Eirian Powell know about any serious deteriorations or collapses, sudden deteriorations, at the time of Child N, not Child M?

**A.** I don't recall.

**Q.** You don't recall anyone saying that: tell us now if you have got any concerns --

**A.** No.

**Q.** -- about it?

**A.** The only thing along that lines would have been the police were definitely involved. Whether it was before the first arrest or after the second arrest, I'm sorry I don't know the time order, but we had to let Cheshire Police know of any deaths on the unit within



a certain time frame. That's the only thing in relation to that question that I remember.

**Q.** The CQC visit to the hospital you deal with at paragraph 21 (sic), between 16 and 19 February. You weren't interviewed as part of that, were you?

**A.** No.

**Q.** Was there any preparation as far as you were concerned within the hospital or the unit for that inspection? Were you all asked to prepare any documents or anything or?

**A.** Not that I can recall.

**Q.** Do you know how it is that some people were interviewed or not? Was that something that was ever shared with you, or not?

**A.** Nothing was shared.

**Q.** You say at paragraph 61 of your statement:

"As time passed I was aware of the increased number of deaths on the unit."

Were you aware how many of those deaths were unexpected? You have obviously given your own evidence in relation to C and E. But in relation to A, D and I, for example, were you aware how many deaths were unexpected over this period of time?

**A.** I don't think they were ever labelled as that to us, no.

**Q.** So were all deaths labelled as deaths in this period between 2015 and 2016, whether they were sudden and unexpected or not?

**A.** To myself as a nurse member, that's what I remember as a nurse.

**Q.** So conversations about the mortality rate, the increased number of deaths, nothing specific --

**A.** I wasn't a part of those conversations.

**Q.** You then say:

"Naively, I believed that due to the increased acuity, and the more complex the patients were with significant risk factors, the mortality rate could logically increase."

**A.** Yes.

**Q.** Can you unpack that for us? What you thought then and when you say "naively" what you mean about that.

**A.** Yes. Naively because my opinion is obviously very different now. But at the time, and I think I mentioned it earlier, was -- as you are working shifts and if a baby dies at only maybe a couple of days old you may never find out about that baby's death.

So I don't think I knew the number of deaths on the unit, the complete total. I definitely didn't know any form of any shift patterns that were being examined on



who was on shift, who was not on shift.

I wasn't aware of that being looked into and the unit was extremely busy. We had babies that appeared with more complex -- complex needs during that year.

**Q.** How do you know that? What was your evidence base for that?

**A.** I think just the, the amount of infusions that these babies need -- that they needed. We had more ITU days on the unit. So I have got no statistics but from -- from my personal memory these babies appeared to require more from the nursing and medical teams during that year.

So "naively" is the word that I have, I have used because it's -- I am looking at everything that I am saying now with very different eyes and you don't think the unthinkable. I didn't think the unthinkable.

**Q.** How is -- how is it so unthinkable? You were, like your colleagues in the middle of this situation, what made it so unthinkable, given the babies were dying and were unexpected?

**A.** It's everything -- sorry.

**Q.** Not at all. Have you got some water there?

**A.** (Nods).

It's everything as a nurse that you will never believe will happen. You know what your duties are as



a nurse and you believe everyone has that same duty. And when it's some people like this, it's easier to see but at the time I didn't see it. I didn't see it at all. As a nurse on shift, we weren't aware of everything above. We didn't see any reports. We didn't see any staffing statistics. We didn't see any insulin results. We didn't have that bigger picture.

And I think the police said it to me that: you have just got a few pieces of the jigsaw puzzle when you go to court. All I went with was my statements and then since the trial I have read some of the evidence. When I then received the Rule 9 I was presented with more evidence that I had never seen before.

So when you have only got your awareness, you can't see the bigger picture and I can't speak for the whole team, that's not fair to them, but I can speak as a shift leader and I wasn't informed of, of any concerns around the bigger picture. What I knew was what I knew.

So ...

**Q.** When you were trained, did you get training on the Beverley Allitt case?

**A.** I definitely was aware of her, yes.

**Q.** And one of the recommendations from an Inquiry that followed that case was that there should be increased awareness, heightened awareness of her crimes



and the potential for those crimes, and the NHS, presumably in charge with communicating that message, be aware.

Do you think there was, as far as you are concerned, or is communication of that message?

**A.** Did I receive that message as a student?

**Q.** Yes, and subsequently when you are actually working in a hospital -- I mean, it is one thing to say heighten awareness but how would that be done? Did you have an awareness of that?

**A.** I had an awareness of it from my training. I don't think I received any further training on it from the Trust.

But what has come to light is the people with all this extra information, with the Consultants, and they were the ones to -- to raise the concerns and suspicions with more pieces of this jigsaw puzzle, as the police put it. And yes, you will hear from, I'm sure you have heard from some and you will hear from some further down the line as to what, what happened with them.

But they were the ones raising the, the concerns.

**Q.** You set out at paragraph 62 of your statements that you were on duty when the triplets were born, O, P and R, and you were allocated one of the triplets once admitted to the NNU, and you remember being very shocked

and worried when you came into work a few days later to find two of the triplets had died and the surviving triplet had been transferred out to another hospital and you say you began to think there might be something more going on. So something in the environment, is that what you were worried about?

**A.** It went through my mind because at this stage with two in such quick succession, and brothers, and the fact that the remaining *(redacted*), the remaining child was removed from the unit and went into a different unit, I guess I started to think --

**Q.** Started to think it's about the unit?

**A.** I started to think is there something more but, again, I had no concerns or suspicions. I thought was there something wrong with the water? I know the Inquiry know that there were filters on the taps in the unit. Was there a contaminated batch of medication?

I was starting to think of other things, but not the unthinkable.

**Q.** You tell us Letby was taken off the unit in June 2016 but you don't recall if you were informed the reasons for this.

**A.** No. I do not recall. Certainly I wasn't aware of the -- the kind of the content of what the Consultants had been saying or the extent of any, any



concerns.

**Q.** I am going to ask you to look at some general emails and also a press release just to see if this helps you in any way to remember events at the time. The first is INQ0004914.

And Nurse W, this is a press release, Information from the Countess of Chester Hospital, Thursday, 7 July at 2 pm.

You may not have seen it at the time, you may have done.

**A.** Sorry, there is nothing on the --

**LADY JUSTICE THIRLWALL:** We've got it now.

**MS LANGDALE:** Have a look at that and tell us if you have seen that before.

(Pause).

**A.** I -- I don't remember seeing it at the time, but it's highly likely that I did see it and if I can just point out the fourth paragraph, I think this is what we were being told as a nursing team; that these reviews were taking place, these independent reviews, and subsequently we were told that nothing was found on, on those reviews.

**Q.** Did you know what the Royal College of Paediatrics and Child Health and the Royal College of Nursing review was looking at?



**A.** No.

**Q.** But you were subsequently told?

**A.** Well, we knew they were looking at the mortality rates but we didn't know what they were looking at within that.

**Q.** And who communicated to you the results of those reviews, can you remember now?

**A.** No.

**Q.** Well, from what you said earlier you had no contact with senior managers, did you?

**A.** Executive level, no.

**Q.** So would it have been doctors or nurses, senior nurses?

**A.** I wouldn't want to say because I can't recall, sorry.

**Q.** Okay.

The next document, if we may, INQ0002879, page 91.

So this is from Yvonne Griffiths to neonatal unit staff, 15 July 2016. Have a read of that, please.

(Pause)

**A.** Yes, so I think at this stage *(redacted)*.

**Q.** *(Redacted)*.

**A.** *(Redacted)*.

**Q.** Okay, so you won't have had emails July and August?



**A.** (Nods).

**Q.** And I won't take you to the other ones as well.

So do you remember any discussion before you went off about what was being examined or investigated or potential secondments or anything like that?

**A.** Not that I recall.

**Q.** Moving to paragraph 65 of your statement. You say there's been a big campaign in the hospital around Speak Up.

At the time, 2015 to 2016, were you aware of the Trust policy on Speak Out Safely by way of reporting a fellow professional, or not?

**A.** I -- I couldn't quote it. I think as part of when I received my Rule 9, they, they asked me did I have anything to contribute kind of in terms of documentation and I searched back within my emails and I provided this Trust Executive blog which was dated July 2018.

And it said within there "we have always supported a culture", I can't comment because I never used the Speak Out Safely line myself, so you will have to use others within the team, ask others within the team that have tried to use the Speak Out system.

But, yes, you are quite right in saying they have

mentioned there, it's only been in the past two years since the criminal trial and the CQC inspection this year that has -- there's been a big campaign within the Trust about Speak Up.

**Q.** Paragraph 72 under "Reflections", you suggest recommendations this Inquiry should make to keep babies safe from any criminal actions of staff.

The first one, and of course you do work at the Trust now, so perhaps you can help us with the implementation of these as far as you are concerned.

The first one, you say:

"Zero separation from the parent/guardian."

**A.** So, so what I am meaning there is that it's 24 hours open access to parents or guardians. I believe still on some neonatal units during the handover times, nursing medical handover, cot side handovers, that parents aren't allowed on to the unit during that time for patient confidentiality and that did exist at Chester during this time period but it doesn't anymore.

**Q.** So how do you get round that issue where --

**A.** You seek an area of privacy and quite often you will actually handover in front of the family if there's no other familiar within the room so they can be part of the handover processes, part of the Family Integrated Care that I mentioned earlier.



**Q.** And you say:

"24-hour unlimited access to parents/guardians.

"... Parent/Guardian bed at each cot side ..."

We know that some of the mothers on the indictment themselves were still in need of care post surgery, so in those situations, can you still be next to the baby when needing --

**A.** So they need to be -- so the mum needs to be medically well after delivery but what is quite common practice at the moment is the mum remains on the postnatal ward and the dad or the supportive partner can be on the cot -- on the bed next to the cot side.

**Q.** So a family member or close friend?

**A.** I'm not sure close friend, but it would be a supportive partner in terms of a same sex relationship, I mean by that.

**Q.** Okay. You say at d:

"Restrict 'traffic' on NNU, minimise swipe access to core staff, sign in/sign out for all non-core staff ..."

Should that be feasible electronically? Do you have that now?

**A.** So that's around our swipe access.

So although the nurses are really good at kind of stopping people and asking them, please can you provide,



you know, show us your swipe card with your photograph on to say, like, who are you, what's your purpose for your visit for safeguarding of the babies. There's a lot of people coming in and out, not necessarily into the nurseries but around the rest of the unit in terms of topping up pharmacy supplies, for instance, or linen supplies, getting rid of waste, kind of the extra things that go on within the unit, not directed necessarily to patient care.

There's a lot of people that can come on to the unit with the swipe of a card.

**Q.** You also say at f:

"When there is a patient death, document at the time all staff present the shift before and current shift. This will highlight any trends, including student nurses/midwives/doctors, allied health professionals ..."

**A.** Yes, so I would never have thought of this before the trial but it's clear to see now that was one of the first things that they looked at within the reviews, which I have only seen since I've been given my Rule 9, is staff who were present around the time.

So I have specifically said also around students and allied health professionals because they are not on our clinical nursing roster, so you would have to go



elsewhere to find out who was on shift from their perspective.

**Q.** And you say, your final suggestion:

"Staff to think the unthinkable."

How does that message -- how could that message be communicated?

**A.** I honestly don't know. I wish I knew the answer. But I will always personally think it from now on.

**Q.** You say in relation to documents you:

"... kept a copy of the email in my NHS email from Letby which outlined her intention to return to practice and the 'apology' from the paediatricians. I have searched for this email but cannot locate it."

Did you delete it or are you suggesting in some way that's been removed from the emails?

**A.** I don't remember deleting it. So I think it's possibly been removed from my emails.

**Q.** So you kept it purposefully, or didn't delete it? You tell us in your own words.

**A.** I have got a folder within my NHS mail secure email called "Investigation" and within there are copies of emails that come from the Trust, the email from Lucy was within that police statement, so in there. Anything that I believe that I may need to refer to again in

terms of investigation is within that folder.
**Q.** And when did you discover that wasn't there then?
**A.** When I went to look for it when I got given my Rule 9 to ask if I had any other documentation.
**Q.** You say the support you had around the criminal trial, what was that like, within the Trust?
**A.** Can I read this because it took me a long time just to -- to write it? Is that okay so I can get the words --
**Q.** Of course.
**A.** -- correct?
**Q.** Of course.
**A.** Yes.
(Pause).
Sorry. I don't know whether I can read it. Can someone read it on my behalf?
**Q.** I can read it. Is this paragraph 75?
**A.** Yes, please.
**Q.** "I would like to make it known that the Trust's initial handling and support around the criminal trial to the staff on the NNU was abysmal ... I found out that a nurse had been arrested from a phone call ... Other units of the hospital found out before the staff working in the NNU. As a team we had to ask repeatedly



for information and updates. The Trust were neither forthcoming nor willing. There were endless broken promises to our team. The Trust were more concerned about protecting their public reputation than providing even a basic level of support to their neonatal team in crisis. The unit became even more isolated."
**A.** Yes. So when it says phone call that was a phone call from a family member, that wasn't a phone call from, from the Trust *(redacted)*, so I received a phone call whilst I was at home.
**Q.** *(Redacted)*, a phone call from a family member, no support or preparation --
**A.** Exactly.
**Q.** -- from the unit you were working in?
**A.** But would it be the unit --
**Q.** The hospital.
**A.** -- that give this information? I would believe this would be an executive level that our team who were in crisis, and had been for a little while, I think we deserved better as a team.
**Q.** In terms of bereavements and supporting parents with bereavement and palliative care, how would you describe the difference in 2015 to 2016 to what is available now in the Trust?
**A.** Yes. So in 2015, 2016 there was a bereavement



link nurse on neonatal. There was -- I don't even think necessarily there was in maternity but there was a midwife with an interest and who did her best.
Now there are two link nurses on the neonatal unit with an interest in bereavement, one with a hospice background, so she brings that perspective, and in maternity there is a designated midwife called the Lavender midwife and she is employed and so she will support antenatal losses, stillbirths, and neonatal deaths, and the two bereavement link nurses on the neonatal unit work well with the Lavender midwife.
**Q.** And you say there is a remembrance service led by the Spiritual Care team?
**A.** Yes.
**Q.** You see in paragraph 77. What's that about?
**A.** So here I am criticising the Trust Executives. I have said that:
"I feel that since 2018 some Executives have become involved where I think they did not need to be, which has created unnecessary obstacles to neonatal bereavement and palliative care projects that we have wanted to take forward. I understand and sincerely respect ..."
**Q.** "... sensitivity must be shown to the families involved with the trial, but this appeared more to



protect the Trust's reputation and not draw any more attention from the media. An example of this would be each year there is a remembrance service led by the Spiritual Care team. Neonatal and maternity bereavement services have wanted for many years to be included within this but also highlighted separately, this has been forbidden by the Executive team."
**A.** Yes. So what I am saying here is with absolutely the most respect to these bereaved families during 2015 and 2016, is neonatal/maternity services have strived to continue to improve their services and the executives have put some form of obstructions within that because they haven't wanted to appear insensitive to the families, is what their stance was.
But I believe there is more of a -- that they don't want to have any more media attention brought upon them.
**Q.** You say finally that you:
"... feel the neonatal team has been failed by the Royal College of Nursing. They have been noticeably absent throughout all aspects of the criminal processes, from the first arrest in 2018 until present."
What's your criticism there of the Royal College of Nursing? What do you think they should have been doing?
**A.** They should have been there from the, from the very beginning. They may not have known about anything

until the first arrest. But from the first arrest they should have reached out to all of their members within their, their body of nursing for any support that they may offer.

We have very much been as a nursing team on our own providing peer support to -- to one another without any regulatory body there to represent us and support us. And I have not written this to take anything away from the families because the families are at the heart of everything that I do but as a nursing team we needed more.

**Q.** While you were all giving statements to the police, it may have been more difficult to have group conversations, presumably you couldn't have those, could you, about the events being investigated? Was that the case? Is that what you were told?

**A.** There were numerous excuses as to why we weren't allowed things. But then over time things did get put in place, so they needed to just consider what could happen rather than what wasn't allowed to happen and I do know that -- I think it was the mid-Staffordshire Hospital reached out to our hospital after their investigations a few years ago and said: let us know how we can support you. Because they had already been through a similar event, not the same but



similar in terms of the nature of the incidents and so that Trust were offering to help the Countess.

So they knew what they could and couldn't do for their staff already. I don't know whether that help was declined but I never saw any evidence of it.

**MS LANGDALE:** Thank you. Those are my questions. Mr Baker has some questions, my Lady.

**LADY JUSTICE THIRLWALL:** Thank you, Ms Langdale. Mr Baker.

**Questions by MR BAKER**

**MR BAKER:** Thank you, my Lady.

Hello, Nurse W, I ask questions on behalf of some of the families.

**A.** Hi.

**Q.** I begin by saying if I say anything that upsets you, or you want a break, just say.

**A.** Many thanks.

**Q.** I also want to say at the outset I'm not here to suggest that you personally should have put all the pieces of the jigsaw together and identified Letby.

**A.** Yes.

**Q.** So please understand that when I am asking these questions.

**A.** Okay.

**Q.** Do you have a copy of your witness statement



in front of you?

**A.** I do.

**Q.** So if we could begin at around paragraph 25, please. This is in relation to Child C whose family I represent. And it's describing the events on the night when Child C was attacked and there had been a discussion at some point that led to Letby being allocated to Nursery 3 as opposed to Nursery 1.

How far away is Nursery 3 from Nursery 1?

**A.** Not very. About five metres.

**Q.** Okay. But it deals with children who are perhaps far less vulnerable than the children in Nursery 1.

**A.** So a baby in Nursery 1 is more likely to be receiving intensive care or high dependency support. However, as I said earlier, there was a baby in Nursery 3 that I was concerned about on that evening, so even a baby out in special care can become poorly and so nurses and the nursery nurses need to be observing those babies accordingly to look out for any signs of decline in their, in their well-being.

**Q.** Yes. And we know that on 13 June, because you refer to it, it's in your witness statement, there is a text message or an instant message from Letby to another person, where she says:



"I just keep thinking about Monday. Feel like I need to be in 1 to overcome it but Nurse W said no."

Do you recall seeing that text message?

**A.** I've seen the text message. Yes, I didn't know anything of any text messages until the criminal trial.

**Q.** Do you think based upon that it may have been your decision to allocate Letby to Nursery 3?

**A.** It could be read in that manner. Even with everything that has happened through the trial and now the Inquiry, irrespective of everything, I would still stand by the allocation, that if a nurse had recently dealt with a bereavement that they shouldn't then go back into ITU, that they should go out into special care as a well-being protection for that staff member.

**Q.** Have you ever --

**A.** I would always have the interests of the staff member at heart.

**Q.** Thank you, and sorry for interrupting you, but have you ever come across an ideal or practice that a nurse should be put straight back into ITU having suffered a bereavement?

**A.** I haven't seen that practice at Chester.

**Q.** Now, your evidence in your witness statement is -- you refer to your police statement. You say:

"I got the impression at the start of a shift that Letby would have preferred to be in Nursery 1 as opposed to Nursery 3 as she was above Sophie in the ranks."

And Sophie is another level 5 nurse, the same level as Letby.

**A.** Yes. So with that, I mean that Lucy had her qualification in speciality and Sophie didn't.

Lucy would quite outrightly tell you that she preferred being in intensive care and high dependency, and different nurses work in different ways. Some prefer the ITU work, some prefer the special care work, and she would, she would say that she preferred ITU or HDU, and she wouldn't have liked the fact that Sophie was being given the chance to have some intensive care experience with support.

**Q.** The way it's phrased in your police statement which you quote at 25 is that she's above Sophie in the ranks, and in the following paragraph, paragraph 26, you say:

"Letby did not appear to like that Sophie, who was a recently qualified Band 5, was allocated to an ITU baby and she had been allocated to special care babies as a senior Band 5."

Now, one interpretation of what you have written there is that it had pricked Letby's ego that she had



been sent to Nursery 3 and a more junior nurse had been sent to the intensive care unit. Is that a fair interpretation?

**A.** I think it's a fair interpretation.

**Q.** As a neonatal nurse and you yourself are a Band 6 nurse, would you see it as being beneath you to go into room 3?

**A.** Absolutely not. No.

**Q.** Why not?

**A.** Because every baby irrespective of dependency level requires the care that we are there to provide. It doesn't matter what level of care, they are someone's baby, and they deserve the utmost best care that you can give them to get them home safely.

**Q.** Do you think in your interactions with Letby on 13 June that she recognised that?

**A.** Sorry, please may you repeat the question?

**Q.** Do you think in your interactions with Letby on 13 June that she recognised the concept of what you just described?

**A.** No.

**Q.** In fact, you had allocated Letby to room 3 because you were concerned about the safety or health of the baby who was in there, hadn't you?

**A.** I'm not sure I did the allocation but whoever



did the allocation --

**Q.** Forgive me.

**A.** -- knew that -- actually, no. Let me go back a step.

I do not recall if the baby in Nursery 3 had those increased work of breathing signs on the day shift. I certainly noted them on the beginning of the night shift and asked for the doctor to review.

So whoever allocated that baby may have been unaware of that but, as I say, irrespective of whether the baby required that extra level of observation, Lucy was allocated that workload to -- to care for those babies and it doesn't matter what level they need, they need some form of level and that's why they are in the neonatal unit and not at home.

**Q.** You say that:

"Letby appeared [to be] quiet with me, and she appeared not to be happy with the allocation."

Another witness described her as being angry at being allocated to room 3. Again, is that a description that you would agree with?

**A.** I don't recall her being outwardly angry. I remember her being quiet. But then I think in terms of I have described that I was angry with her, within my statement I'm not an angry person on the outside, it's



on the, on the inside.

**Q.** Do you think she was being moody with you, sulky?

**A.** Yes.

**Q.** Now, the child who Letby was looking after in Nursery 3, you were concerned about that child, and I don't need to know any more details whether it was a him or her or anything else, but you were worried about that child?

**A.** That's correct. My worries were brought to reality, unfortunately, just after handover that next morning. That baby was given the care that I had -- or had received the investigations that I had requested 12 hours previously, that baby had a very high CRP level which showed he had overwhelming sepsis and he actually was self-ventilating in air at the start of the night shift and he ended up on respiratory support. So my concerns were correct.

**Q.** Yes. And you say at paragraph 30 -- you describe what Nurse Sophie Ellis has said in her witness statement, her recollection of Child C's collapse, and she, I think, had popped out of the room for a little while when Child C collapsed.

**A.** That's what I have written in my statement. My recall is when I was called to help that Sophie

hadn't been there initially.
**Q.** And Letby, however, was in the room, was in Nursery 1 at the time of the collapse, it appeared?
**A.** No, that's not my recollection.
**Q.** So you say:
"I do not remember if I was informed at the time by Nurse Ellis or anyone else about Letby's presence in Nursery 1 [at the time of Child C's collapse]."
**A.** Yes.
**Q.** So the answer is --
**A.** I was shown my transcript of the court because I was saying that I couldn't 100% recall so they showed me the transcript.
**Q.** Yes.
**A.** And I think the judge -- how do I word this -- the judge agreed that I said I couldn't 100% recall -- my memory wasn't that she was there at the time of the collapse, but I said I couldn't 100% confirm that.
**Q.** Yes, so the answer then is you don't know whether she was in the room or not?
**A.** Correct.
**Q.** Yes. But you are aware that Nurse Ellis had been out of the room?
**A.** Correct.
**Q.** Now, you go on to say at 32a, you talk about



the use of the Guedel for -- the Guedel airway.
I mean, I just want to be clear about this. Are you aware of any other occasions when a Band 5 nurse has used a Guedel airway?
**A.** Not that I can recall. We are all trained to do it though as part of our NLS, which is a mandatory course that all neonatal nurses within two years of qualification must attend every four years externally, and we have a yearly update on the ward also. So it is part of NLS training but I can't recall another Band 5 using it so soon within a resuscitation.
**Q.** And then moving on to the period following the cessation of resuscitation, you're, from paragraph 33 onwards, describing events after Child C had moved on to palliative care.
**A.** Mm-hm.
**Q.** So you could understand why Letby would be present at a resuscitation because it's all hands to the pump --
**A.** Correct.
**Q.** -- at that point.
But following that point, there is no good reason at all for her to be in Nursery 1, is there?
**A.** I could see no reason for her to be there anymore.



**Q.** In fact, she really needed to be in Nursery 3 where she was supposed to be caring for a sick baby?
**A.** Correct.
**Q.** You go on to say:
"I was surprised, shocked and frustrated that Letby had refused to comply with my instruction to return to care for another baby."
Why, why did that shock you?
**A.** I think I said it earlier; it appeared very selfish. She wasn't working as a team. She seemed to be working for herself, the -- the babies on this night shift still required the help. I have said within my police statement and it got mentioned in court that Sophie had become upset around the resuscitation of Baby C, we needed to protect her.
The other baby in Nursery 1 was on a ventilator. That baby remained one to one, that baby was originally allocated to Mel so I took on that baby as well as trying to ensure the safety of the rest of the unit.
So it shocked me and I became frustrated by it because she was not playing as a team.
**Q.** And also you are a Band 6 nurse and her direct supervisor in that situation and you told her to go and look after a baby in Nursery 3 and she had ignored it.
**A.** She did ignore it, yes.



**Q.** And it was proven to be detrimental to the baby in Nursery 3 who then deteriorated; that was your impression?
**A.** So the baby didn't get any sicker but the baby also didn't get any better. He didn't acutely collapse. He didn't need resuscitation but should those antibiotics -- should that baby have had a septic screen on that night? Yes, he, he should. And he should have received the antibiotics much, much sooner than he did. There was a delay in the caring treatment for that baby, and ultimately that is the nurse's responsibility. They are the one performing the observations and reporting any escalated concerns on to the shift leader and the medical team and she did not do that.
**Q.** Instead, Letby was inserting herself into Child C's family's grief, wasn't she, she was going in and checking on them asking them things, offering to do things for them?
**A.** She was going into the family room, I don't know what was said until I read it in my Rule 9. But I do know she was going into the family room, yes.
**Q.** I mean, it might be suggested, and it certainly would be suggested by the family of Child C that this was ghoulish behaviour, that she was inserting herself into, into their private space?

**A.** She didn't need to be there. Mel was more than competent to be there at that family support. They didn't need any more people than, than they had. Too many people in that situation can be overwhelming for the family. So they only needed Mel and Mel was coming back to me for support and extra direction if she needed it. Lucy did not need to be there.

**Q.** Indeed the appropriate thing in that situation is to be of light touch, to offer help when it's needed or asked for, but not to overwhelm the family?

**A.** I agree. The health professional didn't need to be there at all times. The parent needed their, their private space.

**Q.** You obviously considered this to be very serious at the time because you reported it to Eirian Powell and also then completed a Datix about it.

**A.** Correct.

**Q.** Is that -- is that because you considered it to be inappropriate behaviour or because you considered it to put the other baby at harm or a combination of the two?

**A.** I think the Datix went through in as a delay in treatment for the baby in Nursery 3. That's the way the context of the Datix went and the delay in treatment came by her going to care for Baby C when she didn't



need to be.

**Q.** Thank you. I am going to move on if I can just to briefly ask you some questions about Child E.

You have said to counsel to the Inquiry that Child E was making good progress as far as you were concerned before the collapse.

**A.** That's right.

**Q.** You have also said that it was Letby who came to talk to you to tell you that Child E had died.

Melanie Taylor in her evidence described her as inappropriately gossipy and excited when she gave her that news. Would you -- would that have been your impression as well?

**A.** "Excited" wouldn't be the word that I would describe. I would say eager; eager to tell me that this situation had happened and -- sorry, my mind's gone blank -- what's -- highly inappropriate.

**Q.** Highly inappropriate, did you say?

**A.** Yes.

**Q.** Indeed I think you also felt that Child E's passing was so unexpected to you that you felt it necessary to go and review the records because you were concerned that you might have missed something?

**A.** That's correct because I had helped care for this baby for 12 hours previously, so I wanted to have



a look at the order of events that had led to Baby E's death during that night.

My first reaction was blame on myself. Had I missed something? Had there been a sign there that I had missed?

**Q.** But you found nothing?

**A.** I found nothing.

**Q.** No. If you had discovered that Mother E had encountered Letby stood by Child E, who was bleeding from the mouth, had told her that she had contacted the Registrar but then discovered that the Registrar had not in fact been contacted for approximately an hour and that the notes had been recorded inaccurately thereafter, what would you have done in response to that?

**A.** If -- can I just clarify what you are asking of me? So had I found that the notes had been written incorrectly?

**Q.** Yes, to -- to describe an inappropriately short interval of time between the Registrar being called and the onset of symptoms?

**A.** I would report it to the manager.

**Q.** Do you think sometimes a debrief with parents as to what they recall happening and sequence of events might be useful? I appreciate it wasn't necessarily the



practice at the time, but might it have been useful if you were able to find out that mum disagreed with what had been written in the notes?

**A.** So in terms of debrief for parents, it's not something I have ever considered for with that terminology around it.

What I do know was in practice then, and is still now, is every set of bereaved parents have the opportunity to meet back with their, their named Consultant at a later opportunity and I believe that is once any results are back from post-mortem, any other air tests that were done at that time and would that be the correct time to offer that service? It probably would and it probably is done to some extent too.

But I don't know whether they look at case notes and things like that together. I have never been a part of that conversation.

**Q.** Just two very brief questions or two very brief topics, one is in relation to Child J. There was a meeting between Child J's parents, Dr Saladi and a nurse where they were complaining that Child J had been left with their nappy off and their stoma leaking and wrapped in a towel. Do you recall if you were the nurse at that meeting?

**A.** I don't recall. I have never been questioned

with anything with regard to Baby G, I'm sorry.
**Q.** J.
**A.** Baby J, I'm sorry.
**Q.** Obviously Child J had a Broviac line in place --
**A.** Yes.
**Q.** -- and so you would understand that allowing a baby to be covered in faeces that has a Broviac line in place would be dangerous?
**A.** Correct.
**Q.** And should be taken very seriously?
**A.** Yes.
**Q.** And should be the subject of a Datix report?
**A.** Yes.
**Q.** Finally then in relation to Child K. You make some comments about finding the endotracheal tube had been displaced and it had moved.
Now, Child K was a small premature baby.
**A.** Yes.
**Q.** Intubated babies are sedated so that they can't move around or risk pulling their own tubes out.
**A.** Not sedated in terms they couldn't move completely, no. That would be a paralysis and sometimes that happens and I do actually think just before Baby K was transferred they, they were given the paralysis



medication.
But during the incident where you are talking at 20 past 7 in the morning, I believe she had some morphine being infused, but that would not be enough to not make that baby move by themselves.
**Q.** But it would be extremely unusual for a tiny premature baby to pull out its own endotracheal tube or push it in?
**A.** If the tube was secured correctly, it would be highly unlikely.
**Q.** Yes. And your account at paragraph 51c records that the tube had previously been secured?
**A.** Had it been just recently resecured? Sorry, was that the question?
**Q.** Yes. So you had noted that it had previously been secured before it became dislodged?
**A.** Yes, that's what was handed over to me, yes. I wasn't there at that time but yes, that's what I'd been told.
**Q.** You say you cannot recall whether any enquiries were made at the time regarding the displacement of the endotracheal tube. Do you think with the benefit of hindsight some form of enquiry as to how this tube moved might have been appropriate?
**A.** So I know at the Liverpool Women's Hospital



they do an audit, I don't know how frequently that happens, and that looks into displacement of ET tubes, so that would -- may be something that could be translated across all units and then that, that may be discussed there.
**Q.** So as to understand how it happened and perhaps how it might be prevented in the future?
**A.** To see if there was a reoccurring theme.
**MR BAKER:** Yes, thank you.
Thank you, my Lady.
I have no more questions, Nurse W.
**MS LANGDALE:** No more questions from me, my Lady.
**LADY JUSTICE THIRLWALL:** Nurse W, I don't have any questions either so thank you very much indeed for coming this morning and being here with us this morning and this afternoon. You are free to go now.
**A.** Thank you.
**LADY JUSTICE THIRLWALL:** Thank you.
**MS LANGDALE:** My Lady, resume at 3.45?
**LADY JUSTICE THIRLWALL:** We will rise until 3.45.
(3.28 pm)
**(A short break)**
**(3.45 pm)**
**LADY JUSTICE THIRLWALL:** Good afternoon. Sorry, Ms Langdale, I'm just waiting for the pen I have left



downstairs but we can start.
**MS LANGDALE:** I think we might need someone to swear the witness in. May I call Nurse ZC.
**LADY JUSTICE THIRLWALL:** Thank you, Nurse ZC. I'm sorry for the slight pause, it's because my clerk has very kindly gone to find the pen I left behind and she is meant to be administering the oath. So perhaps if you would -- are you affirming or are you taking the oath?
**A.** Affirming.
**LADY JUSTICE THIRLWALL:** Affirming. Well, if you would like to just pick up the card which is just in front of you.
NURSE ZC (affirmed)
Questions by MS LANGDALE
**LADY JUSTICE THIRLWALL:** Thank you very much. Ms Langdale.
**MS LANGDALE:** Thank you.
Nurse ZC, you have provided a statement dated 23 May 2024 for the Inquiry. Can you confirm whether the contents are true and accurate as far as you are concerned.
**A.** Yes.
**Q.** Do you have the statement in front of you?
**A.** Yes.

**Q.** So we see from the beginning of the statement, Nurse ZC, that you completed a Diploma in Children's Nursing at the University of Chester in September 2010.

You -- moving to your first Band 5 nursing opportunity, that arose within a temporary placement within the neonatal unit at the Countess of Chester which you joined in 2012, is that right, for that role?

**A.** Yes.

**Q.** You have done other roles before, I'm just focusing on that one.

**A.** Yes.

**Q.** Can you tell us what that role was under the temporary contract --

**A.** Yes, so it was a Band 5 children's nurse on the neonatal unit.

**Q.** You then took employment in children's emergency departments in other hospitals and worked briefly in a hospice and you returned to the Countess of Chester in 2015, is that right?

**A.** Yes.

**Q.** 2015 to 2017?

**A.** Yes.

**Q.** And you were working in the children's unit then not the neonatal unit?

**A.** Yes, the children's ward.



**Q.** Children's ward. So what were your responsibilities then?

**A.** So I was, again, a Band 5 children's nurse on the children's unit, predominantly working night shifts, it was a rotation -- it was meant to be a rotational post between the children's ward hospital at home and the children's assessment unit which I think I just did one short rotation to the assessment unit and then was back on the ward, as I say, predominantly working nights.

And that's looking after acutely unwell children on the children's ward.

**Q.** And when you were working in that time, 2015 doing the nights, what was the overlap between doctors between neonatal unit and the children's ward? Was there any?

**A.** Do you mean on how the doctors rotated?

**Q.** Yes, how the doctors rotated, yes.

**A.** So I think it was -- I think they rotated every six months from different areas and the children's ward and the neonatal unit would share the doctor -- not share them as such, but they would be the same doctors, they didn't have specific doctors based on the neonatal unit and the children's ward; they both worked across the different units and over to the emergency department



when they were required over there.

**Q.** And in terms of the nurses' break rooms or anything similar, were they separate from the children's unit and the neonatal unit or did nurses frequent both or interact much?

**A.** There was a break room that was on the corridor in between both of the units that was accessible to the children's ward, the neonatal unit and often some of the other wards within that building would use that ward. The children's unit did have sort of a resource room that sometimes people might stay in there if the ward was particularly busy and, equally, when I was on the neonatal unit, they also had sort of a little room within the unit there that you could access for a break room.

**Q.** So would you know many nurses from that unit and vice versa or not really?

**A.** I think I knew the nurses because a lot of them were still the nurses that were there when I worked on the neonatal unit previously.

**Q.** Yes.

**A.** But with me working predominantly night shifts it was very rare that I would access the break rooms anyway.

**Q.** As a generality on your ward, were night



shifts quieter than day shifts or how did it work?

**A.** No, I would say, if anything, the night shift probably seemed busier because you had less staff of a night, so in the day you would have more nurses around, more healthcare support workers, and there would be more doctors and Consultants around whereas of a nighttime you would only have the three nurses and one healthcare and then it would be two doctors working between the different units of a night.

So even though it might not have seemed as busy as such, with the workload and less staff it sometimes, I don't think it was ever quieter of a night time.

**Q.** Paragraph 14, you say in your statement:

"Letby and I commenced our employment on the NNU together on the same day in January 2012. While we had no prior acquaintance, our simultaneous start led to frequent interactions during the initial weeks."

And you go on to tell us about something Letby said to you at that early stage that you say caught you off guard. Can you tell us what that was?

**A.** Yes, we had been on a mandatory training -- I can't recall what it was specifically -- and obviously, so during that time we did spend our days together, I think the mandatory training was sort of Monday to Friday, 9 to 5, and she did make a comment

that she'd said that she can't -- something along the lines of she can't wait for her first death to get it out the way with, which -- it took me back because, for me, the thought of having to experience that, it was something that actually even though, you know, I was a trained nurse, it's not something that you actively want to happen. But at the time I just took that as she was trying to make conversation with someone that she didn't know. It wasn't something that I instantly thought "that's alarming", I just thought it was a little bit strange that that was the sort of conversation that she was having with me.

**Q.** You say you didn't perceive any sinister intent behind her statement deeming it rather peculiar rather than necessitating formal reporting?

**A.** Yes. It was sort of said offhand. It wasn't an in-depth conversation, it was just part of a normal conversation that then moved on. So it wasn't like it went any further that made me think, oh, it's something that she's really, you know, thinking about.

**Q.** You then tell us about a baby, and I won't ask you much of the details, in early 2012.

**A.** Yes.

**Q.** A baby that was ready for a step down care in preparation for discharge had been admitted to the



Countess from somewhere else and she was in a process of, you describe it as feeding and growing. What was that, what was expected when she was at the Countess of Chester?

**A.** So with that, it's -- this specific baby had been to a higher-level unit and they had sort of come back and it's kind of a way of the parents adapting really of having a lower-level unit because the runnings are different and it kind of the baby wasn't quite ready for discharge because they need, I think, if I remember rightly they needed to be a certain weight before they could be discharged.

So it was sort of a step down from this higher level to monitor the feed and growing and to give the family support and during that time as well the parents would sort of stay on the unit and they would be provided with sort of basic life-support before they were discharged home with the child.

**Q.** And you explain that you had been on the long day shift and the baby had collapsed unexpectedly during the night shift.

**A.** Yes.

**Q.** And then when you came in the next day, you are looking for the patient on the patient allocation board, is that right?



**A.** Yes.

**Q.** And what do you find out?

**A.** So as I said in my statement, it wasn't unusual that there wouldn't be anyone around at that point because, you know, they would be feeding babies and doing cares and preparing for handover.

So I was kind of looking at the allocation board and the baby's name wasn't there. So obviously I was wondering where she had gone, had they forgot to put the name on, and not long after I had been there Lucy had then sort of presented quite animated and told me everything that had happened with the baby, that she had been involved with resuscitation attempts and, again, it was something that took me -- it took me by surprise because obviously the baby had been so well when she came, came back and equally, I guess I didn't feel that I would be as confident in that situation as Lucy was sort of portraying during that conversation telling me about what had happened.

**Q.** You say you:

"... specifically remember Letby informing me about the blood during intubation and how the doctor had struggled to get the tube down. She expressed the parents' anguish ..."

How was this information communicated to you? What



was the tone of it?

**A.** Throughout the whole conversation, I would say in my statement, she was animated with it. It was kind of like it was an excited -- she was excited to tell me about it but reflecting on it, when I -- at the time, for me it was kind of, was that still the adrenaline, everything that she's experienced that she just needed to offload it to somebody? But it definitely was -- she was animated in telling me about it. It wasn't as if she, she didn't seem upset or that she, it had traumatised her in any way.

**Q.** You tell us that you had a conversation with Yvonne Farmer --

**A.** Yes.

**Q.** -- about it. She was the practice educator, Band 6 nurse --

**A.** Yes.

**Q.** -- and a link for new nurses, as you were, on the NNU, and students. So what was the basis of your concerns with Yvonne, what were you raising with her?

**A.** I think the conversation that I had had with Yvonne, obviously, you know, she was sort of our link that we would go to with us being newly qualified perceptors and new to the neonatal unit.

My concern around that was that I had actually

missed something. I didn't go to Yvonne escalating concerns about how Lucy had conducted herself to me telling me, it was more my concern as a newly qualified nurse that actually had I have picked something up the day before, had -- before my shift, would things have been different?

So that was sort of the basis that I had had a conversation with her, that -- wanting reassurance, really, that, you know, it hadn't been something that I had missed.

**Q.** And you tell us she reassured you you had not missed anything, and:

"... this is something I will experience on neonates."

You were a newly qualified nurse at this stage.

**A.** Mm-hm.

**Q.** Did you accept that they can be unpredictable?

**A.** Yes, so I think, again, there was other nurses on shift, I don't recall who they were, and they had equally told me the same that, you know, premature babies, they can be unpredictable, that this was a baby that had spent time on another high level unit and sometimes, you know, they can deteriorate without any sort of signs.

**Q.** You weren't approaching Yvonne Farmer about



apprehensions about Letby. Do you think you did tell her, as you have described, the animated conversation, or not? Were you more focused on the baby themselves?

**A.** I was more focused on the baby but I know further along I think that my concern -- not my concerns as such but I think maybe I felt a little bit intimidated that I wasn't as confident as Lucy had come across in that situation, that we had both started together and my thoughts were if that had have happened to me at that point, and I was experiencing a baby arresting in the manner that I had been told, that I wouldn't have been as confident dealing with it as she portrayed.

And I think that's sort of where, you know, it was sort of, well no, you know, this was the first Band 5 job that came up and I didn't actually have an interest in pursuing a career in neonates and I think that's sort of what was deemed the difference between myself and Lucy, that actually that's always something she wanted to do and I was just there as a -- to get myself into my career really.

**Q.** You also tell us at paragraph 27 about a time when during Letby's placement at Liverpool Women's Hospital she frequently mentioned a particular baby -- obviously we don't want the names or details -- but what



did she tell you that concerned you or made you question whether she was excessively familiar with particular parents of patients?

**A.** Again, at that time, it didn't make me -- well, looking back on it now it isn't -- it is odd that she did have that sort of relationship. But she would be in touch and come back onto the unit and let us know of sort of events that had happened, what she had experienced, and to me at that time, I had just put that down to that, you know, she was living in an area that she had no family and that was her sort of way of debriefing. You know, if something bad had happened on my shift, I was able to go home and, you know, speak with my parents and, you know, I would have a support network whereas, actually, she was living on her own and, you know, her job became sort of everything.

So, you know, at the time that's what I saw it as. But, you know, on reflection, there was that over-familiarity with that family and, you know, it doesn't sit right now.

**Q.** So she would come into the unit, you say, at the neonatal unit at the Countess of Chester and engage in detailed discussions about experiences and you interpreted those visits as a form of debriefing and trying to seek companionship to share.



**A.** Yes, and equally we were both doing the induction to -- induction to neonates together. So, again, maybe it was a case of me thinking that because we were both doing the same course, we were both up to the same level but she had gone to her placement first, it was her way of sort of letting me know what to expect as well.

**Q.** You have just expressed that you weren't confident you wanted to be a neonatal nurse in any event but how did her descriptions of her placement there, and particularly describing to you resuscitations, impact you?

**A.** It terrified me. I did not want to go on that placement at all. I had -- my contract was initially a six-month contract which was then made to a one-year contract and I was sort of hoping that I would have found a job before I had to go on that placement.

Because my thoughts were it's not something I've got an interest in and I don't actually want to experience what she's experienced there.

**Q.** You in fact did have a brief period, didn't you?

**A.** Yes.

**Q.** Just a matter of four weeks on that placement and how was that for you?

**A.** It was no different to what I had experienced in the Countess of Chester. I wouldn't say in those four weeks that I was there I particularly learned anything more than I did when I was at the Countess. I didn't look after any high level babies, I didn't observe any cardiac arrests or any sort of complex cases whilst I was there.

**Q.** You say you left the Countess in March 2013 and your connection with Lucy Letby "stemmed solely from us starting our nursing jobs together."

Beyond that, you didn't stay in touch, you didn't have shared interests and the like?

**A.** No, I mean, we stayed in touch probably for a couple of months after, but we didn't, like I say, we didn't have any shared interests, we weren't really friends apart from the fact that we had started together on, on the unit.

**Q.** You say at paragraph 34 of your statement -- this is when you are back at the Countess of Chester, 2015 to 2017.

**A.** Yes.

**Q.** You say:

"During a period of night shifts, there appeared to be a notable increase in collapses on the NNU."

**A.** Yes.



**Q.** "Although exact dates escape my memory due to the passage of time, I distinctly recall a stretch where nurses found themselves managing the ward and unwell patients for prolonged durations due to doctors being occupied in the NNU overnight".

So that was the impact for you on the children's unit that you are describing there --

**A.** Yes.

**Q.** -- or children's ward?

**A.** Yes. Especially of a night shift as well, we didn't have any of the Band 6 nurses so it would be reliant on the Band 5 nurses running the shifts and we would be made aware of the collapses that were happening because obviously we were left without a doctor's presence on the ward whilst they were on the other unit.

So, you know, we would be trying to contact doctors for patient reviews, you know, admissions that had come in that they would need to come round and do the clerking in. So we had become made aware that, you know, there were babies unwell because the doctors would be letting us know that we're stuck over on the neonatal unit, there's a baby that's collapsed or deteriorated so you will just have to managed as you are.

**Q.** Do you remember when that was, roughly, that timing? You say you find it difficult to be precise,



but when was this?

**A.** I think based on what I've put in my statement it would have been around the February to the April 2016 time, that's all I can ...

**Q.** And you can't timeline that by anything in particular, so it may or may not be right, you just remember that?

**A.** Yes.

**Q.** You say to us that you recall two occasions with two different doctors making comments about Lucy being on shift. Can you tell us, it's Dr Chang, I think, and Dr Neame, what you remember both of them saying, and what you did and did not think they were saying by that at the time?

**A.** Yes, I remember it being -- these were on some of the night shifts again, and nothing was said in a sinister way or that they thought that there was any malice. It was said more of a, you know, it was Lucy on again, as if they kind of felt sorry that she was experiencing all of these deteriorations or that she had to take over the care and, you know, when they were saying that, knowing sort of her interest previous in neonates and the additional courses that I knew that they had to go on, you know, for me it was a case of, you know, is she -- has she got these babies because



she's the one that's qualified in looking after the higher acuity babies.

**Q.** You say:

"... Dr Chang returning to the ward after a particularly challenging series of shifts, expressing feeling deflated and exhausted. She mentioned, 'It's always Lucy too' which [you say] might have stemmed from the concern for Letby experiencing similarly difficult shifts."

That's how you took that at the time.

**A.** Yes.

**Q.** And you say Dr Neame had also said:

"... he made a comment that he's used more adrenaline during these night shifts than he did in six months at the LWF."

We know he had shifts 13, 14, 15 October like that relating to Baby I. So that seems a bit later than your -- sorry, a bit earlier than your February to April 2016?

**A.** Yes, like I say, it's difficult to recall the exact timelines when, when it was because, like I say, it was a good few years ago. But I do specifically remember those night shifts with, with Matt Neame on and Rachel Chang.

**Q.** And Matt Neame certainly in 2015?

**A.** Yes.
**Q.** So you say at paragraph 37:
"I suspected that many staff members had also noticed this correlation, but like others, hesitated to assume anyone was causing harm to vulnerable patients."
So people recognising that Letby was present at these unexpected deteriorations or collapses but not making any assumption around causing vulnerable causing harm rather?
**A.** Yes. I think, you know, as children's nurses, as medical professionals, you never want to think that an individual wants to cause harm. That's not what we go into the job to do. So I think, you know, there was -- people were making a link but, again, it was a case of, you know, knowing that they have specific training in different areas on, on neonates. It's not -- it's very different to paediatrics where, you know, we cover a range of things. On neonates they are trained to look after certain levels. And, you know, the higher levels it is, you know, I think they used to do the ITU course that some of the nurses would have done and others wouldn't and it was a case of, well, actually, she's probably the one that was on shift that was qualified to look after them and that's sort of where your thought process is because you never want to



think that someone wants to intentionally harm any of the patients.
**Q.** You have commented on junior doctors making the links. Were you aware of nurses, other nurses making such a link or Consultant doctors making such a link?
**A.** Not the Consultants because, like I say, I would have -- working nights I didn't really see as much of the Consultants as you would on a day shift.
Again, I think some of the nurses made links that, you know, she was on shift but again it was probably the same viewpoint as, as, you know, myself, that we don't want to think that anyone would harm a child and is it because she's trained in looking after that level of baby. And, equally, even though we would know things that were going on on the neonatal unit, you know, we didn't know the back story of, actually, was it a case of she had different patients and, you know, on the children's ward if we had a patient that would deteriorate we wouldn't let -- we wouldn't have a less qualified nurse looking after them, we would say, okay, let's look at jigging around our patient allocation so someone more senior can look after that, that child or baby that's deteriorating.
So, you know, we didn't know the back story of the



run-up to that, had she have, you know, was it case of she had taken over from somebody? We didn't know that.
**Q.** You say:
"The link for me was following the event of the death of the triplets that made we concerned. This was potentially more than an experienced nurse always being allocated the unwell babies."
**A.** Mm-hm.
**Q.** And:
"This was during a week I was doing a rotation to days and was on shift on the children's ward when the doctors crash bleep went off for the neonates."
**A.** (Nods).
**Q.** So tell us what you thought then. Paragraph 39 of your statement sets it out.
**A.** Yes, so that -- I did have to do with the odd rotation of days, you know, with -- for service demand. Initially the, you know, the first day I didn't think anything, you know, I didn't think to myself: oh, you know, this is something awful. It was more the second day and realising that actually she was on -- had chose to look after those babies again.
For myself, personally, you know, it's, as I say, we don't -- we go into nursing to make people, make people better. We are fortunate enough that, you know,



children dying isn't a regular occurrence.
So even as nurses, I think when you do have a child that dies, you know, it's nothing in comparison to what the parents go through, but it's really hard going as you are a nurse, you know, it's mentally and physically exhausting, you will look after a patient and, you know, see to all the clinical needs and unfortunately when they do pass away you're then providing the emotional support to the families afterwards.
You would hope that after that shift you've got a day off the next day so you can compartmentalise what's happened because, you know, when you witness a child dying it's awful, it's not normal, it's not something that you should experience.
So for me to go back the next day on shift, if -- you know, if it was me going back on shift, I would want the lowest acuity patient. So, for me, I found it quite strange that she chose to go back.
Again, I don't know if she chose to or whether it was allocated but to then look after the siblings of the child that had died on her watch.
**Q.** So to have O and then go back for P?
**A.** Because I couldn't think of anything worse of -- after -- already having one child die to then go back and have to ...

**Q.** You said you also found it distressing, quite distressing, observing a very skilled doctor appear completely confused regarding one the deaths.

**A.** Yes, and I think we saw that with a lot of the -- the, you know, especially with the triplets, I think they had seen them improve and, you know, they had come in and used the resource room and there would be conversations. So I think when there was the death it took them back a little bit because they didn't expect it and I guess in the back of my mind as well that was something that was maybe sat there, along with me thinking she's gone back the next day and looked after a sibling -- the sibling.

**Q.** You say at paragraph 40, and then I am going to take you to 45, you say at paragraph 40, you went and saw Nicola Lightfoot who was on one of the computers documenting and you recall saying to her, this is after the triplets, "Is it not concerning that she is involved and she is always there?"

"Nicola just shrugged her shoulders and didn't say anything in response."

What did it require to say that to Nicola Lightfoot, from your perspective, speaking up about that link and being concerned about it?

**A.** It was really difficult for me because I had



already had an experience on the ward a few months before where I had escalated concerns about a clinical assessment completely unrelated to the neonatal unit.

**Q.** You don't need to give us the details.

**A.** No, no. And sort of my working life there was made really difficult then by senior managers and the advance nurse practitioners because I had escalated concerns and it had been deemed that as a junior nurse I had sort of undermined someone who was more qualified than me. So it was difficult anyway that I didn't have sort of a relationship with any of the managers apart from Nicky that I felt that I could say, you know, is there no concerns, which unfortunately from reading her statement, she deemed that as me gossipping although it is only myself and her in the room at the time.

**Q.** You say -- so she literally shrugged her shoulders. Did you raise it with anybody else in response?

**A.** No, I didn't because of what I had been through previously and what I had been subject to, it was kind of like this smear campaign against me on the ward, that actually it was only Nicky that I had felt comfortable going to and even sort of the lead nurse at the time had condoned some of the behaviour towards me from the previous issues.



So obviously when I had said that to Nicky and nothing -- there was sort of no validation at all or any sort of, okay, let's have a bit more of a conversation about that, it was kind of like, you know, I don't want to put myself in that position again and actually my voice isn't being heard anyway.

**Q.** You say at paragraph 45:

"Following my conversation with Nicola Lightfoot, I distinctly recall staff were informally advised in shift safety huddles ..."

**A.** Yes.

**Q.** ... (which I do not recall them formally documented) that if anyone discussed the NNU, Letby, or the infant deaths disciplinary measures may be considered."

**A.** Yes.

**Q.** Were you present for any of those safety huddles or discussions?

**A.** I remember being there for one of them which I don't think it was long after when I discussed it with Nicky and it was kind of we -- we were told that there was a potential infection on the unit and that's why we couldn't access it. So it wasn't long after that that that was the conversations that were had, but it was very brief in what was said that, you know, we are not



discussing it, there is no more conversations to be had and, like I say, disciplinary measures would be considered if you were found talking about it.

**Q.** And which of the nurse managers did you hear that from directly yourself, those messages, or did you hear them from others?

**A.** I don't recall exactly which one it was. I do remember Ann Murphy being round at the time but I couldn't specifically say which one it was on shift because sometimes, you know, you would come in and out of a safety brief. You wouldn't be there for the whole of it. So I can't recall exactly which manager that was.

**Q.** Did you see -- I am going to ask for a press release to go on the screen and see if you have seen this. It is INQ0004914.

And this, Nurse ZC, was communicated externally 7 July, so after the death of the two triplets and the time you are talking about.

Did you see that?

**A.** No.

**Q.** So you obviously weren't on the neonatal unit staff list so I'm not going to take you to emails. We know they were sent about what was happening. But did you know there was this Royal College of Paediatrics and

Child Health and Royal College of Nursing review being done?
**A.** No.
**Q.** No one discussed that with you?
**A.** No. I knew that later on, that it had been, the acuity level had dropped but I never saw this.
**Q.** You mean when they downgraded the unit?
**A.** Yes.
**Q.** So babies would come in of later weeks gestation than they had previously?
**A.** Yes. But I'm not sure if that was later on. Like I say, I hadn't seen this.
**Q.** Okay, that can go down, thanks.
You tell us in your statement that there was a time when you were expecting a Care Quality Commission visit and I think that, in fact, was in February 2016 time.
**A.** Mm-hm.
**Q.** And you say -- well, let me ask you this. Were there any instructions about how to respond to that CQC inspection given to you, or to other staff, as far as you are aware?
**A.** Not specifically to myself. But with a CQC visit it's kind of they want to get everything in line and obviously, you know, you would be told of specific individuals that you need to know names of.



But I didn't have any direct briefing prior to the CQC coming in terms of, you know, if things -- what to say to them if I was questioned but I think, again, you know, I was predominantly on nights so I wouldn't really see them.
**Q.** Were you questioned? Were you --
**A.** No, not that I recall.
**Q.** So you didn't attend for an interview.
**A.** No.
**Q.** And it looks -- this was earlier than the triplets. It looks like you thought it was later than it was. It was February 2016, I think.
**A.** (Nods).
**Q.** You say something about you were required to fill in appraisal documentation and sign them?
**A.** Yes.
**Q.** What was that about?
**A.** So obviously as nurses you are meant to have annual appraisals or, I guess, they are called different things in different Trusts, appraisals, PADRs, which was never something that I had had whilst working at the Countess. I can't say that I was aware of other people having them either. But obviously it, it's -- it was something that was mandatory that you had to be compliant with and during that time when CQC were due to



visit we were asked to start filling in our appraisal forms and sign them.
**Q.** So was that something you should have been doing anyway or did you think it was just being done to create an impression for CQC? What are you saying there? What did you think this process involved?
**A.** I thought it was a way of them looking like they were compliant and that they had either started or we had had our appraisals but, like I said, in the two years that I was there, I never received a one-to-one or appraisal or had one booked in.
**Q.** But you weren't backdating or signing with an earlier date or anything like that, were you?
**A.** No.
**Q.** So did you date the documents as to --
**A.** I can't recall.
**Q.** No, okay. You know that I think it was Nurse Lightfoot suggesting that Dr Barrett had said to you or used the term "Nurse Death" about Letby speaking to you. In fact, Dr Barrett says she didn't say that to you and you say the same, Dr Barrett didn't say that to you. Dr Barrett does say she said it to Nurse Lightfoot. So were you party to any discussion with anyone with names like that, Nurse Death or --
**A.** No. That was sort of the first I had become



aware of that when I read the statement.
**Q.** You refer, when you are talking about management generally, to a "circle of trust"?
**A.** Yes.
**Q.** What did you mean by the "circle of trust" and how did that operate?
**A.** So the ward, it was very much based -- it was, you know, the hierarchy you had the managers, the senior managers, and the APMP, and it was commonly known that there was a WhatsApp group from them and they kind of referred themselves to the "circle of trust".
**Q.** What level of management are you talking about here?
**A.** The ward manager, the deputy ward manager.
**Q.** So who are the names of those?
**A.** So it was Anne Martyn, Nicky Lightfoot, Catherine Pollit, some of the Advanced Nurse Practitioners.
**Q.** And is that the group that you wouldn't have felt comfortable raising concerns with?
**A.** No, I wouldn't have felt comfortable going to any of them.
**Q.** Okay. Do you think a confidential helpline would have assisted if you did have concerns about somebody or, as you had done, were making links

certainly after the triplets between Letby and unexpected deaths, would it have helped to be able to leave that concern with somebody independent from the hospital --

**A.** Yes.

**Q.** -- who may be getting similar concerns from others and gathering the picture?

**A.** Yes, I think in other Trusts that I've been in there's been sort of a Freedom to Speak Up Guardian that you could go to, an individual that had nothing to do with the area and speak to them and, you know, they would signpost you or, you know, escalate that further whereas there wasn't anyone that I was aware of at that time in the Trust that I could have gone to and addressed those concerns.

**Q.** So you weren't aware of such a thing there to --

**A.** No.

**Q.** -- separate from --

**A.** And as far as I am aware, it's only more recently that they have brought in a Freedom to Speak Up Guardian.

**Q.** In terms of reflections now if I may.

**A.** Yes.

**Q.** At paragraph 55, what do you set out there?



What do you think, reflecting on what happened, events here, is required to avoid similar events in the future?

**A.** Sorry, could you repeat that question again.

**Q.** Yes. At paragraph 55 you are reflecting --

**A.** Yes.

**Q.** -- on how you think babies could be kept safe in hospital.

**A.** Yes. It's difficult for me to say in terms of, you know, neonates and what happened during that time because I wasn't on that unit to know what their processes were.

But I think, you know, there should be a higher level of review. I think, you know, a lot of the time it may be put to that, you know, they were premature. I don't know what that was, but, you know, I think moving forwards having, you know, an outside agency looking at things and, you know, reviews being a little bit more in-depth.

**Q.** You say analyses, including examination of test results, information, standardised procedures to enable identification of patterns and investigations into deaths and collapses should be carried out by impartial agents not directly involved in the processes.

Would you add to that "or with the people involved"?



**A.** I think where it would be appropriate, yes, especially if -- and I think sometimes because you are working so closely with staff on the ward, with doctors, I think, you know, like a lot of us probably did we didn't want to think anything bad or that individual was doing anything sinister.

So I think when you are working with the people like that, it would be beneficial to have someone that's not involved and that doesn't, don't -- doesn't know the staff to be able to look at things from a different perspective.

**Q.** The Inquiry has heard evidence from Dr Lambie that as early as September 2015 some nurses were sitting together and talking about who could be connected and looking at rotas to events -- untoward, unexpected events, she wasn't sure precisely -- but looking for who might be on shift on occasions. You have given evidence that Dr Neame and others still in 2015 are making the association.

What you are also saying is no one wanted to think anything bad and I want to just ask you more about that.

You make an association, in some cases you know it's an unexpected, an unexpected event without a medical explanation. What is it you would say means people don't want to think anything bad? And it's



a clear option, isn't it, if you don't know what a medical cause is?

**A.** Yes. I think, you know, like I have said previously, you know on the children's ward we would know things were happening but we didn't know the back stories. We didn't know the run-up to the collapses. We would just know that it was that nurse that was on and like I said that could have been due to her being the experienced one.

I think what I mean by you don't want to think, you know, anything bad it's like I said we don't go into this profession -- you like to think we don't go into this profession to do things like that. You know, we want to see people get better, we want to help patients and that's -- it's just not something that you want to even think anybody would do.

**Q.** Did you have training on the Beverley Allitt case in your nursing?

**A.** As a student nurse I think we probably had discussions around Beverley Allitt and why we do things that we do for, I think, you know, us doublechecking drugs came off the back of what happened with Beverley Allitt. But there wasn't a specific, you know, in-depth module about it, we were just, you know, made aware because that was something significant to

children's nursing.

**Q.** And moving forwards, your awareness after being involved in the events at the Countess is no doubt heightened now.

**A.** Mm-hm.

**Q.** How do you think the importance of that message being heightened can be communicated to others, so that they don't not want to think anything bad when something like this is confronting them?

**A.** I think it's having a culture where staff feel that they can have those conversations. You know, we can all sit and say, you know, we don't want to think anything bad is happening but, equally, when we have thought there might be more to this and we have gone to managers to have that discussion, it's -- it's completely shut off and it's not supported and actually it's then flipped, I guess, as: you are the problem, you are the gossip. And that doesn't make anyone feel comfortable in going forward and saying, actually, I've got concerns here.

And I think it's having a more even culture that we can have those difficult conversations even if it is, you know, that, you know, managers are having to deal with uncomfortable situations to be able to speak openly and be listened to. I think that's really important



moving forwards.

**MS LANGDALE:** Yes, thank you, Nurse ZC, no further questions from me.

*(Redacted)*.

**LADY JUSTICE THIRLWALL:** *(Redacted)*.

Thank you very much indeed, Nurse ZC. You are free to go but just remain there while the room is cleared and I'll also leave the room.

**A.** Thank you.

**LADY JUSTICE THIRLWALL:** Thank you very much for coming.

10 o'clock tomorrow morning -- Ms Langdale, 10 o'clock?

**MS LANGDALE:** Yes, 10 o'clock, thank you, my Lady.

**(4.31 pm)**

**(The Inquiry adjourned until 10.00 am, on Tuesday, 15 October 2024)**



**I N D E X**


NURSE T (affirmed) ..... 1
Questions by MS LYONS ..... 1
Questions by LADY JUSTICE THIRLWALL ..... 69
NURSE W (sworn) ..... 73
Questions by MS LANGDALE ..... 73
Questions by MR BAKER ..... 132
NURSE ZC (affirmed) ..... 150
Questions by MS LANGDALE ..... 150

**LADY JUSTICE THIRLWALL: [51]** 1/5 1/11 1/16 2/15 2/19 3/17 3/20 10/9 10/12 10/16 15/5 21/9 24/9 24/12 24/18 24/24 25/3 45/4 61/10 63/9 63/12 69/8 69/20 70/1 70/3 70/7 70/14 70/16 70/20 70/23 72/16 72/24 73/3 73/7 73/14 92/23 99/18 99/21 99/25 100/7 122/12 134/8 151/13 151/18 151/20 151/24 152/4 152/11 152/16 186/5 186/10
**MR BAKER: [2]** 134/11 151/9
**MS LANGDALE: [14]** 73/13 73/18 93/1 99/20 100/4 100/12 122/13 134/6 151/12 151/19 152/2 152/18 186/2 186/14
**MS LYONS: [14]** 1/9 1/18 3/1 10/18 15/12 21/10 24/8 24/22 25/6 45/7 61/11 63/16 69/6 73/1

**'**

**'08 [1]** 2/21
**'15 [2]** 22/20 23/7
**'apology' [1]** 128/13
**'It's [1]** 168/6
**'somebody [1]** 62/4
**'traffic' [1]** 126/18

**1**

**1.09 [1]** 100/1
**10 days [1]** 35/10
**10 June [1]** 41/16
**10 June 2015 [1]** 36/4
**10 minutes [2]** 24/13 24/14
**10 o'clock [4]** 83/15 186/12 186/13 186/14
**10 years [2]** 19/21 19/21
**10.00 [2]** 1/2 186/16
**10.06 [1]** 1/4
**10.42 [1]** 24/15
**10.54 [1]** 24/17
**100 [5]** 61/18 109/24 141/12 141/16 141/18
**11 [2]** 100/13 106/1
**12 [1]** 108/25
**12 hours [3]** 110/8 140/14 146/25
**12 months [1]** 75/24
**12-month [1]** 34/25
**12.14 pm [1]** 73/10
**12.30 pm [1]** 73/12
**13 [4]** 89/2 108/19 109/16 168/16
**13 June [3]** 135/22 138/16 138/19
**14 [2]** 156/13 168/16
**14 June [1]** 88/19
**14 October [1]** 56/18
**14 October 2015 [1]** 54/22
**14 October 2024 [1]** 1/1
**14th [1]** 89/2
**15 [1]** 47/13
**15 July 2016 [1]** 123/19
**15 minutes [3]** 73/1 73/8 73/9
**15 October [1]** 168/16
**15 October 2024 [1]** 186/17
**15 years [2]** 30/25 48/8
**16 [4]** 3/13 3/20 16/5 116/4
**16 July 2018 [1]** 39/6
**17 [1]** 111/14
**18 [3]** 11/4 11/7 111/15
**18 April 2024 [1]** 1/19
**19 [4]** 20/5 23/24 36/1 112/10
**19 February [1]** 116/4
**19 November 2010 [1]** 3/5
**19b [1]** 86/24

**2**

**2 May 2018 [1]** 5/6
**2 pm [1]** 122/8
**2.09 [1]** 100/3
**20 [5]** 9/12 9/13 14/11 26/22 150/2
**2010 [5]** 2/3 2/3 3/4 3/5 153/3
**2012 [3]** 153/7 156/15 157/22
**2013 [1]** 165/8
**2015 [33]** 5/11 6/16 6/23 11/3 15/19 17/5 23/8 28/3 36/4 53/17 54/22 73/25 74/7 77/7 77/20 81/14 82/12 84/14 86/17 89/23 101/25 117/2 124/11 130/23 130/25 132/10 153/19 153/21 154/13 165/20 168/25 183/13 183/18
**2015/2016 [2]** 65/14 77/9
**2016 [32]** 5/12 6/16 11/3 15/20 16/12 16/17 17/5 50/24 57/22 61/22 64/25 65/14 73/25 77/8 77/9 77/20 81/14 82/12 84/14 86/17 101/25 117/2 121/21 123/19 124/11 130/23 130/25 132/10 167/3 168/19 177/16 178/12
**2017 [3]** 65/8 153/21 165/20
**2018 [5]** 5/6 39/6 124/19 131/18 132/21
**2022 [1]** 84/11
**2024 [5]** 1/1 1/19 73/19 152/20 186/17
**21 [3]** 27/25 88/18 116/4
**22 [2]** 32/23 44/19
**23 May 2024 [1]** 152/20
**24 [2]** 34/17 89/3
**24 hours [1]** 125/14
**24-hour [1]** 126/2
**25 [3]** 27/25 135/3 137/17
**25 October 2010 [1]** 3/4
**25 years [2]** 36/12 48/9
**26 [1]** 137/18
**27 [1]** 162/22
**28 October 2016 [1]** 61/22
**29 [2]** 36/5 92/5
**29 July [1]** 108/20
**29 June 2016 [1]** 50/24
**29th [1]** 109/4

**3**

**3 August [2]** 108/22 108/23
**3.28 pm [1]** 151/21
**3.45 [2]** 151/19 151/20
**3.45 pm [1]** 151/23
**30 [1]** 140/19
**30 seconds [1]** 113/16
**31 [2]** 30/2 49/24
**31 May 2010 [1]** 2/3
**31765 [1]** 42/4
**31768 [1]** 42/11
**31770 [1]** 43/1
**31785 [2]** 43/24 44/1
**32336 [2]** 45/13 45/23
**32359 [2]** 47/8 47/10
**32362 [1]** 48/18
**32392 [1]** 49/24
**32a [2]** 96/9 141/25
**33 [1]** 142/13
**34 [2]** 40/7 165/18
**37 [4]** 77/2 77/5 98/3 169/2
**38 [1]** 77/2
**39 [1]** 171/15
**39387 [2]** 54/11 54/16
**39414 [1]** 55/4
**3rd [1]** 109/6

**4**

**4.21 [1]** 42/1
**4.31 pm [1]** 186/15
**40 [2]** 173/14 173/15
**45 [2]** 173/15 175/7
**46 [1]** 51/8
**4s [2]** 74/17 75/10
**4th July 2010 [1]** 2/3

**5**

**51c [1]** 150/11
**55 [2]** 181/25 182/4
**58 [1]** 62/8
**59 [1]** 54/9
**5s [8]** 6/1 6/20 6/21 74/17 75/10 75/16 75/20 95/17

**6**

**60 [2]** 63/24 64/24
**61 [1]** 116/16
**62 [1]** 120/22
**63 [1]** 65/10
**65 [1]** 124/8
**6s [9]** 5/25 6/18 6/19 74/16 75/12 75/14 75/16 75/19 76/16

**7**

**7 August 2024 [1]** 73/19
**7 July [1]** 176/18
**70 [2]** 65/23 66/4
**72 [1]** 125/5
**75 [1]** 129/18
**77 [1]** 131/15

**8**

**8 pm [1]** 28/14
**8.36 [1]** 42/5

**9**

**9 June 2015 [1]** 28/3
**91 [1]** 123/17

**A**

**A's [5]** 28/2 29/1 31/4 32/25 33/6
**abdomen [1]** 56/13
**able [14]** 14/15 20/7 21/23 30/15 67/5 74/13 75/5 80/16 81/5 148/2 163/13 181/2 183/10 185/24
**abnormal [1]** 111/23
**abnormalities [1]** 22/6
**about [213]**
**above [6]** 16/1 80/2 103/24 119/5 137/3 137/17
**absent [1]** 132/20
**absolute [1]** 18/23
**absolutely [5]** 96/23 96/23 97/11 132/9 138/8
**absurd [1]** 104/23
**abuse [1]** 102/22
**abused [1]** 67/23
**abysmal [1]** 129/22
**accept [1]** 161/17
**accepted [1]** 95/8
**access [9]** 29/8 30/16 125/14 126/2 126/18 126/23 155/15 155/23 175/23
**accessible [1]** 155/8
**accordingly [1]** 135/20
**account [1]** 150/11
**accurate [2]** 73/20 152/21
**accusations [1]** 58/13
**accusing [1]** 59/25
**acknowledge [1]** 16/10
**acquaintance [1]** 156/16
**acronym [1]** 76/1
**across [4]** 136/20 151/4 154/24 162/8
**actions [1]** 125/7
**actively [1]** 157/6
**actual [1]** 38/1
**actually [39]** 10/7 10/25 16/18 16/20 25/15 25/19 28/8 29/23 32/16 32/21 33/11 35/17 37/14 52/11 58/24 78/2 78/4 89/13 89/25 94/20 120/7 125/22 139/3 140/15 149/24 157/5 160/25 161/4 162/16 162/19 163/15 164/19 169/23 170/17 171/21 174/22 175/5 185/16 185/19
**acuity [5]** 81/3 117/11 168/2 172/17 177/6
**acutely [2]** 144/5 154/11
**adapting [1]** 158/7

**A**

**add [1]** 182/24
**added [1]** 6/11
**adding [1]** 89/25
**additional [3]** 6/17 6/19 167/23
**addressed [2]** 47/9 181/15
**adequate [1]** 5/16
**adjourn [1]** 73/8
**adjourned [1]** 186/16
**adjournment [1]** 100/2
**administering [2]** 112/25 152/7
**admissions [1]** 166/17
**admitted [2]** 120/25 157/25
**admitting [1]** 42/16
**adrenaline [5]** 113/1 113/3 113/6 160/6 168/14
**advance [1]** 174/7
**Advanced [1]** 180/17
**adversarial [2]** 27/6 66/16
**advice [4]** 58/21 61/3 70/10 97/14
**advised [2]** 61/5 175/9
**affairs [1]** 100/10
**affected [3]** 17/25 77/11 78/19
**affirmed [4]** 1/14 152/14 187/3 187/9
**affirming [3]** 152/8 152/10 152/11
**after [64]** 9/22 16/5 16/18 16/21 16/25 21/11 21/17 22/19 28/9 28/14 31/7 33/7 33/7 33/7 34/22 35/18 37/21 47/1 51/11 52/13 52/22 53/5 59/17 59/18 62/6 65/1 76/3 84/12 88/20 88/21 93/21 106/6 113/16 114/23 115/23 126/9 133/23 140/5 140/11 142/14 143/24 154/11 159/10 165/5 165/14 168/1 168/4 169/19 169/24 170/14 170/21 170/23 171/22 172/6 172/10 172/20 172/24 173/13 173/17 175/20 175/23 176/18 181/1 185/2
**afternoon [4]** 83/4 109/10 151/16 151/24
**afterwards [4]** 34/17 103/15 111/7 172/9
**again [25]** 3/1 37/21 38/25 50/11 100/11 108/1 113/15 121/14 128/25 139/20 154/3 159/13 161/18 163/4 164/3 167/16 167/19 169/14 170/10 170/11 171/22 172/19 175/5 178/3 182/3
**against [4]** 66/16 68/8 87/7 174/21
**agency [1]** 182/16
**agents [1]** 182/23
**ago [7]** 18/23 19/21 19/21 61/15 109/5 133/23 168/22
**agree [9]** 5/10 5/16 12/13 14/4 63/6 88/7 113/13 139/21 145/11
**agreed [1]** 141/16
**aim [3]** 6/6 71/13 74/14
**air [3]** 72/18 140/16 148/12
**airway [3]** 95/23 142/1 142/4
**alarm [1]** 37/22
**alarming [1]** 157/10
**Alder [1]** 72/8
**Alder Hey [1]** 72/8
**alert [1]** 112/2
**alerted [1]** 37/22
**algorithm [2]** 112/23 113/2
**all [77]** 1/6 5/15 6/18 8/7 8/14 8/15 11/13 22/25 23/2 24/12 25/3 25/11 26/6 28/11 28/15 33/10 33/13 33/13 34/4 34/5 35/19 37/5 37/18 44/4 44/12 46/5 46/7 46/17 48/8 49/14 49/21 50/8 50/16 52/8 53/23 59/19 74/15 77/2 79/15 80/22 83/20 85/5 85/16 85/19 90/5 92/22 95/6 99/2 103/14 105/3 110/6 112/9 113/13 116/9 117/1 118/22 119/4 119/10 120/14 126/19 127/14 132/20 133/2 133/12 134/19 142/5 142/7 142/18 142/23 145/12 151/4 164/14 167/4 167/20 172/7 175/2 185/12
**allegations [2]** 59/2 61/17
**allied [2]** 127/16 127/24
**Allitt [8]** 52/5 52/10 52/22 67/11 119/21 184/17 184/20 184/23
**allocate [4]** 46/8 55/23 89/17 136/8
**allocated [34]** 9/10 12/6 12/11 13/8 28/13 45/20 46/12 46/15 46/22 55/17 56/4 74/6 76/20 89/11 90/13 90/17 90/20 90/23 91/7 94/11 95/8 95/17 111/9 120/24 135/8 137/21 137/22 138/22 139/9 139/12 139/20 143/18 171/7 172/20
**allocating [2]** 13/6 89/4
**allocation [18]** 13/12 45/19 46/5 46/11 56/5 89/7 89/8 89/9 90/19 92/9 95/14 136/12 138/25 139/1 139/18 158/24 159/7 170/22
**allowed [6]** 50/13 59/20 110/10 125/17 133/18 133/20
**allowing [1]** 149/7
**allude [1]** 64/13
**alluding [1]** 64/22
**almost [3]** 27/7 66/16 114/5
**alone [1]** 25/14
**along [15]** 38/5 38/24 53/24 59/8 59/10 62/20 62/20 102/7 103/5 105/11 105/19 115/21 157/1 162/5 173/11
**alongside [1]** 111/20
**aloof [1]** 4/1
**already [15]** 32/2 32/11 58/19 58/19 60/10 60/13 66/2 69/13 80/10 81/17 89/10 133/25 134/4 172/24 174/1
**also [32]** 7/22 12/20 14/2 33/20 36/22 39/11 52/16 76/19 90/17 94/24 95/21 96/5 96/14 108/22 122/3 127/12 127/23 132/6 134/18 142/9 143/22 144/5 145/16 146/8 146/20 155/13 162/22 168/12 169/3 173/1 183/20 186/8
**although [6]** 33/11 42/15 92/2 126/24 166/1 174/14
**always [26]** 2/11 4/5 4/22 4/24 7/14 13/9 14/18 52/18 52/18 62/12 71/12 74/13 80/9 81/10 97/18 100/14 102/10 102/12 103/23 124/20 128/8 136/17 162/19 168/7 171/6 173/19
**am [36]** 1/2 1/4 3/16 24/15 24/17 30/9 41/5 45/5 48/4 48/6 52/9 52/9 54/15 71/13 71/13 72/11 73/23 86/24 89/6 89/25 90/11 93/8 105/22 109/24 118/14 118/14 122/2 125/13 131/16 132/8 134/22 146/2 173/14 176/14 181/20 186/16
**amongst [1]** 80/23
**amount [2]** 78/9 118/7
**analyses [1]** 182/19
**anger [2]** 93/22 93/25
**angry [7]** 99/4 99/5 99/7 139/19 139/22 139/24 139/25
**anguish [1]** 159/24
**animated [4]** 159/11 160/3 160/9 162/2
**Ann [6]** 16/2 16/3 21/3 21/5 65/22 176/8
**Ann Murphy [5]** 16/2 21/3 21/5 65/22 176/8
**Anne [1]** 180/16
**Anne Martyn [1]** 180/16
**annual [3]** 67/18 77/24 178/19
**anonymity [1]** 104/12
**anonymous [1]** 104/7
**anonymously [1]** 80/14
**another [21]** 6/19 15/10 17/20 20/11 44/18 70/11 71/3 71/10 82/25 98/19 102/2 103/12 106/13 121/3 133/6 135/25 137/4 139/19 142/10 143/7 161/22
**answer [9]** 24/23 24/24 66/22 102/9 114/4 114/5 128/8 141/10 141/19
**answers [1]** 34/12
**antenatal [2]** 87/6 131/9
**antenatal/postnatal [1]** 87/6
**antenatally [1]** 114/13
**antibiotic [1]** 37/25
**antibiotics [5]** 37/25 42/21 42/25 144/7 144/9
**anxiety [1]** 25/23
**anxious [2]** 25/23 62/5
**any [123]** 4/3 5/2 6/24 8/19 12/14 13/21 15/21 16/10 20/5 21/1 21/7 28/19 31/15 33/1 35/9 35/20 35/20 36/14 38/20 40/12 40/22 40/24 41/17 50/9 63/18 64/8 65/1 65/11 65/11 65/12 67/13 67/17 68/16 71/1 71/20 72/3 77/15 79/2 79/3 81/19 81/20 81/20 82/13 83/8 83/15 84/18 85/20 85/20 86/5 86/10 90/18 95/13 95/25 99/10 101/17 102/11 103/9 103/12 105/8 105/10 105/23 110/17 110/19 110/23 111/10 115/7 115/13 115/18 115/25 116/7 116/9 117/24 117/25 119/5 119/6 119/6 119/17 120/12 121/25 121/25 122/4 124/4 125/7 127/15 129/5 132/1 132/16 133/3 133/6 134/5 135/20 136/5 140/7 142/3 144/4 144/5 144/13 145/3 148/11 148/11 150/20 151/13 154/16 157/13 157/19 160/11 161/23 164/9 165/5 165/6 165/6 165/15 166/11 167/17 169/8 170/1 174/11 175/2 175/17 177/19 178/1 179/23 180/22
**anybody [5]** 20/7 55/24 55/25 174/17 184/16
**anymore [5]** 33/22 108/8 113/20 125/19 142/25
**anyone [20]** 15/19 16/4 19/25 59/20 63/3 71/8 71/9 78/16 101/6 110/16 111/2 115/17 141/7 159/4 169/5 170/13 175/13 179/24 181/13 185/18
**anything [51]** 8/19 19/23 20/13 29/3 30/23 30/24 31/1 31/23 48/13 51/16 52/3 59/8 62/3 62/18 65/20 72/25 80/23 80/24 84/16 96/2 96/4 101/11 103/4 105/11

## A

**anything... [27]** 111/12 116/10 124/6 124/16 128/24 132/25 133/8 134/15 136/5 140/8 149/1 155/3 156/2 161/12 165/4 167/5 171/19 172/23 173/21 179/13 183/5 183/6 183/21 183/25 184/11 185/8 185/13
**anyway [6]** 11/15 90/19 155/24 174/10 175/6 179/4
**anywhere [1]** 26/12
**apart [2]** 165/16 174/11
**APMP [1]** 180/9
**apologise [1]** 92/24
**apparently [1]** 80/14
**appear [6]** 10/3 82/19 107/1 132/13 137/20 173/2
**appeared [13]** 4/24 50/8 77/21 93/12 110/1 118/3 118/10 131/25 139/17 139/18 141/3 143/9 165/23
**applicable [1]** 5/10
**appraisal [3]** 178/15 179/1 179/11
**appraisals [3]** 178/19 178/20 179/9
**appreciate [1]** 147/25
**apprehensions [1]** 162/1
**approach [2]** 104/5 104/17
**approachable [4]** 2/13 81/18 86/21 87/14
**approaching [2]** 81/19 161/25
**appropriate [15]** 2/11 2/24 5/1 23/4 43/15 63/23 97/10 97/12 106/16 110/5 110/6 114/15 145/8 150/24 183/1
**appropriately [1]** 68/13
**approximately [1]** 147/12
**April [4]** 1/19 16/12 167/3 168/19
**are [122]** 1/19 1/22 3/22 6/24 8/4 15/22 24/18 27/8 27/9 28/23 29/2 29/4 31/15 32/21 37/9 44/9 45/1 45/8 45/10 51/5 54/12 54/15 61/10 61/13 65/4 67/4 68/11 68/22 69/6 71/10 71/21 72/23 73/5 73/7 73/14 73/20 73/21 76/5 76/23 77/23 78/22 80/7 83/8 84/6 84/6 84/22 88/6 94/6 94/7 94/8 95/11 102/13 102/16 102/21 103/4 103/13 105/2 107/2 110/25 112/22 113/4 114/12 114/12 117/20 118/25 120/4 120/7 124/25 125/10 126/24 127/2 127/24 128/15 128/22 131/4 133/9 134/6 135/11 138/5 138/11 138/12 139/14 141/22 142/2 142/5 143/22 144/12 147/16 148/11 149/20 150/2 151/16 152/8 152/8 152/21 152/21 158/9 158/24 165/19 166/7 166/23 169/18 171/25 172/5 175/25 176/19 177/21 178/18 178/19 179/5 180/2 180/12 180/15 182/4 183/2 183/7 183/18 183/20 185/17 185/18 185/23 186/6
**area [3]** 125/21 163/10 181/11
**areas [2]** 154/20 169/16
**aren't [2]** 16/18 125/17
**argue [4]** 13/1 13/5 13/5 13/10
**arose [1]** 153/5
**around [44]** 8/5 8/14 10/13 23/9 33/22 46/4 53/16 77/2 82/8 83/3 83/10 84/16 89/11 89/16 89/22 89/22 89/24 90/1 98/14 104/9 105/14 105/17 107/23 110/11 119/18 124/9 126/23 127/5 127/22 127/23 129/6 129/21 135/3 143/14 148/6 149/21 156/5 156/6 159/4 160/25 167/3 169/8 170/22 184/20
**around June [1]** 89/16
**arranged [1]** 34/10
**arrest [6]** 84/12 115/23 115/23 132/21 133/1 133/1
**arrested [1]** 129/23
**arresting [1]** 162/11
**arrests [1]** 165/6
**arrived [2]** 46/13 112/11
**article [1]** 80/13
**as [208]**
**as September 2015 [1]** 183/13
**Ashleigh [1]** 54/14
**ask [27]** 2/15 5/4 11/5 27/21 44/1 47/9 54/6 69/10 69/17 72/25 87/25 93/3 95/12 98/11 99/15 100/11 108/10 122/2 124/23 129/5 129/25 134/12 146/3 157/21 176/14 177/18 183/21
**asked [30]** 7/20 11/2 17/3 27/21 39/25 39/25 53/20 55/11 56/4 61/19 62/3 70/25 71/3 71/19 91/11 93/4 93/15 96/3 96/5 97/14 98/13 99/13 115/2 115/3 115/4 116/9 124/15 139/8 145/10 179/1
**asking [13]** 27/20 45/5 69/18 69/21 93/11 93/21 113/25 114/15 114/21 126/25 134/22 144/17 147/16
**aspects [1]** 132/20
**assessment [3]** 154/7 154/8 174/3
**assistance [3]** 87/22 87/25 88/1
**assisted [1]** 180/24
**association [3]** 74/12 183/19 183/22
**assume [1]** 169/5
**assumption [1]** 169/8
**at [297]**
**at page 12 [1]** 108/25
**atmosphere [2]** 11/2 77/7
**attack [1]** 67/10
**attacked [1]** 135/6
**attempt [1]** 31/10
**attempts [1]** 159/13
**attend [6]** 35/10 102/4 102/6 102/12 142/8 178/8
**attendance [1]** 101/24
**attended [1]** 102/14
**attending [3]** 10/8 34/24 87/5
**attention [2]** 132/2 132/16
**attributed [1]** 61/20
**audit [1]** 151/1
**August [4]** 73/19 108/22 108/23 123/25
**auscultate [1]** 113/17
**autumn [2]** 17/1 22/20
**available [5]** 67/3 83/21 97/21 98/5 130/24
**avoid [2]** 87/9 182/2
**awake [2]** 54/12 54/15
**aware [59]** 6/24 7/3 13/10 31/4 31/11 31/15 33/5 39/16 40/1 41/21 52/5 52/6 52/9 52/9 52/16 52/17 52/20 53/12 54/4 56/9 56/9 57/21 57/23 57/24 57/25 58/14 64/8 64/21 83/23 84/22 88/22 92/6 96/14 96/19 97/23 97/24 101/6 115/11 116/17 116/19 116/22 118/2 119/4 119/22 120/3 121/24 124/11 141/22 142/3 166/13 166/19 170/4 177/21 178/22 180/1 181/13 181/16 181/20 184/25
**awareness [8]** 16/16 119/14 119/25 119/25 120/9 120/10 120/11 185/2
**away [6]** 35/18 37/8 106/18 133/8 135/9 172/8
**awful [3]** 53/25 171/20 172/13

## B

**B's [7]** 29/7 31/18 36/2 39/7 39/24 39/25 51/12
**babies [64]** 4/24 12/6 12/11 22/5 26/19 27/17 27/19 28/11 32/15 35/13 37/10 45/20 46/5 46/7 46/12 46/15 48/9 52/7 55/17 56/23 58/13 60/1 64/9 66/19 67/5 71/14 71/22 75/7 81/5 83/9 87/18 88/17 89/11 89/17 90/17 90/21 92/3 95/17 95/19 106/24 108/12 114/9 114/11 118/3 118/8 118/10 118/19 125/6 127/3 135/20 137/22 139/13 143/11 149/20 159/5 161/21 165/5 166/20 167/25 168/2 171/7 171/22 177/9 182/6
**babies' [1]** 98/5
**babies's [1]** 56/25
**baby [153]** 7/15 10/6 10/24 13/8 14/17 14/22 14/24 15/1 15/2 15/10 28/9 28/13 28/15 29/1 29/7 29/12 34/6 35/1 35/5 35/18 37/8 38/4 46/9 46/20 46/23 46/25 47/1 48/2 49/5 55/19 55/22 56/4 56/11 58/17 66/23 71/10 77/25 78/2 78/3 80/3 80/6 80/17 80/19 86/6 86/10 88/13 90/23 91/3 91/4 91/8 91/10 91/11 91/14 91/15 91/18 91/19 91/20 91/21 91/21 92/6 92/6 92/16 93/2 93/4 93/5 93/8 93/13 93/14 93/17 94/10 94/15 97/1 97/7 98/8 98/15 98/19 101/13 103/6 106/10 106/11 106/15 106/17 106/18 107/5 107/10 107/15 107/18 107/19 109/12 109/24 110/9 111/9 111/14 111/16 113/6 113/7 113/9 114/8 117/21 126/6 135/14 135/16 135/18 137/22 138/10 138/13 138/24 139/5 139/9 139/11 140/12 140/14 143/2 143/7 143/15 143/16 143/17 143/17 143/18 143/24 144/2 144/4 144/4 144/7 144/10 145/20 145/23 145/25 146/25 147/1 149/1 149/3 149/8 149/18 149/24 150/5 150/7 157/21 157/24 158/5 158/9 158/20 159/12 159/15 161/21 162/3 162/4 162/10 162/24 166/22 168/17 170/15 170/24
**Baby A [1]** 29/12
**Baby A's [1]** 29/1
**Baby B [2]** 48/2 101/13
**Baby B's [1]** 29/7
**Baby C [15]** 91/4 91/21 92/6 92/6 92/16 93/2 93/13 93/14 94/10 94/15 97/1 98/8 106/18 143/15 145/25
**Baby C's [1]** 97/7
**Baby D [1]** 35/18
**Baby E [2]** 109/12 109/24

**B**

**Baby E's [1]** 147/1
**Baby F [1]** 111/9
**Baby G [1]** 149/1
**Baby I [2]** 55/19 168/17
**Baby I had [1]** 55/22
**Baby J [1]** 149/3
**Baby K [3]** 77/25 78/3 149/24
**Baby M [2]** 111/14 111/16
**baby's [9]** 30/17 30/21 91/7 91/13 105/18 107/8 114/6 117/22 159/8
**back [61]** 4/11 4/17 4/20 7/10 8/1 8/12 19/23 19/24 22/12 29/1 29/9 29/13 30/15 33/9 35/14 37/16 38/3 45/2 50/15 58/7 59/18 60/15 62/15 68/16 68/19 68/19 69/15 75/6 99/11 99/23 100/23 103/7 105/25 112/20 113/18 124/17 136/14 136/21 139/3 145/6 148/9 148/11 154/9 157/3 158/7 159/16 163/5 163/7 165/19 170/17 170/25 172/15 172/16 172/18 172/22 172/25 173/9 173/10 173/12 184/5 184/22
**backdating [1]** 179/12
**background [2]** 64/21 131/6
**backwards [1]** 56/11
**bad [7]** 163/12 183/5 183/21 183/25 184/11 185/8 185/13
**bags [1]** 109/20
**Baker [4]** 134/7 134/9 134/10 187/8
**baking [1]** 80/3
**balance [1]** 67/14
**band [54]** 5/25 5/25 6/1 6/1 6/7 6/18 6/19 6/20 6/21 6/24 7/4 7/9 12/16 57/2 57/2 57/2 74/1 74/16 74/17 74/17 75/9 75/10 75/10 75/12 75/14 75/16 75/16 75/19 76/13 76/16 81/1 81/1 91/21 95/8 95/15 95/15 95/17 95/18 95/18 95/24 96/6 137/21 137/23 138/6 142/3 142/10 143/22 153/4 153/14 154/3 160/16 162/15 166/11 166/12
**Band 5 [10]** 6/24 57/2 95/15 95/18 137/21 137/23 142/10 153/4 162/15 166/12
**Band 5s [6]** 6/1 6/20 6/21 74/17 75/16 95/17
**Band 6 [7]** 6/7 12/16 57/2 91/21 95/18 160/16 166/11
**Band 6s [9]** 5/25 6/18 6/19 74/16 75/12 75/14 75/16 75/19 76/16
**bank [1]** 77/6
**BAPM [3]** 5/14 74/9 74/11
**Barrett [4]** 179/18 179/20 179/21 179/22
**base [1]** 118/6
**based [5]** 90/14 136/7 154/23 167/2 180/7
**basic [3]** 93/12 130/5 158/17
**basic-level [1]** 93/12
**basically [1]** 83/11
**basis [4]** 76/21 81/2 160/19 161/7
**basket [1]** 96/18
**batch [2]** 51/23 121/17
**be [251]**
**be November '15 [1]** 23/7
**beating [1]** 113/15
**became [10]** 20/14 31/4 57/25 58/14 89/16 96/14 130/6 143/20 150/16 163/16
**because [129]** 4/4 7/19 9/9 9/20 13/12 20/22 21/6 21/22 22/1 22/24 23/3 25/17 28/16 35/21 36/19 36/24 37/17 37/19 37/22 37/24 38/10 41/1 41/10 43/10 43/17 43/21 44/7 44/8 46/17 46/22 46/25 48/2 49/4 50/5 52/20 52/24 55/22 57/8 57/19 58/16 59/17 59/20 60/2 60/8 60/13 60/20 61/1 62/21 63/8 63/19 63/21 65/4 66/24 68/3 68/15 70/5 71/2 72/2 78/11 82/19 85/22 88/13 89/11 89/13 92/2 93/5 94/5 94/17 94/22 95/15 97/23 101/3 104/15 105/1 106/8 108/14 111/8 112/13 113/6 114/4 114/11 117/18 118/14 121/7 123/14 124/21 127/24 129/8 132/13 133/9 133/24 135/22 138/10 138/23 141/11 142/18 143/21 145/15 145/18 145/19 146/22 146/24 152/5 155/18 156/3 157/3 158/8 158/10 159/5 159/15 164/3 164/18 166/14 166/20 167/25 168/21 169/25 170/7 170/14 172/12 172/23 173/9 173/25 174/7 174/19 176/10 182/10 183/2 184/25
**become [11]** 41/21 57/24 76/24 96/19 100/9 107/19 131/18 135/18 143/14 166/19 179/25
**becomes [1]** 68/2
**bed [4]** 83/15 97/19 126/3 126/12
**been [145]** 1/7 3/2 9/10 14/19 17/2 20/23 20/25 21/17 22/4 22/6 22/11 27/21 28/13 29/14 30/14 30/25 33/13 33/16 35/15 35/21 37/19 37/23 39/4 39/12 39/13 41/4 41/6 41/12 41/19 41/19 43/8 44/12 46/15 47/11 49/9 50/19 55/15 56/10 56/11 57/6 57/21 58/1 58/11 58/16 58/20 58/22 59/22 60/1 61/1 61/7 61/20 66/23 67/10 68/4 69/1 69/4 78/3 80/9 83/9 83/9 83/11 83/12 84/1 84/2 84/13 92/10 94/1 95/8 96/3 96/16 96/19 97/10 97/11 97/15 97/24 106/2 106/13 106/17 107/16 110/10 112/3 115/22 121/3 121/25 123/12 124/9 125/1 125/3 127/21 128/16 128/18 129/23 130/19 132/7 132/18 132/19 132/23 132/24 133/5 133/13 133/25 135/6 136/7 137/22 138/1 138/1 139/9 141/1 141/23 146/12 147/4 147/12 147/13 147/17 148/1 148/3 148/16 148/22 148/25 149/17 150/12 150/13 150/16 150/19 150/24 156/21 157/25 158/6 158/19 159/10 159/13 159/15 161/6 161/9 162/11 162/12 167/3 174/8 174/19 174/20 177/5 179/3 181/8 181/9 184/8
**before [39]** 9/24 16/5 18/25 26/19 28/18 29/3 30/23 33/12 36/6 39/4 46/12 65/5 67/11 83/5 83/7 83/7 83/15 101/3 101/8 106/18 111/7 111/12 115/23 119/13 122/14 124/4 127/14 127/19 129/24 146/6 149/24 150/16 153/9 158/11 158/17 161/5 161/5 164/17 174/2
**beforehand [1]** 101/21
**began [2]** 88/9 121/4
**begin [3]** 92/2 134/15 135/3
**beginning [4]** 91/2 132/25 139/7 153/1
**behalf [2]** 129/17 134/12
**behaving [2]** 42/22 104/9
**behaviour [5]** 102/25 103/13 144/24 145/19 174/24
**behind [3]** 68/18 152/6 157/14
**being [72]** 3/25 7/20 13/19 13/21 18/21 19/18 22/1 27/10 27/16 29/22 35/19 36/6 36/16 37/17 40/2 43/18 49/21 51/1 53/6 53/7 55/9 55/23 64/8 64/10 67/23 69/24 80/17 88/5 91/15 93/22 94/5 96/13 100/23 101/3 112/2 113/1 115/12 117/25 118/2 120/25 122/19 124/5 133/15 135/7 135/21 136/15 137/9 137/14 138/6 139/19 139/20 139/22 139/23 140/2 147/20 150/4 151/15 160/23 166/4 167/11 167/15 171/6 173/24 175/6 175/19 176/8 177/1 179/4 182/17 184/8 185/3 185/7
**belief [1]** 1/21
**believe [19]** 7/19 16/19 28/7 41/23 62/17 78/23 91/14 92/14 103/16 109/15 109/23 118/25 119/1 125/14 128/25 130/18 132/15 148/10 150/3
**believed [4]** 18/4 68/23 102/10 117/10
**belittling [1]** 87/8
**beneath [1]** 138/6
**beneficial [2]** 35/15 183/8
**benefit [1]** 150/23
**Bennion [1]** 29/6
**bereaved [2]** 132/9 148/8
**bereavement [11]** 78/20 79/5 79/21 130/22 130/25 131/5 131/10 131/21 132/4 136/13 136/22
**bereavements [2]** 84/16 130/21
**Berger [1]** 84/20
**Bernadette [1]** 7/3
**Bernadette Butterworth [1]** 7/3
**best [6]** 1/20 79/11 87/14 105/1 131/3 138/13
**better [7]** 47/2 100/9 100/25 130/20 144/5 171/25 184/14
**between [31]** 3/12 7/23 7/25 11/6 14/3 14/12 17/5 26/21 26/23 32/23 34/5 35/17 56/12 78/15 79/18 85/11 86/15 89/18 95/3 107/8 116/4 117/2 147/20 148/20 154/6 154/14 154/15 155/7 156/9 162/18 181/1
**between June 2015 [1]** 17/5
**Beverley [7]** 52/10 52/22 67/11 119/21 184/17 184/20 184/23
**Beverley Allitt [7]** 52/10 52/22 67/11 119/21 184/17 184/20 184/23
**beyond [3]** 22/14 80/2 165/11
**bias [1]** 105/24
**bicarb [1]** 113/1
**big [6]** 13/19 60/24 60/24 103/25 124/9 125/3
**bigger [4]** 86/4 119/7 119/15 119/18
**bile [1]** 111/22

**B**

**birthdays [1]** 80/3
**bit [20]** 4/15 6/4 8/2 12/15 37/7 43/1 44/25 45/3 48/6 50/1 50/2 60/7 75/5 157/11 162/6 168/17 168/18 173/9 175/3 182/18
**black [1]** 27/6
**blame [1]** 147/3
**blank [1]** 146/17
**bleeding [1]** 147/9
**bleep [3]** 10/11 10/25 171/12
**blind [1]** 72/3
**blog [1]** 124/18
**blood [1]** 159/22
**blotchy [1]** 38/14
**board [2]** 158/25 159/7
**body [3]** 30/21 133/3 133/7
**bombarded [1]** 110/12
**booked [2]** 102/2 179/11
**born [5]** 22/6 78/3 83/9 114/12 120/23
**both [14]** 41/11 49/6 49/7 69/25 70/1 101/8 154/24 155/4 155/7 162/8 164/1 164/4 164/4 167/12
**bottom [2]** 55/3 112/16
**box [1]** 54/18
**breach [2]** 60/21 69/22
**breached [1]** 26/1
**break [13]** 24/8 24/10 24/16 73/11 99/22 108/6 108/7 134/16 151/22 155/2 155/6 155/15 155/23
**breaks [4]** 74/25 108/3 108/11 108/13
**Brearey [9]** 27/9 60/4 113/22 113/25 114/1 114/17 114/22 115/5 115/13
**breathe [1]** 108/15
**breathing [8]** 30/14 30/18 37/6 37/8 108/17 112/5 113/8 139/6
**breaths [1]** 30/18
**brief [5]** 148/18 148/19 164/21 175/25 176/11
**briefing [1]** 178/1
**briefly [3]** 28/1 146/3 153/18
**bring [4]** 31/7 32/10 88/14 112/20
**brings [1]** 131/6
**British [1]** 74/12
**British Association [1]** 74/12
**broader [1]** 102/25
**broadly [1]** 81/15
**broken [1]** 130/2
**brother [5]** 38/13 38/19 38/25 111/9 111/19
**brothers [1]** 121/8
**brought [7]** 71/16 84/3 84/10 84/13 132/16 140/10 181/21
**Broviac [2]** 149/4 149/8
**building [1]** 155/9
**bulk [1]** 17/21
**bullied [2]** 23/24 25/7
**busier [1]** 156/3
**busy [15]** 15/7 17/16 74/23 75/2 77/9 77/12 79/5 79/24 91/19 92/16 94/18 94/19 118/3 155/12 156/10
**busyness [1]** 94/22
**but [263]**
**Butterworth [1]** 7/3

**C**

**C's [7]** 95/23 96/15 97/7 106/3 140/21 141/8 144/16
**cakes [1]** 80/3
**Calderbank [2]** 53/2 53/13
**calendar [1]** 80/4
**call [15]** 8/16 9/3 10/1 33/10 43/18 73/13 97/18 97/21 129/23 130/7 130/8 130/9 130/10 130/11 152/3
**called [17]** 1/10 8/17 9/8 10/18 10/18 32/1 39/12 75/25 76/1 80/8 87/15 112/23 128/22 131/7 140/25 147/21 178/19
**calling [2]** 84/17 114/21
**came [30]** 8/19 9/24 29/9 39/20 43/5 43/20 53/18 55/21 58/7 58/10 58/10 62/15 69/15 82/25 83/4 83/5 90/4 94/21 109/11 109/18 109/23 113/18 121/1 145/25 146/8 158/23 159/16 159/16 162/16 184/22
**camp [1]** 20/1
**campaign [4]** 103/25 124/9 125/3 174/21
**can [100]** 2/15 6/13 7/23 9/17 14/20 14/22 16/23 19/23 19/24 20/9 24/4 24/21 24/23 25/4 28/1 36/10 37/11 41/24 43/24 44/17 44/19 45/2 45/13 46/19 46/20 46/21 47/8 47/23 50/21 53/5 54/9 54/10 55/11 56/16 60/15 62/9 65/23 66/3 69/17 71/24 73/8 73/19 74/4 74/11 76/24 77/23 77/24 78/21 83/1 83/24 88/23 89/2 90/18 90/23 101/19 102/24 108/7 109/17 112/21 113/11 114/17 116/11 117/15 119/16 122/17 123/7 125/9 125/23 126/6 126/11 126/25 127/10 129/8 129/9 129/16 129/16 129/18 133/24 135/18 138/13 142/5 145/4 146/2 147/16 152/1 152/20 153/12 156/20 161/17 161/21 161/23 167/4 167/11 170/23 172/11 177/13 185/7 185/11 185/12 185/22
**can't [49]** 7/5 8/1 13/9 13/16 13/16 13/20 15/21 19/22 22/17 28/23 31/5 33/4 39/1 39/18 39/23 39/23 40/3 40/21 41/1 41/2 41/18 57/4 58/9 59/7 61/18 62/19 63/1 63/4 64/6 71/18 71/19 72/21 81/7 83/6 88/25 90/22 119/14 119/15 123/14 124/21 142/10 149/21 156/22 157/1 157/2 167/5 176/12 178/22 179/16
**cannot [3]** 65/12 128/14 150/20
**capable [1]** 2/7
**card [3]** 127/1 127/11 152/12
**cardiac [5]** 113/24 114/1 114/8 114/12 165/6
**care [47]** 27/16 28/2 32/20 36/1 53/18 55/12 65/15 71/16 75/21 80/7 80/9 88/19 92/7 93/2 97/1 98/6 98/15 106/10 107/21 107/21 125/25 126/5 127/9 130/22 131/13 131/21 132/4 135/15 135/18 136/14 137/9 137/11 137/14 137/22 138/2 138/11 138/12 138/13 139/12 140/12 142/15 143/7 145/25 146/24 157/24 167/21 177/15
**career [5]** 4/1 18/20 43/12 162/17 162/21
**careful [3]** 38/7 38/11 68/9
**cares [1]** 159/6
**caring [6]** 4/24 52/7 71/11 106/21 143/2 144/10
**Caroline [1]** 29/6
**Caroline Bennion [1]** 29/6
**carried [7]** 50/20 51/14 52/11 79/10 79/25 93/17 182/22
**carry [1]** 113/11
**carrying [1]** 80/18
**case [22]** 36/21 41/3 41/6 51/5 52/5 67/9 67/12 68/6 88/2 88/8 113/14 119/21 119/24 133/16 148/15 164/3 167/24 169/15 169/22 170/17 171/1 184/18
**cases [3]** 102/22 165/6 183/22
**catastrophic [1]** 34/7
**Catherine [1]** 180/17
**Catherine Pollit [1]** 180/17
**caught [1]** 156/19
**cause [5]** 12/14 50/19 114/10 169/12 184/2
**caused [4]** 36/21 51/18 52/7 113/24
**causes [1]** 32/24
**causing [6]** 51/17 62/4 62/19 169/5 169/8 169/8
**cautious [3]** 36/7 36/21 37/18
**CCTV [1]** 66/22
**celebrate [1]** 83/11
**celebrating [1]** 80/3
**central [2]** 29/8 87/5
**certain [7]** 13/8 25/8 25/9 109/24 116/1 158/11 169/19
**certainly [18]** 4/22 5/2 20/19 20/21 74/23 74/24 75/1 77/5 78/10 86/5 88/11 94/1 97/24 121/23 139/7 144/23 168/25 181/1
**cessation [1]** 142/13
**cetera [1]** 80/4
**challenge [2]** 14/16 14/21
**challenging [3]** 92/19 93/23 168/5
**Chambers [1]** 82/25
**chance [2]** 46/2 137/14
**chances [1]** 100/22
**Chang [3]** 167/11 168/4 168/24
**change [7]** 30/6 30/10 47/4 56/5 87/7 90/16 90/19
**changed [7]** 46/4 63/2 74/6 89/12 89/24 90/6 90/12
**changeover [1]** 15/4
**changes [1]** 52/17
**charge [4]** 80/17 90/3 90/13 120/2
**charged [2]** 68/7 71/10
**chart [1]** 22/20
**chat [4]** 19/2 19/2 93/6 93/6
**check [4]** 21/20 28/18 112/1 112/1
**checked [2]** 28/15 37/17
**checking [1]** 144/17
**Cheshire [1]** 115/25
**Cheshire Police [1]** 115/25
**chest [3]** 29/20 29/25 30/20
**Chester [12]** 80/9 80/11 122/7 125/19 136/23 153/3 153/6 153/19 158/4 163/22 165/2 165/19
**Chief [1]** 82/19
**Chief Executive [1]** 82/19
**child [114]** 27/23 28/2 29/17 30/4 30/4 30/7 30/12 30/14 31/4 31/12 31/21 32/1 32/1 32/5 32/6 32/7 32/25 33/3 33/6 35/23 36/1 36/2 36/6 36/9 36/11 36/11 36/15 36/22 36/25 37/1 38/16 39/7 39/11 39/17 39/25 40/9 40/15 40/16 40/19 41/5 41/6 41/9 41/9 41/15 41/22 42/1 42/14 42/16 42/17 43/9 43/9 43/10 43/11 44/8 44/10 47/16 47/17 51/12 54/7 55/12 62/15 88/19 88/20 88/21 88/21 92/13 95/23 96/15 96/20 101/7 101/7

**C**

**child... [43]** 106/3 106/6 108/20 113/14 113/23 114/22 115/8 115/10 115/11 115/15 115/15 121/9 122/24 135/4 135/6 140/5 140/6 140/9 140/21 140/23 141/8 142/14 144/16 144/23 146/3 146/5 146/9 146/20 147/9 148/19 148/20 148/21 149/4 149/15 149/18 158/18 170/13 170/23 172/2 172/13 172/21 172/24 177/1
**Child A [22]** 27/23 30/7 30/12 30/14 31/12 31/21 32/1 33/3 36/6 36/11 37/1 40/9 40/19 41/5 41/9 41/15 43/9 43/10 47/16 47/17 88/21 101/7
**Child A's [4]** 28/2 31/4 32/25 33/6
**Child B [18]** 30/4 30/4 35/23 36/1 36/9 36/11 36/15 36/22 36/25 38/16 39/11 39/17 41/6 41/9 43/9 43/11 88/21 101/7
**Child B's [4]** 36/2 39/7 39/25 51/12
**Child C [11]** 44/8 88/19 88/20 92/13 96/20 106/6 135/4 135/6 140/23 142/14 144/23
**Child C's [6]** 95/23 96/15 106/3 140/21 141/8 144/16
**Child D [5]** 41/22 42/1 42/16 42/17 44/10
**Child E [5]** 108/20 146/3 146/5 146/9 147/9
**Child E's [1]** 146/20
**Child I [1]** 54/7
**Child I's [1]** 55/12
**Child J [3]** 148/19 148/21 149/4
**Child J's [1]** 148/20
**Child K [2]** 149/15 149/18
**Child M [4]** 113/14 113/23 115/8 115/15
**Child M's [1]** 114/22
**Child N [3]** 115/10 115/11 115/15
**child's [1]** 67/22
**children [7]** 8/19 87/21 104/9 135/11 135/12 154/11 172/1
**children's [26]** 86/3 94/20 153/2 153/14 153/16 153/23 153/25 154/1 154/3 154/4 154/6 154/7 154/12 154/15 154/20 154/24 155/3 155/8 155/10 166/6 166/9 169/10 170/19 171/11 184/4 185/1
**choose [2]** 99/19 99/21
**chose [3]** 171/21 172/18 172/19
**Christmas [2]** 12/3 80/4
**cipher [1]** 11/22
**circle [3]** 180/3 180/5 180/11
**circumstances [1]** 48/20
**clarify [1]** 147/16
**clear [11]** 3/25 17/18 17/19 30/21 77/22 90/22 91/11 98/1 127/19 142/2 184/1
**cleared [1]** 186/7
**clearly [2]** 17/19 111/17
**clerk [1]** 152/5
**clerking [1]** 166/19
**clinical [10]** 16/2 81/25 83/21 83/24 98/14 103/7 113/12 127/25 172/7 174/2
**clinically [3]** 92/8 109/7 110/9
**clinicians [1]** 50/24
**close [6]** 49/18 50/8 101/16 113/14 126/13 126/14
**closely [1]** 183/3
**closest [2]** 72/7 100/15
**closure [1]** 107/1
**clothes [1]** 82/22
**co [1]** 27/13
**co-operative [1]** 27/13
**cohesive [2]** 27/12 66/10
**cold [2]** 100/21 102/7
**collapse [29]** 31/4 31/8 32/7 33/6 36/21 39/8 40/16 40/16 51/12 88/21 88/23 101/13 106/3 107/12 107/13 107/15 107/16 107/18 107/22 113/24 114/9 114/9 114/23 140/21 141/3 141/8 141/18 144/5 146/6
**collapsed [16]** 29/14 30/4 32/6 32/16 34/7 36/19 37/1 37/21 38/14 49/5 49/14 101/8 106/25 140/23 158/20 166/22
**collapses [11]** 7/15 40/10 41/15 47/16 107/5 115/14 165/24 166/13 169/7 182/22 184/6
**collate [1]** 102/19
**colleague [4]** 15/10 60/25 70/12 99/3
**colleagues [9]** 11/12 11/14 11/16 17/1 71/20 72/20 81/13 99/1 118/18
**College [7]** 62/14 122/23 122/24 132/19 132/22 176/25 177/1
**colour [3]** 30/6 30/10 30/22
**combination [1]** 145/20
**come [49]** 1/12 7/10 10/21 16/6 19/23 19/24 25/15 28/5 31/21 35/22 37/11 37/20 37/24 38/12 41/9 42/18 57/20 59/18 62/3 66/16 69/2 72/1 77/12 82/13 84/15 85/22 88/12 88/12 94/13 99/2 101/2 102/7 102/11 110/10 113/12 115/3 120/14 127/10 128/23 136/20 158/6 162/7 163/7 163/21 166/17 166/18 173/7 176/10 177/9
**comfortable [6]** 65/19 92/9 174/23 180/20 180/21 185/19
**comfortably [2]** 51/9 52/4
**coming [21]** 2/17 25/16 25/21 39/22 46/8 46/18 53/6 69/11 90/3 90/5 90/12 90/13 90/18 99/10 103/2 106/5 127/4 145/5 151/15 178/2 186/11
**commenced [1]** 156/14
**comment [16]** 3/14 7/22 18/13 38/20 38/22 61/20 83/10 83/13 96/22 96/24 101/17 104/23 104/23 124/21 156/25 168/13
**commented [1]** 170/3
**commenting [1]** 48/13
**comments [9]** 18/19 27/10 64/8 97/7 97/11 97/12 103/13 149/16 167/10
**Commission [1]** 177/15
**common [6]** 49/3 49/11 71/22 100/20 114/10 126/9
**commonly [1]** 180/9
**communicate [1]** 71/5
**communicated [5]** 123/6 128/6 159/25 176/17 185/7
**communicating [1]** 120/2
**communication [4]** 2/11 4/3 23/21 120/5
**companionship [1]** 163/25
**comparison [1]** 172/3
**compartmentalise [1]** 172/11
**compassionate [2]** 32/19 80/7
**competence [1]** 91/23
**competencies [2]** 85/3 85/9
**competency [1]** 23/20
**competent [1]** 145/2
**complaining [1]** 148/21
**complete [3]** 40/14 40/15 117/24
**completed [10]** 6/22 40/18 40/23 74/24 75/1 76/21 89/17 98/17 145/16 153/2
**completely [9]** 26/11 32/8 63/14 95/14 101/22 149/23 173/3 174/3 185/16
**completing [2]** 40/13 113/22
**complex [4]** 117/11 118/4 118/4 165/6
**compliance [1]** 85/2
**compliant [2]** 178/25 179/8
**comply [1]** 143/6
**comprehend [1]** 71/8
**compressions [4]** 29/20 29/25 30/20 113/20
**compromised [2]** 98/6 98/19
**compulsory [3]** 101/25 102/1 102/3
**computer [2]** 28/22 53/20
**computers [1]** 173/16
**concept [1]** 138/19
**concern [13]** 10/25 33/15 91/17 97/9 99/11 103/9 104/22 109/9 160/25 161/3 162/5 168/8 181/3
**concerned [28]** 5/11 40/8 40/10 51/2 58/15 58/20 73/21 91/3 93/5 93/8 95/11 98/20 102/23 104/11 107/2 116/8 120/5 125/10 130/3 135/17 138/23 140/6 146/6 146/23 152/22 163/1 171/5 173/24
**concerning [1]** 173/18
**concerns [46]** 4/7 5/2 20/6 20/20 20/21 21/1 21/2 21/6 21/11 25/10 52/19 65/11 65/14 66/14 67/20 67/25 68/3 81/21 86/5 91/8 92/2 102/19 103/4 103/12 103/20 104/8 104/24 115/18 119/17 120/16 120/21 121/14 122/1 140/18 144/13 160/20 161/2 162/5 174/2 174/8 174/13 180/20 180/24 181/6 181/15 185/20
**concludes [1]** 73/4
**conclusion [3]** 99/12 99/12 113/12
**concurrent [1]** 41/8
**condition [3]** 33/17 36/23 113/24
**conditions [1]** 114/12
**condoned [1]** 174/24
**conduct [4]** 8/22 35/7 94/2 103/12
**conducted [3]** 9/10 110/14 161/2
**confident [4]** 159/17 162/7 162/12 164/9
**confidential [5]** 57/9 61/3 70/11 104/7 180/23
**confidentiality [4]** 26/1 60/21 69/23 125/18
**confirm [3]** 73/20 141/18 152/20
**confrontational [1]** 93/10
**confronting [1]** 185/9
**confused [1]** 173/3
**congenital [1]** 22/6

## C

**connected [2]** 33/21 183/14
**connection [1]** 165/9
**conscientious [1]** 2/7
**consider [2]** 92/18 133/19
**consideration [1]** 40/12
**considered [8]** 21/2 107/25 145/14 145/18 145/19 148/5 175/15 176/3
**considering [1]** 72/6
**consist [1]** 8/25
**consolidating [1]** 76/3
**Consultant [9]** 8/16 9/1 9/3 9/9 39/24 57/2 86/2 148/10 170/5
**Consultants [15]** 15/6 26/22 26/24 27/4 27/8 51/5 62/13 85/15 85/24 103/6 120/15 121/25 156/6 170/7 170/9
**consumed [1]** 93/13
**contact [6]** 9/14 15/14 21/18 59/20 123/10 166/16
**contacted [4]** 39/13 65/5 147/10 147/12
**contained [2]** 2/12 4/2
**contaminated [1]** 121/17
**content [1]** 121/24
**contents [3]** 1/20 73/20 152/21
**context [3]** 19/1 102/25 145/24
**continue [8]** 24/18 24/20 33/19 42/24 57/17 92/12 100/4 132/11
**continued [1]** 38/4
**continuing [1]** 3/24
**continuity [1]** 55/17
**continuous [1]** 67/1
**contract [4]** 153/13 164/14 164/15 164/16
**contracted [1]** 77/4
**contribute [1]** 124/16
**contributing [1]** 23/22
**controlled [3]** 32/22 67/8 67/16
**convenient [1]** 99/19
**conversation [25]** 19/6 56/1 58/24 59/11 60/14 62/10 62/16 62/24 62/25 63/3 95/13 108/11 148/17 157/8 157/12 157/17 157/18 159/18 160/2 160/12 160/21 161/8 162/2 175/3 175/8
**conversations [14]** 21/15 21/25 22/2 22/17 107/8 115/8 117/6 117/8 133/14 173/8 175/24 176/1 185/11 185/22
**convicted [1]** 52/13
**cooperative [1]** 66/10
**coordinator [1]** 97/19
**copies [1]** 128/22
**copy [2]** 128/11 134/25
**core [2]** 126/19 126/19
**corner [2]** 53/19 111/19
**Coroner [1]** 65/2
**correct [25]** 1/24 1/25 11/10 16/14 34/22 74/3 75/9 80/18 83/22 92/11 95/14 96/7 100/17 106/8 129/12 140/10 140/18 141/21 141/24 142/20 143/3 145/17 146/24 148/13 149/10
**correctly [3]** 16/11 70/21 150/9
**correlation [1]** 169/4
**corridor [1]** 155/7
**corridors [1]** 66/25
**cot [10]** 29/7 39/14 46/14 85/6 89/18 90/8 125/16 126/3 126/12 126/12
**could [85]** 4/1 7/14 8/16 9/5 10/1 10/14 13/1 13/1 14/3 14/15 14/18 17/23 17/25 18/14 23/21 25/18 25/23 28/20 29/10 29/11 30/16 32/2 33/18 34/11 34/11 36/22 36/22 36/24 44/21 46/19 46/23 51/23 52/23 55/3 59/22 66/15 66/15 67/6 68/4 68/21 69/1 69/4 70/10 71/8 75/9 75/11 77/1 77/6 78/5 79/1 79/11 80/5 81/22 84/23 87/1 87/10 90/19 94/13 97/22 101/22 103/18 104/6 104/22 108/2 108/10 112/2 117/12 128/5 133/14 133/20 134/3 135/3 136/9 142/17 142/24 151/3 155/14 158/12 174/12 181/10 181/14 182/3 182/6 183/14 184/8
**couldn't [16]** 10/23 25/1 51/10 71/2 72/2 110/1 124/14 133/14 134/3 141/12 141/16 141/18 149/22 172/23 175/23 176/9
**Council's [1]** 79/15
**counsel [1]** 146/4
**Countess [14]** 66/23 122/7 134/2 153/6 153/18 158/1 158/3 163/22 165/2 165/4 165/8 165/19 178/22 185/3
**counts [1]** 85/19
**couple [4]** 48/3 84/10 117/21 165/14
**courage [1]** 104/13
**course [22]** 6/15 6/19 6/22 7/2 42/25 75/20 75/23 75/25 76/1 76/4 76/14 76/20 86/24 95/24 97/17 98/7 125/8 129/11 129/13 142/7 164/4 169/21
**courses [5]** 18/14 18/17 76/10 76/19 167/23
**court [4]** 22/21 119/10 141/11 143/13
**cover [2]** 67/19 169/18
**covered [1]** 149/8
**covering [1]** 8/18
**covers [2]** 34/25 67/4
**CPAP [3]** 37/5 37/6 37/23
**CQC [7]** 116/3 125/2 177/20 177/22 178/2 178/25 179/5
**crash [1]** 171/12
**crashed [1]** 32/2
**create [1]** 179/5
**created [1]** 131/20
**crimes [3]** 52/11 119/25 120/1
**criminal [9]** 96/15 104/2 107/17 125/2 125/7 129/7 129/21 132/20 136/5
**crisis [2]** 130/6 130/19
**criteria [1]** 89/12
**critical [1]** 25/9
**critically [1]** 107/19
**criticising [1]** 131/16
**criticism [3]** 17/24 98/22 132/22
**cross [2]** 43/7 52/8
**crossed [1]** 52/23
**CRP [1]** 140/14
**cry [1]** 81/12
**cuddle [1]** 33/9
**culture [7]** 11/2 77/7 78/22 80/11 124/21 185/10 185/21
**curiosity [1]** 106/21
**curious [1]** 107/23
**current [1]** 127/14

## D

**D's [1]** 47/17
**dad [1]** 126/11
**daily [2]** 8/24 16/6
**dangerous [1]** 149/9
**data [3]** 29/21 82/9 82/11
**date [4]** 34/10 85/9 179/13 179/15
**dated [6]** 1/19 5/6 39/5 73/19 124/19 152/19
**dated July 2018 [1]** 124/19
**dates [6]** 3/3 65/4 65/7 65/9 80/4 166/1
**Datix [8]** 40/13 40/14 40/18 98/14 145/16 145/22 145/24 149/13
**day [44]** 7/23 7/25 8/9 8/14 8/21 9/2 9/4 9/4 9/8 9/20 15/4 25/22 28/19 55/15 78/4 82/8 82/24 83/2 83/16 89/9 109/6 109/8 109/9 109/11 111/6 111/7 111/8 111/11 111/21 111/24 139/6 156/1 156/4 156/15 158/20 158/23 161/5 170/9 171/18 171/21 172/11 172/11 172/15 173/12
**days [19]** 15/10 35/10 74/24 75/2 81/25 82/2 85/6 88/20 88/21 88/23 106/5 106/18 113/23 117/21 118/9 121/1 156/23 171/11 171/17
**de [1]** 84/20
**dead [1]** 113/7
**deal [5]** 14/5 44/15 79/21 116/3 185/23
**dealing [2]** 115/10 162/12
**deals [1]** 135/11
**dealt [3]** 89/15 97/16 136/13
**death [29]** 22/24 32/25 33/6 34/22 35/11 40/25 41/2 41/22 51/6 65/1 78/5 88/19 88/20 88/23 101/12 103/6 106/3 110/23 111/3 111/4 117/22 127/13 147/2 157/2 171/5 173/8 176/18 179/19 179/24
**deaths [27]** 22/4 32/17 47/17 49/18 51/1 51/11 51/20 53/7 58/17 62/4 62/19 77/19 78/9 101/12 115/25 116/18 116/19 116/22 117/1 117/1 117/7 117/23 131/10 173/3 175/14 181/2 182/22
**debrief [35]** 33/6 34/3 34/3 34/9 34/22 34/24 35/2 35/8 35/10 35/14 35/19 35/20 41/4 41/5 41/8 50/16 81/13 100/6 100/14 100/20 100/21 100/21 101/7 102/4 102/6 102/6 102/7 102/11 102/19 103/2 103/2 103/10 103/13 147/23 148/4
**debriefing [4]** 102/10 105/19 163/12 163/24
**debriefs [5]** 33/25 34/14 34/18 101/24 102/24
**decision [2]** 56/15 136/8
**decisions [1]** 27/11
**decline [1]** 135/20
**declined [1]** 134/5
**deemed [3]** 162/18 174/8 174/14
**deeming [1]** 157/14
**deeply [2]** 56/14 96/24
**definitely [11]** 55/20 75/2 79/1 81/1 87/12 88/8 107/23 115/22 117/24 119/22 160/8
**definitive [1]** 50/19
**deflated [1]** 168/6
**delay [3]** 144/10 145/22 145/24
**delayed [2]** 1/3 98/15
**delete [2]** 128/15 128/19
**deleting [1]** 128/17
**deliberate [2]** 51/18 64/16
**deliberately [3]** 64/10 68/25 71/9
**deliveries [1]** 14/8
**delivery [1]** 126/9
**demand [1]** 171/17
**department [2]** 8/20 154/25
**departments [1]**

**D**

**departments... [1]** 153/17
**depend [1]** 18/2
**dependency [4]** 107/20 135/15 137/9 138/10
**dependent [1]** 87/19
**depends [3]** 102/15 102/17 107/11
**depth [5]** 46/25 84/8 157/17 182/18 184/24
**deputy [4]** 17/8 55/13 82/7 180/14
**descending [1]** 57/5
**describe [15]** 17/3 17/9 25/18 30/3 71/21 79/9 82/24 85/18 96/22 105/9 130/23 140/20 146/15 147/19 158/2
**described [14]** 5/7 37/13 53/17 61/16 76/13 80/14 81/11 88/3 107/10 138/20 139/19 139/24 146/10 162/2
**describes [1]** 43/3
**describing [5]** 80/7 135/5 142/14 164/11 166/7
**description [1]** 139/20
**descriptions [1]** 164/10
**deserve [1]** 138/13
**deserved [1]** 130/20
**designated [5]** 28/6 36/2 89/1 90/21 131/7
**desk [3]** 23/5 23/10 90/8
**despite [1]** 80/17
**detail [3]** 13/21 35/25 57/11
**detailed [2]** 46/14 163/23
**details [6]** 15/2 25/11 140/7 157/22 162/25 174/4
**deteriorate [3]** 38/4 161/23 170/20
**deteriorated [3]** 106/25 144/2 166/22
**deteriorates [1]** 107/5
**deteriorating [1]** 170/24
**deterioration [1]** 36/13
**deteriorations [4]** 115/14 115/14 167/20 169/7
**detrimental [1]** 144/1
**develop [1]** 12/22
**development [1]** 20/12
**dictatorial [1]** 17/11
**did [186]** 8/22 9/6 11/16 11/17 11/20 12/14 13/2 13/17 14/15 14/15 14/20 18/7 19/25 21/25 22/2 22/10 23/1 23/13 24/5 25/17 25/17 26/10 27/1 27/14 27/15 28/8 28/18 35/12 35/13 35/25 36/25 37/1 37/11 38/9 38/14 40/12 40/19 40/25 41/21 42/14 43/7 43/11 44/5 46/9 50/4 50/13 51/19 52/8 56/1 56/6 56/7 57/14 57/17 57/20 57/20 57/24 58/21 58/22 59/5 59/7 59/19 59/24 60/3 60/10 60/11 60/16 60/17 60/19 61/4 61/15 62/9 63/6 63/16 64/1 64/19 64/20 64/22 68/6 70/4 70/17 74/21 75/20 75/23 76/14 76/22 76/22 77/5 77/13 78/10 79/10 79/18 81/16 82/2 82/12 83/11 84/14 84/15 85/3 85/4 85/6 86/12 87/3 88/3 89/21 91/14 93/3 93/24 94/3 95/12 96/19 98/11 98/18 98/21 99/7 99/10 99/15 99/15 99/16 101/18 108/5 110/4 110/16 110/19 110/23 111/2 111/7 111/22 111/23 112/19 114/23 115/5 119/20 120/6 120/9 122/17 122/23 123/10 124/15 125/18 128/15 129/2 131/3 131/19 133/18 137/20 138/25 139/1 143/8 143/25 144/9 144/14 145/7 146/18 154/7 155/4 155/10 156/1 156/23 156/25 161/17 162/1 163/1 163/6 164/10 164/13 164/21 165/4 167/13 167/13 168/14 171/16 173/22 174/17 176/4 176/5 176/14 176/20 176/24 179/4 179/6 179/15 180/5 180/6 180/24 183/4 184/17
**didn't [121]** 4/3 4/4 8/6 8/10 9/25 10/3 11/15 12/3 14/5 14/7 16/9 17/14 20/21 21/4 21/6 21/6 22/1 23/2 23/23 25/20 27/12 29/22 34/6 35/12 36/14 36/17 36/19 43/10 43/14 50/5 50/6 50/9 52/2 52/2 53/10 56/14 57/7 57/7 57/8 57/10 58/20 60/21 60/23 62/17 62/22 63/2 63/22 64/13 64/14 64/15 64/23 70/8 70/11 70/12 72/12 72/13 83/17 84/23 86/8 86/14 86/21 92/1 94/17 98/1 98/7 104/4 104/21 110/6 117/24 118/16 119/3 119/3 119/5 119/5 119/6 119/7 123/4 128/19 136/4 137/7 144/4 144/5 144/5 144/6 145/1 145/3 145/11 145/25 154/23 157/9 157/13 159/16 160/10 161/1 162/16 163/4 164/21 165/5 165/5 165/11 165/11 165/14 165/15 166/11 170/8 170/17 170/25 171/2 171/18 171/19 173/9 173/20 174/10 174/19 178/1 178/8 179/20 179/21 183/5 184/5 184/6
**die [4]** 32/16 48/9 113/6 172/24
**died [16]** 33/7 36/6 40/15 42/1 42/16 44/8 78/2 88/20 101/7 106/15 106/24 107/10 109/13 121/2 146/9 172/21
**dies [2]** 117/21 172/3
**difference [5]** 7/24 68/23 112/19 130/23 162/18
**differences [1]** 7/23
**different [35]** 11/1 15/15 43/23 48/19 48/22 48/25 49/1 49/8 57/1 68/22 103/14 104/19 105/2 105/3 105/15 107/14 108/12 117/19 118/15 121/10 137/10 137/10 154/20 154/25 156/9 158/9 161/6 165/1 167/10 169/16 169/17 170/18 178/19 178/20 183/10
**differently [4]** 5/3 69/5 79/19 104/17
**difficult [16]** 9/14 24/5 44/12 49/4 71/8 101/4 101/20 133/13 166/25 168/8 168/20 173/25 174/6 174/10 182/8 185/22
**difficulties [3]** 27/15 87/25 89/3
**dimly [1]** 67/4
**Diploma [1]** 153/2
**direct [3]** 62/24 143/22 178/1
**directed [1]** 127/8
**direction [1]** 145/6
**directly [4]** 35/8 98/16 176/5 182/23
**disagree [1]** 63/6
**disagreed [2]** 14/17 148/2
**disbelief [1]** 72/19
**discharge [2]** 157/25 158/10
**discharged [2]** 158/12 158/18
**disciplinary [3]** 71/13 175/14 176/2
**discolouration [9]** 30/3 31/12 33/2 38/16 39/10 39/17 40/1 40/9 43/15
**discover [1]** 129/2
**discovered [2]** 147/8 147/11
**discuss [9]** 23/3 34/11 35/4 60/25 63/2 79/18 80/23 110/23 111/2
**discussed [11]** 13/21 41/20 63/18 63/20 72/15 79/22 103/1 151/5 175/13 175/20 177/4
**discussing [3]** 31/21 35/18 176/1
**discussion [15]** 10/6 10/23 13/20 32/18 38/20 40/22 40/24 41/10 77/15 78/15 111/10 124/4 135/7 179/23 185/15
**discussions [9]** 32/23 32/25 33/1 41/17 41/18 106/2 163/23 175/18 184/20
**dislodged [1]** 150/16
**displaced [1]** 149/17
**displacement [2]** 150/22 151/2
**display [1]** 93/24
**distance [1]** 92/4
**distended [1]** 56/13
**distinctly [4]** 90/25 93/15 166/2 175/9
**distinguish [1]** 82/23
**distress [1]** 91/10
**distressing [2]** 173/1 173/2
**divided [1]** 86/19
**do [141]** 1/16 5/10 6/25 7/14 9/3 9/6 12/3 12/24 13/5 14/4 14/5 15/13 17/12 19/13 21/10 22/15 22/19 22/23 23/6 28/13 29/2 31/3 31/11 31/23 32/25 33/18 35/11 35/14 35/16 38/23 39/1 39/15 40/22 41/2 47/4 54/13 56/23 58/18 60/12 60/19 60/23 61/3 64/20 66/6 66/18 67/8 67/15 68/16 69/23 69/24 70/8 71/8 71/18 71/19 72/21 72/25 75/14 75/16 75/20 76/4 80/21 85/15 86/17 86/24 93/3 94/21 95/24 96/13 96/17 98/11 101/10 101/15 102/2 102/13 102/21 103/15 103/17 104/3 104/7 105/16 106/15 109/6 110/24 111/15 114/23 116/12 118/5 120/4 121/23 124/4 125/8 125/20 126/21 132/23 133/10 133/21 134/3 134/25 135/2 136/3 136/7 138/15 138/18 139/5 140/2 141/6 141/15 142/6 144/14 144/17 144/21 147/23 148/7 148/23 149/24 150/22 151/1 152/24 154/17 159/2 162/1 162/20 166/18 166/24 168/22 169/13 169/21 171/16 172/2 172/8 175/12 176/7 180/23 181/10 181/25 182/1 184/13 184/16 184/20 184/21 185/6
**doctor [13]** 9/14 9/25 10/15 10/19 14/16 14/25 15/5 15/13 15/15 139/8 154/21 159/22 173/2
**doctor's [1]** 166/14
**doctors [36]** 8/15 8/22 9/21 9/21 9/22 14/12 15/4 15/8 22/12 22/24 31/16 38/21 39/13 59/25 60/3 66/17 85/12 85/15 85/20 123/12 127/16 154/14 154/17 154/18 154/22 154/23 156/6

## D

**doctors... [9]** 156/8 166/4 166/16 166/20 167/10 170/3 170/5 171/12 183/3
**document [9]** 23/6 23/14 50/21 55/4 56/16 56/24 78/12 123/17 127/13
**documentation [3]** 124/17 129/5 178/15
**documented [2]** 39/10 175/13
**documenting [1]** 173/17
**documents [3]** 116/9 128/10 179/15
**does [8]** 4/20 6/9 10/8 81/20 104/14 107/9 128/5 179/22
**doesn't [11]** 62/22 64/13 64/17 108/8 125/19 138/12 139/13 163/20 183/9 183/9 185/18
**doing [21]** 15/8 30/20 30/25 32/19 37/5 37/25 38/1 42/23 53/21 65/19 83/18 94/4 113/14 132/23 154/14 159/6 164/1 164/4 171/10 179/4 183/6
**domestic [1]** 67/23
**don't [124]** 3/17 13/10 13/19 15/2 16/4 19/14 19/15 20/15 20/23 21/5 21/5 23/15 23/22 24/13 24/20 24/25 25/10 25/12 26/8 31/8 31/13 31/17 31/17 33/22 34/16 38/7 40/18 40/24 43/14 49/16 49/16 49/20 50/16 59/8 63/8 63/8 63/12 63/18 63/20 66/22 67/6 67/17 67/19 68/1 68/1 68/5 68/13 68/15 69/1 69/4 79/8 79/24 84/4 84/18 89/8 90/21 91/15 92/23 95/13 96/2 96/4 97/23 98/12 98/25 98/25 101/9 101/14 101/23 102/5 102/9 102/20 103/1 106/12 106/17 109/3 110/18 111/13 112/18 112/19 113/5 114/25 115/16 115/17 115/24 116/24 117/23 118/15 120/12 121/21 122/16 128/7 128/17 129/16 131/1 132/15 134/4 139/22 140/7 141/19 144/19 148/15 148/25 151/1 151/13 156/12 161/19 162/25 164/19 170/12 171/24 172/19 174/4 175/4 175/20 176/7 182/15 183/9 183/25 184/1 184/10 184/11 184/12 185/8 185/12
**done [31]** 26/2 28/8 28/24 32/3 40/20 46/11 46/17 51/1 55/18 65/20 66/18 68/13 68/25 76/13 76/18 76/19 81/9 84/23 99/17 101/22 111/6 120/9 122/10 147/14 148/12 148/14 153/9 169/22 177/2 179/4 180/25
**door [5]** 29/9 30/20 39/20 79/1 79/4
**doors [1]** 14/7
**doses [1]** 113/3
**doublechecking [1]** 184/21
**doubt [1]** 185/3
**doubts [1]** 68/20
**down [25]** 1/12 1/13 1/16 9/13 30/14 43/1 44/17 44/24 45/3 49/22 51/23 56/16 58/16 82/13 82/25 84/15 86/8 87/22 88/12 120/19 157/24 158/13 159/23 163/10 177/13
**downgraded [4]** 16/6 16/20 58/1 177/7
**downstairs [1]** 152/1
**Dr [41]** 29/6 29/7 30/17 35/3 37/18 41/13 53/15 53/24 59/2 60/4 60/4 62/9 62/11 62/16 63/4 63/16 63/22 63/25 64/5 72/10 94/14 96/25 112/11 113/22 113/25 114/1 114/17 114/22 115/5 115/13 148/20 167/11 167/12 168/4 168/12 179/18 179/20 179/21 179/22 183/12 183/18
**Dr Barrett [4]** 179/18 179/20 179/21 179/22
**Dr Brearey [8]** 60/4 113/22 113/25 114/1 114/17 114/22 115/5 115/13
**Dr Chang [2]** 167/11 168/4
**Dr Gibbs [1]** 94/14
**Dr Gibbs' [1]** 96/25
**Dr Harkness [3]** 29/6 29/7 30/17
**Dr Jayaram [10]** 59/2 60/4 62/9 62/11 62/16 63/16 63/22 63/25 64/5 112/11
**Dr Lambie [4]** 37/18 53/15 53/24 183/12
**Dr Neame [3]** 167/12 168/12 183/18
**Dr Rachel Lambie [1]** 41/13
**Dr Saladi [2]** 35/3 148/20
**Dr U [1]** 72/10
**Dr Za [1]** 63/4
**drained [1]** 101/22
**draw [1]** 132/1
**drawing [1]** 37/25
**drink [1]** 93/1
**dropdown [1]** 30/20
**dropped [4]** 37/15 37/15 58/16 177/6
**drug [1]** 67/8
**drugs [4]** 112/14 112/17 113/1 184/22
**due [6]** 51/20 117/10 166/1 166/4 178/25 184/8
**dunno [1]** 48/22
**durations [1]** 166/4
**during [37]** 2/1 2/3 2/4 2/14 5/21 6/7 8/21 15/1 15/3 15/19 22/5 49/15 57/14 72/14 80/15 97/21 112/12 118/4 118/11 125/15 125/17 125/19 132/10 147/2 150/2 156/17 156/23 158/15 158/20 159/18 159/22 162/23 165/23 168/14 171/10 178/25 182/9
**duties [1]** 118/25
**duty [13]** 5/21 5/23 6/6 17/15 19/7 23/18 28/5 44/8 55/8 90/12 90/13 119/1 120/23
**dying [3]** 118/19 172/1 172/13

## E

**E's [2]** 146/20 147/1
**e-learning [1]** 85/2
**each [13]** 6/7 11/8 14/6 14/7 46/9 57/17 72/21 79/14 81/12 95/19 108/10 126/3 132/3
**eager [2]** 146/15 146/15
**earlier [20]** 31/9 51/15 56/19 60/16 65/18 75/5 79/20 79/20 88/23 101/12 101/13 101/19 117/20 123/9 125/25 135/16 143/9 168/18 178/10 179/13
**early [12]** 16/7 75/10 75/11 80/17 80/25 81/5 83/4 96/6 96/12 156/19 157/22 183/13
**earmarked [2]** 18/21 18/21
**easier [2]** 37/9 119/2
**easily [1]** 10/5
**easy [3]** 2/13 87/22 110/2
**eat [1]** 108/2
**echo [3]** 113/22 114/2 114/15
**education [1]** 85/4
**educator [1]** 160/15
**effect [2]** 29/5 113/7
**efficient [3]** 47/3 47/6 47/7
**effort [1]** 37/8
**ego [1]** 137/25
**Eirian [43]** 16/8 17/7 17/9 18/5 18/8 19/5 19/19 20/11 20/15 20/22 21/10 21/24 21/25 22/2 22/16 22/23 23/2 24/2 25/7 26/5 27/5 27/10 35/6 55/19 61/21 61/25 62/6 63/20 64/12 78/25 81/17 82/1 82/7 82/8 97/13 98/4 98/10 98/18 99/2 99/7 114/21 115/13 145/16
**Eirian Powell [18]** 16/8 17/7 19/19 21/10 22/16 24/2 25/7 61/21 61/25 62/6 81/17 82/1 98/4 98/18 99/7 114/21 115/13 145/16
**Eirian Powell's [4]** 17/9 18/5 35/6 98/10
**Eirian's [1]** 66/13
**either [7]** 31/11 32/6 102/4 115/12 151/14 178/23 179/8
**elaborate [1]** 85/13
**elective [2]** 102/7 102/8
**electronically [1]** 126/21
**Ellis [3]** 140/20 141/7 141/22
**else [16]** 4/6 5/2 19/25 26/6 32/10 40/19 43/18 58/2 63/3 71/9 72/25 78/16 140/8 141/7 158/1 174/17
**elsewhere [1]** 128/1
**email [5]** 128/11 128/11 128/14 128/22 128/23
**emails [8]** 82/19 122/3 123/24 124/17 128/16 128/18 128/23 176/23
**embedded [1]** 80/11
**emergency [3]** 87/16 153/17 154/25
**emotional [5]** 44/13 84/6 98/12 101/5 172/8
**emotions [1]** 101/19
**emotive [1]** 92/20
**employed [1]** 131/8
**employment [2]** 153/16 156/14
**enable [1]** 182/21
**encountered [1]** 147/9
**encouraged [1]** 76/6
**end [5]** 2/17 2/21 52/11 62/25 75/13
**ended [2]** 59/10 140/17
**endless [1]** 130/2
**endotracheal [3]** 149/16 150/7 150/22
**ends [1]** 49/24
**engage [1]** 163/22
**engaged [2]** 3/23 4/23
**enough [4]** 9/21 61/6 150/4 171/25
**enquire [4]** 106/5 106/11 108/15 108/18
**enquiries [1]** 150/21
**enquiry [3]** 107/2 107/9 150/23
**ensure [4]** 74/17 85/2 101/2 143/19
**ensured [1]** 85/8
**ensuring [1]** 93/19
**entered [5]** 29/24 31/6 31/9 31/10 109/22
**entertaining [1]** 80/5
**entirely [1]** 87/23
**environment [4]** 92/20 105/2 105/8 121/5
**EP [1]** 62/6
**episode [1]** 37/13
**episodes [2]** 44/13 55/22
**equally [6]** 155/12 159/16 161/20 164/1 170/15 185/13
**equation [1]** 22/8
**equipment [2]** 51/24 85/3

## E

**escalate [3]** 15/14 15/17 181/12
**escalated [4]** 62/6 144/13 174/2 174/7
**escalating [1]** 161/1
**escape [1]** 166/1
**especially [4]** 66/13 166/10 173/5 183/2
**established [2]** 79/22 85/25
**et [2]** 80/4 151/2
**et cetera [1]** 80/4
**Eve [1]** 82/24
**even [20]** 14/6 43/14 48/24 66/22 81/7 93/14 101/25 130/5 130/6 131/1 135/18 136/9 156/10 157/5 170/15 172/2 174/23 184/16 185/21 185/22
**evening [2]** 28/6 135/17
**event [8]** 67/21 92/15 100/16 107/2 133/25 164/9 171/4 183/23
**events [21]** 29/24 41/16 51/2 52/4 66/19 103/3 105/10 107/24 110/20 122/4 133/15 135/5 142/14 147/1 147/24 163/8 182/1 182/2 183/15 183/16 185/3
**ever [14]** 13/20 32/17 50/16 74/20 75/12 82/12 99/10 99/15 116/13 116/24 136/16 136/20 148/5 156/12
**every [15]** 4/4 40/25 41/2 46/23 46/25 47/1 66/23 79/10 88/2 88/7 113/16 138/10 142/8 148/8 154/20
**everybody [4]** 20/14 46/10 46/23 46/24
**everyone [6]** 28/18 90/2 90/6 90/8 101/1 119/1
**everyone's [3]** 43/17 85/8 101/2
**everything [14]** 10/4 23/16 113/2 118/14 118/21 118/24 119/5 133/10 136/10 136/11 159/12 160/7 163/16 177/23
**evidence [28]** 12/5 12/8 14/2 16/11 24/13 31/18 39/24 40/4 45/19 47/14 50/25 53/2 53/15 56/19 60/16 65/4 66/3 73/5 101/20 116/20 118/5 119/11 119/13 134/5 136/24 146/10 183/12 183/17
**exact [9]** 22/17 39/1 58/9 59/7 62/19 86/23 100/22 166/1 168/21
**exactly [13]** 13/16 13/20 18/16 28/23 31/5 31/8 39/18 64/6 88/15 115/5 130/13 176/7 176/12
**examination [1]** 182/19
**examined [2]** 117/25 124/5
**example [3]** 52/5 116/22 132/2
**examples [2]** 19/20 88/2
**exceedingly [1]** 80/10
**except [1]** 31/2
**excessively [1]** 163/2
**exchange [4]** 44/18 49/23 56/18 95/3
**exchanged [1]** 55/9
**excited [4]** 146/11 146/14 160/4 160/4
**excuses [1]** 133/17
**Exec [1]** 83/6
**executive [6]** 82/19 82/25 123/11 124/18 130/18 132/7
**executives [4]** 82/13 131/16 131/18 132/12
**exhausted [1]** 168/6
**exhausting [1]** 172/6
**exist [2]** 108/8 125/18
**expand [6]** 2/9 9/17 36/10 66/3 78/21 112/21
**expect [5]** 32/9 99/7 103/11 164/6 173/10
**expectation [1]** 42/22
**expected [4]** 17/13 112/8 112/9 158/3
**expecting [1]** 177/15
**experience [14]** 12/20 13/4 36/12 42/23 66/12 81/24 82/3 113/4 137/15 157/4 161/13 164/20 172/14 174/1
**experienced [7]** 76/14 160/7 163/9 164/20 165/1 171/6 184/9
**experiences [1]** 163/23
**experiencing [3]** 162/10 167/20 168/8
**expertise [1]** 76/12
**explain [2]** 6/13 158/19
**explained [1]** 112/3
**explanation [2]** 36/14 183/24
**express [3]** 14/16 46/20 46/21
**expressed [2]** 159/23 164/8
**expressing [1]** 168/5
**extended [1]** 94/10
**extent [2]** 121/25 148/14
**externally [2]** 142/8 176/17
**extra [12]** 8/6 22/10 36/7 36/20 75/20 76/23 76/24 90/1 120/15 127/7 139/11 145/6
**extract [3]** 41/24 44/19 54/9
**extremely [3]** 79/5 118/3 150/6
**eyes [5]** 105/9 105/13 105/17 105/20 118/15

## F

**face [3]** 56/6 56/8 82/19
**facilitate [2]** 85/3 87/20
**fact [14]** 4/7 19/25 36/15 71/3 114/6 121/9 137/13 138/22 143/1 147/12 164/21 165/16 177/16 179/20
**factors [1]** 117/12
**factual [1]** 68/22
**faeces [1]** 149/8
**failed [1]** 132/18
**fair [6]** 88/5 94/5 110/14 119/16 138/2 138/4
**fairly [1]** 111/17
**familiar [2]** 125/23 163/2
**familiarity [1]** 163/19
**families [11]** 4/25 71/14 71/23 80/7 131/24 132/9 132/14 133/9 133/9 134/13 172/9
**family [27]** 27/21 27/22 80/8 81/12 92/17 93/13 93/14 94/10 94/10 94/11 106/7 111/8 125/22 125/24 126/13 130/8 130/11 135/4 144/19 144/21 144/23 145/2 145/5 145/10 158/15 163/11 163/19
**family's [1]** 144/16
**far [18]** 18/20 33/5 73/20 83/23 95/11 98/20 101/6 101/11 107/2 116/7 120/4 125/10 135/9 135/12 146/5 152/21 177/20 181/20
**Farmer [4]** 82/1 84/25 160/13 161/25
**Farmer's [1]** 82/5
**fast [1]** 36/13
**father [4]** 31/4 31/19 39/16 96/15
**fatigue [1]** 78/20
**favourably [1]** 19/18
**favoured [2]** 20/19 66/13
**favourite [1]** 66/14
**favourites [4]** 17/18 17/19 18/3 18/5
**feasible [1]** 126/21
**February [5]** 116/4 167/3 168/18 177/16 178/12
**fed [1]** 50/15
**feed [1]** 158/14
**feedback [3]** 4/5 97/7 99/10
**feeding [2]** 158/2 159/5
**feeds [1]** 56/13
**feel [29]** 14/15 14/15 17/14 20/3 20/15 22/24 24/5 25/23 27/3 27/9 27/12 33/20 57/8 60/16 60/19 63/22 66/12 86/12 86/21 87/4 87/8 95/1 95/4 131/18 132/18 136/1 159/16 185/10 185/18
**feeling [11]** 20/3 39/2 50/6 51/3 51/11 55/20 78/17 79/9 100/6 106/9 168/6
**fell [1]** 18/2
**fellow [3]** 65/12 67/20 124/13
**felt [46]** 2/22 5/3 11/13 13/2 13/11 14/18 14/19 15/9 15/11 15/12 20/7 20/9 20/13 23/24 25/6 25/25 26/11 26/23 27/7 27/12 36/20 51/1 51/4 52/19 60/20 62/12 65/19 66/9 78/13 78/14 79/2 79/18 81/14 83/13 87/24 88/3 93/21 100/14 146/20 146/21 162/6 167/19 174/12 174/22 180/20 180/21
**few [18]** 3/18 29/11 32/15 41/10 41/11 56/12 80/5 84/11 88/23 100/23 106/5 109/5 113/23 119/9 121/1 133/23 168/22 174/1
**FiCare [2]** 80/9 80/12
**figures [1]** 78/12
**fill [1]** 178/15
**filling [1]** 179/1
**filters [1]** 121/16
**FIN [1]** 76/2
**final [2]** 3/6 128/3
**finally [2]** 132/17 149/15
**find [17]** 25/1 62/18 62/22 62/23 64/14 64/16 64/17 71/7 72/22 114/4 117/22 121/2 128/1 148/2 152/6 159/2 166/25
**finding [4]** 53/6 111/23 114/10 149/16
**findings [1]** 62/15
**fine [4]** 24/25 28/16 29/8 42/24
**finger [1]** 18/16
**finish [1]** 42/25
**finishing [3]** 28/20 28/22 28/25
**first [39]** 2/1 2/23 3/2 3/3 9/23 22/15 27/23 45/17 54/25 58/17 65/16 67/9 68/4 71/16 75/23 84/12 96/3 96/19 103/22 103/23 106/14 109/21 110/2 113/5 115/23 122/5 125/8 125/11 127/20 132/21 133/1 133/1 147/3 153/4 157/2 162/15 164/5 171/18 179/25
**fit [1]** 85/18
**five [11]** 6/2 6/2 6/4 6/6 8/11 77/19 77/20 90/7 108/9 108/10 135/10
**five deaths [1]** 77/19
**five members [1]** 6/6
**five metres [1]** 135/10
**five nurses [1]** 8/11
**five on [1]** 6/2
**five-minute [1]** 90/7
**fixed [1]** 1/7
**flag [2]** 58/22 97/8
**flagged [1]** 69/3
**flipped [1]** 185/17
**fluids [4]** 29/4 33/21 33/24 51/23
**focused [2]** 162/3 162/4

**F**

**focusing [1]** 153/10
**folder [2]** 128/21 129/1
**follow [4]** 68/2 68/12 68/14 93/24
**followed [1]** 119/24
**following [12]** 33/6 35/10 39/7 41/16 98/2 103/6 112/22 137/18 142/12 142/22 171/4 175/8
**food [1]** 109/20
**foot [1]** 30/19
**forbidden [1]** 132/7
**forever [1]** 87/17
**Forgive [1]** 139/2
**forgot [2]** 63/14 159/9
**form [10]** 27/14 40/13 40/14 98/14 103/7 117/25 132/12 139/14 150/23 163/24
**formal [4]** 34/9 34/14 34/18 157/15
**formally [1]** 175/12
**formed [1]** 114/11
**former [1]** 91/23
**forms [1]** 179/2
**forthcoming [1]** 130/2
**fortnight [1]** 44/9
**fortunate [1]** 171/25
**forward [2]** 131/22 185/19
**forwards [4]** 56/11 182/16 185/2 186/1
**found [14]** 2/6 2/13 114/14 122/21 129/22 129/24 147/6 147/7 147/17 164/17 166/3 172/17 173/1 176/3
**Foundation [1]** 76/1
**four [11]** 5/23 6/4 8/10 51/18 88/21 108/9 108/9 108/10 142/8 164/24 165/3
**four days [1]** 88/21
**four weeks [2]** 164/24 165/3
**four years [1]** 142/8
**fourth [1]** 122/18
**frame [1]** 116/1
**free [3]** 73/5 151/16 186/6
**Freedom [2]** 181/9 181/21
**frequency [2]** 77/21 91/12
**frequent [3]** 76/21 155/4 156/17
**frequently [5]** 8/21 8/22 82/10 151/1 162/24
**fresh [6]** 105/9 105/13 105/17 105/20 105/21 105/23
**Friday [1]** 156/25
**fridge [1]** 109/20
**friend [5]** 47/19 60/25 70/12 126/13 126/14
**friendly [1]** 2/13
**friends [12]** 11/12 11/15 11/17 12/18 19/14 21/23 56/9 59/21 72/7 81/13 105/3 165/16
**friendship [1]** 72/9
**front [5]** 73/24 125/22 135/1 152/13 152/24
**frustrated [2]** 143/5 143/20
**full [6]** 29/15 76/22 76/23 77/4 90/4 92/14
**full-time [1]** 77/4
**fully [1]** 39/13
**further [20]** 23/3 26/4 35/5 35/10 43/1 49/22 63/2 63/18 63/21 63/23 68/11 92/13 99/13 115/7 120/12 120/19 157/19 162/5 181/12 186/2
**future [3]** 4/9 151/7 182/2

**G**

**gain [1]** 2/10
**gather [2]** 24/11 100/25
**gathering [1]** 181/7
**gave [10]** 13/13 29/20 29/25 46/4 53/2 56/19 90/4 109/14 110/21 146/11
**general [6]** 4/7 19/2 19/2 19/6 20/3 122/2
**generality [1]** 155/25
**generally [14]** 10/12 13/24 14/13 17/23 18/10 20/13 21/19 74/21 75/6 85/14 106/22 113/11 113/21 180/3
**gentleman [1]** 83/5
**gestation [2]** 92/7 177/10
**get [31]** 12/20 24/25 26/12 31/7 31/21 34/11 45/13 46/24 61/2 67/17 67/18 67/22 75/11 91/11 91/14 95/4 96/7 99/10 105/4 119/20 125/20 129/9 133/19 138/14 144/4 144/5 157/2 159/23 162/20 177/23 184/14
**getting [3]** 29/4 127/7 181/6
**ghoulish [1]** 144/24
**Gibbs [1]** 94/14
**Gibbs' [1]** 96/25
**give [11]** 30/16 33/9 40/12 49/23 54/23 70/10 77/24 130/17 138/14 158/14 174/4
**given [22]** 21/7 47/14 49/20 50/18 64/21 65/10 68/21 87/23 109/12 110/22 112/13 112/17 113/3 116/20 118/19 127/21 129/4 137/14 140/12 149/25 177/20 183/17
**gives [3]** 18/24 37/6 104/12
**giving [2]** 30/18 133/12
**glitch [1]** 1/6
**gloves [1]** 38/1
**glucose [1]** 113/1
**go [77]** 3/13 10/14 12/1 17/13 18/15 18/18 18/20 28/17 28/20 32/1 32/10 38/2 42/4 42/9 43/1 43/24 45/2 45/3 46/6 47/8 48/7 49/22 50/1 54/23 55/3 60/15 60/25 70/14 70/15 72/19 73/5 77/11 78/5 79/1 93/16 95/5 101/3 101/4 103/7 104/6 105/7 105/8 105/17 111/14 113/6 119/9 127/8 127/25 136/13 136/14 138/7 139/3 141/25 143/4 143/23 146/22 151/16 156/18 160/23 161/1 163/13 164/13 164/17 167/24 169/13 171/24 172/4 172/15 172/18 172/22 172/24 176/15 177/13 181/10 184/11 184/12 186/7
**goal [1]** 71/22
**going [48]** 4/1 8/12 25/16 26/12 28/10 32/12 33/20 34/5 39/3 42/7 44/1 44/18 46/7 46/11 47/23 51/10 53/21 55/23 59/22 59/24 61/25 66/24 71/24 72/12 73/7 73/23 79/6 80/25 81/6 99/8 105/25 114/14 121/5 122/2 144/16 144/19 144/21 145/25 146/2 170/16 172/4 172/16 173/14 174/23 176/14 176/23 180/21 185/19
**gone [16]** 20/19 20/22 21/5 23/12 57/25 65/21 81/22 87/12 92/16 146/16 152/6 159/9 164/5 173/12 181/14 185/14
**good [27]** 1/9 2/8 4/8 4/9 5/9 5/13 11/14 11/19 14/13 18/13 18/22 19/16 20/16 21/23 24/19 32/5 61/2 62/12 70/14 70/15 80/10 102/10 126/24 142/22 146/5 151/24 168/22
**goodbyes [1]** 96/17
**gosh [1]** 107/23
**gossip [1]** 185/18
**gossipping [1]** 174/14
**gossipy [1]** 146/11
**got [43]** 4/5 4/10 11/13 11/13 18/14 25/13 25/21 28/12 28/15 37/17 39/22 46/10 46/10 46/13 46/14 54/21 65/7 65/9 67/2 67/2 68/9 80/16 93/1 95/9 96/21 108/2 112/4 112/25 113/8 115/18 118/9 118/22 119/9 119/14 122/12 128/21 129/4 137/1 143/13 164/19 167/25 172/10 185/20
**grand [1]** 9/8
**grandparents [1]** 92/17
**grateful [1]** 87/17
**great [5]** 13/21 14/5 18/20 68/18 84/2
**grief [1]** 144/16
**grievance [1]** 61/21
**Griffiths [13]** 17/8 55/13 56/1 58/3 58/5 58/6 59/1 59/5 69/11 81/18 82/1 82/6 123/18
**group [10]** 11/14 17/20 17/24 19/6 76/16 84/3 100/25 133/13 180/10 180/19
**groups [5]** 22/22 57/2 86/20 105/2 105/4
**growing [2]** 158/2 158/14
**guard [1]** 156/20
**guardian [4]** 125/12 126/3 181/9 181/22
**guardians [2]** 125/14 126/2
**Guedel [7]** 95/23 96/2 96/3 96/4 142/1 142/1 142/4
**guess [13]** 23/19 23/19 47/3 51/6 51/14 65/21 79/25 114/3 121/11 159/16 173/10 178/19 185/17
**guidance [2]** 68/2 68/12
**guilt [1]** 68/21

**H**

**had [395]**
**hadn't [11]** 7/1 13/8 14/19 76/21 78/2 79/20 83/14 138/24 141/1 161/9 177/12
**hair [1]** 105/7
**half [3]** 28/5 75/11 77/5
**halfway [1]** 9/12
**hand [2]** 109/19 111/18
**handed [1]** 150/17
**handing [1]** 47/3
**handle [1]** 58/23
**handling [1]** 129/21
**handover [23]** 9/23 28/10 28/12 28/15 46/1 46/5 46/6 46/9 46/14 80/18 89/18 90/2 90/5 90/9 90/14 90/17 110/11 125/15 125/16 125/22 125/24 140/11 159/6
**handovers [2]** 46/22 125/16
**hands [1]** 142/18
**hanging [1]** 72/18
**happen [13]** 34/16 34/16 35/12 35/12 35/13 68/6 74/13 111/24 112/8 118/25 133/20 133/20 157/7
**happened [31]** 22/11 23/4 25/19 31/8 35/4 42/13 43/3 49/20 81/8 89/8 89/9 89/18 89/21 90/2 91/1 98/7 111/23 114/6 120/20 136/10 146/16 151/6 159/12 159/19 162/9 163/8 163/12 172/12 182/1 182/9 184/22
**happening [11]** 17/2 19/3 41/7 52/24 71/2 78/10 147/24 166/13 176/24 184/5 185/13
**happens [3]** 67/21 149/24 151/2

## H

**happy [3]** 13/22 83/8 139/18
**hard [6]** 18/16 19/20 44/12 66/21 82/23 172/4
**Harkness [3]** 29/6 29/7 30/17
**harm [9]** 51/18 52/7 71/9 145/20 169/5 169/9 169/12 170/1 170/13
**harmed [1]** 64/10
**harming [2]** 58/13 60/1
**has [27]** 1/7 12/5 12/8 14/2 22/25 32/6 50/23 67/10 68/9 69/22 92/13 106/15 115/2 119/1 120/14 125/3 131/20 132/6 132/18 134/7 136/10 140/20 142/3 149/8 152/5 167/25 183/12
**hat [1]** 80/16
**have [336]**
**haven't [2]** 132/13 136/23
**having [17]** 22/23 44/15 50/16 62/16 95/8 99/11 99/12 136/21 157/4 157/12 158/8 172/24 178/23 182/16 185/10 185/21 185/23
**HDU [1]** 137/13
**he [57]** 15/7 29/14 29/14 33/7 36/19 36/23 63/6 63/16 64/13 64/13 64/13 64/14 64/14 64/15 64/16 64/20 64/22 83/4 83/5 83/6 91/9 92/7 92/8 106/18 106/20 108/23 108/24 109/6 109/7 109/8 109/9 109/13 111/17 111/18 111/19 111/20 111/22 112/5 112/17 112/19 113/18 113/22 114/2 114/6 115/1 140/15 140/15 140/17 144/5 144/6 144/8 144/8 144/8 144/9 168/13 168/14 168/16
**he's [2]** 64/6 168/13
**head [2]** 43/23 95/5
**health [9]** 62/15 84/15 84/19 122/24 127/16 127/24 138/23 145/11 177/1
**healthcare [2]** 156/5 156/8
**hear [9]** 4/14 25/20 60/24 62/9 84/7 120/18 120/19 176/4 176/6
**heard [21]** 12/5 12/8 14/2 19/18 45/19 50/24 58/18 60/8 62/2 65/18 70/6 70/20 70/25 72/8 75/3 84/20 87/18 105/14 120/19 175/6 183/12
**hearing [1]** 46/23
**heart [6]** 39/22 113/15 114/7 114/12 133/9 136/18
**heartbeat [4]** 29/14 113/8 113/18 113/19
**heighten [1]** 120/9
**heightened [3]** 119/25 185/4 185/7
**held [4]** 67/13 100/6 100/15 103/5
**Hello [1]** 134/12
**help [13]** 10/18 10/19 20/9 47/23 61/4 94/21 125/9 134/2 134/4 140/25 143/12 145/9 184/14
**helped [3]** 17/15 146/24 181/2
**helpful [3]** 41/4 41/6 87/14
**helpline [1]** 180/23
**helps [1]** 122/4
**her [156]** 2/2 2/11 2/13 2/14 2/17 2/21 2/22 2/23 2/23 3/1 3/2 3/3 3/6 3/8 3/23 3/23 4/1 4/3 4/6 4/12 4/12 4/18 4/20 4/21 4/23 7/6 12/19 12/21 12/21 12/22 13/8 16/4 16/21 17/19 18/1 18/2 18/8 18/10 18/12 18/20 20/16 20/20 21/12 21/15 21/18 21/23 22/3 23/12 25/14 25/18 25/20 27/10 29/1 37/6 37/14 37/14 37/17 38/13 38/18 38/25 39/7 41/13 42/17 42/17 42/20 42/20 42/21 42/25 44/15 48/2 52/11 52/16 53/15 55/23 57/20 59/15 59/25 60/10 60/11 61/6 61/7 64/2 68/8 68/20 72/7 72/8 72/9 72/13 76/14 76/19 91/5 91/11 91/11 91/23 93/4 93/11 93/15 93/22 93/23 95/5 97/13 97/14 98/5 98/12 99/2 99/6 99/7 99/10 99/12 104/6 111/11 115/1 115/4 119/22 119/25 128/12 131/3 137/6 139/19 139/22 139/23 139/24 140/8 140/20 140/21 142/23 142/24 143/15 143/22 143/23 145/25 146/10 146/10 146/11 147/10 157/2 157/14 160/11 160/20 161/8 162/2 163/11 163/15 163/16 164/5 164/6 164/10 164/10 167/22 172/21 173/17 173/20 174/13 174/15 174/16 184/8
**here [14]** 44/9 66/20 83/9 83/9 96/17 109/23 112/22 131/16 132/8 134/18 151/15 180/13 182/2 185/20
**herself [6]** 37/6 42/22 143/11 144/15 144/25 161/2
**hesitated [1]** 169/4
**hesitation [1]** 81/19
**Hey [1]** 72/8
**Hi [1]** 134/14
**hierarchy [1]** 180/8
**high [11]** 77/9 77/12 92/20 101/4 107/20 109/25 135/15 137/9 140/14 161/22 165/5
**higher [9]** 15/25 16/3 22/8 77/20 158/6 158/13 168/2 169/20 182/12
**highest [1]** 97/20
**highlight [2]** 45/6 127/15
**highlighted [2]** 52/21 132/6
**highly [11]** 48/11 48/14 76/14 92/15 100/24 100/24 109/24 122/17 146/17 146/18 150/10
**Hill [2]** 67/12 68/6
**him [26]** 30/15 33/8 33/10 39/2 83/4 83/7 83/7 91/8 96/17 106/6 106/19 108/20 108/23 108/24 111/20 112/1 112/1 112/3 112/8 112/13 112/17 112/20 114/18 114/24 115/1 140/8
**himself [2]** 112/4 113/19
**hindsight [4]** 68/18 72/11 99/17 150/23
**his [27]** 30/15 30/16 30/17 30/21 31/2 33/8 36/15 36/21 62/20 62/21 82/19 88/19 91/16 92/7 92/17 94/10 106/6 109/8 109/10 109/10 111/9 111/19 111/20 111/22 111/25 113/15 113/19
**history [1]** 42/18
**hm [11]** 6/10 39/9 40/11 42/6 59/4 103/21 142/16 161/16 171/8 177/17 185/5
**home [14]** 8/16 28/20 32/12 67/23 71/14 71/22 101/3 101/4 130/10 138/14 139/15 154/6 158/18 163/13
**honest [1]** 108/14
**honestly [1]** 128/7
**hope [1]** 172/10
**hopeful [1]** 112/13
**hoping [1]** 164/16
**horrible [1]** 44/12
**horrified [2]** 96/23 96/24
**hospice [2]** 131/5 153/18
**hospital [22]** 15/18 53/16 66/19 67/9 67/12 97/19 106/13 116/3 116/8 120/8 121/3 122/7 124/9 129/24 130/16 133/22 133/22 150/25 154/6 162/24 181/4 182/7
**hospitals [2]** 56/12 153/17
**hot [4]** 100/20 100/21 102/6 103/13
**hour [5]** 75/11 83/16 88/12 126/2 147/12
**hours [9]** 9/25 77/1 77/4 77/5 80/20 110/8 125/14 140/14 146/25
**house [3]** 58/7 76/7 83/20
**how [93]** 5/21 8/21 8/22 10/3 17/9 18/10 18/13 20/18 31/3 34/6 41/21 42/18 42/22 42/23 42/23 46/4 46/9 49/19 51/2 54/12 54/15 57/9 57/9 57/24 58/9 58/10 58/13 58/22 64/19 65/11 66/6 66/7 66/23 67/6 67/19 67/22 69/1 69/4 71/24 72/2 72/11 74/5 75/14 77/1 77/11 78/13 78/14 79/18 80/15 81/14 82/10 85/3 85/4 85/13 95/21 96/22 106/17 108/7 108/22 108/24 110/21 110/22 116/12 116/19 116/22 118/5 118/17 118/17 120/9 125/20 128/5 128/5 130/22 133/24 135/9 141/15 150/24 151/1 151/6 151/7 154/17 154/18 156/1 159/22 159/25 161/2 164/10 164/25 168/10 177/19 180/6 182/6 185/6
**however [8]** 76/22 77/22 85/17 87/13 91/6 92/15 135/16 141/2
**huddle [3]** 53/19 90/7 90/7
**huddles [2]** 175/10 175/18
**Hudson [1]** 75/3
**hugely [1]** 81/12
**Hummingbird [1]** 65/3
**hurried [1]** 29/13
**hurry [1]** 3/18

## I

**I actually [1]** 58/24
**I agree [1]** 145/11
**I allocated [2]** 56/4 89/11
**I almost [1]** 114/5
**I already [2]** 58/19 58/19
**I also [1]** 134/18
**I always [4]** 4/5 52/18 52/18 62/12
**I am [27]** 48/4 48/6 52/9 52/9 54/15 71/13 71/13 72/11 73/23 86/24 89/6 89/25 90/11 93/8 105/22 109/24 118/14 118/14 122/2 125/13 131/16 132/8 134/22 146/2 173/14 176/14 181/20
**I appreciate [1]** 147/25
**I ask [1]** 134/12
**I asked [1]** 93/4
**I asking [1]** 45/5
**I became [3]** 57/25 58/14 143/20
**I began [1]** 88/9
**I begin [1]** 134/15
**I believe [15]** 7/19 16/19 28/7 41/23 62/17 78/23 91/14 92/14 109/15 109/23 125/14 128/25 132/15 148/10 150/3
**I believed [2]** 68/23 117/10
**I call [2]** 73/13 152/3

**I**

**I came [1]** 29/9
**I can [12]** 14/22 24/23 90/18 116/11 119/16 122/17 129/9 129/16 129/18 142/5 146/2 167/4
**I can't [39]** 7/5 8/1 13/16 13/16 13/20 15/21 19/22 22/17 28/23 31/5 33/4 39/1 39/18 39/23 39/23 40/3 40/21 41/1 41/2 41/18 57/4 58/9 59/7 61/18 62/19 63/1 63/4 64/6 81/7 83/6 88/25 119/15 123/14 124/21 142/10 156/22 176/12 178/22 179/16
**I certainly [3]** 20/19 20/21 139/7
**I commenced [1]** 156/14
**I completed [2]** 40/18 98/17
**I completely [1]** 63/14
**I could [13]** 14/18 18/14 25/18 25/23 29/10 29/11 79/1 81/22 87/10 101/22 142/24 174/12 181/14
**I couldn't [8]** 51/10 72/2 124/14 141/12 141/16 141/18 172/23 176/9
**I definitely [2]** 117/24 119/22
**I did [20]** 11/17 13/2 21/25 22/2 23/1 28/8 28/18 57/20 59/7 64/1 78/10 81/16 98/21 111/7 111/23 122/17 138/25 164/13 165/4 171/16
**I didn't [41]** 4/3 12/3 17/14 20/21 21/4 21/6 21/6 22/1 29/22 50/5 50/6 56/14 57/7 57/8 57/10 58/20 60/21 60/23 64/23 70/8 70/11 70/12 72/12 86/14 86/21 92/1 110/6 118/16 119/3 119/3 136/4 159/16 161/1 162/16 165/5 165/5 170/8 171/18 171/19 174/10 178/1
**I discussed [2]** 63/20 175/20
**I distinctly [3]** 93/15 166/2 175/9
**I divided [1]** 86/19
**I do [22]** 22/19 28/13 39/1 58/18 60/12 67/8 67/15 69/23 96/13 109/6 121/23 133/10 133/21 135/2 139/5 141/6 144/21 148/7 149/24 168/22 175/12 176/7
**I don't [90]** 13/10 13/19 16/4 19/14 19/15 20/15 20/23 21/5 21/5 23/15 23/22 24/25 25/10 26/8 31/8 31/13 31/17 31/17 33/22 40/18 40/24 43/14 49/16 49/16 49/20 50/16 59/8 63/8 63/8 63/18 63/20 66/22 67/6 68/1 68/1 68/13 68/15 69/1 69/4 79/8 79/24 84/4 84/18 89/8 90/21 91/15 95/13 96/2 96/4 97/23 98/12 98/25 98/25 101/9 101/14 101/23 102/9 103/1 106/17 109/3 110/18 111/13 112/18 112/19 114/25 115/16 115/24 116/24 117/23 120/12 122/16 128/17 129/16 131/1 134/4 139/22 140/7 144/19 148/15 148/25 151/1 151/13 156/12 161/19 164/19 172/19 175/4 175/20 176/7 182/15
**I dunno [1]** 48/22
**I e-mailed [1]** 26/4
**I expected [1]** 112/9
**I feel [5]** 20/3 27/3 27/9 33/20 131/18
**I felt [12]** 2/22 11/13 14/18 15/9 25/25 52/19 60/20 66/9 79/2 93/21 162/6 174/12
**I find [1]** 71/7
**I found [6]** 2/6 2/13 129/22 147/7 147/17 172/17
**I gave [2]** 29/20 29/25
**I generally [1]** 20/13
**I get [1]** 96/7
**I give [1]** 77/24
**I go [2]** 38/2 72/19
**I got [6]** 11/13 11/13 37/17 96/21 129/4 137/1
**I guess [13]** 23/19 23/19 47/3 51/6 51/14 65/21 79/25 114/3 121/11 159/16 173/10 178/19 185/17
**I had [77]** 20/15 20/20 20/22 21/15 23/11 28/13 28/15 29/13 30/21 30/24 30/25 38/1 42/20 43/12 49/6 49/6 49/8 49/17 49/20 52/13 52/19 55/14 55/18 57/10 58/18 58/20 58/22 59/18 60/7 60/8 60/13 61/1 61/7 62/12 64/12 66/11 70/20 79/3 83/4 83/7 91/8 91/8 92/2 92/18 93/6 95/13 97/24 109/9 110/8 119/13 120/11 121/14 129/5 140/12 140/13 146/24 147/5 159/10 160/21 160/25 161/7 161/10 162/11 163/9 164/14 164/17 165/1 173/25 174/2 174/7 174/9 174/19 174/20 174/22 175/1 178/21 179/25
**I hadn't [2]** 13/8 177/12
**I handle [1]** 58/23
**I have [55]** 13/15 20/17 21/5 21/7 26/20 28/8 31/1 32/17 36/12 37/13 39/19 40/3 40/19 45/1 46/19 47/5 48/9 61/11 64/12 71/12 72/7 87/1 87/12 88/13 89/7 94/7 94/8 96/7 96/10 97/22 102/9 105/14 107/12 115/3 115/6 118/13 118/13 119/11 124/16 127/21 127/23 128/13 128/21 131/17 133/8 139/24 140/24 143/12 148/5 148/16 148/25 151/11 151/25 161/4 184/3
**I haven't [1]** 136/23
**I honestly [1]** 128/7
**I hurried [1]** 29/13
**I instantly [1]** 157/9
**I just [30]** 2/15 23/4 23/15 24/11 25/1 25/6 26/11 27/11 28/17 29/3 33/18 38/11 51/6 66/12 69/10 69/17 71/4 77/22 86/22 93/17 95/1 95/4 100/7 115/5 136/1 142/2 147/16 154/7 157/7 157/10
**I kind [2]** 56/8 86/19
**I knew [26]** 17/1 20/18 21/24 25/22 42/17 42/17 44/6 44/6 44/7 49/8 58/15 58/16 63/19 63/19 70/10 72/9 72/10 91/23 101/9 117/23 119/18 119/18 128/7 155/18 167/23 177/5
**I know [16]** 12/17 12/18 13/2 24/4 29/21 31/6 51/4 61/15 66/24 71/25 94/6 105/16 105/18 121/15 150/25 162/4
**I left [3]** 20/18 63/1 152/6
**I look [2]** 68/19 68/19
**I made [3]** 38/22 68/20 91/10
**I may [7]** 41/18 41/19 41/19 73/24 88/16 128/25 181/23
**I maybe [1]** 11/15
**I mean [19]** 12/1 18/19 22/25 32/15 36/11 37/4 41/19 48/7 56/8 60/20 68/13 68/18 113/19 126/16 137/6 142/2 144/22 165/13 184/10
**I meant [1]** 44/11
**I mentioned [4]** 51/15 98/15 117/20 125/25
**I missed [1]** 147/4
**I must [1]** 55/14
**I myself [1]** 12/19
**I need [4]** 58/21 95/2 95/4 136/2
**I needed [3]** 28/16 79/2 93/23
**I never [7]** 51/15 51/17 80/22 124/21 134/5 177/6 179/10
**I nipped [1]** 29/8
**I now [2]** 72/3 72/4
**I particularly [1]** 165/3
**I phoned [1]** 69/14
**I presume [1]** 40/20
**I probably [3]** 28/23 59/17 101/18
**I provided [1]** 124/18
**I rang [1]** 58/21
**I re-entered [1]** 29/24
**I read [3]** 129/8 144/20 180/1
**I really [3]** 25/17 26/3 35/16
**I recall [5]** 40/5 56/3 99/14 124/7 178/7
**I recalled [1]** 40/5
**I receive [1]** 120/6
**I received [3]** 120/12 124/15 130/9
**I refer [2]** 78/24 91/5
**I remember [13]** 28/21 34/24 58/10 90/25 91/15 98/13 111/17 114/18 116/2 117/5 139/23 158/10 175/19
**I represent [1]** 135/5
**I right [2]** 30/9 41/5
**I said [14]** 8/1 26/7 29/2 38/3 62/17 66/21 135/16 141/16 141/18 143/9 159/3 179/9 184/8 184/11
**I saw [9]** 12/1 16/21 22/20 22/23 23/1 59/18 97/13 108/24 163/17
**I say [14]** 25/17 38/9 69/24 113/18 134/15 139/10 154/9 165/14 168/20 168/21 170/7 171/23 176/2 177/12
**I searched [1]** 124/17
**I see [1]** 103/9
**I seem [1]** 42/16
**I should [4]** 61/3 69/14 99/17 110/9
**I started [2]** 121/11 121/13
**I still [2]** 71/23 72/22
**I suppose [1]** 23/16
**I suspected [1]** 169/3
**I tend [1]** 48/7
**I then [1]** 119/12
**I think [130]** 1/12 6/21 6/23 7/19 9/19 20/17 20/24 33/12 34/18 35/16 37/11 38/5 38/12 38/22 40/24 41/7 42/21 43/17 44/24 49/17 49/24 51/22 55/13 55/18 55/19 56/19 59/16 60/4 61/18 64/1 64/11 66/8 67/17 67/17 69/2 69/11 69/25 69/25 70/16 71/19 72/17 74/23 77/4 82/18 82/22 82/24 85/19 86/19 88/9 89/23 89/25 90/11 99/6 99/20 100/8 100/19 101/19 102/15 102/17 103/2 103/3 103/22 104/12 104/12 104/18 105/1 105/13 105/14 105/15 107/11 108/13 117/19 118/7 119/8 122/18 123/21 124/14 128/17 130/20 131/19 133/21 138/4 139/23 140/22 141/15 143/9 145/22 146/20 152/2 154/7

**I**

**I think... [40]** 154/19 154/19 155/18 156/24 158/10 160/21 161/18 162/5 162/6 162/14 162/17 167/2 167/12 169/10 169/13 169/20 170/10 172/2 173/4 173/6 173/8 177/16 178/3 178/12 179/17 181/8 182/12 182/13 182/15 183/1 183/2 183/4 183/7 184/3 184/10 184/19 184/21 185/10 185/21 185/25
**I thought [6]** 23/15 23/19 26/3 48/12 121/14 179/7
**I took [1]** 143/18
**I trust [1]** 72/19
**I understand [2]** 1/7 131/22
**I understood [1]** 16/11
**I used [2]** 37/12 48/12
**I very [1]** 12/21
**I want [1]** 183/21
**I wanted [3]** 60/25 63/21 146/25
**I was [99]** 3/22 7/20 13/10 15/7 19/4 19/5 19/15 20/25 21/16 22/14 25/16 25/20 26/12 28/6 28/9 29/10 29/18 29/18 30/18 30/20 32/9 33/20 35/13 37/24 39/3 42/15 42/16 43/10 48/13 49/4 49/17 51/22 52/14 52/16 52/16 52/20 55/14 56/9 56/9 57/19 57/23 58/15 58/15 58/20 60/9 62/13 62/16 72/2 72/7 72/13 75/13 79/2 82/4 91/3 91/25 93/5 93/11 96/5 96/23 96/24 99/3 99/4 101/22 110/12 111/6 111/8 114/4 114/13 114/15 115/3 119/12 121/18 130/10 135/17 139/24 140/25 141/6 141/11 141/12 143/5 154/3 155/13 157/5 159/7 159/8 162/4 162/10 162/20 163/13 164/16 165/3 165/4 165/7 171/10 178/3 178/4 178/22 179/10 181/13
**I wasn't [13]** 29/10 48/11 57/9 57/19 68/15 70/20 97/23 117/8 118/2 119/17 121/23 162/7 182/10
**I went [4]** 28/16 38/13 119/10 129/4
**I wish [1]** 128/7
**I won't [2]** 124/2 157/21
**I word [1]** 141/15
**I worked [2]** 11/17 155/19
**I would [38]** 5/16 5/19 12/1 20/23 20/24 25/22 28/10 28/12 32/9 65/21 82/5 82/18 85/25 88/7 97/12 97/13 97/18 97/24 99/9 103/16 105/9 107/14 108/8 127/18 130/17 136/11 136/17 146/14 146/15 147/22 155/23 156/2 159/17 160/2 163/14 164/16 170/8 172/16
**I wouldn't [9]** 5/18 25/14 68/21 82/21 123/14 162/12 165/2 178/4 180/21
**I'd [8]** 5/4 11/1 11/5 27/19 45/22 47/9 54/6 150/18
**I'll [8]** 4/16 26/16 43/25 49/23 54/23 77/11 102/12 186/8
**I'm [49]** 1/5 3/11 3/16 4/14 8/12 9/19 9/19 15/1 16/18 16/19 16/20 18/22 27/20 28/24 42/7 44/1 44/18 45/1 48/2 50/3 54/12 61/25 66/7 75/15 88/1 88/25 93/7 93/10 93/10 97/1 101/23 102/9 106/17 109/23 110/18 110/25 115/24 120/18 126/14 134/18 138/25 139/25 149/1 149/3 151/25 152/4 153/9 176/23 177/11
**I's [1]** 55/12
**I've [10]** 12/18 27/21 65/9 96/3 127/21 136/4 164/18 167/2 181/8 185/19
**ideal [1]** 136/20
**ideally [2]** 74/9 105/3
**identification [1]** 182/21
**identified [1]** 134/20
**if [175]** 3/13 4/10 6/11 8/17 9/6 10/1 10/1 10/5 10/9 10/18 10/22 12/2 13/1 13/10 14/16 15/16 15/19 15/22 16/11 17/16 17/24 17/24 19/23 20/20 22/5 22/7 24/23 24/24 27/6 27/23 27/25 28/18 32/9 32/11 33/1 36/23 36/23 40/12 40/14 40/16 40/16 41/8 41/25 42/1 42/4 42/9 43/1 43/14 44/21 45/3 47/2 47/2 48/24 49/22 49/24 50/1 50/19 52/19 54/10 54/22 55/3 55/16 55/16 57/4 59/1 60/15 62/3 64/22 65/20 67/8 67/22 67/24 68/2 68/2 68/9 69/10 69/14 71/19 73/24 73/24 74/24 74/25 74/25 75/4 75/11 75/13 76/16 76/25 77/5 77/24 78/2 79/2 79/2 79/2 79/3 80/25 81/5 81/21 86/5 86/9 86/22 87/1 87/1 88/1 88/16 89/8 89/10 91/24 97/24 99/22 101/15 102/1 102/2 103/4 103/8 104/4 104/8 104/19 105/5 106/6 106/10 106/24 106/24 107/8 107/21 111/14 113/4 113/8 113/23 115/18 117/21 121/21 122/3 122/13 122/17 123/17 125/22 129/5 134/15 135/3 136/12 139/5 141/6 145/6 146/2 147/8 147/16 148/1 148/23 150/9 151/8 152/7 152/11 155/12 156/2 158/10 160/9 162/9 163/12 167/19 170/19 172/15 172/16 172/19 175/13 176/3 176/15 177/11 178/2 178/3 180/24 181/23 183/2 184/1 185/22
**ignore [2]** 50/3 143/25
**ignored [1]** 143/24
**image [1]** 95/4
**immediate [1]** 35/8
**immediately [1]** 112/5
**impact [3]** 27/16 164/11 166/6
**imparted [1]** 110/4
**impartial [1]** 182/23
**implementation [1]** 125/10
**importance [1]** 185/6
**important [2]** 102/22 185/25
**impression [14]** 2/4 3/8 4/8 4/19 13/13 18/24 27/14 66/11 84/24 86/14 137/1 144/3 146/13 179/5
**improve [3]** 42/24 132/11 173/6
**improved [3]** 42/19 88/10 103/18
**improvement [1]** 42/20
**improving [2]** 42/13 42/14
**inaccurately [1]** 147/13
**inadvertently [1]** 57/10
**inappropriate [4]** 83/14 145/19 146/17 146/18
**inappropriately [2]** 146/11 147/19
**incident [8]** 25/25 35/9 40/13 53/17 54/2 98/14 103/7 150/2
**incidents [6]** 25/8 41/20 51/18 56/10 57/7 134/1
**include [1]** 81/20
**included [2]** 33/1 132/5
**including [2]** 127/15 182/19
**incompatible [1]** 22/7
**incompetence [1]** 51/20
**incomprehensible [1]** 72/22
**incorrectly [1]** 147/18
**increase [7]** 3/24 12/25 58/17 77/21 91/12 117/13 165/24
**increased [7]** 22/25 91/16 116/17 117/7 117/10 119/25 139/6
**incredibly [4]** 92/19 93/22 94/3 94/4
**incubator [9]** 29/2 29/12 30/15 30/19 39/19 109/7 111/20 111/25 112/4
**incubators [1]** 67/5
**indeed [12]** 59/19 69/9 73/4 73/14 77/15 79/12 92/5 98/4 145/8 146/20 151/14 186/6
**independent [5]** 104/20 105/5 105/21 122/20 181/3
**indicated [1]** 19/15
**indictment [7]** 14/24 27/20 34/25 35/1 56/24 87/19 126/4
**individual [6]** 18/1 90/9 102/17 169/12 181/10 183/5
**individuals [1]** 177/25
**induction [5]** 15/3 15/9 75/25 164/2 164/2
**infant [2]** 80/19 175/14
**infection [1]** 175/22
**inferior [1]** 87/9
**inform [2]** 69/14 69/18
**informal [2]** 106/2 107/7
**informally [3]** 108/1 108/11 175/9
**information [12]** 78/7 97/25 98/1 110/12 110/21 110/22 120/15 122/6 130/1 130/17 159/25 182/20
**informed [4]** 39/13 119/17 121/21 141/6
**informing [4]** 32/4 32/5 98/5 159/21
**infrequent [1]** 81/8
**infrequently [1]** 82/15
**infused [1]** 150/4
**infusions [2]** 94/21 118/7
**initial [3]** 52/12 129/21 156/17
**initially [6]** 37/22 68/7 68/8 141/1 164/14 171/18
**input [1]** 92/1
**INQ0000101 [1]** 44/19
**INQ0000424 [1]** 54/9
**INQ0000758 [1]** 41/24
**INQ0002879 [1]** 123/17
**INQ0004914 [2]** 122/5 176/16
**Inquiry [32]** 1/19 1/23 3/13 3/19 5/11 12/5 12/8 14/2 28/1 31/19 35/6 35/16 37/12 41/14 50/23 52/22 53/15 65/5 72/1 72/8 73/19 75/3 95/21 102/18 119/23 121/16 125/6 136/11 146/4 152/20 183/12 186/16
**inquisitive [1]** 114/3
**insensitive [1]** 132/13

**I**

**inserting [3]** 29/7 144/15 144/24
**inside [3]** 39/2 105/18 140/1
**insistence [1]** 35/3
**inspection [3]** 116/9 125/2 177/20
**instance [2]** 77/25 127/6
**instant [1]** 135/24
**instantly [1]** 157/9
**instead [3]** 65/20 80/18 144/15
**instruction [1]** 143/6
**instructions [3]** 93/24 98/3 177/19
**insulin [7]** 67/8 67/10 67/11 67/12 67/13 109/10 119/6
**Integrated [2]** 80/9 125/25
**intelligent [3]** 2/8 2/8 3/23
**intensive [7]** 53/18 75/21 107/21 135/15 137/9 137/14 138/2
**intent [1]** 157/14
**intention [1]** 128/12
**intentionally [1]** 170/1
**interact [1]** 155/5
**interactions [3]** 138/15 138/18 156/17
**interest [5]** 131/3 131/5 162/16 164/19 167/22
**interests [3]** 136/17 165/12 165/15
**interpersonal [1]** 23/21
**interpret [1]** 64/19
**interpretation [3]** 137/24 138/3 138/4
**interpreted [1]** 163/24
**interrupting [2]** 88/4 136/19
**interval [1]** 147/20
**interview [2]** 28/8 178/8
**interviewed [2]** 116/5 116/13
**intimidated [2]** 23/25 162/7
**into [43]** 8/19 23/4 23/12 25/21 28/21 30/14 33/10 46/6 51/7 66/16 71/16 72/19 84/3 86/20 90/4 92/13 92/16 104/8 110/2 110/10 114/21 115/4 118/2 121/1 121/10 127/4 136/14 136/14 136/21 138/7 144/15 144/19 144/21 144/25 144/25 151/2 162/20 163/21 169/13 171/24 182/22 184/11 184/12
**intrigued [1]** 114/14
**introduced [1]** 47/4
**intubated [2]** 30/13 149/20
**intubation [1]** 159/22
**invariably [1]** 9/23
**investigated [4]** 68/11 99/12 124/5 133/15
**investigating [1]** 102/19
**investigation [2]** 128/22 129/1
**investigations [3]** 133/23 140/13 182/21
**involved [27]** 26/20 29/16 29/18 29/19 32/9 32/12 34/10 35/8 35/13 41/17 53/7 54/2 65/1 88/18 104/21 113/2 115/7 115/22 131/19 131/25 159/13 173/18 179/6 182/23 182/25 183/9 185/3
**involvement [3]** 28/2 35/25 88/17
**irrespective [3]** 136/11 138/10 139/10
**is [210]**
**isn't [9]** 32/19 62/22 67/9 98/22 107/16 163/5 172/1 175/6 184/1
**isolated [1]** 130/6
**issue [4]** 23/20 23/21 114/8 125/20
**issues [5]** 4/3 15/11 81/20 102/24 174/25
**it [545]**
**it's [94]** 12/24 14/22 14/24 18/16 18/22 22/25 32/19 40/7 41/1 41/19 50/11 52/24 53/25 54/15 61/15 66/21 66/25 67/1 67/20 68/13 71/2 71/6 71/6 72/18 72/18 72/18 78/14 79/6 80/8 80/11 81/8 81/9 98/1 98/24 101/3 102/5 102/7 102/22 102/22 105/18 105/21 107/19 112/9 114/10 118/14 118/21 118/24 119/2 119/2 121/12 122/17 125/1 125/13 127/19 128/17 135/5 135/23 137/16 138/4 139/25 142/18 145/9 148/4 152/5 157/6 157/19 158/5 158/7 164/18 167/11 168/20 169/16 169/17 171/23 172/3 172/4 172/5 172/13 172/13 172/13 177/23 178/23 181/20 182/8 183/23 183/25 184/11 184/15 185/10 185/15 185/15 185/16 185/17 185/21
**items [1]** 104/10
**its [2]** 62/15 150/7
**ITU [12]** 92/3 92/7 95/17 95/19 107/22 118/8 136/14 136/21 137/11 137/12 137/21 169/21
**IV [1]** 94/21

**J**

**J's [1]** 148/20
**January [1]** 156/15
**Jayaram [13]** 27/9 58/12 59/2 60/4 62/2 62/9 62/11 62/16 63/16 63/22 63/25 64/5 112/11
**Jennifer [1]** 94/24
**jigging [1]** 170/22
**jigsaw [3]** 119/9 120/17 134/20
**job [8]** 4/10 18/12 60/2 72/21 162/16 163/16 164/17 169/13
**jobs [3]** 71/18 71/19 165/10
**joined [1]** 153/7
**joint [1]** 35/19
**Jones [1]** 94/25
**Jones-Key [1]** 94/25
**judge [4]** 104/15 105/6 141/15 141/16
**July [9]** 2/3 16/5 39/6 108/20 122/7 123/19 123/24 124/19 176/18
**July 16 [1]** 16/5
**June [14]** 17/5 17/5 28/3 36/4 41/16 50/24 74/7 88/19 89/16 89/23 121/21 135/22 138/16 138/19
**June 2015 [1]** 89/23
**junior [9]** 41/14 44/13 81/4 85/15 85/20 95/15 138/1 170/3 174/8
**just [156]** 2/15 3/16 3/16 3/17 4/14 8/10 10/3 10/6 10/23 13/22 14/7 16/7 18/10 18/10 18/19 19/5 19/8 19/10 19/11 20/25 21/20 23/4 23/15 23/16 23/22 24/11 24/21 25/1 25/4 25/6 25/19 25/23 26/11 27/11 28/17 28/24 29/3 29/4 33/18 34/4 34/6 34/23 37/6 37/9 37/19 38/7 38/11 42/7 43/25 44/14 44/21 45/2 45/4 47/5 47/23 48/13 49/12 49/17 49/23 49/25 50/10 50/11 51/6 52/24 53/22 54/1 55/3 55/21 57/1 57/3 59/1 60/15 60/23 61/5 61/15 61/25 62/16 62/21 63/10 64/16 66/3 66/7 66/12 69/10 69/17 70/5 71/2 71/4 71/6 72/17 73/7 74/4 74/11 77/22 78/13 79/24 81/13 83/17 86/22 87/1 89/13 92/24 93/11 93/12 93/17 94/5 95/1 95/4 97/4 99/1 99/18 100/7 101/2 101/21 108/16 112/7 114/3 115/5 118/7 119/9 122/3 122/18 129/9 133/19 134/16 136/1 138/20 140/11 142/2 146/3 147/16 148/18 149/24 150/13 151/25 152/12 152/12 153/9 154/7 157/7 157/10 157/17 160/7 162/20 163/9 164/8 164/24 166/23 167/6 173/20 179/4 183/21 184/7 184/15 184/24 186/7
**JUSTICE [2]** 69/7 187/5

**K**

**Karen [8]** 16/6 16/16 21/3 21/4 26/4 26/5 26/6 62/7
**Karen Rees [8]** 16/6 16/16 21/3 21/4 26/4 26/5 26/6 62/7
**Kathryn [3]** 52/25 53/2 84/20
**Kathryn Percival [1]** 52/25
**keen [5]** 2/9 2/10 4/23 12/24 18/11
**keenness [1]** 12/21
**keep [6]** 66/18 67/2 95/1 98/1 125/6 136/1
**kept [9]** 1/5 39/13 53/6 53/6 67/1 97/24 128/11 128/19 182/6
**key [2]** 80/4 94/25
**kicking [1]** 112/3
**kill [1]** 71/9
**kind [33]** 17/20 33/9 34/1 56/8 59/9 81/18 84/7 84/8 86/19 87/14 90/7 97/15 97/20 98/12 101/2 105/6 105/23 108/11 121/24 124/16 126/24 127/7 158/7 158/9 159/7 160/3 160/6 167/19 174/21 175/4 175/21 177/23 180/10
**kindly [1]** 152/6
**kitchen [2]** 109/19 110/13
**knew [37]** 17/1 19/14 20/18 21/22 21/24 21/24 25/22 42/17 42/17 44/6 44/6 44/7 49/8 50/18 58/15 58/16 58/19 59/17 60/10 63/19 63/19 69/13 70/10 72/9 72/10 91/23 101/9 117/23 119/18 119/18 123/3 128/7 134/3 139/3 155/18 167/23 177/5
**knocked [1]** 37/14
**know [245]**
**knowing [4]** 20/18 43/18 167/22 169/15
**knowledge [4]** 1/21 2/9 2/24 3/24
**known [10]** 13/24 14/1 20/14 78/1 82/16 97/6 99/2 129/20 132/25 180/9
**KR [1]** 62/7

**L**

**labelled [3]** 80/12 116/24 117/1
**labour [2]** 87/5 105/16
**Lady [14]** 1/9 24/22 69/6 69/7 73/1 73/13 99/20 134/7 134/11 151/10 151/12 151/19 186/14 187/5
**Lambie [5]** 37/18 41/13 53/15 53/24 183/12
**LANGDALE [8]** 73/17 134/8 151/25 152/15 152/17 186/12 187/7 187/10
**last [7]** 53/2 54/10 54/16 55/4 75/3 81/8 94/23
**lasting [1]** 84/24
**late [2]** 22/20 75/8
**later [10]** 3/10 34/10

## L

**later... [8]** 69/16 121/1 148/10 168/17 177/5 177/9 177/11 178/11
**Lavender [2]** 131/8 131/11
**lazy [1]** 48/6
**lead [2]** 16/3 174/23
**leader [22]** 13/6 28/4 28/6 28/7 28/11 46/7 46/8 46/12 46/18 55/15 74/1 74/5 74/8 74/15 74/19 81/2 89/1 89/4 90/18 92/18 119/17 144/13
**leaders [1]** 45/20
**leadership [1]** 87/7
**leaking [1]** 148/22
**learn [1]** 82/2
**learned [1]** 165/3
**learning [3]** 4/23 72/11 85/2
**learnt [1]** 97/4
**least [2]** 46/1 85/23
**leave [12]** 16/9 75/5 75/10 76/14 77/24 80/17 80/19 80/25 81/5 84/23 181/3 186/8
**leaving [5]** 12/3 55/21 58/8 80/19 89/19
**led [8]** 8/25 9/1 107/24 131/12 132/3 135/7 147/1 156/16
**left [15]** 20/18 28/19 30/17 30/17 53/16 63/1 72/17 100/4 109/19 110/8 148/22 151/25 152/6 165/8 166/14
**left-hand [1]** 109/19
**less [6]** 8/13 101/8 135/12 156/3 156/11 170/20
**let [13]** 21/20 42/7 43/25 45/13 95/5 96/7 115/12 115/24 133/23 139/3 163/7 170/20 177/18
**let's [3]** 18/25 170/22 175/3
**Letby [75]** 2/4 3/15 11/25 12/5 12/8 18/4 18/9 19/18 20/1 20/6 21/1 21/11 42/5 43/3 45/9 45/22 46/16 48/17 50/10 54/11 54/20 56/2 57/14 59/3 59/24 61/6 61/16 63/24 64/23 69/12 89/4 91/5 91/5 91/7 93/3 93/18 93/21 94/24 95/22 95/25 96/11 98/2 99/8 99/13 111/25 121/20 128/12 134/20 135/7 135/24 136/8 137/2 137/5 137/20 138/15 138/18 138/22 139/17 140/5 141/2 142/17 143/5 144/15 146/8 147/9 156/14 156/18 159/21 162/1 165/9 168/8 169/6 175/13 179/19 181/1
**Letby's [10]** 1/23 2/2 4/18 53/6 55/6 64/4 76/11 137/25 141/7 162/23
**letter [1]** 21/20
**letting [2]** 164/6 166/21
**level [31]** 18/1 46/25 58/16 68/15 76/11 79/21 83/17 84/7 91/24 93/12 123/11 130/5 130/18 137/4 137/4 138/11 138/12 139/11 139/13 139/14 140/14 158/6 158/8 158/14 161/22 164/5 165/5 170/14 177/6 180/12 182/13
**levels [9]** 5/7 5/9 5/15 5/20 8/8 25/23 82/9 169/19 169/20
**lid [1]** 29/12
**life [4]** 22/7 112/23 158/17 174/5
**life-support [2]** 112/23 158/17
**lifting [1]** 29/11
**light [3]** 69/2 120/14 145/9
**Lightfoot [6]** 173/16 173/23 175/8 179/18 179/23 180/16
**lightly [2]** 94/9 98/25
**like [89]** 1/11 5/4 11/1 11/5 15/7 24/8 24/9 25/19 26/12 27/12 27/12 27/19 29/4 30/23 30/24 31/1 32/6 35/21 38/13 38/25 38/25 39/2 41/20 43/5 43/11 43/22 44/14 45/22 46/6 47/9 54/6 57/1 57/2 57/8 61/2 61/6 66/9 66/21 67/24 68/5 70/13 72/8 73/15 76/16 80/23 80/24 81/11 85/13 85/20 95/1 102/1 102/25 105/15 118/18 119/2 124/6 127/2 129/7 129/20 136/1 137/20 148/16 152/12 157/18 160/4 165/12 165/14 168/16 168/20 168/21 169/4 170/7 174/21 175/4 176/2 177/12 178/11 179/7 179/9 179/13 179/24 183/4 183/8 184/3 184/8 184/11 184/12 184/13 185/9
**liked [3]** 18/10 20/2 137/13
**likely [3]** 8/9 122/17 135/14
**limit [1]** 77/1
**line [23]** 22/9 33/16 36/17 38/5 42/4 42/11 43/1 43/24 45/23 47/8 48/18 54/11 55/4 65/16 103/22 103/23 104/7 105/11 120/20 124/22 149/4 149/8 177/23
**line 31765 [1]** 42/4
**line 31768 [1]** 42/11
**line 31770 [1]** 43/1
**line 31785 [1]** 43/24
**line 32359 [1]** 47/8
**line 32362 [1]** 48/18
**linen [1]** 127/6
**lines [12]** 29/7 29/8 38/24 53/25 59/8 59/10 62/20 62/21 103/5 105/19 115/21 157/2
**link [11]** 114/1 131/1 131/4 131/10 160/18 160/22 169/14 170/5 170/6 171/4 173/24
**links [3]** 170/4 170/10 180/25
**list [4]** 11/22 25/11 57/6 176/23
**listen [4]** 86/6 91/14 93/23 113/16
**listened [6]** 14/18 14/19 15/11 20/23 20/24 185/25
**listening [2]** 15/13 93/8
**lists [4]** 22/22 23/22 57/1 57/3
**lit [1]** 67/4
**literally [2]** 81/7 174/16
**little [22]** 4/15 6/4 12/15 34/1 37/6 37/9 37/15 44/24 48/6 60/7 69/15 71/15 90/1 105/7 108/16 130/19 140/22 155/14 157/11 162/6 173/9 182/17
**Liverpool [2]** 150/25 162/23
**lives [1]** 108/16
**living [2]** 163/10 163/15
**locate [1]** 128/14
**logical [1]** 23/17
**logically [1]** 117/13
**long [15]** 8/12 18/23 29/10 46/24 57/7 61/15 66/24 67/1 71/15 76/22 129/8 158/19 159/10 175/20 175/23
**long-term [1]** 71/15
**longer [2]** 74/25 75/13
**loo [1]** 28/17
**look [28]** 3/21 4/11 4/13 4/17 23/17 27/25 43/11 43/14 54/10 68/19 68/19 103/8 122/2 122/13 129/4 135/20 143/24 147/1 148/15 165/5 169/19 169/24 170/22 170/23 171/22 172/6 172/20 183/10
**looked [8]** 38/18 39/2 51/7 71/12 78/11 118/2 127/20 173/12
**looking [32]** 3/22 4/20 23/19 28/9 30/21 35/14 43/5 43/20 43/21 43/22 43/22 47/1 54/1 68/16 105/22 112/13 118/14 122/25 123/3 123/5 140/5 154/11 158/24 159/7 163/5 168/1 170/14 170/21 179/7 182/17 183/15 183/16
**looks [6]** 32/6 38/13 38/25 151/2 178/10 178/11
**loop [1]** 67/1
**losses [1]** 131/9
**lost [4]** 37/24 45/1 48/19 63/15
**lot [18]** 6/19 8/13 14/7 23/15 44/14 57/8 67/3 84/25 95/18 109/8 112/14 112/17 127/4 127/10 155/18 173/4 182/13 183/4
**lots [1]** 67/22
**loud [2]** 93/10 100/9
**low [1]** 81/3
**lower [1]** 158/8
**lowest [1]** 172/17
**Lucy [61]** 2/6 6/22 7/6 11/25 12/18 12/19 13/22 18/13 18/14 18/19 19/16 20/19 21/16 21/24 22/10 28/25 35/17 38/2 41/23 45/6 46/16 55/18 56/4 56/9 58/10 58/11 58/19 58/22 59/17 59/18 60/14 61/6 63/20 64/23 69/12 69/14 69/18 70/18 90/20 94/17 98/16 99/4 99/8 109/15 110/21 110/22 112/4 128/23 137/6 137/8 139/11 145/7 159/10 159/17 161/2 162/7 162/19 165/9 167/10 167/18 168/7
**Lucy Letby [7]** 11/25 46/16 61/6 64/23 69/12 99/8 165/9
**Lucy's [2]** 23/1 38/5
**lunch [1]** 108/2
**luncheon [1]** 100/2
**lunchtime [1]** 83/3
**LWF [1]** 168/15
**LYONS [6]** 1/15 1/17 24/20 69/9 72/25 187/4

## M

**M's [1]** 114/22
**machine [1]** 37/23
**made [31]** 24/5 25/20 38/22 39/7 39/16 52/17 56/15 57/23 58/12 59/2 64/9 68/20 84/20 87/8 88/5 91/10 92/10 112/19 114/7 118/19 150/21 157/19 163/1 164/15 166/13 166/19 168/13 170/10 171/5 174/6 184/24
**mail [1]** 128/21
**mailed [1]** 26/4
**main [3]** 11/25 20/17 33/15
**maintain [1]** 63/21
**majority [5]** 5/19 5/20 75/19 81/16 114/11
**make [20]** 10/8 18/11 27/10 27/11 47/5 53/22 77/22 87/4 96/7 125/6 129/20 149/15 150/4 156/25 157/8 163/4 171/24 171/24 183/22 185/18
**makes [3]** 21/14 37/8 95/17
**making [12]** 31/11 87/24 93/17 146/5 167/10 169/8 169/14 170/3 170/5 170/5 180/25 183/18
**malice [1]** 167/18
**manage [1]** 108/5

**M**

**managed [3]** 69/4 112/20 166/23
**management [8]** 14/17 15/19 17/4 17/10 35/4 112/24 180/3 180/12
**manager [20]** 15/14 15/16 15/24 15/25 17/7 17/8 26/24 55/14 65/17 82/7 82/7 97/13 103/23 103/24 104/5 104/20 147/22 176/12 180/14 180/14
**manager's [1]** 16/8
**managerial [2]** 76/6 76/7
**managers [13]** 17/6 26/21 78/16 78/25 110/17 123/10 174/6 174/11 176/4 180/8 180/9 185/15 185/23
**managing [1]** 166/3
**mandatory [7]** 67/18 85/2 102/5 142/6 156/21 156/24 178/24
**manner [6]** 4/25 36/13 38/15 110/15 136/9 162/11
**many [19]** 5/21 8/5 8/5 9/25 41/1 47/11 75/14 75/20 77/1 87/13 106/17 108/7 116/19 116/22 132/5 134/17 145/4 155/16 169/3
**March [2]** 6/23 165/8
**Martyn [1]** 180/16
**matched [1]** 29/23
**maternity [4]** 131/2 131/7 132/4 132/10
**matron [1]** 103/24
**Matt [2]** 168/23 168/25
**Matt Neame [1]** 168/25
**matter [3]** 138/12 139/13 164/24
**matters [3]** 7/15 102/18 103/9
**may [46]** 1/9 2/3 5/6 13/14 35/22 41/18 41/19 41/19 65/6 69/10 69/10 73/1 73/13 73/24 75/10 78/1 85/21 88/3 88/16 104/14 105/15 107/16 107/25 108/18 114/7 117/22 122/9 122/9 123/17 128/25 132/25 133/4 133/13 136/7 138/17 139/9 151/3 151/4 152/3 152/20 167/6 167/6 175/14 181/6 181/23 182/14
**maybe [21]** 10/7 11/15 20/24 33/23 34/12 36/17 46/24 61/7 68/1 69/3 70/10 83/3 104/1 105/18 106/13 106/13 107/13 117/21 162/6 164/3 173/11
**me [114]** 12/18 13/14 13/21 13/21 18/8 18/13 18/24 19/5 21/20 22/3 25/15 25/15 26/2 29/23 35/17 43/12 43/16 43/19 44/7 44/8 44/14 45/8 48/14 50/3 51/10 54/14 55/21 56/4 56/9 57/20 58/11 59/9 59/12 59/19 59/19 60/12 60/22 61/5 62/24 64/15 68/20 69/19 70/10 72/2 72/3 72/4 72/6 72/15 82/8 82/9 88/14 94/13 94/21 96/7 98/13 99/2 109/23 110/1 110/12 110/21 111/1 114/19 114/25 115/2 115/4 119/8 124/15 129/8 139/2 139/3 139/17 141/13 143/20 145/6 146/15 147/17 150/17 151/12 155/22 157/3 157/4 157/12 157/19 159/11 159/14 159/14 159/18 159/21 160/4 160/6 160/9 161/2 161/3 161/20 162/10 163/4 163/9 164/3 164/6 164/13 167/24 171/4 172/15 172/16 172/17 173/12 173/25 174/10 174/14 174/21 174/24 177/18 182/8 186/3
**mean [35]** 12/1 13/5 17/12 18/19 22/25 27/1 32/15 36/11 37/4 41/19 44/5 48/7 56/8 60/20 62/22 64/14 64/17 66/4 68/13 68/18 85/15 102/2 107/11 113/19 117/16 120/8 126/16 137/6 142/2 144/22 154/17 165/13 177/7 180/5 184/10
**meaning [1]** 125/13
**means [2]** 6/13 183/24
**meant [10]** 9/17 44/11 45/23 74/25 76/17 76/20 81/6 152/7 154/5 178/18
**measures [2]** 175/14 176/2
**media [2]** 132/2 132/16
**medical [18]** 7/20 8/13 8/13 32/24 33/17 39/7 41/14 51/21 71/20 79/15 94/15 115/11 118/11 125/16 144/14 169/11 183/24 184/2
**medically [2]** 23/18 126/9
**medication [2]** 121/17 150/1
**medications [1]** 30/16
**Medicine [1]** 74/12
**meet [4]** 12/4 25/14 111/8 148/9
**meeting [8]** 5/14 26/5 50/17 50/17 50/24 61/21 148/20 148/24
**meetings [1]** 25/18
**Mel [19]** 28/22 29/1 90/20 91/19 91/20 91/24 93/6 93/7 94/11 94/12 94/13 95/5 95/12 95/14 95/15 143/18 145/1 145/5 145/5
**Mel's [1]** 96/25
**Melanie [6]** 94/23 95/6 95/12 95/21 95/24 146/10
**member [15]** 4/9 44/13 65/12 67/20 67/25 85/10 91/22 102/23 104/22 117/4 126/13 130/8 130/11 136/15 136/18
**members [7]** 6/6 6/7 6/11 27/22 85/8 133/2 169/3
**memory [6]** 8/11 29/23 115/10 118/10 141/17 166/1
**mentally [1]** 172/5
**mention [2]** 56/2 110/16
**mentioned [15]** 33/23 38/11 48/2 51/15 53/7 63/10 66/2 67/11 98/15 117/20 125/1 125/25 143/13 162/24 168/6
**mentor [3]** 1/24 2/14 4/18
**mentored [3]** 2/2 3/1 4/12
**mentoring [1]** 3/15
**mentorship [6]** 2/1 2/5 3/4 3/9 52/17 76/19
**message [20]** 13/14 41/23 42/4 49/23 54/11 54/25 55/6 56/18 58/2 58/5 120/2 120/5 120/6 128/5 128/5 135/24 135/24 136/3 136/4 185/7
**messages [6]** 35/17 45/10 48/3 55/8 136/5 176/5
**messaging [1]** 94/24
**met [9]** 49/6 83/4 83/7 85/21 90/2 91/8 106/6 106/19 108/20
**metres [1]** 135/10
**microphone [1]** 100/8
**mid [1]** 133/22
**mid-Staffordshire [1]** 133/22
**middle [2]** 17/22 118/18
**midnight [1]** 37/13
**midwife [5]** 105/16 131/3 131/7 131/8 131/11
**midwifery [1]** 87/6
**midwives [12]** 14/3 86/16 86/20 86/21 87/3 87/10 87/11 87/13 87/15 87/20 88/1 127/16
**might [29]** 3/21 6/1 6/2 6/3 7/8 32/7 35/21 41/4 41/5 43/8 44/24 51/20 65/19 75/5 81/5 102/19 121/4 144/22 146/23 147/25 148/1 150/24 151/7 152/2 155/11 156/10 168/7 183/17 185/14
**milestones [1]** 80/4
**mind [11]** 25/20 43/8 47/24 52/8 52/23 71/10 86/22 107/15 107/18 121/7 173/10
**mind's [1]** 146/16
**mine [1]** 96/25
**mini [1]** 34/1
**minimise [1]** 126/18
**minute [3]** 45/4 90/7 110/13
**minutes [10]** 24/13 24/14 29/11 50/23 61/20 61/24 73/1 73/8 73/9 80/6
**missed [8]** 74/25 88/13 146/23 147/4 147/5 161/1 161/10 161/12
**missing [1]** 74/25
**mistake [1]** 16/22
**mix [1]** 74/20
**Mm [11]** 6/10 39/9 40/11 42/6 59/4 103/21 142/16 161/16 171/8 177/17 185/5
**Mm-hm [11]** 6/10 39/9 40/11 42/6 59/4 103/21 142/16 161/16 171/8 177/17 185/5
**moderately [1]** 76/15
**module [1]** 184/24
**moment [7]** 49/23 54/23 77/12 92/24 99/19 113/7 126/10
**moments [1]** 3/18
**Monday [4]** 1/1 95/1 136/1 156/25
**monitor [3]** 67/3 112/1 158/14
**monitoring [1]** 105/18
**month [3]** 16/23 34/25 164/15
**months [6]** 3/10 75/24 154/20 165/14 168/15 174/1
**moody [1]** 140/2
**morale [1]** 78/19
**more [86]** 7/14 8/9 12/15 19/18 20/24 22/4 22/11 22/22 32/2 32/21 33/11 34/12 39/23 43/15 45/3 46/14 47/3 47/6 47/7 51/22 51/24 55/16 55/24 56/7 56/14 57/6 61/11 67/15 69/1 75/16 76/24 77/3 77/19 78/10 79/5 79/22 81/4 84/8 90/7 93/21 95/16 95/18 102/21 117/11 118/4 118/8 118/11 119/12 120/17 121/4 121/13 130/3 130/6 131/25 132/1 132/15 132/16 133/11 133/13 135/14 138/1 140/7 145/1 145/3 151/11 151/12 156/4 156/5 156/6 161/3 162/3 162/4 165/4 167/18 168/13 170/23 171/6 171/20 174/9 175/3 176/1 181/20 182/18 183/21 185/14 185/21
**morning [15]** 1/9 25/24 41/16 42/2 42/5 56/19 88/12 101/21 110/3 111/24 140/12 150/3 151/15 151/15 186/12
**morphine [1]** 150/3
**mortality [8]** 77/10

## M

**mortality... [7]** 77/13 77/14 77/14 77/16 117/6 117/12 123/4
**mortem [4]** 50/13 50/17 50/19 148/11
**mortems [1]** 50/12
**most [7]** 5/16 10/14 32/16 75/19 114/10 114/12 132/9
**Mother [9]** 31/3 31/18 31/25 39/15 39/24 110/20 110/24 111/3 147/8
**Mother A [4]** 31/3 31/18 31/25 39/24
**Mother E [4]** 110/20 110/24 111/3 147/8
**mothers [1]** 126/4
**mouth [1]** 147/10
**move [9]** 11/1 24/21 26/19 27/19 37/10 146/2 149/21 149/22 150/5
**moved [9]** 57/21 58/11 60/1 93/2 106/13 142/14 149/17 150/24 157/18
**moving [7]** 88/16 124/8 142/12 153/4 182/16 185/2 186/1
**Mr [5]** 82/25 134/7 134/9 134/10 187/8
**Mr Baker [4]** 134/7 134/9 134/10 187/8
**Mr Chambers [1]** 82/25
**Mrs [1]** 53/13
**Mrs Percival-Calderbank [1]** 53/13
**MS [15]** 1/15 1/17 24/20 69/9 72/25 73/17 75/3 134/8 151/25 152/15 152/17 186/12 187/4 187/7 187/10
**Ms Hudson [1]** 75/3
**MS LANGDALE [8]** 73/17 134/8 151/25 152/15 152/17 186/12 187/7 187/10
**MS LYONS [6]** 1/15 1/17 24/20 69/9 72/25 187/4
**much [32]** 11/16 12/21 20/18 22/13 32/21 49/20 55/25 59/16 67/6 69/8 73/4 76/6 78/15 79/4 79/20 80/8 81/9 84/6 91/24 92/1 100/9 133/5 144/9 144/9 151/14 152/16 155/5 157/22 170/9 180/7 186/6 186/10
**multi [1]** 71/13
**multiple [1]** 113/3
**mum [5]** 105/18 109/9 126/8 126/10 148/2
**Mum's [1]** 33/17
**murdering [2]** 60/1 61/16
**Murphy [5]** 16/2 21/3 21/5 65/22 176/8
**must [4]** 24/4 55/14 131/24 142/8
**mustn't [1]** 63/13
**my [123]** 1/9 3/19 11/13 16/21 18/16 20/17 21/15 21/15 24/11 24/22 25/10 25/23 26/1 26/9 28/15 28/15 29/23 37/11 38/9 39/1 42/21 43/12 43/22 45/17 48/8 52/12 52/12 52/23 52/24 55/20 58/7 62/19 63/15 64/11 65/9 66/12 66/21 69/6 69/6 70/13 71/2 71/6 71/12 71/12 71/20 72/19 73/1 73/13 78/25 82/5 86/19 86/22 88/12 89/7 91/17 91/23 94/1 95/5 96/4 96/7 96/21 97/13 99/1 99/1 99/20 101/19 101/19 107/15 107/18 109/4 117/18 118/10 119/10 120/11 121/7 124/15 124/17 127/21 128/11 128/18 128/21 129/4 129/17 134/6 134/7 134/11 139/24 140/10 140/17 140/24 140/25 141/4 141/11 141/17 143/6 143/12 144/20 146/16 147/3 151/10 151/12 151/19 152/5 159/3 160/3 160/25 161/3 161/5 162/5 162/5 162/9 162/20 163/13 163/14 164/14 164/18 166/1 167/2 173/10 174/5 175/5 175/8 186/14
**my Lady [9]** 1/9 69/6 73/1 99/20 134/7 134/11 151/10 151/12 186/14
**myself [23]** 12/19 15/10 20/15 21/19 26/5 35/2 35/17 59/21 94/5 97/25 102/11 110/15 117/4 124/22 147/3 162/18 162/20 170/12 171/19 171/23 174/15 175/5 177/22

## N

**naively [4]** 117/10 117/16 117/18 118/13
**name [11]** 6/25 23/1 38/7 38/8 38/9 38/10 53/6 63/9 80/16 159/8 159/10
**named [4]** 58/12 60/4 87/18 148/9
**names [8]** 22/22 23/23 56/25 57/3 162/25 177/25 179/24 180/15
**nappy [1]** 148/22
**natural [2]** 12/25 106/9
**naturally [7]** 41/9 105/1 105/8 106/11 106/19 108/13 109/21
**nature [3]** 61/1 99/1 134/1
**Neame [5]** 167/12 168/12 168/23 168/25 183/18
**nearly [2]** 19/21 28/24
**necessarily [10]** 4/5 17/14 27/18 66/11 103/11 106/12 127/4 127/8 131/2 147/25
**necessary [2]** 68/3 146/22
**necessitating [1]** 157/15
**need [37]** 8/17 12/20 13/3 15/2 24/11 24/20 25/12 26/3 26/10 29/2 44/24 58/21 92/23 94/17 95/2 95/4 118/8 126/5 126/8 128/25 131/19 135/19 136/2 139/13 139/14 140/7 144/6 145/1 145/3 145/7 145/11 146/1 152/2 158/10 166/18 174/4 177/25
**needed [28]** 9/15 10/1 10/7 10/10 10/22 28/16 29/15 60/17 60/19 79/2 84/9 88/1 91/25 93/23 106/14 107/18 114/5 118/8 133/10 133/19 143/1 143/15 145/5 145/6 145/9 145/12 158/11 160/7
**needing [1]** 126/7
**needs [6]** 46/24 68/11 71/15 118/4 126/8 172/7
**neither [2]** 72/15 130/1
**neonatal [64]** 2/24 3/25 5/8 6/15 8/18 9/5 9/24 11/3 12/22 12/23 32/15 36/12 47/11 51/1 64/9 67/4 74/2 76/1 76/9 76/18 81/11 83/20 83/20 83/25 84/2 84/21 86/2 86/15 87/4 87/21 88/9 100/16 114/2 123/18 125/15 130/5 131/1 131/4 131/9 131/11 131/20 132/4 132/10 132/18 138/5 139/15 142/7 153/6 153/15 153/24 154/15 154/21 154/23 155/4 155/8 155/13 155/20 160/24 163/22 164/9 166/21 170/16 174/3 176/22
**neonatal/maternity [1]** 132/10
**neonates [14]** 9/6 9/11 9/22 30/25 52/14 114/9 161/14 162/17 164/2 167/23 169/16 169/18 171/12 182/9
**network [1]** 163/15
**never [29]** 17/15 21/7 26/12 30/24 31/1 35/20 36/12 48/9 51/15 51/17 52/23 67/24 71/10 75/9 80/22 83/4 117/22 118/24 119/13 124/21 127/18 134/5 148/16 148/25 169/11 169/25 177/6 178/21 179/10
**new [13]** 12/23 15/5 15/8 82/24 83/2 83/8 83/9 83/11 85/7 89/18 105/12 160/18 160/24
**New Year [3]** 83/8 83/9 83/11
**New Year's Eve [1]** 82/24
**newborn [1]** 112/23
**newer [1]** 91/22
**newly [4]** 85/7 160/23 161/3 161/15
**newly-qualified [1]** 85/7
**news [4]** 109/12 109/14 110/2 146/12
**newspaper [1]** 80/13
**next [24]** 42/9 43/24 54/23 55/7 73/9 83/16 91/21 95/19 97/13 98/4 100/23 106/5 109/11 111/8 111/19 113/23 123/17 126/6 126/12 140/11 158/23 172/11 172/15 173/12
**NG [1]** 111/22
**NHS [4]** 105/20 120/1 128/11 128/21
**Nicky [5]** 174/12 174/22 175/1 175/21 180/16
**Nicky Lightfoot [1]** 180/16
**Nicola [4]** 173/16 173/20 173/22 175/8
**Nicola Lightfoot [2]** 173/16 175/8
**night [56]** 7/23 7/25 8/2 8/7 8/9 8/10 8/11 8/14 8/15 9/20 12/2 28/2 28/9 36/4 36/6 39/4 41/8 47/21 48/1 49/15 49/21 78/3 80/15 89/2 89/5 89/10 90/21 90/25 92/13 94/20 97/21 99/4 101/20 108/20 109/2 109/4 111/4 135/6 139/7 140/16 143/11 144/8 147/2 154/4 155/22 155/25 156/2 156/4 156/9 156/12 158/21 165/23 166/10 167/16 168/14 168/23
**nights [5]** 9/22 154/10 154/14 170/8 178/4
**nighttime [2]** 49/15 156/7
**nip [1]** 29/3
**nipped [1]** 29/8
**NLS [2]** 142/6 142/10
**NNU [23]** 5/22 7/12 11/6 11/20 15/19 16/17 17/4 19/3 19/3 26/21 50/13 64/25 77/7 77/9 120/25 126/18 129/22 129/25 156/14 160/19 165/24 166/5 175/13
**no [113]** 3/18 14/25 15/3 15/3 15/6 19/10 19/10 20/8 22/19 25/1 26/6 27/18 29/4 29/4 29/14 31/24 33/5 33/7 34/9 34/20 34/23 38/10 38/10 38/24 40/19 43/10 50/11 51/22 52/23 53/14 54/3 54/5 54/15 56/25 58/6 58/6 63/17 64/11 65/7 73/1 75/15 77/18 78/18 79/8 80/22 80/23 80/25 82/21 83/14 83/21 86/11 88/14 90/7 92/2 95/2 95/6 96/25 97/11

## N

**no... [55]** 102/4 110/6 110/22 113/8 115/9 115/10 115/19 116/6 116/25 118/9 121/14 121/23 123/1 123/8 123/9 123/11 125/23 130/12 136/2 138/8 138/21 139/3 141/4 142/22 142/24 147/8 149/23 151/11 151/12 156/2 156/16 162/15 163/11 165/1 165/13 174/5 174/5 174/13 174/19 175/2 176/1 176/21 177/3 177/4 177/5 178/7 178/9 179/14 179/17 179/25 180/21 181/18 183/20 185/3 186/2

**nobody [3]** 4/6 5/2 101/11

**Nods [10]** 47/18 56/22 57/13 95/10 98/9 112/6 118/23 124/1 171/13 178/13

**non [2]** 81/25 126/19

**non-clinical [1]** 81/25

**non-core [1]** 126/19

**nonsense [1]** 22/25

**nor [1]** 130/2

**norm [2]** 34/19 34/23

**normal [5]** 91/10 106/4 114/18 157/17 172/13

**normally [1]** 113/6

**North [1]** 75/25

**North-West [1]** 75/25

**noses [1]** 37/10

**not [183]** 3/11 7/20 8/5 12/23 14/22 14/24 15/22 15/24 18/3 19/8 20/7 20/19 20/24 21/18 26/10 27/18 34/18 34/21 35/12 35/13 38/24 40/23 41/19 41/19 43/11 43/18 45/2 46/24 48/24 49/5 51/9 52/3 52/14 54/14 55/19 56/3 56/13 61/7 62/9 63/5 63/17 65/5 67/1 70/17 72/5 74/6 75/13 75/15 77/2 78/1 78/11 78/18 79/23 81/1 81/13 83/7 83/7 84/22 85/17 86/13 87/3 88/1 88/7 89/6 91/4 91/10 91/18 92/22 93/7 93/7 93/10 93/10 93/15 93/18 93/24 93/25 94/1 94/8 96/13 97/9 97/10 97/11 97/24 98/2 98/24 99/1 99/14 101/24 102/5 102/14 103/9 104/25 105/19 107/9 108/13 109/23 110/2 110/20 110/22 110/25 111/12 111/23 112/9 113/8 113/9 113/19 114/24 115/15 116/11 116/13 116/14 117/3 118/1 118/22 119/16 121/18 121/23 122/9 124/7 124/13 126/14 127/4 127/8 127/24 131/19 132/1 132/25 133/8 133/25 134/18 135/10 137/20 138/8 138/9 138/25 139/5 139/15 139/18 139/25 141/4 141/6 141/20 142/5 143/21 144/14 145/7 145/10 147/11 148/4 149/22 150/4 150/4 153/24 154/21 155/17 156/10 157/6 159/10 161/11 162/3 162/5 164/13 164/18 167/6 167/13 169/7 169/12 169/17 170/7 172/13 172/13 173/18 175/12 175/25 176/23 177/11 177/22 178/7 182/23 183/9 184/15 185/8 185/16

**notable [1]** 165/24

**note [2]** 39/6 80/19

**noted [2]** 139/7 150/15

**notes [6]** 28/22 51/5 147/13 147/17 148/3 148/15

**nothing [17]** 32/2 34/9 51/1 63/7 72/9 72/10 112/8 116/15 117/7 122/11 122/21 147/6 147/7 167/16 172/3 175/2 181/10

**notice [2]** 57/8 78/10

**noticeably [1]** 132/19

**noticed [3]** 30/10 100/7 169/4

**November [4]** 3/5 23/7 23/8 56/20

**November 2015 [1]** 23/8

**now [60]** 1/7 3/5 4/20 5/4 8/12 11/1 27/19 33/4 36/11 41/1 48/9 54/6 62/5 62/8 71/23 72/3 72/4 72/19 75/25 80/8 80/11 90/22 91/1 94/11 96/17 99/22 100/20 101/10 101/23 102/5 102/5 103/24 104/3 106/20 109/3 111/16 115/6 115/18 117/19 118/15 122/12 123/7 125/9 126/22 127/19 128/8 130/24 131/4 136/10 136/24 137/24 140/5 141/25 148/8 149/18 151/16 163/5 163/20 181/23 185/4

**number [6]** 41/14 77/20 109/25 116/17 117/7 117/23

**numbers [4]** 22/8 57/4 74/20 78/13

**numbness [1]** 34/5

**numerous [1]** 133/17

**nurse [123]** 1/9 1/11 1/14 1/18 2/7 3/25 5/25 7/4 11/23 11/24 12/22 12/23 18/22 19/16 20/12 21/20 21/22 25/14 35/2 36/2 38/12 42/16 47/11 52/12 52/12 53/24 55/16 59/21 62/2 62/2 62/5 72/4 72/13 73/13 73/16 73/18 74/1 76/9 77/4 78/2 78/24 78/24 79/12 83/15 83/20 83/20 86/7 89/15 89/16 89/19 89/21 90/3 90/12 90/13 91/7 91/22 95/2 95/5 97/18 97/20 103/11 104/4 106/9 110/19 110/23 115/1 117/4 117/5 118/24 119/1 119/4 122/6 129/23 131/1 134/12 136/2 136/12 136/21 137/4 138/1 138/5 138/6 140/20 141/7 141/22 142/3 143/22 148/21 148/24 151/11 151/13 152/3 152/4 152/14 152/19 153/2 153/14 154/3 157/6 160/16 161/4 161/15 164/9 170/21 171/6 172/5 174/7 174/8 174/23 176/4 176/17 179/18 179/19 179/22 179/24 180/17 184/7 184/19 186/2 186/6 187/3 187/6 187/9

**Nurse Death [2]** 179/19 179/24

**Nurse Lightfoot [1]** 179/18

**Nurse T [10]** 1/9 1/11 1/14 1/18 38/12 62/2 62/5 89/15 89/21 187/3

**Nurse W [13]** 73/13 73/16 73/18 79/12 95/2 95/5 115/1 122/6 134/12 136/2 151/11 151/13 187/6

**Nurse X [5]** 11/23 11/24 25/14 35/2 72/13

**Nurse Z [3]** 21/22 59/21 72/4

**Nurse ZC [8]** 152/3 152/14 152/19 153/2 176/17 186/2 186/6 187/9

**nurse's [2]** 103/12 144/11

**nurseries [1]** 127/5

**nursery [45]** 5/25 6/3 12/6 12/12 12/20 13/25 28/16 28/21 39/20 74/16 81/4 91/3 91/20 92/1 93/4 93/6 93/9 93/18 95/7 98/6 98/16 109/7 111/18 135/8 135/8 135/9 135/9 135/13 135/14 135/17 135/19 136/8 137/2 137/3 138/1 139/5 140/6 141/3 141/8 142/23 143/1 143/16 143/24 144/2 145/23

**Nursery 1 [20]** 12/6 12/12 12/20 13/25 28/16 28/21 91/20 92/1 95/7 109/7 111/18 135/8 135/9 135/13 135/14 137/2 141/3 141/8 142/23 143/16

**Nursery 3 [18]** 91/3 93/4 93/6 93/9 93/18 98/6 98/16 135/8 135/9 135/17 136/8 138/1 139/5 140/6 143/1 143/24 144/2 145/23

**nurses [80]** 5/21 5/23 5/24 6/3 6/16 6/24 7/1 8/10 8/11 11/6 11/8 12/15 12/16 13/17 14/3 14/12 16/10 17/4 17/23 20/1 31/15 31/20 38/21 41/15 45/20 50/12 52/6 53/21 66/14 66/16 74/15 74/16 74/21 78/16 79/14 79/23 80/2 80/15 81/4 81/4 84/21 85/1 85/7 85/11 86/1 86/1 86/16 87/4 90/20 94/21 106/4 123/12 123/13 126/24 127/16 131/4 131/10 135/19 135/19 137/10 142/7 155/4 155/16 155/18 155/19 156/4 156/7 160/18 161/18 166/3 166/11 166/12 169/10 169/21 170/4 170/4 170/10 172/2 178/18 183/13

**nurses' [2]** 108/1 155/2

**nurses/midwives/doctors [1]** 127/16

**nursing [42]** 3/5 6/15 7/12 7/18 7/20 8/8 8/8 11/12 11/14 16/3 23/18 32/24 36/12 43/12 51/21 53/19 71/20 76/15 78/6 78/18 79/15 81/11 83/25 84/9 94/1 118/11 122/19 122/25 125/16 127/25 132/19 132/23 133/3 133/5 133/10 153/3 153/4 165/10 171/24 177/1 184/18 185/1

## O

**o'clock [4]** 83/15 186/12 186/13 186/14

**oath [4]** 1/13 73/15 152/7 152/9

**observation [2]** 95/25 139/11

**observations [4]** 91/13 91/16 111/21 144/12

**observe [1]** 165/6

**observed [2]** 30/3 111/11

**observing [2]** 135/19 173/2

**obstacles [1]** 131/20

**obstructions [1]** 132/12

**obvious [1]** 104/14

**obviously [24]** 2/7 4/19 12/17 23/11 63/19 68/3 84/11 97/3 110/8 116/20 117/18 145/14 149/4 156/23 159/8 159/15 160/22 162/25 166/14 175/1 176/22 177/24 178/18 178/23

**occasion [4]** 12/19 13/2 14/20 39/15

**occasionally [4]** 75/4 75/10 82/20 84/17

**occasions [6]** 22/4 52/6 108/2 142/3 167/9 183/17

**occasions, [1]** 1/24

**occasions, is [1]** 1/24

## O

**occupational [2]** 84/15 84/18
**occupied [1]** 166/5
**occur [1]** 51/19
**occurred [2]** 66/19 111/4
**occurrence [1]** 172/1
**occurring [1]** 53/9
**occurs [2]** 19/23 101/1
**October [7]** 1/1 3/4 54/22 56/18 61/22 168/16 186/17
**odd [9]** 47/21 47/25 48/1 48/6 48/8 48/12 48/19 163/5 171/16
**off [25]** 28/10 28/17 28/20 29/3 29/9 29/12 29/14 46/7 46/11 50/21 58/11 77/23 77/24 86/9 100/4 104/23 112/4 121/20 124/5 148/22 156/19 171/12 172/11 184/22 185/16
**off-going [3]** 28/10 46/7 46/11
**offer [3]** 133/4 145/9 148/13
**offered [3]** 4/10 84/7 102/11
**offering [2]** 134/2 144/17
**offhand [1]** 157/16
**office [14]** 16/8 17/18 20/12 20/14 20/14 23/5 23/12 56/15 57/22 60/2 81/25 82/6 114/21 115/4
**offload [1]** 160/8
**often [10]** 5/23 5/24 8/8 8/11 9/24 55/15 55/16 80/2 125/21 155/9
**oh [16]** 13/22 15/7 22/23 23/16 38/2 38/24 39/21 46/19 54/17 62/17 63/11 64/6 88/11 107/23 157/19 171/19
**okay [29]** 5/20 25/8 26/14 28/18 29/2 42/3 42/25 44/23 45/16 54/8 54/17 54/19 55/2 60/12 61/13 74/8 87/1 99/24 123/16 123/24 126/17 129/9 134/24 135/11 170/21 175/3 177/13 179/17 180/23
**old [4]** 46/1 46/17 109/18 117/21
**older [1]** 83/5
**on [383]**
**on-call [2]** 97/18 97/21
**on-coming [2]** 46/8 46/18
**once [7]** 76/9 85/23 92/16 93/2 93/21 120/24 148/11
**one [82]** 5/5 6/21 7/6 8/17 8/18 9/2 9/4 9/4 10/16 11/17 15/6 18/4 20/13 22/21 25/25 26/6 26/20 27/6 36/17 40/15 40/20 40/22 52/21 53/21 55/16 55/20 55/24 61/11 63/10 66/13 71/12 72/7 75/5 75/12 76/3 80/23 82/8 82/24 84/4 87/23 88/6 88/14 89/19 91/20 91/20 94/20 95/18 95/18 99/21 102/4 111/18 119/23 120/8 120/24 125/8 125/11 127/19 131/5 133/6 137/24 143/17 143/17 144/12 148/19 153/10 154/8 156/7 164/15 168/1 169/23 172/24 173/3 173/16 175/19 176/7 176/9 177/4 179/11 179/11 179/11 183/20 184/9
**ones [5]** 45/8 84/4 120/16 120/21 124/2
**ongoing [1]** 71/15
**only [38]** 5/23 6/22 7/6 9/1 12/23 19/15 22/12 26/4 28/7 34/24 35/2 36/16 40/14 49/4 56/3 58/12 68/23 72/4 72/13 75/12 77/25 84/10 91/3 99/6 104/1 109/9 110/8 115/21 116/1 117/21 119/14 125/1 127/21 145/5 156/7 174/15 174/22 181/20
**onset [1]** 147/21
**onto [1]** 163/7
**onwards [2]** 89/3 142/14
**open [6]** 64/18 69/1 79/1 79/4 95/23 125/14
**open-door [2]** 79/1 79/4
**openly [1]** 185/24
**operate [1]** 180/6
**operated [1]** 14/9
**Operation [1]** 65/3
**Operation Hummingbird [1]** 65/3
**operative [1]** 27/13
**opinion [3]** 86/7 86/16 117/18
**opportunities [1]** 85/4
**opportunity [4]** 98/5 148/9 148/10 153/5
**opposed [2]** 135/8 137/2
**opposite [1]** 17/21
**option [1]** 184/1
**or [203]**
**oral [1]** 31/18
**order [3]** 57/5 115/24 147/1
**organisation [1]** 76/12
**originally [1]** 143/17
**other [60]** 3/11 4/6 6/24 7/1 7/6 9/7 11/8 11/16 12/4 12/20 13/3 13/15 13/17 14/6 14/8 17/1 19/9 19/17 22/9 26/20 27/7 31/15 35/9 36/16 45/8 45/19 47/22 48/3 50/7 56/12 57/17 64/8 72/22 81/12 88/2 91/21 95/19 101/17 103/9 108/10 108/15 110/19 121/18 124/2 125/23 129/5 129/24 142/3 143/16 145/20 148/11 153/9 153/17 155/9 161/18 166/15 170/4 177/20 178/22 181/8
**others [9]** 81/21 124/23 124/23 169/4 169/22 176/6 181/7 183/18 185/7
**otherwise [2]** 9/9 102/17
**our [24]** 4/4 22/24 34/13 35/3 71/13 71/16 71/18 71/19 114/1 126/23 127/25 130/3 130/18 133/5 133/22 142/6 156/14 156/16 156/23 160/22 165/10 170/22 179/1 179/9
**out [67]** 11/4 11/15 11/17 12/1 12/2 17/16 21/23 22/5 22/7 25/16 29/9 37/11 37/14 37/17 37/20 37/24 39/6 43/5 43/20 49/14 50/20 51/10 51/14 52/11 53/6 59/21 61/25 66/4 71/6 72/1 73/8 75/11 78/4 80/16 80/18 83/11 83/12 89/2 95/4 117/22 120/22 121/3 122/18 124/12 124/22 124/24 126/19 127/4 128/1 129/23 129/24 133/2 133/22 135/18 135/20 136/14 140/22 141/23 148/2 149/21 150/7 157/3 159/2 171/15 176/10 181/25 182/22
**outlined [1]** 128/12
**outpatients [1]** 62/3
**outrightly [1]** 137/8
**outset [1]** 134/18
**outside [6]** 11/21 19/3 57/17 58/9 139/25 182/16
**outwardly [2]** 93/24 139/22
**over [23]** 30/25 38/12 38/13 47/3 53/19 67/4 77/6 84/9 88/10 101/21 105/17 106/5 107/13 111/25 116/23 133/18 150/17 154/25 155/1 163/19 166/21 167/21 171/2
**over-familiarity [1]** 163/19
**overall [1]** 18/24
**overarching [1]** 78/8
**overcome [2]** 95/2 136/2
**overheard [2]** 31/19 64/12
**overlap [1]** 154/14
**overnight [1]** 166/5
**oversight [1]** 80/20
**overview [3]** 46/10 46/11 46/13
**overwhelm [1]** 145/10
**overwhelmed [1]** 79/2
**overwhelming [3]** 43/6 140/15 145/4
**own [12]** 33/17 38/7 38/8 82/22 87/20 102/20 116/20 128/20 133/5 149/21 150/7 163/15
**oxygen [1]** 37/15

## P

**PADRs [1]** 178/20
**paediatric [3]** 8/18 9/4 16/3
**paediatricians [1]** 128/13
**paediatrics [8]** 9/21 9/23 52/14 52/15 62/15 122/24 169/17 176/25
**paeds [1]** 9/7
**page [21]** 41/25 42/9 42/9 42/11 43/24 44/19 44/21 45/18 54/9 54/23 55/7 100/13 106/1 108/19 108/25 109/16 111/14 111/15 112/10 112/16 123/17
**page 11 [1]** 106/1
**page 13 [2]** 108/19 109/16
**page 17 [1]** 111/14
**page 18 [1]** 111/15
**page 19 [1]** 112/10
**page 2 [1]** 41/25
**page 22 [1]** 44/19
**page 3 [1]** 42/9
**page 59 [1]** 54/9
**page 91 [1]** 123/17
**pain [1]** 94/15
**palliative [5]** 93/2 97/1 130/22 131/21 142/15
**paragraph [58]** 3/13 3/20 9/12 9/13 11/4 11/7 14/11 20/5 23/24 26/22 30/2 32/23 34/17 36/1 36/5 40/7 51/8 62/8 63/24 64/24 65/10 65/23 66/4 73/25 77/8 88/18 89/3 92/5 96/9 98/3 100/13 106/1 109/16 111/15 116/4 116/16 120/22 122/18 124/8 125/5 129/18 131/15 135/3 137/18 137/18 140/19 142/13 150/11 156/13 162/22 165/18 169/2 171/15 173/14 173/15 175/7 181/25 182/4
**paragraph 11 [1]** 100/13
**Paragraph 14 [1]** 156/13
**paragraph 16 [2]** 3/13 3/20
**paragraph 18 [2]** 11/4 11/7
**paragraph 19 [3]** 20/5 23/24 36/1
**paragraph 20 [4]** 9/12 9/13 14/11 26/22
**paragraph 21 [2]** 88/18 116/4
**paragraph 22 [1]** 32/23
**paragraph 24 [2]** 34/17 89/3
**paragraph 25 [1]** 135/3
**paragraph 26 [1]** 137/18
**paragraph 27 [1]** 162/22

**P**

**paragraph 29 [2]** 36/5 92/5
**paragraph 31 [1]** 30/2
**paragraph 32a [1]** 96/9
**paragraph 33 [1]** 142/13
**paragraph 34 [2]** 40/7 165/18
**paragraph 37 [2]** 98/3 169/2
**Paragraph 39 [1]** 171/15
**paragraph 40 [2]** 173/14 173/15
**paragraph 45 [1]** 175/7
**paragraph 46 [1]** 51/8
**paragraph 51c [1]** 150/11
**paragraph 55 [2]** 181/25 182/4
**paragraph 58 [1]** 62/8
**paragraph 60 [2]** 63/24 64/24
**paragraph 61 [1]** 116/16
**paragraph 62 [1]** 120/22
**paragraph 63 [1]** 65/10
**paragraph 65 [1]** 124/8
**paragraph 70 [2]** 65/23 66/4
**Paragraph 72 [1]** 125/5
**paragraph 75 [1]** 129/18
**paragraph 8 [1]** 73/25
**paragraph 9 [1]** 77/8
**paragraphs [1]** 27/25
**paralysis [2]** 149/23 149/25
**Pardon [3]** 12/7 53/1 58/4
**parent [4]** 80/3 125/12 126/3 145/12
**parent/guardian [2]** 125/12 126/3
**parental [1]** 87/16
**parents [30]** 8/6 32/4 32/5 32/11 32/13 32/18 33/8 39/12 80/5 87/18 88/8 88/10 92/17 96/16 96/20 97/8 111/2 125/14 125/17 126/2 130/22 147/23 148/4 148/8 148/20 158/7 158/15 163/3 163/14 172/4
**parents' [1]** 159/24
**parents/guardians [1]** 126/2
**part [20]** 51/21 71/13 71/21 76/25 83/6 90/1 90/9 91/18 96/25 102/23 104/25 116/5 117/8 124/14 125/24 125/24 142/6 142/10 148/16 157/17
**particular [9]** 10/2 10/4 10/25 24/21 51/23 74/5 162/24 163/2 167/6
**particularly [13]** 9/19 15/21 16/4 19/16 20/2 20/16 25/11 62/18 98/14 155/12 164/11 165/3 168/5
**partly [1]** 25/15
**partner [2]** 126/11 126/15
**party [2]** 12/3 179/23
**partying [1]** 83/12
**pass [2]** 18/12 172/8
**passage [1]** 166/2
**passed [5]** 30/13 33/8 35/18 106/18 116/17
**passing [1]** 146/21
**past [6]** 84/1 84/9 99/23 104/1 125/1 150/3
**patient [13]** 57/22 65/15 65/15 125/18 127/9 127/13 158/24 158/24 166/17 170/19 170/22 172/6 172/17
**patients [10]** 67/10 108/12 108/14 117/11 163/3 166/4 169/5 170/2 170/18 184/14
**patronising [1]** 87/8
**patterns [3]** 100/22 117/25 182/21
**pause [12]** 24/7 44/2 44/22 45/4 45/12 45/15 55/1 65/25 122/15 123/20 129/15 152/5
**pausing [1]** 89/13
**peace [1]** 80/6
**peculiar [1]** 157/14
**peer [2]** 78/24 133/6
**pen [2]** 151/25 152/6
**people [41]** 4/6 6/15 8/5 8/6 11/16 12/4 12/20 12/25 13/3 13/15 17/19 21/18 30/16 53/8 84/8 87/25 100/21 102/15 102/16 104/10 104/15 107/8 108/7 116/12 119/2 120/14 126/25 127/4 127/10 145/3 145/4 155/11 169/6 169/14 171/24 171/25 178/22 182/24 183/7 183/25 184/14
**people's [1]** 108/15
**perceive [1]** 157/13
**perceptors [1]** 160/24
**Percival [3]** 52/25 53/2 53/13
**Percival-Calderbank [1]** 53/2
**perfectly [2]** 29/23 114/11
**performing [2]** 114/2 144/12
**perhaps [9]** 49/2 88/4 90/23 96/14 99/18 125/9 135/12 151/7 152/7
**Perinatal [1]** 74/12
**period [22]** 2/1 2/6 3/9 3/14 4/11 4/17 4/21 5/11 6/20 15/3 34/25 57/15 68/24 74/6 75/2 78/1 116/23 117/2 125/19 142/12 164/21 165/23
**periods [1]** 75/4
**person [20]** 2/12 4/2 7/7 19/15 20/13 26/7 26/10 58/11 68/7 68/10 71/10 81/13 83/5 93/10 93/11 102/15 103/24 105/21 135/25 139/25
**personal [3]** 79/3 108/16 118/10
**personalities [3]** 27/4 66/8 104/21
**personality [2]** 93/25 105/6
**personally [4]** 40/6 128/8 134/19 171/23
**perspective [8]** 105/12 105/22 105/22 105/23 128/2 131/6 173/23 183/11
**pharmacy [1]** 127/6
**phone [6]** 129/23 130/7 130/8 130/8 130/10 130/11
**phoned [1]** 69/14
**photograph [2]** 39/25 127/1
**phrased [1]** 137/16
**physical [1]** 51/25
**physically [1]** 172/5
**pick [4]** 19/25 76/23 90/23 152/12
**picked [4]** 13/15 80/16 114/13 161/4
**picture [4]** 119/7 119/15 119/18 181/7
**pieces [3]** 119/9 120/17 134/20
**place [15]** 2/23 3/2 33/16 61/2 66/23 70/14 70/15 71/17 89/10 108/12 109/21 122/20 133/19 149/5 149/9
**placed [1]** 105/1
**placement [11]** 2/14 2/23 3/3 3/4 153/5 162/23 164/5 164/10 164/14 164/17 164/24
**placements [1]** 3/11
**plate [1]** 61/6
**play [2]** 27/4 83/24
**played [1]** 84/19
**playing [1]** 143/21
**please [26]** 1/10 36/10 38/3 41/24 43/25 44/17 44/18 44/20 44/21 46/19 47/8 50/21 50/22 54/9 56/16 65/24 73/2 86/24 88/16 99/23 123/19 126/25 129/19 134/22 135/4 138/17
**pm [9]** 28/14 73/10 73/12 100/1 100/3 122/8 151/21 151/23 186/15
**point [26]** 7/2 7/9 10/20 25/14 25/21 26/3 31/1 31/5 31/8 31/9 33/12 43/12 60/11 61/5 62/25 85/12 90/12 90/18 111/10 115/11 122/18 135/7 142/21 142/22 159/5 162/10
**police [22]** 5/5 5/6 6/5 7/11 28/7 37/12 39/5 65/1 65/2 65/5 107/13 109/5 112/15 115/22 115/25 119/8 120/17 128/24 133/13 136/25 137/16 143/13
**policy [5]** 35/7 65/13 79/1 79/4 124/12
**politely [1]** 83/14
**Pollit [1]** 180/17
**poor [4]** 26/24 27/1 86/17 86/18
**poorly [1]** 135/18
**pop [2]** 28/17 38/2
**popped [2]** 37/16 140/22
**portrayed [1]** 162/13
**portraying [1]** 159/18
**position [6]** 72/23 73/15 75/8 89/20 104/6 175/5
**positive [1]** 4/19
**possibility [1]** 64/9
**possible [4]** 6/11 32/24 71/15 100/15
**possibly [4]** 70/24 97/22 107/21 128/18
**post [7]** 50/12 50/13 50/17 50/19 126/5 148/11 154/6
**post-mortem [3]** 50/13 50/17 148/11
**post-mortems [1]** 50/12
**postgraduate [2]** 76/18 76/19
**postnatal [3]** 32/13 87/6 126/11
**potential [3]** 120/1 124/6 175/22
**potentially [1]** 171/6
**Powell [18]** 16/8 17/7 19/19 21/10 22/16 24/2 25/7 61/21 61/25 62/6 81/17 82/1 98/4 98/18 99/7 114/21 115/13 145/16
**Powell's [4]** 17/9 18/5 35/6 98/10
**practical [2]** 3/11 67/6
**practice [13]** 25/10 32/4 32/5 34/21 40/25 85/5 126/10 128/12 136/20 136/23 148/1 148/7 160/15
**practise [1]** 2/10
**practitioners [2]** 174/7 180/18
**pre [1]** 46/22
**pre-allocated [1]** 46/22
**precise [1]** 166/25
**precisely [1]** 183/16
**predominantly [6]** 5/9 5/13 154/4 154/9 155/22 178/4
**prefer [2]** 137/11 137/11
**preference [4]** 12/6 12/9 12/14 46/20
**preferred [6]** 12/11 13/24 14/1 137/2 137/9 137/12
**preliminary [2]** 62/14 62/17
**premature [4]** 149/18 150/7 161/20 182/14
**preparation [4]** 38/2 116/7 130/12 157/25
**prepare [1]** 116/9
**preparing [1]** 159/6
**presence [2]** 141/7

**P**

**presence... [1]** 166/15
**present [14]** 26/6 40/1 41/11 53/10 53/12 56/10 63/3 101/7 127/14 127/22 132/21 142/18 169/6 175/17
**presented [3]** 22/21 119/12 159/11
**press [3]** 122/3 122/6 176/14
**pressure [2]** 37/7 37/23
**presumably [3]** 114/24 120/2 133/14
**presume [1]** 40/20
**presumed [2]** 51/6 99/9
**prevented [1]** 151/7
**previous [14]** 22/9 29/22 48/3 77/13 77/17 77/18 79/6 89/9 89/15 90/4 105/10 106/19 167/22 174/25
**previously [13]** 30/24 85/22 91/9 106/6 110/9 140/14 146/25 150/12 150/15 155/20 174/20 177/10 184/4
**pricked [1]** 137/25
**prided [1]** 79/13
**prior [4]** 37/13 68/20 156/16 178/1
**privacy [1]** 125/21
**private [6]** 26/9 57/9 93/6 106/16 144/25 145/13
**proactive [1]** 4/23
**probably [21]** 20/3 23/3 28/23 28/24 58/18 59/17 60/13 64/6 65/21 69/13 101/18 105/9 108/9 148/13 148/14 156/3 165/13 169/23 170/11 183/4 184/19
**probe [1]** 112/4
**problem [8]** 26/8 26/9 26/11 33/23 36/16 51/24 81/6 185/17
**procedures [2]** 68/2 182/20
**proceedings [2]** 1/3 107/17
**process [5]** 28/19 65/13 158/1 169/25 179/6
**processes [4]** 125/24 132/20 182/11 182/23
**productive [1]** 102/24
**profession [2]** 184/12 184/13
**professional [11]** 20/12 63/21 79/15 81/20 85/12 85/20 94/2 106/21 110/14 124/13 145/11
**professionals [3]** 127/17 127/24 169/11
**progress [1]** 146/5
**projects [1]** 131/21
**prolonged [1]** 166/4
**promises [1]** 130/3
**prongs [7]** 37/9 37/11 37/14 37/16 37/19 37/24 38/3
**proper [1]** 89/18
**protect [2]** 132/1 143/15
**protected [1]** 68/10
**protecting [1]** 130/4
**protection [1]** 136/15
**protocol [1]** 68/12
**proven [1]** 144/1
**provide [3]** 87/16 126/25 138/11
**provided [10]** 1/18 27/17 73/18 83/20 84/25 107/12 109/5 124/18 152/19 158/17
**providing [3]** 130/4 133/6 172/8
**prudent [1]** 36/20
**psychologist [1]** 83/24
**psychologists [1]** 83/21
**public [1]** 130/4
**pull [2]** 80/15 150/7
**pulling [1]** 149/21
**pump [1]** 142/19
**purple [3]** 45/5 45/9 54/16
**purpose [1]** 127/2
**purposefully [1]** 128/19
**pursuing [1]** 162/17
**push [2]** 63/23 150/8
**put [21]** 18/16 20/17 44/19 54/10 86/8 96/10 96/17 98/13 102/21 109/20 120/18 132/12 133/19 134/19 136/21 145/20 159/9 163/9 167/2 175/5 182/14
**puzzle [2]** 119/9 120/17

**Q**

**QIS [8]** 6/12 6/13 6/14 6/21 7/4 7/9 76/5 76/21
**qualification [5]** 6/17 75/21 76/4 137/7 142/8
**qualified [18]** 6/14 7/16 7/17 18/12 52/13 76/8 76/15 76/15 76/17 85/7 137/21 160/23 161/3 161/15 168/1 169/24 170/21 174/9
**quality [3]** 17/3 27/16 177/15
**query [1]** 10/5
**question [18]** 24/21 25/4 26/20 44/1 45/17 54/6 61/11 70/25 71/3 99/16 100/11 107/3 115/2 116/2 138/17 150/14 163/1 182/3
**questioned [4]** 13/7 148/25 178/3 178/6
**questions [28]** 1/15 27/20 27/21 34/13 69/6 69/7 69/10 73/17 79/3 107/25 114/16 134/6 134/7 134/10 134/12 134/23 146/3 148/18 151/11 151/12 151/14 152/15 186/3 187/4 187/5 187/7 187/8 187/10
**quick [2]** 93/6 121/8
**quicker [2]** 69/3 76/25
**quickly [3]** 37/16 66/15 112/11
**quiet [5]** 2/12 4/2 80/6 139/17 139/23
**quieter [5]** 8/3 8/4 75/4 156/1 156/12
**quite [35]** 2/8 2/12 2/12 2/13 3/25 4/1 4/2 6/18 12/24 16/7 17/11 25/1 27/6 32/21 38/4 50/8 53/11 66/9 66/15 66/15 83/13 85/24 86/5 110/25 112/2 112/14 112/17 124/25 125/21 126/9 137/8 158/9 159/11 172/17 173/1
**quote [2]** 124/14 137/17

**R**

**Rachel [2]** 41/13 168/24
**Rachel Chang [1]** 168/24
**raise [9]** 20/7 20/22 52/20 65/16 67/19 103/12 103/20 120/16 174/17
**raised [8]** 4/7 5/2 15/11 21/11 68/4 97/8 99/11 104/24
**raising [9]** 10/7 10/24 21/2 25/9 66/14 103/15 120/21 160/20 180/20
**ran [1]** 85/6
**random [1]** 70/12
**rang [1]** 58/21
**range [2]** 18/2 169/18
**ranks [2]** 137/3 137/18
**rapid [1]** 49/9
**rapidly [1]** 38/4
**rapidness [1]** 49/12
**rare [4]** 67/20 81/2 102/22 155/23
**rarely [2]** 50/15 81/7
**rash [10]** 33/2 38/14 38/23 43/5 43/8 43/11 43/17 43/20 43/22 43/22
**rashes [3]** 35/22 43/13 43/14
**rate [7]** 22/25 39/22 77/10 77/13 78/19 117/6 117/12
**rates [4]** 77/14 77/14 77/16 123/4
**rather [7]** 32/20 48/7 68/24 133/20 157/14 157/15 169/9
**ratios [1]** 8/8
**Ravi [3]** 27/9 58/12 62/2
**Ravi Jayaram [2]** 27/9 62/2
**Ravi Jayaram had [1]** 58/12
**RCN [6]** 58/21 58/24 60/18 61/2 69/14 70/13
**re [2]** 29/24 30/13
**re-intubated [1]** 30/13
**reached [2]** 133/2 133/22
**reaching [1]** 30/19
**react [2]** 7/16 7/18
**reaction [5]** 42/12 59/15 60/6 64/4 147/3
**read [18]** 42/7 43/7 43/25 44/21 49/23 54/24 61/25 65/23 87/1 119/11 123/19 129/8 129/16 129/17 129/18 136/9 144/20 180/1
**reading [1]** 174/13
**ready [4]** 24/18 99/23 157/24 158/9
**reaffirm [1]** 72/1
**real [2]** 98/22 104/24
**realising [1]** 171/21
**reality [1]** 140/11
**reallocate [1]** 55/12
**reallocated [1]** 94/11
**reallocation [1]** 94/13
**really [48]** 7/15 11/25 17/15 19/20 21/4 25/16 25/17 26/3 33/22 34/3 34/5 35/16 49/20 50/5 56/14 59/12 60/22 70/9 72/22 83/10 85/9 93/5 93/8 93/11 93/12 94/6 94/7 101/3 101/4 101/20 101/20 112/18 112/19 114/13 126/24 143/1 155/17 157/20 158/8 161/9 162/21 165/15 170/8 172/4 173/25 174/6 178/4 185/25
**reason [7]** 20/18 47/5 50/7 50/9 70/3 142/22 142/24
**reasonable [1]** 94/12
**reasons [1]** 121/22
**reassurance [1]** 161/8
**reassured [1]** 161/11
**recall [58]** 13/20 31/3 31/11 33/4 33/22 39/15 39/23 40/3 40/5 40/18 40/22 40/24 41/1 42/17 56/3 64/25 65/12 83/6 88/25 90/21 91/15 95/13 96/13 99/14 109/3 110/18 111/13 115/16 115/17 116/11 121/21 121/23 123/14 124/7 136/3 139/5 139/22 140/25 141/12 141/16 142/5 142/10 147/24 148/23 148/25 150/20 156/22 161/19 166/2 167/9 168/20 173/17 175/9 175/12 176/7 176/12 178/7 179/16
**recalled [3]** 40/5 41/13 53/24
**receive [1]** 120/6
**received [10]** 90/9 90/16 110/10 119/12 120/12 124/15 130/9 140/13 144/9 179/10
**receiving [3]** 37/5 92/7 135/15
**recently [5]** 44/5 136/12 137/21 150/13 181/21
**reclaim [1]** 75/6
**recognise [1]** 80/21
**recognised [6]** 21/19 82/17 82/18 82/21

## R

**recognised... [2]** 138/16 138/19
**recognising [1]** 169/6
**recollection [6]** 40/20 83/3 95/6 115/3 140/21 141/4
**recollections [1]** 39/19
**recommenced [1]** 109/10
**recommendations [2]** 119/23 125/6
**recommended [1]** 5/15
**reconfigure [1]** 73/2
**recorded [3]** 39/11 61/24 147/13
**records [3]** 39/7 146/22 150/12
**recovered [5]** 37/16 40/17 107/1 107/1 107/9
**recurring [1]** 55/22
**red [1]** 97/8
**redacted [34]** 16/12 16/14 16/21 16/24 16/25 22/18 22/19 26/13 26/17 29/6 36/18 57/12 57/15 57/20 58/6 59/18 62/12 64/24 66/25 72/12 72/15 77/18 80/10 86/3 88/10 88/15 121/9 123/21 123/22 123/23 130/9 130/11 186/4 186/5
**redirection [1]** 32/19
**Rees [8]** 16/6 16/16 21/3 21/4 26/4 26/5 26/6 62/7
**refer [7]** 78/24 91/5 100/5 128/25 135/23 136/25 180/2
**referred [2]** 86/22 180/11
**referring [7]** 7/18 27/8 46/3 46/16 48/4 76/5 96/18
**reflect [1]** 34/12
**reflecting [4]** 47/19 160/5 182/1 182/4
**reflection [1]** 163/18
**reflections [3]** 68/16 125/5 181/23
**refused [1]** 143/6
**regard [4]** 33/25 34/14 50/12 149/1
**regarding [2]** 150/21 173/3
**regards [1]** 35/23
**registered [2]** 5/24 6/3
**Registrar [8]** 8/17 8/25 9/10 57/3 91/12 147/11 147/11 147/20
**Registrars [1]** 50/25
**regular [1]** 172/1
**regularly [2]** 72/14 99/5
**regulatory [1]** 133/7
**related [3]** 33/17 70/24 70/24
**relating [1]** 168/17
**relation [8]** 92/6 116/1 116/21 116/21 128/10 135/4 148/19 149/15
**relationship [19]** 11/5 11/19 14/3 14/12 20/16 26/21 26/23 27/2 27/5 27/13 27/15 62/13 63/22 66/10 72/10 86/15 126/16 163/6 174/11
**relationships [2]** 85/11 85/18
**release [3]** 122/3 122/6 176/15
**reliant [1]** 166/12
**relief [1]** 94/15
**remain [2]** 4/20 186/7
**remained [1]** 143/17
**remaining [2]** 121/9 121/9
**remains [1]** 126/10
**remember [78]** 7/5 8/1 13/16 13/19 15/21 16/4 16/23 18/22 18/23 19/20 22/15 22/17 28/14 28/21 28/23 31/5 31/13 33/1 34/24 38/23 39/1 39/2 39/18 40/21 41/2 41/18 50/16 53/5 56/23 57/4 58/9 58/10 59/7 62/19 63/1 63/4 64/6 84/17 84/18 88/24 90/25 91/15 96/2 96/4 98/12 98/13 101/12 101/14 101/23 106/17 109/3 109/6 111/16 111/17 112/12 113/21 114/17 114/18 114/20 116/2 117/5 120/25 122/4 122/16 123/7 124/4 128/17 139/23 141/6 158/10 159/21 166/24 167/7 167/12 167/15 168/23 175/19 176/8
**remembered [1]** 101/15
**remembrance [2]** 131/12 132/3
**removed [5]** 21/17 59/17 121/10 128/16 128/18
**reoccurring [1]** 151/8
**repeat [3]** 25/4 138/17 182/3
**repeatedly [2]** 98/2 129/25
**replied [1]** 53/21
**reply [3]** 48/21 62/20 62/21
**report [6]** 62/14 62/17 65/11 104/10 147/22 149/13
**reported [7]** 63/10 63/13 65/2 80/13 88/8 98/4 145/15
**reporting [6]** 65/14 104/22 114/18 124/12 144/12 157/15
**reports [2]** 82/8 119/5
**represent [2]** 133/7 135/5
**representative [2]** 104/3 104/4
**reputation [2]** 130/4 132/1
**request [4]** 50/14 61/19 87/22 88/5
**requested [3]** 39/12 115/12 140/13
**require [2]** 118/11 173/22
**required [7]** 75/7 94/16 139/11 143/12 155/1 178/14 182/2
**requires [1]** 138/11
**research [1]** 100/19
**resecured [1]** 150/13
**resource [3]** 46/6 155/11 173/7
**respect [3]** 86/7 131/23 132/9
**respectful [2]** 85/25 86/1
**respiratory [4]** 37/4 91/9 114/10 140/17
**respond [3]** 112/20 113/5 177/19
**responding [1]** 112/18
**responds [1]** 48/17
**response [9]** 14/23 14/25 55/6 70/24 98/10 98/13 147/14 173/21 174/18
**responsibilities [1]** 154/2
**responsibility [1]** 144/11
**responsible [1]** 74/15
**rest [11]** 49/22 82/20 92/15 92/19 93/19 94/6 94/18 94/18 110/11 127/5 143/19
**Restrict [1]** 126/18
**result [1]** 98/6
**results [6]** 50/13 50/18 119/7 123/6 148/11 182/20
**resume [1]** 151/19
**resus [2]** 32/10 32/20
**resuscitation [21]** 29/15 29/16 30/10 31/10 33/8 92/14 95/22 96/6 96/12 107/19 112/12 112/24 113/9 113/11 113/13 142/11 142/13 142/18 143/14 144/6 159/13
**resuscitations [1]** 164/11
**return [4]** 62/5 93/4 128/12 143/6
**returned [1]** 153/18
**returning [1]** 168/4
**review [9]** 22/24 51/14 56/21 62/4 122/25 139/8 146/22 177/1 182/13
**reviewed [5]** 51/5 78/12 91/12 91/14 91/15
**reviewing [2]** 23/16 78/8
**reviews [8]** 103/5 122/20 122/20 122/22 123/7 127/21 166/17 182/17
**rid [1]** 127/7
**right [26]** 6/9 13/10 18/5 24/12 25/3 30/9 30/16 38/12 41/5 43/15 45/7 45/9 45/11 55/9 63/17 90/15 95/11 97/15 111/18 124/25 146/7 153/7 153/19 158/25 163/20 167/6
**right-hand [1]** 111/18
**rightly [1]** 158/11
**ring [1]** 60/17
**ringing [1]** 32/12
**rise [4]** 24/14 62/19 99/25 151/20
**rising [1]** 25/23
**risk [3]** 57/22 117/12 149/21
**RJ's [1]** 62/6
**role [9]** 71/12 74/4 74/8 82/5 83/23 89/17 97/20 153/7 153/12
**roles [1]** 153/9
**room [33]** 31/6 31/10 33/11 33/13 46/6 63/1 73/2 73/8 90/2 90/4 92/17 93/14 108/1 108/6 108/7 125/23 138/7 138/22 139/20 140/22 141/2 141/20 141/23 144/19 144/21 155/6 155/11 155/14 155/15 173/7 174/15 186/7 186/8
**rooms [2]** 155/2 155/23
**roster [1]** 127/25
**rota [1]** 53/22
**rotas [1]** 183/15
**rotate [1]** 15/4
**rotated [4]** 85/21 154/17 154/18 154/19
**rotation [4]** 154/5 154/8 171/10 171/17
**rotational [1]** 154/5
**roughly [3]** 16/23 102/13 166/24
**round [17]** 8/22 8/24 9/1 9/4 9/5 9/7 9/8 15/4 15/9 39/22 74/7 86/6 88/13 94/21 125/20 166/18 176/8
**round June 2015 [1]** 74/7
**rounds [1]** 105/15
**route [3]** 103/14 103/17 103/19
**route is [1]** 103/19
**routes [1]** 107/2
**routinely [3]** 12/4 40/14 41/2
**Royal [7]** 62/14 122/23 122/24 132/19 132/22 176/25 177/1
**Rule [8]** 61/19 96/4 96/21 119/12 124/15 127/22 129/5 144/20
**Rule 9 [8]** 61/19 96/4 96/21 119/12 124/15 127/22 129/5 144/20
**run [2]** 171/1 184/6
**run-up [2]** 171/1 184/6
**running [2]** 74/18 166/12
**runnings [1]** 158/8

## S

**sadly [5]** 22/6 33/7 42/16 67/21 106/15
**safe [6]** 66/19 67/2 70/11 70/13 125/7 182/6
**safeguarding [3]** 67/18 104/8 127/3
**safely [3]** 124/12 124/22 138/14
**safety [13]** 57/22 65/15 81/5 81/9 90/6 90/7 92/18 93/19

**S**

**safety... [5]** 138/23 143/19 175/10 175/17 176/11
**said [132]** 5/5 5/8 6/5 7/11 7/13 7/17 8/1 8/2 11/7 12/18 12/19 13/9 17/13 22/1 22/3 22/23 23/2 24/5 25/17 26/6 26/7 26/8 26/9 27/6 28/23 28/24 29/2 30/6 31/19 32/1 34/19 38/2 38/3 38/12 38/23 39/19 40/2 43/19 43/21 44/4 45/25 47/5 50/3 53/5 53/8 53/9 53/10 53/11 53/13 53/16 53/20 55/22 56/6 59/12 60/12 60/16 61/25 62/17 63/6 63/7 63/16 63/16 63/20 63/25 64/5 64/12 64/12 64/13 64/17 66/21 69/14 69/22 69/24 70/17 71/1 79/19 83/8 83/8 83/10 83/14 86/12 89/7 89/23 93/7 95/2 95/5 96/7 96/16 96/16 96/19 97/9 101/11 101/16 112/5 112/7 114/17 114/22 115/1 115/5 115/6 119/8 123/9 124/20 127/23 131/17 133/23 135/16 136/2 140/20 141/16 141/18 143/9 143/12 144/20 146/4 146/8 156/18 157/1 157/16 159/3 167/16 167/18 168/12 173/1 175/1 175/25 179/9 179/18 179/22 184/3 184/8 184/11
**Saladi [2]** 35/3 148/20
**same [24]** 7/11 30/6 37/1 38/18 55/17 83/17 89/22 95/5 99/21 105/19 106/24 107/7 107/9 119/1 126/15 133/25 137/4 154/22 156/15 161/20 164/4 164/5 170/12 179/21
**sat [2]** 78/11 173/11
**satisfied [1]** 37/19
**saturation [1]** 37/15
**saturations [1]** 37/15
**Saturday [1]** 9/6
**saw [22]** 4/1 12/1 12/21 16/21 19/17 22/20 22/23 23/1 23/6 23/13 56/20 59/18 59/21 72/14 97/13 108/23 108/24 134/5 163/17 173/4 173/16 177/6
**say [162]** 5/18 5/19 9/13 10/3 12/2 13/3 13/5 13/17 20/5 21/14 23/24 25/17 26/22 27/7 32/23 33/20 33/25 35/11 36/5 38/7 38/9 46/2 46/19 50/4 50/9 51/8 52/2 59/5 59/8 60/3 62/4 62/9 63/17 63/24 64/15 65/10 65/12 69/21 69/24 70/17 74/11 77/8 77/11 78/12 78/19 79/12 79/25 80/1 80/24 81/10 83/19 84/25 85/12 85/25 86/16 86/17 87/12 87/23 88/7 89/21 90/2 90/11 90/18 92/5 93/16 93/20 99/5 99/6 100/14 101/24 104/15 105/25 106/1 106/4 106/22 108/8 108/22 109/16 111/25 112/10 112/15 113/18 115/5 116/16 117/9 117/16 120/8 121/4 123/14 124/9 125/11 126/1 126/17 127/2 127/12 128/3 128/10 129/6 131/12 132/17 134/15 134/16 134/18 136/25 137/12 137/19 139/10 139/16 140/19 141/5 141/25 143/4 146/15 146/18 150/20 154/9 156/2 156/13 156/19 157/13 159/20 160/2 163/21 165/2 165/8 165/14 165/18 165/22 166/25 167/9 168/3 168/7 168/12 168/20 168/21 169/2 170/7 170/21 171/3 171/23 173/14 173/15 173/20 173/22 174/12 174/16 175/7 176/2 176/9 177/12 177/18 178/3 178/14 178/22 179/20 179/21 179/21 179/22 182/8 182/19 183/24 185/12
**saying [27]** 22/13 31/20 37/23 39/21 47/20 48/17 50/7 53/24 86/9 88/2 88/6 95/6 110/25 115/17 118/15 121/25 124/25 132/8 134/15 141/12 167/13 167/14 167/22 173/17 179/5 183/20 185/19
**says [7]** 31/25 35/7 43/4 82/5 130/7 135/25 179/20
**scan [4]** 113/22 114/13 114/15 114/18
**scanning [1]** 114/6
**screen [6]** 41/25 44/20 50/22 54/10 144/7 176/15
**scribing [1]** 87/16
**scroll [2]** 44/24 45/14
**searched [2]** 124/17 128/14
**second [9]** 2/2 2/17 2/22 4/12 4/18 81/11 113/5 115/23 171/20
**secondments [1]** 124/6
**seconds [1]** 113/16
**secure [1]** 128/21
**secured [3]** 150/9 150/12 150/16
**sedated [2]** 149/20 149/22
**see [55]** 4/3 9/25 11/17 14/7 16/3 16/8 18/14 23/1 26/8 29/10 29/11 32/1 42/1 42/4 47/2 50/13 54/13 57/7 57/17 57/20 67/5 67/5 69/12 69/14 72/12 82/13 82/13 85/18 88/12 102/24 103/8 103/9 113/23 119/2 119/3 119/3 119/5 119/6 119/6 119/15 122/3 122/17 127/19 131/15 138/6 142/24 151/8 153/1 170/8 172/7 176/14 176/15 176/20 178/5 184/14
**seeing [4]** 10/15 10/16 122/16 136/3
**seek [2]** 125/21 163/25
**seem [6]** 4/1 42/16 83/17 102/20 104/14 160/10
**seemed [10]** 4/22 33/15 44/14 49/19 61/2 70/13 95/14 143/10 156/3 156/10
**seems [5]** 23/17 43/15 45/18 48/24 168/17
**seen [29]** 30/7 30/23 30/24 31/1 31/12 32/17 40/3 40/9 42/20 42/20 43/12 48/9 50/23 50/23 56/24 57/10 67/9 83/7 111/11 114/23 119/13 122/9 122/14 127/21 136/4 136/23 173/6 176/15 177/12
**self [1]** 140/16
**self-ventilating [1]** 140/16
**selfish [5]** 93/22 94/3 94/4 98/19 143/10
**send [2]** 71/14 71/22
**senior [16]** 12/15 15/18 50/24 76/24 86/20 87/3 87/9 87/11 104/5 105/16 123/10 123/13 137/23 170/23 174/6 180/8
**sense [2]** 10/8 95/18
**sensitive [1]** 112/2
**sensitivity [1]** 131/24
**sent [9]** 18/14 18/17 31/6 35/17 45/10 82/20 138/1 138/2 176/24
**separate [3]** 85/17 155/3 181/19
**separately [2]** 14/9 132/6
**separation [1]** 125/12
**sepsis [5]** 43/6 43/11 43/13 43/22 140/15
**September [6]** 2/21 53/16 53/17 64/25 153/3 183/13
**September 2015 [1]** 53/17
**septic [1]** 144/7
**sequence [1]** 147/24
**series [1]** 168/5
**serious [2]** 115/13 145/15
**seriously [2]** 52/19 149/11
**service [5]** 84/2 131/12 132/3 148/13 171/17
**services [3]** 132/5 132/10 132/11
**sessions [1]** 84/4
**set [7]** 11/3 39/6 66/4 89/2 120/22 148/8 181/25
**sets [1]** 171/15
**seven [2]** 28/5 35/10
**several [3]** 22/4 25/13 87/15
**sex [1]** 126/15
**shadowing [1]** 82/4
**shall [1]** 38/2
**share [4]** 68/17 154/21 154/22 163/25
**shared [8]** 20/12 81/25 82/6 86/3 116/14 116/15 165/12 165/15
**sharing [2]** 19/8 19/9
**she [329]**
**she'd [1]** 157/1
**she's [15]** 2/7 2/12 3/5 38/13 39/22 44/9 93/7 137/17 157/20 160/7 164/20 168/1 169/23 170/14 173/12
**shift [103]** 4/5 5/22 6/2 6/7 7/23 8/10 8/11 9/20 10/14 13/6 16/8 25/22 28/2 28/3 28/7 36/4 45/19 46/7 46/8 46/12 46/18 49/15 55/14 55/15 55/15 55/16 55/24 74/1 74/5 74/8 74/14 74/16 74/19 74/21 75/12 78/3 78/4 79/10 79/14 81/1 82/25 83/2 83/16 88/22 89/1 89/4 89/9 89/10 89/17 89/19 90/3 90/4 90/5 90/18 90/19 90/25 91/2 91/17 91/19 91/25 92/18 93/23 97/21 100/22 101/1 102/1 106/5 109/2 111/4 111/7 111/7 117/25 118/1 118/1 119/4 119/17 127/14 127/15 128/1 137/1 139/6 139/8 140/17 143/12 144/13 156/2 158/20 158/21 161/5 161/19 163/13 166/10 167/11 169/23 170/9 170/11 171/11 172/10 172/15 172/16 175/10 176/9 183/17
**shifts [28]** 7/25 8/2 8/21 9/20 13/6 22/10 41/8 74/5 75/7 76/23 76/24 77/6 77/23 80/15 106/19 117/20 154/4 155/22 156/1 156/1 165/23 166/12 167/16 168/5 168/9 168/14 168/16 168/23
**SHO [3]** 8/18 9/11 57/3
**shock [1]** 143/8
**shocked [6]** 34/4 60/9 83/13 120/25 143/5 143/20
**shocking [1]** 70/5
**short [10]** 5/14 5/18 24/16 48/7 48/10 73/11 78/1 147/20 151/22 154/8
**short-staffed [2]** 5/14 5/18

**S**

**shortly [3]** 28/14 37/21 52/13
**should [40]** 11/22 13/2 31/21 40/23 59/9 59/12 60/22 61/3 66/18 67/8 67/15 69/14 69/18 69/21 69/23 69/24 95/9 99/17 100/6 100/15 110/9 119/24 125/6 126/21 132/23 132/24 133/2 134/19 136/14 136/21 144/6 144/7 144/8 144/8 149/11 149/13 172/14 179/3 182/12 182/22
**shoulder [1]** 81/12
**shoulders [2]** 173/20 174/17
**shouldn't [4]** 26/2 63/9 70/17 136/13
**show [2]** 68/24 127/1
**showed [2]** 140/15 141/12
**showing [4]** 15/8 82/8 82/9 91/9
**shown [3]** 29/22 131/24 141/11
**shrugged [2]** 173/20 174/16
**shut [2]** 86/8 185/16
**sibling [2]** 173/13 173/13
**siblings [2]** 80/5 172/20
**sic [2]** 100/14 116/4
**sick [1]** 143/2
**sicker [1]** 144/4
**side [11]** 29/7 30/16 30/17 39/14 46/14 85/6 90/8 109/19 125/16 126/3 126/12
**sides [1]** 57/5
**sign [6]** 64/25 126/19 126/19 147/4 178/15 179/2
**significance [1]** 84/18
**significant [5]** 100/16 102/20 102/21 117/12 184/25
**significantly [2]** 22/8 83/12
**signing [1]** 179/12
**signpost [1]** 181/12
**signs [4]** 91/9 135/20 139/6 161/24
**similar [12]** 8/9 22/21 38/15 38/18 39/3 43/8 71/21 133/25 134/1 155/3 181/6 182/2
**similarly [1]** 168/8
**simple [1]** 112/3
**simply [1]** 93/11
**simultaneous [1]** 156/16
**since [9]** 31/1 69/2 88/9 104/1 104/1 119/11 125/2 127/21 131/18
**sincerely [1]** 131/22
**single [1]** 4/5
**sinister [5]** 51/16 52/3 157/13 167/17 183/6
**sister [2]** 31/2 36/15
**sit [7]** 1/12 1/13 1/16 37/9 108/7 163/20 185/12
**sitting [4]** 46/18 51/9 52/4 183/13
**situation [20]** 15/12 32/8 32/16 32/20 39/4 68/5 68/5 97/16 104/17 105/17 111/17 112/24 114/16 118/18 143/23 145/4 145/8 146/16 159/17 162/8
**situations [4]** 32/22 87/17 126/6 185/24
**six [6]** 3/10 75/23 88/20 154/20 164/15 168/15
**six days [1]** 88/20
**six months [3]** 3/10 154/20 168/15
**skill [1]** 74/20
**skilled [2]** 75/19 173/2
**skills [5]** 2/10 2/25 3/23 12/22 13/1
**skin [9]** 30/3 31/12 33/2 38/16 39/10 39/16 39/25 109/8 109/8
**slight [1]** 152/5
**small [5]** 17/20 50/1 53/19 92/7 149/18
**smear [1]** 174/21
**smooth [1]** 74/17
**so [430]**
**social [1]** 11/14
**socialise [2]** 11/15 11/21
**society [1]** 104/16
**sodium [1]** 113/1
**solely [1]** 165/9
**some [74]** 6/18 7/22 21/25 27/3 27/19 27/20 31/9 33/9 33/10 33/12 34/13 35/17 37/7 37/8 45/18 51/20 51/23 53/7 59/25 61/2 66/2 68/1 68/10 68/12 68/12 75/6 81/25 85/21 87/3 87/6 88/17 90/11 91/8 91/9 93/11 93/21 94/21 102/15 102/16 107/12 107/25 111/22 116/12 118/22 119/2 119/11 120/19 120/19 122/2 125/15 126/4 128/15 131/18 132/12 134/7 134/12 135/7 137/10 137/11 137/14 139/14 146/3 148/14 149/16 150/3 150/23 155/9 167/15 169/21 170/10 174/24 180/17 183/13 183/22
**somebody [17]** 26/2 31/6 32/10 40/19 51/17 53/22 58/2 67/3 68/10 68/25 71/9 80/13 101/16 160/8 171/2 180/25 181/3
**someone [18]** 70/9 80/25 82/23 95/16 97/7 104/5 104/9 104/20 104/21 104/25 105/5 129/17 152/2 157/8 170/1 170/23 174/9 183/8
**someone's [2]** 68/9 138/12
**something [70]** 5/4 10/2 10/7 10/9 17/25 26/1 26/2 31/20 33/16 38/24 38/25 40/4 43/23 47/21 48/1 49/2 51/9 51/13 51/24 52/3 53/9 53/24 57/25 59/8 59/10 60/24 62/22 62/22 64/14 64/16 64/17 79/22 88/4 105/23 112/3 112/22 114/14 116/13 121/4 121/5 121/13 121/15 146/23 147/4 148/5 151/3 156/18 157/1 157/5 157/6 157/9 157/19 159/14 161/1 161/4 161/9 161/13 162/19 163/12 164/18 171/20 172/14 173/11 178/14 178/21 178/24 179/3 184/15 184/25 185/9
**sometimes [17]** 6/1 6/2 9/14 10/14 13/3 14/19 71/23 87/19 87/24 88/6 147/23 149/23 155/11 156/11 161/23 176/10 183/2
**somewhat [1]** 49/9
**somewhere [1]** 158/1
**soon [3]** 31/7 59/18 142/11
**sooner [3]** 69/3 84/13 144/9
**Sophie [15]** 90/20 91/22 91/22 91/24 94/12 95/15 137/3 137/4 137/7 137/13 137/17 137/20 140/20 140/25 143/14
**sorry [55]** 1/5 3/16 4/14 4/16 12/7 16/21 21/20 25/4 33/18 33/20 45/1 45/2 49/24 50/1 54/17 60/15 61/9 61/10 61/12 63/11 63/11 63/15 75/15 88/25 89/21 92/12 92/21 93/16 97/2 100/11 101/14 101/23 102/9 106/17 107/3 107/4 110/18 110/25 111/13 115/24 118/21 122/11 123/15 129/16 136/19 138/17 146/16 149/1 149/3 150/13 151/24 152/5 167/19 168/18 182/3
**sort [43]** 7/24 11/5 13/1 17/20 51/20 51/25 52/18 66/25 68/1 155/10 155/13 156/24 157/11 157/16 158/6 158/13 158/16 158/17 159/11 159/18 160/22 161/7 161/24 162/14 162/15 162/17 163/6 163/8 163/11 163/16 164/6 164/16 165/6 167/22 169/24 174/5 174/9 174/11 174/23 175/2 175/3 179/25 181/9
**sorted [1]** 73/8
**sorts [1]** 34/18
**sound [1]** 6/9
**sounded [1]** 61/6
**sounds [1]** 87/23
**space [5]** 48/10 106/16 108/17 144/25 145/13
**speak [26]** 4/16 16/9 78/21 98/16 98/25 98/25 99/3 99/8 99/15 103/25 104/3 108/5 108/14 115/4 119/15 119/16 124/10 124/12 124/22 124/24 125/4 163/13 181/9 181/11 181/21 185/24
**speaking [7]** 15/7 18/9 65/13 114/24 114/25 173/23 179/19
**special [6]** 107/20 107/21 135/18 136/14 137/11 137/22
**speciality [5]** 6/14 76/5 76/8 76/17 137/7
**specific [9]** 28/12 50/7 67/17 117/7 154/23 158/5 169/15 177/24 184/23
**specifically [9]** 31/13 39/23 67/24 127/23 156/22 159/21 168/22 176/9 177/22
**specifics [2]** 18/23 18/25
**speculating [2]** 48/11 50/3
**spend [1]** 156/23
**spent [1]** 161/22
**sphere [1]** 71/7
**Spiritual [2]** 131/13 132/4
**spoke [3]** 18/8 31/16 63/24
**spoken [2]** 81/22 97/6
**spot [1]** 67/22
**stable [4]** 92/3 92/8 109/8 111/20
**staff [55]** 5/17 6/6 6/7 6/12 7/12 7/14 7/16 7/17 7/18 7/20 7/21 8/13 8/14 17/21 18/2 19/7 22/22 23/17 28/19 32/24 35/8 35/9 41/14 44/14 51/21 53/19 65/12 67/20 67/25 84/3 84/16 100/16 102/23 115/12 123/19 125/7 126/19 126/19 127/14 127/22 128/4 129/22 129/24 134/4 136/15 136/17 156/3 156/11 169/3 175/9 176/23 177/20 183/3 183/10 185/10
**staff's [1]** 104/23
**staffed [2]** 5/14 5/18
**staffing [5]** 5/7 5/9 5/20 82/8 119/6
**Staffordshire [1]** 133/22
**stage [13]** 2/16 2/22 5/1 32/14 47/12 47/24 96/12 112/25 113/4 121/7 123/21 156/19 161/15
**stance [1]** 132/14
**stand [2]** 1/12 136/12
**standardised [1]** 182/20
**standards [1]** 74/9
**standing [5]** 28/25 30/18 39/21 58/8 84/5
**start [9]** 11/3 53/8 91/17 99/23 137/1 140/16 152/1 156/16 179/1
**started [10]** 2/20

## S

**started... [9]** 16/19 29/4 113/15 121/11 121/12 121/13 162/8 165/16 179/8
**starting [5]** 68/20 75/24 107/15 121/18 165/10
**state [4]** 64/24 66/16 100/9 101/5
**stated [1]** 96/15
**statement [69]** 1/19 1/20 3/14 3/19 5/6 5/7 6/5 7/11 7/22 9/12 11/4 11/7 20/17 28/1 30/2 35/6 36/1 37/12 37/12 37/13 38/10 39/5 39/6 40/8 41/13 47/9 47/15 62/6 62/8 64/11 64/19 66/22 73/19 73/23 81/10 82/5 86/20 86/22 89/7 100/5 105/25 108/19 109/4 111/15 116/16 124/8 128/24 134/25 135/23 136/24 136/25 137/16 139/25 140/21 140/24 143/13 152/19 152/24 153/1 156/13 157/14 159/3 160/3 165/18 167/2 171/15 174/14 177/14 180/1
**statements [8]** 5/5 40/4 68/19 68/22 107/12 119/10 120/22 133/12
**stating [1]** 65/1
**statistics [2]** 118/9 119/6
**stay [5]** 57/14 75/7 155/11 158/16 165/11
**stayed [1]** 165/13
**stemmed [2]** 165/9 168/7
**step [3]** 139/4 157/24 158/13
**stepped [1]** 33/9
**Stepping [2]** 67/12 68/6
**steps [1]** 68/12
**stethoscope [1]** 113/17
**Steve [1]** 27/9
**still [23]** 37/5 67/13 71/23 72/22 80/17 92/16 92/18 93/5 94/14 94/18 101/25 102/5 102/5 109/6 125/15 126/5 126/6 136/11 143/12 148/7 155/19 160/6 183/18
**stillbirths [1]** 131/9
**stock [1]** 67/13
**stoma [1]** 148/22
**stonewalled [1]** 26/12
**stood [1]** 147/9
**stop [3]** 26/16 113/9 113/13
**stopped [1]** 33/8
**stopping [1]** 126/25
**store [1]** 33/12
**stored [2]** 66/24 67/1
**storeroom [1]** 33/12
**stories [1]** 184/6
**story [2]** 170/17 170/25
**straight [2]** 30/15 136/21
**strained [1]** 14/4
**strange [4]** 43/20 83/10 157/11 172/18
**streamline [1]** 46/22
**stretch [1]** 166/2
**strived [1]** 132/11
**strong [5]** 27/4 66/8 84/5 94/6 94/7
**strongly [2]** 100/6 100/14
**structure [1]** 76/12
**struggled [1]** 159/23
**struggling [1]** 4/14
**stuck [2]** 79/9 166/21
**student [11]** 2/19 2/20 3/6 4/8 4/21 18/11 52/20 91/23 120/6 127/16 184/19
**students [5]** 4/4 76/20 85/7 127/23 160/19
**study [3]** 4/19 57/11 85/6
**style [1]** 17/10
**subject [3]** 63/2 149/13 174/20
**submitted [2]** 82/10 82/11
**submitting [1]** 82/10
**subsequently [3]** 120/7 122/21 123/2
**succession [2]** 101/16 121/8
**such [18]** 7/15 32/25 34/7 48/10 60/24 70/5 77/25 92/19 101/17 101/19 101/24 121/8 154/22 156/11 162/6 170/5 170/5 181/16
**sudden [8]** 37/2 37/3 39/8 40/15 49/19 50/8 115/14 117/2
**suddenly [5]** 36/20 47/22 48/4 48/10 100/8
**suddenness [4]** 34/4 40/10 47/15 49/12
**suffered [1]** 136/22
**sufficient [2]** 7/16 7/17
**suggest [5]** 96/6 110/19 114/7 125/5 134/19
**suggested [3]** 95/22 144/22 144/23
**suggesting [3]** 3/21 128/15 179/18
**suggestion [2]** 33/21 128/3
**suggests [1]** 100/19
**suite [1]** 87/5
**sulky [1]** 140/3
**summer [3]** 16/17 56/10 57/22
**Sunday [1]** 9/7
**supernumerary [2]** 74/9 91/25
**supervised [1]** 93/18
**supervision [2]** 17/4 85/1
**supervisor [1]** 143/23
**supplies [2]** 127/6 127/7
**support [41]** 2/14 17/4 18/1 37/4 59/23 60/17 78/24 79/3 83/19 83/24 84/3 84/11 84/15 84/16 84/21 85/1 87/16 94/13 94/15 95/20 110/11 112/23 129/6 129/21 130/5 130/12 131/9 133/3 133/6 133/7 133/24 135/15 137/15 140/17 145/2 145/6 156/5 158/15 158/17 163/14 172/9
**supported [3]** 11/8 124/20 185/16
**supporting [2]** 91/24 130/21
**supportive [10]** 4/25 17/23 18/1 21/11 22/3 75/22 78/23 81/12 126/11 126/15
**suppose [1]** 23/16
**supposed [2]** 89/5 143/2
**sure [20]** 3/11 18/11 36/16 48/24 53/11 53/22 57/9 65/4 70/20 89/6 90/22 93/7 93/17 96/7 110/25 120/18 126/14 138/25 177/11 183/16
**surgery [2]** 106/14 126/5
**surprise [1]** 159/14
**surprised [1]** 143/5
**survive [1]** 113/10
**surviving [1]** 121/2
**suspect [1]** 52/3
**suspected [3]** 51/15 51/17 169/3
**suspicions [6]** 68/7 68/10 71/1 103/4 120/16 121/14
**suspicious [1]** 48/13
**swear [1]** 152/3
**swipe [5]** 29/21 126/18 126/23 127/1 127/11
**switched [1]** 46/9
**sworn [2]** 73/16 187/6
**symptoms [1]** 147/21
**system [1]** 124/24

## T

**take [23]** 1/12 3/17 21/21 24/13 26/3 44/17 44/18 46/23 50/21 56/6 56/16 57/7 73/15 73/23 79/6 92/24 99/22 124/2 131/22 133/8 167/21 173/15 176/23
**taken [10]** 28/10 40/1 49/17 87/21 97/7 97/12 97/22 121/20 149/11 171/2
**takes [1]** 37/7
**taking [3]** 108/12 122/20 152/8
**talk [12]** 21/23 23/12 24/13 33/1 35/19 45/18 70/9 70/11 70/12 103/3 141/25 146/9
**talked [1]** 72/4
**talking [20]** 7/12 15/22 15/22 16/20 31/13 33/14 41/15 48/2 64/20 78/22 84/7 103/4 110/19 113/21 150/2 176/3 176/19 180/2 180/12 183/14
**taps [1]** 121/16
**tattles [1]** 105/7
**Taylor [6]** 94/23 95/6 95/12 95/21 95/24 146/10
**teaching [1]** 85/7
**team [48]** 4/9 28/6 28/11 46/18 71/13 71/22 76/7 76/7 78/6 78/8 78/18 79/9 81/11 81/16 83/6 84/2 84/5 84/12 85/8 85/10 85/25 88/9 90/5 91/23 100/22 103/2 104/25 105/3 110/11 113/12 119/16 122/19 124/23 124/23 129/25 130/3 130/5 130/18 130/20 131/13 132/4 132/7 132/18 133/5 133/10 143/10 143/21 144/14
**teams [3]** 84/9 87/7 118/11
**technical [1]** 1/6
**technically [1]** 76/9
**tell [51]** 7/24 14/11 24/4 28/1 55/11 59/19 59/22 59/24 60/10 60/11 61/7 62/8 62/10 70/17 73/25 74/4 81/7 81/24 83/1 88/18 89/2 91/1 98/3 98/18 101/19 108/19 109/17 109/23 110/1 113/21 114/20 115/17 121/20 122/13 128/20 137/8 146/9 146/15 153/12 156/18 156/20 157/21 160/4 160/12 161/11 162/1 162/22 163/1 167/11 171/14 177/14
**telling [7]** 59/9 59/12 60/22 69/12 159/18 160/9 161/3
**temporary [2]** 153/5 153/13
**ten [1]** 99/23
**tend [2]** 8/6 48/7
**tended [1]** 8/2
**tension [1]** 12/14
**term [7]** 67/1 71/15 100/20 105/13 105/14 105/20 179/19
**termination [1]** 107/14
**terminology [1]** 148/6
**terms [23]** 5/14 8/4 83/24 85/11 89/4 89/6 94/14 102/18 111/20 112/23 124/16 126/15 127/5 129/1 130/21 134/1 139/23 148/4 149/22 155/2 178/2 181/23 182/8
**terrified [1]** 164/13
**test [1]** 182/20
**tests [1]** 148/12
**text [4]** 135/24 136/3 136/4 136/5
**texter [1]** 48/6
**than [41]** 14/8 16/4 20/24 22/9 32/20 32/22 33/23 36/16 48/8 50/7 55/16 55/24 56/14 68/24 75/16 76/25 77/3 77/19 79/5 79/6 90/7 93/21 101/8 130/4 133/20 135/12 144/9 145/2 145/3 145/3 156/1 157/15 165/4 168/14 168/17

**T**

**than... [6]** 168/18 171/6 174/10 177/10 178/10 178/11
**thank [33]** 10/16 24/19 41/25 44/16 50/22 56/16 69/8 70/23 72/24 73/4 73/6 86/25 92/25 99/22 99/24 134/6 134/8 134/11 136/19 146/2 151/9 151/10 151/14 151/17 151/18 152/4 152/16 152/18 186/2 186/6 186/9 186/10 186/14
**thanks [2]** 134/17 177/13
**that [1201]**
**that's [83]** 1/25 7/19 13/8 17/2 24/25 32/20 43/13 43/23 44/11 45/7 45/9 49/4 54/11 54/14 54/14 63/17 64/11 72/5 72/17 74/3 75/9 78/11 83/22 86/17 87/1 88/6 88/15 90/9 92/11 94/9 94/9 97/20 97/20 99/20 100/9 100/19 102/6 103/8 103/9 103/16 104/25 105/22 106/8 107/18 107/19 107/20 107/25 108/14 109/19 112/7 113/18 114/2 116/1 117/4 119/16 126/23 128/16 139/14 140/10 140/24 141/4 145/23 146/7 146/24 150/17 150/18 154/11 157/10 162/14 162/17 162/19 163/17 166/22 167/4 168/1 168/10 169/12 169/24 170/24 175/22 183/8 184/15 185/25
**their [38]** 12/25 14/17 27/5 37/10 40/10 71/14 71/23 80/6 82/22 85/23 87/14 87/20 87/20 90/9 97/19 102/20 103/5 128/1 130/4 130/5 132/11 132/14 133/2 133/3 133/3 133/23 134/4 135/21 135/21 144/25 145/12 145/13 148/9 148/9 148/22 148/22 149/21 182/10
**them [91]** 4/25 6/25 10/1 10/1 10/11 10/22 10/23 10/25 15/21 20/7 20/22 20/22 22/11 26/23 31/7 31/7 31/11 31/13 31/16 31/22 32/12 33/9 35/19 39/21 40/25 41/2 41/7 46/19 49/6 49/21 50/14 52/20 53/20 53/23 55/17 55/20 57/5 71/16 72/15 75/20 81/19 81/22 82/16 82/17 82/21 84/5 84/17 85/17 85/21 86/1 86/19 87/17 94/24 95/3 96/16 97/4 97/12 97/22 101/8 102/16 102/21 119/16 120/20 126/25 132/16 138/14 138/14 139/7 144/17 144/17 144/18 154/22 155/19 167/12 169/24 170/21 173/6 173/9 175/12 175/19 176/6 178/3 178/5 178/15 178/23 179/2 179/7 180/10 180/22 181/11 185/9
**thematic [3]** 22/24 51/14 56/20
**theme [1]** 151/8
**themselves [7]** 78/21 80/24 126/5 150/5 162/3 166/3 180/11
**then [85]** 1/13 2/16 5/25 6/20 8/1 8/17 10/11 16/6 16/9 17/20 17/21 28/12 32/9 40/25 41/3 41/9 43/25 45/17 46/7 46/13 48/8 54/22 55/19 58/6 58/8 61/7 69/12 69/15 70/24 71/3 75/20 76/3 76/4 76/7 76/8 76/8 83/10 89/24 90/6 90/8 90/14 92/13 94/17 101/1 103/23 105/5 106/10 107/22 112/15 113/14 114/20 117/9 117/16 119/10 119/12 129/3 133/18 136/13 139/23 141/19 142/12 144/2 145/16 147/11 148/7 149/15 151/4 153/16 153/24 154/2 154/8 156/8 157/18 157/21 158/23 159/11 164/15 171/14 172/8 172/20 172/22 172/24 173/14 174/6 185/17
**therapies [2]** 84/8 84/8
**there [270]**
**there's [16]** 3/18 47/21 48/1 67/2 71/25 72/6 72/7 97/18 101/16 124/9 125/3 125/23 127/3 127/10 166/22 181/9
**thereafter [1]** 147/14
**these [30]** 19/8 27/21 34/18 44/12 45/1 51/2 51/11 51/18 52/4 55/8 62/4 68/3 71/14 71/22 78/9 87/9 87/15 97/2 118/8 118/10 122/19 122/20 125/10 132/9 134/23 167/15 167/20 167/25 168/14 169/7
**they [233]**
**they forgot [1]** 159/9
**they have [1]** 124/25
**they're [1]** 113/8
**thing [16]** 12/25 22/12 36/16 52/1 53/25 60/24 70/5 96/5 102/7 102/8 110/2 115/21 116/1 120/8 145/8 181/16
**things [35]** 14/8 25/18 27/11 35/21 36/17 37/10 52/21 54/12 54/15 67/23 69/1 69/2 69/3 71/25 72/6 72/7 93/12 121/18 127/7 127/20 133/18 133/18 144/17 144/18 148/16 161/5 169/18 170/15 178/2 178/20 182/17 183/10 184/5 184/13 184/20
**think [235]**
**thinking [17]** 9/19 15/1 16/18 16/19 30/9 41/5 47/24 49/11 49/17 51/22 69/21 95/1 112/12 136/1 157/20 164/3 173/12
**third [5]** 3/2 3/3 3/5 4/12 4/18
**THIRLWALL [2]** 69/7 187/5
**this [141]** 2/4 2/21 3/1 3/8 5/11 13/18 15/8 15/18 18/21 19/2 19/2 22/1 26/3 28/25 32/8 34/6 37/12 39/15 39/16 43/3 43/5 43/8 45/18 46/4 46/9 46/21 47/9 47/12 47/24 48/17 54/22 55/6 56/11 56/11 56/19 58/21 58/22 59/13 60/5 61/12 62/9 63/3 66/2 67/9 68/4 69/22 71/22 72/23 75/20 86/17 88/12 88/25 89/7 90/1 90/25 91/8 91/10 91/11 91/25 93/5 93/8 93/23 93/25 96/5 101/21 102/18 109/3 110/20 113/14 114/8 114/15 115/2 115/11 116/23 117/1 118/18 119/2 120/15 120/17 121/7 121/22 122/3 122/6 122/18 123/18 123/21 124/18 125/2 125/6 125/19 127/15 127/18 128/14 129/8 129/18 130/17 130/18 131/25 132/2 132/6 132/6 133/8 135/4 141/15 142/2 143/11 144/24 145/14 146/15 146/25 150/24 151/15 151/15 151/16 158/5 158/13 159/25 161/13 161/15 161/21 162/15 165/19 167/1 169/4 171/5 171/10 171/20 173/17 174/21 176/16 176/17 176/25 177/6 177/12 177/18 178/10 179/6 184/12 184/13 185/9 185/14
**those [52]** 3/22 6/14 21/2 22/7 29/24 33/1 34/10 39/23 41/17 41/18 56/10 59/10 61/24 62/20 68/11 69/6 75/13 76/10 78/20 82/2 82/2 87/20 90/21 92/2 101/4 102/22 103/5 103/15 105/3 106/19 116/19 117/8 120/1 122/22 123/7 126/6 133/14 134/6 135/19 139/5 139/12 144/6 163/24 165/2 168/23 171/22 175/17 176/5 180/15 181/15 185/11 185/22
**though [10]** 8/9 12/17 14/6 49/6 93/14 111/8 142/6 156/10 157/5 170/15
**thought [28]** 18/13 19/16 21/8 23/15 23/16 23/19 26/3 41/4 48/12 49/20 58/18 59/16 60/13 63/15 69/13 106/14 117/15 121/14 127/18 157/4 157/10 157/10 167/17 169/25 171/14 178/11 179/7 185/14
**thoughts [3]** 24/11 162/9 164/18
**three [8]** 5/24 6/3 6/11 6/21 48/9 49/18 51/1 156/7
**through [20]** 14/7 16/7 28/16 28/21 30/19 47/24 53/18 53/22 73/23 78/5 78/20 84/3 85/21 85/22 121/7 133/25 136/10 145/22 172/4 174/20
**throughout [7]** 20/4 22/14 29/20 30/1 39/14 132/20 160/2
**Thursday [2]** 53/3 122/7
**time [157]** 2/6 5/15 5/16 5/19 5/20 6/20 7/25 8/12 18/23 21/16 21/17 21/21 22/18 23/2 27/14 29/13 29/24 30/9 33/10 33/15 33/22 34/12 34/16 34/23 36/25 37/5 38/21 39/1 40/5 43/7 46/4 46/10 46/24 48/10 50/10 51/3 51/19 52/13 53/8 55/8 58/17 60/7 61/15 63/19 67/4 68/23 74/19 75/2 75/6 75/15 75/24 76/22 76/23 76/25 77/4 77/6 77/15 77/22 78/25 79/14 79/19 79/23 80/20 81/8 81/14 82/4 82/7 82/12 82/22 83/18 84/14 85/14 85/24 86/2 86/17 88/10 88/19 88/25 89/11 89/22 89/22 90/1 96/3 97/6 97/13 97/15 97/16 97/23 99/6 100/15 101/9 101/11 101/18 101/21 101/23 102/2 106/16 108/2 108/15 108/18 110/5 110/16 113/7 115/12 115/15 115/24 116/1 116/17 116/23 117/19 119/3 122/4 122/9 122/16 124/11 125/17 125/19 127/14 127/22 129/8 133/18 141/3 141/6 141/8 141/17 145/15 147/20 148/1 148/12 148/13 150/18 150/21 154/13 156/12 156/23 157/7 158/15 160/5 161/22 162/22 163/4 163/9 163/17 166/2 167/4 167/14 168/10 174/15 174/24 176/8 176/19 177/14 177/16 178/25 181/14 182/10 182/13
**timeline [1]** 167/5
**timelines [1]** 168/21
**times [11]** 5/13 5/18

## T

**times... [9]** 12/17 13/7 13/11 14/4 25/9 56/12 87/15 125/15 145/12
**timing [1]** 166/25
**tiny [1]** 150/6
**tittle [1]** 105/7
**today [7]** 15/8 47/14 66/3 83/9 84/5 98/19 104/16
**together [22]** 11/8 34/11 49/18 50/8 79/9 100/23 100/25 101/2 102/11 102/21 103/3 103/14 108/5 134/20 148/16 156/15 156/24 162/9 164/2 165/10 165/16 183/14
**told [46]** 13/14 16/17 20/13 20/25 21/16 21/18 22/14 22/15 26/1 26/7 44/8 49/9 50/10 58/11 58/20 58/22 59/2 59/6 59/19 59/22 60/5 61/1 61/8 64/2 69/11 69/19 72/3 72/6 81/17 88/11 95/21 96/14 109/17 112/15 122/19 122/21 123/2 133/16 143/23 147/10 150/19 159/11 161/20 162/11 175/21 177/24
**tolerating [1]** 56/13
**toll [1]** 79/6
**tomorrow [1]** 186/12
**tone [1]** 160/1
**too [6]** 13/4 41/6 55/24 76/22 145/3 148/14
**too' [1]** 168/7
**took [15]** 22/5 22/7 52/18 56/8 74/24 94/23 129/8 143/18 153/16 157/3 157/7 159/14 159/14 168/10 173/9
**tool [1]** 104/10
**top [6]** 6/20 42/11 43/25 57/6 100/5 100/13
**topic [2]** 11/1 13/19
**topics [1]** 148/19
**topping [1]** 127/6
**total [1]** 117/24
**touch [6]** 57/14 72/14 145/9 163/7 165/11 165/13
**towards [7]** 2/17 2/21 4/24 29/10 52/11 93/22 174/24
**towel [1]** 148/23
**train [1]** 63/15
**trained [5]** 119/20 142/5 157/6 169/19 170/14
**training [23]** 2/2 2/20 2/23 5/1 52/12 52/12 52/17 65/11 67/18 67/22 67/24 75/21 85/2 85/4 85/23 119/20 120/11 120/12 142/10 156/21 156/24 169/16 184/17
**transcript [2]** 141/11 141/13
**transferred [3]** 78/4 121/3 149/25
**translated [1]** 151/4
**trauma [1]** 78/20
**traumatic [1]** 92/15
**traumatised [1]** 160/11
**treated [1]** 19/18
**treatment [5]** 33/11 33/13 144/10 145/23 145/24
**trends [1]** 127/15
**trial [14]** 29/23 72/1 89/8 91/18 96/15 104/2 119/11 125/2 127/19 129/7 129/22 131/25 136/6 136/10
**tried [1]** 124/24
**trigger [1]** 107/9
**triplet [1]** 121/3
**triplets [9]** 120/23 120/24 121/2 171/5 173/5 173/18 176/18 178/11 181/1
**trips [1]** 72/8
**true [8]** 1/20 26/7 26/10 68/21 71/24 72/5 73/20 152/21
**trust [25]** 35/7 68/14 71/19 72/19 72/21 82/20 88/9 103/25 120/13 124/12 124/18 125/4 125/9 128/23 129/7 130/1 130/3 130/9 130/24 131/16 134/2 180/3 180/5 180/11 181/14
**Trust's [2]** 129/21 132/1
**Trusts [2]** 178/20 181/8
**truth [1]** 94/9
**truthful [1]** 68/22
**try [5]** 19/20 74/17 102/12 108/13 108/16
**trying [10]** 18/22 66/7 76/11 87/14 90/11 114/4 143/19 157/8 163/25 166/16
**tube [9]** 30/14 30/18 149/16 150/7 150/9 150/12 150/22 150/24 159/23
**tubes [2]** 149/21 151/2
**Tuesday [1]** 186/17
**turn [3]** 27/23 30/15 54/23
**turned [3]** 29/9 79/10 79/14
**turning [1]** 25/24
**twin [2]** 36/15 111/18
**twins [2]** 36/20 36/24
**two [38]** 1/24 5/24 6/1 6/3 6/7 11/17 11/25 15/10 27/10 69/10 75/12 76/3 76/10 76/18 76/18 77/24 84/1 86/20 92/3 95/17 95/17 95/19 101/16 104/1 121/2 121/8 125/1 131/4 131/10 142/7 145/21 148/18 148/18 156/8 167/9 167/10 176/18 179/10
**two days [1]** 15/10
**two weeks [1]** 77/24
**two years [6]** 76/3 84/1 104/1 125/1 142/7 179/10
**type [1]** 112/1

## U

**ultimate [1]** 74/14
**ultimately [5]** 78/19 79/4 79/6 106/9 144/11
**unaware [1]** 139/10
**unbelievable [1]** 71/6
**uncomfortable [2]** 87/9 185/24
**under [4]** 65/3 74/21 125/5 153/12
**underlying [3]** 51/13 113/24 114/7
**undermined [1]** 174/9
**underneath [1]** 22/22
**understand [16]** 1/7 20/9 22/1 25/6 34/6 34/17 40/7 47/23 72/2 76/11 77/13 131/22 134/22 142/17 149/7 151/6
**understanding [5]** 21/16 65/14 71/7 83/18 89/24
**understands [1]** 1/23
**understood [5]** 16/11 21/9 26/18 70/16 72/16
**undertaken [2]** 6/15 7/2
**unexpected [16]** 32/9 37/2 41/21 49/10 92/14 114/5 116/20 116/23 117/3 118/20 146/21 169/7 181/2 183/15 183/23 183/23
**unexpectedly [1]** 158/20
**unexpectedness [2]** 47/16 49/13
**unfortunate [2]** 22/10 68/24
**unfortunately [4]** 104/16 140/11 172/7 174/13
**unfounded [1]** 25/10
**unhappy [1]** 13/11
**Union [1]** 70/13
**unit [146]** 2/24 4/7 5/2 5/8 8/6 8/18 9/5 9/24 11/3 12/16 13/15 13/17 14/12 15/24 16/5 16/5 16/7 16/20 17/7 17/8 17/15 17/16 17/25 20/4 20/6 20/18 21/18 21/19 21/25 26/23 27/10 27/17 28/12 28/17 29/3 29/9 29/10 29/14 29/24 31/7 32/11 32/15 37/18 39/12 42/18 49/7 51/25 52/24 53/18 58/1 58/11 58/16 62/5 64/10 71/2 74/2 74/14 74/18 74/21 75/22 75/24 78/1 78/5 79/21 80/14 81/9 82/13 83/19 84/3 84/21 85/21 85/22 87/21 92/3 92/16 92/19 93/19 94/6 94/14 94/18 104/8 104/20 109/18 109/22 110/13 114/2 115/25 116/8 116/18 117/24 118/3 118/9 121/10 121/11 121/12 121/17 121/20 123/18 125/17 127/5 127/8 127/11 130/6 130/14 130/15 131/4 131/11 138/2 139/15 143/19 153/6 153/15 153/23 153/24 154/4 154/7 154/8 154/15 154/21 154/24 155/4 155/4 155/8 155/10 155/13 155/14 155/16 155/20 158/6 158/8 158/16 160/24 161/22 163/7 163/21 163/22 165/17 166/7 166/15 166/22 170/16 174/3 175/22 176/22 177/7 182/10
**unit' [1]** 62/5
**units [10]** 22/9 67/4 67/13 105/15 125/15 129/24 151/4 154/25 155/7 156/9
**University [1]** 153/3
**unless [2]** 10/4 72/21
**unlikely [2]** 100/24 150/10
**unlimited [1]** 126/2
**unnecessary [1]** 131/20
**unpack [2]** 59/1 117/15
**unpredictable [2]** 161/17 161/21
**unrelated [1]** 174/3
**unsure [1]** 36/5
**unthinkable [6]** 118/16 118/16 118/17 118/19 121/19 128/4
**until [12]** 2/3 3/4 65/6 68/11 112/18 113/12 132/21 133/1 136/5 144/20 151/20 186/16
**until May [1]** 65/6
**untoward [3]** 53/9 62/18 183/15
**unusual [15]** 32/21 33/2 39/16 41/20 48/7 48/11 48/14 49/18 50/6 51/4 95/16 96/5 96/12 150/6 159/4
**unusualness [1]** 47/15
**unwelcome [1]** 88/5
**unwell [6]** 55/23 107/20 154/11 166/3 166/20 171/7
**up [41]** 1/12 4/16 12/4 13/15 15/25 19/25 22/13 25/20 25/24 29/23 30/21 35/22 37/25 41/9 45/2 45/14 50/1 58/10 65/13 69/3 71/24 76/23 79/14 85/9 90/24 103/25 104/3 114/13 124/10 125/4 127/6 140/17 152/12 161/4 162/16 164/4 171/1 173/23 181/9 181/21 184/6
**Up representative [1]** 104/3
**update [1]** 142/9
**updates [3]** 67/18 67/19 130/1
**upholding [1]** 79/15
**upon [6]** 53/19 87/15 103/18 112/21 132/16 136/7
**upset [6]** 12/15 24/25 79/2 96/24 143/14

## U

**upset... [1]** 160/10
**upsets [1]** 134/16
**upshot [1]** 26/4
**urgently [1]** 10/2
**us [72]** 7/24 14/11 20/9 21/24 24/4 28/1 34/5 34/10 37/22 41/11 45/13 47/23 50/10 50/16 50/18 55/11 56/12 59/22 62/8 62/10 68/17 69/11 73/25 74/4 78/21 81/17 81/24 83/1 83/8 84/2 84/7 84/11 84/13 88/11 88/18 89/2 91/1 98/3 108/19 109/17 113/21 114/20 115/17 116/25 117/15 121/20 122/13 125/9 127/1 128/20 133/7 133/7 133/24 151/15 153/12 156/18 156/20 157/21 160/12 160/23 161/11 162/22 163/7 165/10 166/21 167/9 167/11 171/14 174/4 177/14 183/4 184/21
**use [8]** 61/16 67/6 102/16 107/14 124/22 124/24 142/1 155/10
**used [17]** 37/12 48/12 67/10 67/11 67/12 96/13 97/2 105/14 105/20 112/2 118/13 124/21 142/4 168/13 169/20 173/7 179/19
**useful [5]** 35/21 41/12 104/10 147/25 148/1
**using [5]** 43/17 95/22 96/1 96/11 142/11
**usual [1]** 34/21
**usually [3]** 5/24 9/11 32/21
**utmost [1]** 138/13

## V

**vague [1]** 39/19
**validation [1]** 175/2
**value [2]** 56/7 56/8
**valued [1]** 85/9
**values [1]** 79/16
**varied [1]** 6/4
**vary [1]** 9/5
**ventilated [1]** 91/19
**ventilating [1]** 140/16
**ventilator [1]** 143/16
**verbally [1]** 13/14
**versa [1]** 155/17
**version [1]** 56/20
**very [80]** 2/8 4/19 8/9 12/21 18/11 18/22 22/3 22/13 24/4 25/9 27/3 32/15 38/18 46/23 49/9 50/15 52/16 52/16 52/18 58/15 59/16 64/18 66/8 69/8 73/4 75/22 76/6 77/9 77/12 78/23 79/3 80/8 81/2 81/2 81/7 81/9 82/15 82/15 82/23 83/13 84/6 86/21 87/3 87/4 87/8 91/24 92/16 94/12 96/11 97/1 97/1 97/1 97/2 100/9 102/24 106/4 112/11 113/13 117/19 118/15 120/25 132/25 133/5 135/10 140/14 143/9 145/14 148/18 148/18 149/11 151/14 152/6 152/16 155/23 169/17 173/2 175/25 180/7 186/6 186/10
**via [3]** 13/14 30/18 58/1
**vice [1]** 155/17
**vice versa [1]** 155/17
**vicinity [1]** 100/23
**view [3]** 4/20 30/21 85/13
**viewpoint [1]** 170/12
**views [2]** 14/16 19/8
**violence [1]** 67/23
**visible [4]** 10/5 10/23 17/14 86/5
**visit [6]** 57/20 116/3 127/3 177/15 177/23 179/1
**visited [1]** 15/19
**visiting [3]** 15/22 16/4 16/16
**visits [5]** 8/23 84/14 84/21 87/20 163/24
**voice [2]** 46/1 175/6
**vomit [1]** 107/15
**vulnerable [3]** 135/12 169/5 169/8

## W

**wait [3]** 88/11 110/1 157/2
**waiting [2]** 1/6 151/25
**wake [1]** 71/23
**walk [2]** 16/7 110/2
**walked [3]** 23/4 109/21 111/25
**walking [3]** 28/21 53/18 110/13
**want [44]** 3/21 13/3 24/23 24/24 24/25 25/11 33/18 38/11 46/2 68/5 68/17 70/11 70/12 72/25 77/22 91/6 96/17 99/15 104/4 106/9 123/14 132/16 134/16 134/18 142/2 157/7 162/25 164/13 164/19 169/11 169/25 170/13 172/16 175/4 177/23 183/5 183/21 183/25 184/10 184/14 184/14 184/15 185/8 185/12
**wanted [17]** 10/6 18/14 18/17 25/6 28/17 35/3 60/25 63/21 71/4 95/7 131/22 132/5 132/13 146/25 162/19 164/9 183/20
**wanting [4]** 12/22 12/25 93/13 161/8
**wants [2]** 169/12 170/1
**ward [52]** 8/19 8/22 8/24 9/1 9/4 9/4 9/5 12/1 12/2 32/13 59/20 66/11 66/12 80/15 81/3 83/1 86/3 86/6 87/6 88/13 94/20 94/22 104/4 105/15 105/16 126/11 142/9 153/25 154/1 154/6 154/9 154/12 154/15 154/21 154/24 155/8 155/10 155/12 155/25 166/3 166/9 166/15 168/4 170/19 171/11 174/1 174/22 180/7 180/14 180/14 183/3 184/4
**wards [1]** 155/9
**was [786]**
**was February 2016 [1]** 178/12
**wasn't [69]** 5/15 13/12 13/22 13/22 15/13 21/24 23/3 27/12 29/10 34/3 34/23 35/1 40/4 42/15 48/11 53/11 53/22 55/24 57/9 57/19 59/20 60/21 60/24 64/14 64/17 66/10 68/5 68/15 70/20 74/13 81/6 86/2 87/22 94/5 97/23 100/8 102/1 106/10 110/7 110/14 110/14 112/5 112/13 112/18 117/8 118/2 119/17 121/23 129/2 130/8 133/20 141/17 143/10 144/16 147/25 150/18 157/9 157/16 157/18 158/9 159/3 159/8 160/9 162/7 175/23 181/13 182/10 183/16 184/23
**waste [1]** 127/7
**watch [1]** 172/21
**water [2]** 118/22 121/15
**way [32]** 9/7 18/8 20/10 24/6 34/8 37/1 46/17 46/21 47/2 48/12 71/21 86/10 98/18 99/1 99/3 102/10 104/9 107/14 110/4 110/7 122/4 124/12 128/15 137/16 145/23 157/3 158/7 160/11 163/11 164/6 167/17 179/7
**ways [2]** 19/17 137/10
**we [260]**
**we'd [2]** 40/14 112/25
**we're [6]** 15/7 22/23 32/18 43/17 53/25 166/21
**we've [4]** 39/22 45/19 48/2 122/12
**Wednesday [1]** 9/8
**Wednesdays [1]** 9/1
**week [9]** 75/3 77/2 77/5 77/23 86/2 94/23 101/8 101/13 171/10
**weekend [2]** 9/2 9/3
**weeks [7]** 17/2 77/24 100/24 156/17 164/24 165/3 177/9
**weight [1]** 158/11
**weird [5]** 43/5 43/13 43/21 43/21 43/22
**welcome [1]** 87/4
**well [50]** 11/8 26/7 28/9 28/13 34/7 38/17 44/6 44/10 57/19 60/7 62/21 64/22 65/16 69/22 71/1 76/14 82/23 86/4 88/3 89/24 90/12 91/25 94/17 97/19 98/17 101/3 101/22 102/13 104/19 108/22 110/9 123/3 123/9 124/3 126/9 131/11 135/21 136/15 143/18 146/13 152/11 158/15 159/15 162/15 163/5 164/7 166/10 169/22 173/10 177/18
**well-being [2]** 101/3 135/21
**went [23]** 9/23 28/16 33/10 38/13 46/8 46/13 47/22 48/4 76/4 80/2 86/12 90/8 115/1 119/10 121/7 121/10 124/4 129/4 145/22 145/24 157/19 171/12 173/15
**were [305]**
**weren't [28]** 10/2 10/5 10/7 10/12 10/22 14/18 15/11 22/8 29/16 32/11 36/15 47/1 55/23 65/10 86/4 97/3 99/5 102/3 115/7 116/5 119/4 133/18 161/25 164/8 165/15 176/22 179/12 181/16
**West [1]** 75/25
**what [243]**
**what's [10]** 26/11 36/11 69/24 83/23 90/22 127/2 131/15 132/22 146/17 172/12
**whatever [6]** 28/25 36/21 71/16 72/10 86/12 103/18
**WhatsApp [1]** 180/10
**whatsoever [1]** 105/19
**when [151]** 4/11 4/11 4/17 4/17 5/13 7/14 7/15 7/17 9/15 13/5 13/8 13/11 14/20 15/4 15/12 16/19 16/20 17/15 18/12 19/4 20/6 22/15 23/5 23/6 23/13 25/16 25/22 28/3 30/4 31/3 31/25 32/5 32/6 34/11 37/21 38/5 42/15 43/7 44/4 44/8 45/13 45/25 46/17 49/5 50/3 51/5 52/6 53/10 53/11 53/17 55/21 56/6 58/1 58/8 59/5 60/5 61/16 62/3 63/16 64/11 64/13 68/3 68/18 74/19 75/7 76/23 77/23 78/3 78/22 82/25 87/4 88/22 89/21 96/19 96/21 97/3 101/7 101/25 102/20 103/13 106/25 107/5 108/22 108/23 108/24 109/11 109/21 110/8 112/4 113/4 113/18 113/22 114/9 114/9 114/12 114/23 117/16 119/2 119/9 119/11 119/14 119/20 120/7 120/23 121/1 124/15 126/7 127/13 129/2 129/4 129/4 130/7 134/22 135/6 140/23 140/25 142/3 145/9 145/25 146/11 154/13 155/1 155/13 155/19 158/3 158/23 159/15 160/5

## W

**when... [23]** 162/23 165/4 165/19 166/24 167/1 167/21 168/21 168/21 171/11 172/2 172/7 172/12 173/8 175/1 175/20 177/7 177/15 178/25 180/1 180/2 183/7 185/8 185/13
**where [53]** 3/25 17/17 18/2 25/9 25/14 25/25 29/1 32/8 32/17 34/10 37/14 39/19 39/20 43/3 50/17 67/10 68/6 70/10 78/4 89/5 89/12 90/16 100/4 101/1 102/22 102/22 103/8 105/14 105/16 106/11 106/16 106/20 107/25 108/2 108/5 109/16 109/19 109/19 112/25 125/20 131/19 135/25 143/2 148/21 150/2 159/9 162/14 166/2 169/17 169/25 174/2 183/1 185/10
**where's [1]** 107/3
**whereas [4]** 46/21 156/6 163/15 181/13
**wherever [2]** 32/13 87/10
**whether [41]** 7/3 7/5 7/6 19/4 19/5 31/15 31/21 32/11 39/15 40/18 40/19 40/22 41/3 48/25 60/22 63/1 63/1 63/4 67/15 68/21 69/21 71/1 74/6 91/16 101/9 102/6 107/20 114/25 115/1 115/22 117/2 129/16 134/4 139/10 140/7 141/20 148/15 150/20 152/20 163/2 172/19
**which [51]** 1/6 6/16 6/22 15/8 19/17 27/8 29/21 31/9 35/2 37/7 52/13 55/18 56/23 60/3 74/9 76/5 76/5 76/17 76/20 81/25 84/11 90/23 91/10 92/19 94/12 95/11 98/17 102/19 111/15 111/22 124/18 127/21 128/12 131/19 137/17 140/15 142/6 152/12 153/7 154/7 157/3 164/15 168/7 174/13 175/12 175/19 176/4 176/7 176/9 176/12 178/20
**while [6]** 69/15 130/19 133/12 140/23 156/15 186/7
**whilst [7]** 49/6 62/13 93/18 130/10 165/7 166/15 178/21
**white [2]** 27/7 45/9
**who [55]** 5/25 6/15 6/16 8/16 11/20 11/20 13/6 15/18 16/2 17/6 20/11 21/4 35/9 46/8 53/10 53/23 55/11 57/6 60/17 67/19 76/13 80/14 82/10 83/6 87/15 89/16 90/17 90/20 90/22 95/25 104/21 109/14 111/19 118/1 118/1 123/6 127/2 127/22 128/1 130/19 131/3 135/11 137/20 138/24 140/5 144/2 146/8 147/9 161/19 173/16 174/9 180/15 181/6 183/14 183/16
**who's [1]** 107/10
**whoever [4]** 80/16 106/18 138/25 139/9
**whole [7]** 12/2 17/25 19/6 78/5 119/15 160/2 176/11
**whose [1]** 135/4
**why [32]** 13/7 18/7 18/9 19/13 20/9 21/24 22/1 25/6 36/5 36/19 42/14 47/4 50/3 50/9 55/11 60/16 60/19 86/17 93/7 94/3 102/8 104/14 112/18 114/2 133/17 138/9 139/14 142/17 143/8 143/8 175/22 184/20
**Why's [1]** 100/18
**wider [1]** 102/24
**will [29]** 24/12 24/14 85/17 87/17 99/2 99/18 99/22 99/25 100/4 104/16 104/17 105/1 105/17 106/2 111/6 113/6 118/24 118/25 120/18 120/19 124/22 125/22 127/15 128/8 131/8 151/20 161/13 166/23 172/6
**willing [1]** 130/2
**wise [1]** 8/13
**wish [2]** 84/12 128/7
**wished [1]** 35/9
**within [53]** 15/18 39/6 44/9 75/2 75/23 76/12 76/15 85/23 89/7 94/1 97/19 100/23 102/1 103/25 105/2 105/3 105/8 105/20 107/3 107/16 110/13 113/2 113/23 114/1 114/8 114/16 115/25 116/8 123/5 124/17 124/20 124/23 124/23 125/3 125/23 127/8 127/20 128/21 128/22 128/24 129/1 129/7 132/6 132/12 133/2 139/24 142/7 142/11 143/12 153/5 153/6 155/9 155/14
**without [10]** 10/14 67/13 71/18 80/20 84/5 105/23 133/6 161/23 166/14 183/23
**witness [11]** 1/18 3/14 73/9 89/15 134/25 135/23 136/24 139/19 140/20 152/3 172/12
**witnessed [4]** 36/13 80/22 100/16 114/25
**Women's [2]** 150/25 162/23
**won't [4]** 104/15 123/24 124/2 157/21
**wonder [3]** 64/22 67/8 67/15
**wondered [1]** 71/4
**wondering [1]** 159/9
**word [9]** 13/10 43/15 48/12 61/16 66/7 105/22 118/13 141/15 146/14
**wording [1]** 96/8
**words [18]** 3/22 25/2 29/5 38/5 39/1 48/7 58/9 59/7 62/20 78/20 79/8 86/23 94/7 94/7 94/8 97/2 128/20 129/10
**wore [1]** 82/22
**work [35]** 4/4 11/15 11/18 11/19 11/21 12/1 13/25 19/4 21/23 25/21 25/24 37/7 51/10 57/18 57/19 59/21 72/15 72/19 74/22 74/24 75/1 76/22 77/2 77/6 79/13 85/4 110/10 121/1 125/8 131/11 137/10 137/11 137/11 139/6 156/1
**worked [13]** 4/6 11/8 11/17 12/24 20/6 49/6 49/14 74/23 75/6 80/14 153/17 154/24 155/19
**workers [1]** 156/5
**working [46]** 16/10 20/16 23/11 26/21 26/23 27/2 27/5 27/13 27/15 28/3 32/19 52/14 62/12 63/22 66/10 66/12 74/1 74/16 75/12 76/23 76/24 76/25 77/23 79/20 81/24 100/8 100/22 105/2 105/8 117/20 120/8 129/25 130/14 143/10 143/11 153/23 154/4 154/9 154/13 155/22 156/8 170/8 174/5 178/21 183/3 183/7
**workload [3]** 86/4 139/12 156/11
**worried [7]** 50/25 74/20 86/9 86/10 121/1 121/6 140/8
**worries [1]** 140/10
**worry [2]** 3/17 63/12
**worrying [1]** 39/3
**worse [1]** 172/23
**worst [1]** 106/12
**would [242]**
**wouldn't [32]** 5/18 8/5 19/6 19/10 20/21 25/14 40/15 65/18 67/5 68/21 78/6 78/6 81/19 82/21 97/15 103/11 105/6 105/10 106/14 123/14 137/13 146/14 159/4 162/12 165/2 169/22 170/20 170/20 176/11 178/4 180/19 180/21
**wrapped [1]** 148/23
**write [1]** 129/9
**writing [1]** 29/1
**written [9]** 80/19 87/2 94/8 94/8 133/8 137/24 140/24 147/17 148/3
**wrong [8]** 20/25 25/21 31/20 33/16 65/7 65/9 68/6 121/15

## Y

**Yeah [2]** 10/20 65/7
**year [23]** 2/2 2/18 2/22 3/2 3/3 3/5 3/6 4/12 4/18 22/5 22/14 72/14 77/19 78/22 79/5 83/8 83/9 83/11 118/4 118/12 125/3 132/3 164/15
**year's [3]** 77/14 82/24 83/2
**yearly [1]** 142/9
**years [26]** 19/21 19/21 22/9 30/25 36/12 41/1 47/11 48/8 48/9 76/3 77/17 77/18 79/20 84/1 84/10 84/11 104/1 107/13 109/5 125/1 132/5 133/23 142/7 142/8 168/22 179/10
**years' [1]** 77/14
**yes [240]**
**yet [1]** 67/12
**you [1164]**
**you'll [1]** 113/17
**you're [8]** 15/22 33/5 47/19 47/20 48/24 83/23 142/13 172/8
**you've [7]** 1/18 44/4 47/8 67/2 89/2 96/16 172/10
**your [128]** 1/20 2/4 3/8 3/13 4/20 5/5 5/6 6/5 9/12 11/4 11/7 11/12 11/22 14/11 14/16 15/14 16/11 16/16 17/6 21/21 24/13 26/8 26/11 27/25 28/2 30/2 34/17 35/25 36/1 38/7 38/8 38/10 39/5 40/8 42/11 43/7 46/12 47/9 47/14 47/19 47/24 48/21 51/8 51/11 52/8 60/5 60/16 61/19 62/8 65/13 65/16 65/17 65/23 66/3 70/24 72/21 73/4 74/19 74/21 76/4 79/13 81/10 81/11 85/12 86/7 86/16 88/16 89/23 90/17 93/25 96/16 100/5 100/8 103/22 103/22 103/23 104/5 105/25 106/9 106/14 108/15 108/19 109/20 109/20 110/17 111/14 116/16 116/20 118/5 118/18 118/25 119/14 120/22 124/8 127/1 127/1 127/2 127/3 128/3 128/20 132/22 134/25 135/23 136/8 136/24 136/24 136/25 137/16 138/15 138/18 144/2 146/12 150/11 153/4 154/1 155/25 156/13 160/19 165/9 165/18 168/18 168/18 169/25 171/15 173/23 177/14 184/18 185/2
**your February [1]** 168/18
**yourself [4]** 79/13 98/2 138/5 176/5
**Yvonne [33]** 17/8 20/11 20/11 55/13 55/19 55/21 56/1 58/3 58/5 58/6 58/18 59/1 59/5 60/8 60/12 60/22

## Y

**Yvonne... [17]** 69/11 69/19 69/22 78/25 81/18 82/1 82/1 82/4 82/6 82/6 84/25 123/18 160/13 160/20 160/22 161/1 161/25
**Yvonne Farmer [2]** 84/25 161/25
**Yvonne Griffiths [12]** 17/8 55/13 56/1 58/3 58/5 58/6 59/1 59/5 69/11 81/18 82/1 123/18

## Z

**Za [1]** 63/4
**ZC [9]** 152/3 152/4 152/14 152/19 153/2 176/17 186/2 186/6 187/9
**Zero [1]** 125/12