

Wednesday, 2 October 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Good morning.
Ms Langdale.

MS LANGDALE: My Lady, may I call Dr Lambie.

DR RACHEL LAMBIE (affirmed)

Questioned by MS LANGDALE

LADY JUSTICE THIRLWALL: Do sit down, Dr Lambie,
thank you for coming.

MS LANGDALE: Can you give us your name and
qualifications?

A. My name is Dr Rachel Lambie and I am
a community paediatric Consultant.

Q. Dr Lambie, you helpfully provided the Inquiry
with a statement dated 28 June 2024, do you have that
with you?

A. I do.

Q. Can you confirm for us that the contents are
true and accurate as far as you are concerned?

A. Yes, I can.

Q. You are one of a number of Registrars or at
least Registrars at the time of the event we are looking
at giving evidence today. Can you tell us firstly what
being a Registrar involves, the rotations, shifts, how
it works and what you are doing now?

1

Q. The paediatrics, is that what they call the
children's unit?

A. Children's unit, yes.

Q. So children and neonate. So you have
experience of both units or wards?

A. Yes, as part of your training as well.

Q. If you go to your statement at paragraph 5, we
asked you about the culture and atmosphere of the
neonatal unit in 2015 to 2016. What do you say about
that?

A. So I felt the culture was very positive.
I was asked very specifically the relationships between
different people. So personally I thought the
relationship between the junior doctors and the
Consultants was very open, very supportive. I also
found the relationship between the nursing staff and the
junior doctors very open and supportive as well.

Q. You say at paragraph 6:

"I recall the Consultants routinely seeking the
nursing staff's opinions and views on the children's
care and welfare."

Is that on the children's unit or the neonatal unit
as well?

A. Both, on the neonatal unit as well,
I particularly remember it in Chester, if they were

3

A. So a Registrar is coming towards the end of
your training as a junior doctor. So I had completed
a more old-fashioned style of training so I was a house
officer and a senior house officer and then moved on to
Registrar.

The training changed and that renamed us ST, so
I was what's known as an ST6, which is a middle grade
Registrar. So my role in Chester would have been
immediately below the Consultant, so if there is no
Consultant on shift I would have been the most senior
doctor in that department.

My role would have been to look after the children
and the babies but also I was responsible for the house
officers and the SHOs below me and then I was also
responsible to the Consultants on-call for that day.

Q. You worked at the Countess of Chester
27 April 2015 until 1 September 2015?

A. Yes.

Q. So what wards or units did you rotate amongst
in that role?

A. During that time? What was called cross
cover, so for Chester you covered paediatrics and
neonates. So during the daytime you were either one or
the other, but on-call you would cover both. So during
a nightshift, for example, you cross covered both.

2

doing a ward round it was quite normal for the
Consultant to actively seek the opinion of the nurses
which in my experience you didn't always see. I have
worked in a number of different units, Chester did stand
out as one where that relationship was particularly
prominent.

Q. How regularly were those Consultant ward
rounds taking place?

A. Every day.

Q. Every day, once a day?

A. I would have thought so. I can't recall
exactly. But at least once a day, I would have expected
them to have been once a day.

Q. Did you always attend those when you were on
shift?

A. If -- I would be expected to, yes, there might
have been an occasion where I was called away, so again
you are part of a wider team so if during a ward round
there is an incident somewhere else, I might be asked to
go and care for that child or baby but then I would
always attempt to return to that ward round. But
I would be part of the normal ward round team, yes.

Q. You say there was:

"... an overall positive training culture where
junior doctors spoke openly with their Consultants"?

4

1 A. Yes, very much so.

2 Q. So could you tell them if you were a bit
3 fearful about doing something new or worried about how
4 it was going on?

5 A. Yes. As a general -- as a group of
6 Consultants, yes.

7 Q. You do say the relationship between the
8 midwives and nursing staff and clinicians could be more
9 difficult at times and you would describe as a frequent
10 experience of hostility directed from members of
11 midwifery staff towards medical and nursing staff?

12 A. Yes.

13 Q. Can you expand upon that, what are examples of
14 that hostility?

15 A. I want to make it clear that I didn't find
16 that any different to or particularly different at any
17 other unit that I have worked on in the country.

18 In my personal experience I found that quite
19 commonly that there was some difficult relationship
20 between the midwifery, particularly if they were asking
21 for medical support. The impression I personally had is
22 it was almost seen as a failure that something had gone
23 wrong for us to be called, which obviously was not
24 always the case.

25 **LADY JUSTICE THIRLWALL:** Seen as a failure by whom?

5

1 A. No, I wouldn't have expected hostility there.

2 It was -- the hostility I personally perceived was very
3 much if you were called for an acute situation. So if
4 you were called to the midwifery team or obstetrics to
5 help with a baby it was not uncommon for there to be --
6 it wasn't every single time but it wasn't unusual for
7 there to have been some hostility, almost the feeling
8 that you weren't welcome that something had gone wrong
9 that you shouldn't be there. It was always seen as
10 a negative.

11 Q. You do say:

12 "I did not feel that this impacted on the quality
13 of care delivered to the babies on the NNU"?

14 A. No.

15 Q. Can you be confident of that?

16 A. I can only be confident of my perception. So
17 personally, no, I can't think of an instance where there
18 was a delay in calling us, for example, which would be
19 one time that I think that might have impacted. I can't
20 say I have experienced that. It was very much a -- it
21 made communication a little bit more challenging at
22 times, but not in a way that I felt would have impacted
23 the care of any of the babies in my experience, no.

24 Q. You say at paragraph 8 you:

25 "... recall being aware of increasing levels of

7

1 A. By the midwife, but that's my perception. So
2 in my experience it was not uncommon to have an air of
3 difficulty between -- between the two teams.

4 **MS LANGDALE:** You do describe it as a frequent
5 experience of hostility, which isn't the same as them
6 feeling perhaps disappointed at asking for medical
7 assistance. What did you mean by "hostility"?

8 A. Again it's my perception but, yes, hostility
9 is the best way I can describe it. It was --
10 I perceived it as a feeling of failure that you weren't
11 really wanted, that if the medics were there that was --
12 that was seen as a bad thing even though it wasn't. We
13 were there to very much support and offer our expertise.

14 Q. You say that's in common with your experience
15 in other hospitals; that wasn't unique to Chester?

16 A. Yes, I wouldn't have said Chester was
17 different.

18 Q. What about the levels of communication? We
19 have heard from parents of babies named on the
20 indictment that they would have to rely on midwives
21 perhaps to take them down to the neonatal unit and phone
22 calls being made between neonatal staff and the midwives
23 to help the post-caesarean section mother get down to
24 the unit. Are you saying those -- what would expect
25 interest that kind of interaction, that that would be --

6

1 anxiety following the death of Child A and collapse of
2 Child B soon afterwards largely due to the unexpected
3 and similar natures of their collapses and the
4 appearance of the unusual rash."

5 And you say:

6 "As ... babies become unexpectedly seriously ill,
7 (collapsed) or died, I recall medical and nursing staff
8 reporting to each other they were nervous at the start
9 of their shifts."

10 I am going to ask you about Babies A and B first
11 and then come back to that, if I may, and what your
12 level of concern was at that time?

13 A. (Nods)

14 Q. Dealing with Baby A you set out from
15 paragraph 9, can you tell us when you were called to
16 Baby A?

17 A. So Baby A was at the start of my nightshift so
18 I was not on the unit. From memory I would have been in
19 handover and there was a crash call put out so I would
20 have been very close to the neonatal unit, most likely
21 on the paediatric ward which is immediately next door,
22 so I would have arrived within a few minutes at most and
23 from recollection, CPR, cardiopulmonary resuscitation,
24 was already under way and I attended very much to
25 assist. CPR was being led by my colleague. I can't

8

1 recall whether I took part in the airway or the cardiac
2 side of things.

3 But I do remember assisting for a very short period
4 of time until my Consultant or Consultants arrived.

5 **Q.** You say you recall Dr Harkness and Dr Jayaram
6 being present and another doctor writing down events,
7 a designated scribe, you call this?

8 **A.** Yes, so Dr Harkness was my Registrar colleague
9 who was leading the event. He was with the child when
10 they became unwell, and Dr Jayaram was the Consultant
11 who called in, who attended very quickly.

12 **Q.** You we know gave the handover the next day to
13 Dr Ogden. Can I ask, please, to Ms Killingback, if we
14 can have on screen, Dr Ogden's statement which is
15 reference 0102019, page 3. So 0102019, page 3.

16 It is paragraph 12. Scroll down to paragraph 12:

17 "We were informed in the handover the next day by
18 Dr Lambie (Paediatric Registrar) about Child A's death.
19 I was surprised. I do not recall the details of exactly
20 what we were told in that handover other than he had
21 died. I don't recall specifically who else was in the
22 handover that morning or whether there was any further
23 discussion but the morning handovers were normally
24 attended by the day and night medical teams."

25 He continues:

9

1 Dr Harkness in particular?

2 **Q.** With any of them, either that night or the
3 next day about the unexpected nature of Child A's death?

4 **A.** Not the following morning. I do recall
5 speaking with Dr Harkness after Child B had collapsed.
6 I can't remember exactly when that was but it was
7 certainly within a few days because we were both very
8 concerned about the similar nature of the collapse but
9 particularly the unusual rash that neither of us had
10 seen before.

11 The children were also in very close proximity to
12 each other, so we did discuss those concerns, were they
13 related.

14 **Q.** Paragraph 14 of your statement, you detail
15 your involvement in the care of Child B?

16 **A.** Yes.

17 **Q.** Can you tell us about that?

18 **A.** Yes, so again it was -- so this was the
19 following night, I was on nights, the second night of
20 the night shift. It was soon after midnight. I had
21 a crash call, so a very urgent bleep to attend to the
22 unit and I was informed that Child B was having
23 difficulty breathing and was having support -- was being
24 given support for her breathing.

25 I had been made aware that she had been well

11

1 "It came completely out the blue. I was surprised
2 by his death. I didn't expect him when I left on 8 June
3 to die that same day."

4 Do you remember, does that refresh your memory of
5 the handover and the discussions that you had or?

6 **A.** I don't recall that particular handover in
7 detail but what she has written would -- would make
8 sense, that is what would normally have happened. So
9 I would have handed over everything that had happened
10 the night before to the day team including any patients
11 that were due to come in, but certainly a significant
12 event of that nature, yes, I would have handed it over
13 to the day team.

14 **Q.** We know from his statement your colleague
15 Dr Harkness, I think, had to take some time off, he
16 found that very upsetting, didn't he, that death?

17 **A.** Yes.

18 **Q.** Various witnesses, Nurse Taylor, Nurse
19 Bennion, Nurse T, Dr Harkness, have given statements to
20 the Inquiry about their surprise at that death and it
21 was certainly unexpected, Dr Harkness says. Do you
22 remember the discussion that morning about that or did
23 that happen subsequently, the discussion about it being
24 unexpected?

25 **A.** Sorry, do you mean the discussion I had with

10

1 beforehand, she was not highlighted to me as a child
2 that I needed to be particularly worried about, for her
3 in particular. She was covered in a very unusual rash,
4 the only way I can describe it a Registrar that we
5 sometimes see with children a condition called
6 meningococcal septicaemia, it is a very blotchy rash,
7 but that diagnosis didn't fit in this situation so
8 nothing made sense.

9 **Q.** Why not?

10 **A.** The rash didn't look exactly the same, the
11 rash was moving which isn't what tends to happen with
12 a child with meningococcal sepsis, children with
13 meningococcal sepsis tend to be -- not always, but tend
14 to be -- don't become so acutely ill so quickly.

15 She also responded remarkably quickly which is not
16 the case for children with meningococcal sepsis.

17 So there were lots of factors that didn't make
18 sense.

19 **Q.** You say at paragraph 15 you didn't fully
20 understand why she had collapsed and you were concerned
21 that she could deteriorate quickly again because you
22 didn't know why it happened?

23 **A.** Absolutely, it wasn't an obvious it wasn't a
24 spot diagnosis, there wasn't a single event that I could
25 pin everything on which meant that I didn't know how she

12

1 was then going to react to the treatment I was giving
 2 her or whether she would then go on to deteriorate. If
 3 this was an unusual infection or a contamination,
 4 something like that, it could -- she could potentially
 5 deteriorate again, so I was very keen to make her as
 6 safe as possible which is why I screened her and treated
 7 her as if it was an infection as generically as
 8 possible. I made sure she was placed on a ventilator so
 9 I had full control of her breathing, I gave her
 10 morphine, which is what we do for children who we
 11 anticipate to be a ventilator for a more prolonged
 12 period of time. So I was trying to safeguard her as
 13 much as a possible in case she then deteriorated again.

14 **Q.** Letby's evidence at the criminal trial was
 15 that at the collapse of B she says she was joined by
 16 Rachel Lambie and was asked to get the unit camera to
 17 take a photo of the colour change.

18 Do you remember you or indeed anyone else at the
 19 resuscitation scene asking Letby to get a camera to take
 20 a photo?

21 **A.** No, I don't and it's not something that
 22 I would routinely do. It would be -- I can't think of
 23 an example and it would have to be an exceptional
 24 circumstance for me to ask anyone to step away from
 25 an active resuscitation to the point where I can't think

13

1 similarity that raised that concern with you?

2 **A.** Yes. So I can't recall -- I honestly can't
 3 recall whether I knew about the rash when Child B
 4 collapsed. I think I must have but I don't -- I don't
 5 recall.

6 **Q.** Just pausing there, you tell us you don't
 7 remember seeing it on Child A yourself or clocking it,
 8 if you like?

9 **A.** No, no, I don't think I saw it on Child A and
 10 I can't recall whether that was discussed in particular.
 11 I suspect it was, but I don't -- I certainly didn't go
 12 into Child B's collapse thinking "oh, this rash looks
 13 similar", that was the first time I had seen that rash
 14 was on Child B. But I do recall talking to Dr Harkness
 15 in particular but other members of staff, nursing and
 16 medical, soon afterwards about the similar nature of the
 17 two babies.

18 **Q.** You say at paragraph 18:

19 "I was concerned that they were geographically
 20 close to each other and wondered if there could be
 21 a link, such as an infection that both children carried,
 22 or could be in the environment or some form of product
 23 contamination. I recall discussing this with the
 24 Consultant the following morning, particularly the
 25 similar rash ..."

15

1 of an example where I would do that.

2 It was also -- the rash was also moving, it was
 3 very brief. So no, I don't recall asking Lucy Letby or
 4 anybody to either step away from the resuscitation or to
 5 get a camera.

6 **Q.** Was the rash and its unusualness being
 7 discussed between you all at the time?

8 **A.** When mean at the time?

9 **Q.** When you were with Child B and you could see
 10 it?

11 **A.** So I recall the nurse that was with Child B
 12 saying to me: this is the same thing that happened to
 13 Child A yesterday and recalling that the rash was the
 14 same.

15 **Q.** So one of the nurses on duty with you said
 16 that at the time?

17 **A.** Yes, one of the nurses that was present with
 18 me during the resuscitation I remember them saying: oh
 19 no, this is what happened yesterday or last night and
 20 the rash was similar, that was mentioned, yes.

21 **Q.** At paragraph 18 you explain:

22 "I was concerned that there may have been a link
 23 between the collapse of Child A and Child B primarily
 24 due to the recurrence of the unusual rash."

25 So it was your colleague that had pointed out the

14

1 **A.** Yes.

2 **Q.** Which Consultant was that, Dr Newby or
 3 a different one? We know you speak to Dr Newby later?

4 **A.** Yes, that was later. I would need to check
 5 the medical notes to be certain but I believe it was
 6 Dr Saladi that was -- it was the daytime Consultant.

7 **Q.** So you were raising your concerns to
 8 Dr Saladi, you also did with Dr Newby?

9 **A.** So Dr Newby was later, Dr Newby -- would you
 10 like me to talk about that?

11 **Q.** Yes, please tell us?

12 **A.** So I recall Dr Newby coming to find me, it was
 13 days or weeks later. She came to find me and I believe
 14 it was in the coffee room, it was not a formal sit-down
 15 conversation, she came to find me specifically to ask me
 16 about the rash.

17 She had either heard about a similar incident or
 18 been involved in a similar incident and was very keen to
 19 speak to me firsthand and ask me to describe the rash,
 20 I do recall that. But that was some time afterwards.

21 **Q.** You tell us at paragraph 20:

22 "I recall her [that's Dr Newby] that's Dr Newby
 23 telling me that this was being discussed amongst
 24 Consultant colleagues who were aware of, and shared,
 25 concerns raised by junior staff and nursing colleagues

16

1 as outlined above".

2 So you understood the Consultants were sharing
3 those concerns?

4 **A.** Yes, and I raised my concerns with the
5 Consultants a number of times and each time I had a very
6 positive response and I was very much under the
7 impression that they were listening, they shared our
8 concerns and they were being dealt with.

9 **Q.** Indeed Dr Gibbs was taken to an email --
10 perhaps Ms Killingback, we can go to it, 0025743,
11 page 2. That's page 1, if we can go to page 2, thank
12 you.

13 Dr Lambie, you will see Dr Gibbs's email to his
14 fellow Consultants:

15 "Rachel Lambie came to see me this morning, I think
16 because I was the only person in the office when she
17 came, to say the Registrars were very concerned about
18 the recent neonatal deaths and collapses. Child B where
19 all the infants showed a strange purpuric looking rash
20 rash that probably wasn't true purpura ..."

21 And then he says:

22 "Although I have mentioned we are looking into
23 this, I am not sure exactly how this is being done but
24 I didn't say this to Rachel."

25 So pausing there. What did you say to Dr Gibbs and

17

1 already quite anxious going into Child A and B because
2 I had had that particularly unusual event.

3 **Q.** You have provided a statement to the police
4 about that event as well, have you?

5 **A.** Yes.

6 **Q.** I am not going to ask you about that.

7 So at this point you are worried about an earlier
8 incident and you are worried about A and B?

9 **A.** Yes.

10 **Q.** And we see you speak to Dr Gibbs on 23 June.

11 If we go to page 1 of that document, page 2 is currently
12 on screen, if we go back to page 1. We see there
13 Dr Lambie, an email from Dr Brearey to Consultants and
14 you can see he says:

15 "There is a PMM tomorrow afternoon."

16 I presume that's Perinatal Mortality Meeting?

17 **A.** Yes.

18 **Q.** "Please encourage all juniors and nurses to
19 attend and discuss in this forum rather than privately."

20 Were you ever invited to a Perinatal --

21 **A.** Yes, I would have been. I don't believe
22 I attended, I had a look at the minutes, I presume I was
23 on leave or on shift elsewhere. I am not quite sure but
24 I didn't attend that but yes, we would have been
25 routinely been invited to attend, we often presented at

19

1 was there any action described to you or not or just

2 a "we share your concerns"?

3 **A.** So I don't recall this specific conversation,
4 but I do recall speaking to a number of the Consultants
5 about my personal concerns and also expressing the
6 concerns of others because it was a topic of
7 conversation almost every day, particularly as we got
8 later into the events.

9 **Q.** Pausing there, you tell us about A and B and
10 we are only interested in the indictment babies, I think
11 you were also concerned about an earlier death --

12 **A.** Yes.

13 **Q.** -- as well, I don't want the details of that
14 as it is not on the indictment, but an earlier death;
15 was that right?

16 **A.** No, an earlier incident.

17 **Q.** Incident.

18 **A.** So there was a child that predated Child A by
19 about 10 to 14 days and again I would need to check the
20 medical records, I am pretty sure it was Dr Gibbs
21 I spoke to about that incident. It was a very, very
22 unusual incident, something I have never experienced
23 before or since.

24 That was immediately prior to -- well, 10 to
25 14 days before Child A. So I was already -- I was

18

1 them.

2 **Q.** Can you remember attending one where Child A
3 or B were discussed?

4 **A.** No, I believe that's the meeting that
5 I wasn't -- I didn't attend. I presume I was on leave
6 or on another shift, I am not sure --

7 **Q.** Do you remember being invited for one to
8 discuss those babies?

9 **A.** It wasn't -- it wasn't a case you were
10 formally invited, you were expected to attend. They
11 were month -- I am pretty sure they were monthly and it
12 was -- particularly as part of your training you were
13 expected to attend and as I said, we quite often were
14 asked to present. It was part of -- a recognised part
15 of our training.

16 **Q.** One record the Inquiry has found about
17 a clinicians' meeting, you are not there -- well, let me
18 take you to it. It's INQ0036166, page 1. This is
19 a meeting you can see Consultants Jayaram, Newby,
20 Saladi, Gibbs, Ann Murphy, I think she was head of
21 children's unit, wasn't she?

22 **A.** (Nods).

23 **Q.** Eirian Powell.

24 If we look at the second page, look at the middle
25 two paragraphs:

20

1 "Eirian also raised first of all as an aside
2 an issue that neonatal staff felt that parents were not
3 getting updates regularly enough from Consultant staff.
4 Bit of a debate around this, generally the Paed of the
5 week is available and if parents need to be updated the
6 nurses should be able to ask the Consultants to come
7 down. Consultant may not be free at a particular time
8 but clearly if there is a sick child it is anticipated
9 parents would be updated anyway. I have asked Eirian to
10 get the nurses to document specific examples where this
11 is happening. Consultants at the meeting were slightly
12 unclear as to what the issue was."

13 Were you aware of that kind of issue?

14 **A.** No, no, I wasn't, it was -- in my experience
15 it was common practice to speak with the parents on
16 occasions the parents were present during ward round and
17 certainly my memory is that was encouraged, particularly
18 for the very unwell children. It was not unusual for
19 families to phone during the daytime. It was slightly
20 dependent on how busy you were who would answer the
21 phone and it certainly was unusual personally for me to
22 say "I am in the middle of something at the moment but
23 I will contact them back" or maybe give a message to the
24 nurses to speak to them.

25 So I can imagine at times families would find that

21

1 **A.** Do you mean with myself?

2 **Q.** Yes, with yourself?

3 **A.** So I don't recall formal debrief for these
4 children. Again, in my experience, a formal debrief
5 tended to happen more often when there was a death or
6 a -- I was going to say unusual incident but yes, much
7 more with a death. If you had an acute deterioration,
8 I would sometimes expect a debrief if it was very
9 traumatic or there was a particular reason to do so.

10 But I would not -- I not wasn't surprised that
11 there wasn't a formal debrief for all of the children.
12 I don't know if there was a formal debrief for Child A.
13 I had very little involvement and as such I wouldn't
14 necessarily have been expected to have been invited to
15 the debrief. I would have expected that to focus more
16 on Dr Harkness and the other team that were more
17 involved. But for the other children, no.

18 **Q.** It looks like the clinicians' meeting on 29th
19 is only speaking of the deaths and Baby B is lost in
20 that, isn't it, because it is a focus on deaths?

21 **A.** That's also a Consultant meeting which as an
22 ST6, so a middle grade Registrar, I wouldn't have
23 expected to have been invited to. I don't know how it
24 worked in Chester, but certainly as you get closer to
25 finishing your training, I was in Leighton as an ST8,

23

1 difficult that we were not able to speak to them
2 immediately, but my experience was that as a team we
3 would always try and get back to them or speak to them
4 the following day.

5 **Q.** And if you look at the paragraph below that
6 one:

7 "There was also an issue raised around the fact
8 that with the three recent neonatal deaths the
9 Registrars had been quite worried and feel that nothing
10 is being done. Behind the scene reviews are going on
11 but it is felt formal debriefs should probably take
12 place rather than in a specific meeting to discuss all
13 three."

14 This is Monday, 29 June, so by then I take that to
15 mean the reference to A, C and D's deaths, the babies we
16 are concerned with. Were you aware what was being done
17 in terms of reviews or anything else that were looking
18 at deaths?

19 **A.** No, no.

20 **Q.** You of course -- and indeed you say you had
21 a concern about an earlier incident, a deterioration
22 incident, you were concerned about B's deterioration and
23 an earlier deterioration. Do you think those were
24 discussed formally, appropriately, to gather learning
25 from those events?

22

1 which is the final year, and as an ST8 I was regularly
2 invited to more management-led meetings or Consultant
3 meetings. I don't know if that happened at Leighton
4 because I was only an ST6, but I certainly wasn't
5 involved in those meetings.

6 **Q.** It looks like long after you had left the
7 Countess of Chester in April 2016, you were asked to
8 furnish a statement to the Coroner about Baby A. If
9 I can ask Ms Killingback for 0008894, page 1. Do we see
10 here that's page 1, if we go to page 2, a brief
11 statement prepared by you in April 2016, confirming the
12 notes and your involvement, such as it was with Baby A?

13 **A.** Yes.

14 **Q.** Can you remember who asked you to supply that,
15 what they sent you, what their request was?

16 **A.** No, not at all. Just looking at the date,
17 I would have been -- I left, I was working in
18 a different hospital at that point. I don't recall
19 being asked to produce this. I mean, I clearly did
20 looking at the information but I don't have direct
21 memory of it, no.

22 **Q.** It looks pretty perfunctory, doesn't it, just
23 a few facts, dates, et cetera?

24 **A.** Yes.

25 **Q.** One of the questions my Lady is examining in

24

1 the context of this Inquiry is the adequacy of
2 information provided to the Coroner and indeed how
3 that's put together by the unit in providing it. But it
4 sounds like you didn't really have a brief about what
5 you were required to send or what information you were
6 trying to provide?

7 **A.** Specifically related to the Coroner, no.

8 **Q.** No. Do you know as a matter of interest what
9 information the Coroner is interested in or should have?
10 It is not a test, by the way, you may not, I just ...

11 **A.** From the point of view of the Consultant or
12 the Registrar or just general?

13 **Q.** From a Coroner's point of view, what
14 information might be relevant to a Coroner?

15 **A.** So, I mean, the situation leading up to the
16 deterioration or deaths of the prior 24 hours, the
17 background to the case, you know, the detailed medical
18 background of that child. But also who was involved,
19 what was undertaken, so things like CPR can have, you
20 know, anatomical consequences. So they would need to
21 take that into account. But also it depends where the
22 death has happened: whether it is in hospital or out of
23 hospital.

24 **Q.** Of course one of the key issues might be
25 whether it is an unexpected death, an unexplained and
25

1 with A and B in particular being so close together? You
2 know, is there something in the immediate environment
3 that we are not aware of?

4 And then moving on from that, is there anything
5 else linking the two, such as TPN or feeding -- liquid
6 feed products or fluids? Is there a contamination in
7 the bag? Then you escalate through what becomes less
8 and less obvious or less and less common.

9 **Q.** You say at paragraph 23 when you left in
10 September 2015, you -- well, tell us what you set out
11 there?

12 **A.** So is this referring to ...

13 **Q.** The nursing staff in a small huddle?

14 **A.** So I remember towards the end when I left in
15 September, as I have already said we were discussing
16 about, you know, is there something going on that we
17 can't explain and I recall before I left walking through
18 the Intensive Care Unit and there was a huddle of nurses
19 in the corner over the computer and I asked what they
20 were doing and one of the nurses replied that they were
21 going through the rota just to make sure that there
22 wasn't somebody that was on for each one. I can't
23 recall precisely what she said, I am paraphrasing. But
24 it was very much: it is an awful thing to think, but we
25 are just looking.

27

1 unexpected death?

2 **A.** Yes.

3 **Q.** Can you remember when you were asked to put
4 that together -- you may not remember anything about it
5 -- whether that was something you were asked to comment
6 on or not?

7 **A.** I honestly can't remember.

8 **Q.** Okay. You say at paragraph 22: .

9 "As the number of unexpected events increased
10 (sudden collapses and deaths) I was concerned and spoke
11 to the Consultants at handover. I recall possible
12 causes being discussed between junior doctors and nurses
13 ..."

14 Can you tell us what those were? I think you have
15 to an extent, but I just want to see if that developed
16 as more deaths or events occurred?

17 **A.** Yes. So as a doctor, you are very much
18 trained to work through differential diagnosis, and you
19 would naturally go to what is common and then as you
20 decide that isn't the case, you would have to raise your
21 concerns to more unusual problems. And at this point,
22 I think everyone felt that the normal -- you couldn't
23 explain it through normal channels, so more unusual
24 events such as an unusual virus, is this an unusual
25 mould or fungus or some sort of infection, particularly
26

26

1 **Q.** So these were nurses?

2 **A.** Nurses specifically, yes.

3 **Q.** Specifically.

4 **A.** Neonatal nurses.

5 **Q.** Neonatal nurses. Do you remember which ones?

6 **A.** No, I don't.

7 **Q.** So a group of nurses trying to work out, were
8 they looking for the deaths?

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

10 **Q.** You don't know?

11 **A.** They were huddled over the computer and one of
12 the nurses said to me: we are looking through the rota
13 to see if anyone was on for all of them, and I don't
14 know what "them" they referred to in particular.

15 **Q.** And what did you say to that, if anything?

16 **A.** I don't recall saying anything. I remember
17 being quite shocked and thinking, you know, oh.
18 I agreed that it's an awful thing to think; I mean, it
19 is the unthinkable. But that's what they were
20 discussing.

21 **Q.** But by September 2015 it sounds like people
22 were thinking it. Thinking the unthinkable, there maybe
23 a link here with a person?

24 **A.** Yes, they were starting to think the
25 unthinkable.

28

1 Q. Were you at any time in your training made
2 aware of the case of Beverley Allitt and the murders in
3 Grantham?

4 A. Not within training. I was aware of it as
5 a public citizen from the news.

6 Q. So can you just tell me when you say "thinking
7 the unthinkable", can you just expand on that?

8 A. So for me personally "thinking the
9 unthinkable" in this case was that there might be
10 a person who's deliberately causing harm.

11 Q. So by their actions you are saying the nurses
12 were thinking about that by trying to look at a rota and
13 see who's there for these specific events?

14 A. It was starting to become part of their
15 thought processes yes.

16 Q. And you didn't ask which events they were
17 putting together for this?

18 A. No, I recall walking through -- I was in the
19 middle of a shift, I recall walking through the unit, so
20 I was working at the time.

21 Q. But you described to us as far as A,B and the
22 other incident you have referred to, it was the
23 unexpected and unusual nature of them that was
24 significant, it is not just that there was a death of
25 Child A, it was an unexpected death?

29

1 not as far as you are concerned, the Consultants were
2 aware of the rash on B being similar to the rash on A?

3 A. My impression was yes. If this -- does this
4 postdate when I spoke with Dr Newby? I am not sure of
5 the timeline.

6 Q. 2 July yes, it does. You speak to Dr Newby --

7 A. So they would have been, yes, as far as I am
8 aware, yes.

9 Q. We asked you at paragraph 27 about how deaths
10 are investigated in the neonatal unit and you say you
11 are not certain how they are investigated. What's your
12 sense now, what do you think -- you are a Consultant
13 now, are you?

14 A. I am a community paediatric Consultant which
15 is very different to an acute hospital Consultant. So
16 I don't have any experience as an acute hospital
17 Consultant having experienced something like this. So
18 I have never been involved in a child death as
19 a paediatric Consultant, so I am not overly familiar
20 with the processes.

21 Q. So when you were working there, you wouldn't
22 know what an unexpected death should trigger or events
23 in terms of referrals or generally?

24 A. Not in detail, no.

25 Q. When you say "not in detail", what did you

31

1 A. Yes, and the unusual nature of what we saw and
2 what I personally experienced.

3 Q. Did you understand, and you may not have
4 asked, that the task they were undertaking was simply
5 linking a person with deaths or was it following
6 specifically unexplained, unexpected events and seeing
7 if the person was there?

8 A. I don't know, I just recall them saying --
9 checking who was on for all of them, is how -- what
10 I remember them saying.

11 Q. You say in terms of review of deaths and
12 adverse events at paragraph 25, the review held on
13 2 July by Dr Brearey relating to the deaths of Child A,
14 C and D you weren't aware of that meeting or what was
15 discussed when those three babies were discussed?

16 Had you been there, you would have been able to
17 assist with the commonality of the rashes, wouldn't you,
18 between A and B?

19 A. It depends what you mean by "assist". They
20 were fully aware of my concerns and of my colleagues',
21 yes, I would have been very happy to have attended and
22 I would have been very happy to have described the
23 events again, but it would have been repeating what
24 I was very aware the Consultants already knew.

25 Q. So whether that meeting refers to Baby B or

30

1 think? You clearly raised your concerns with --

2 A. I was aware that the Coroner would be
3 informed, I was aware the parents would be informed and
4 I was aware that the Consultants would be discussing it
5 amongst themselves and my impression was raising that
6 through the normal processes through the hospital
7 management.

8 Q. When you were at the Countess of Chester, what
9 safeguarding training did you get either from the
10 hospital or generally?

11 A. So you have a mandatory induction when you
12 join any hospital and Chester was no different and part
13 of that is safeguarding training. It is from memory
14 generalised, but within our paediatric training, we have
15 paediatric-specific safeguarding training to our grade.
16 So the safeguarding training you have as a house
17 officer, an SHO, is slightly different to a Registrar
18 which is slightly different to a Consultant. It depends
19 what your level of experience is. And that's mandatory,
20 you have to do that and it's checked and monitored.

21 Q. Was it useful in the sense that you would know
22 who you had to go to talk to? Sometimes we know what
23 policies say, but we don't know who we have got to go
24 and talk to. So would you have known Dr Mittal, I will
25 tell him any concerns I have got or somebody else,

32

1 Paula Lewis, whoever it may have been, I don't know?

2 **A.** I mean, I probably would have known at the
3 time, just because I knew who the consultants were, but
4 my memory of working in Chester is such that I would
5 have felt happy to approach almost all the Consultants
6 so even if I didn't know who to go to specifically,
7 I would have been quite happy to have asked almost all
8 of them, you know: I have got these concerns, what do
9 I do, who do I speak to?

10 **Q.** Indeed we see that you do go to the
11 Consultants and say what you think?

12 **A.** Yes.

13 **Q.** You say that towards the end of your
14 placement -- going back in your statement to the very
15 beginning, you say: .

16 "As further babies became unexpectedly seriously
17 ill, I recall medical and nursing staff reporting to
18 each other that they were nervous at the start of their
19 shifts. I personally recall being nervous at the start
20 of a set of night shifts towards the end of my placement
21 as I was almost expecting something bad to happen."

22 **A.** Yes.

23 **Q.** I want to get to a sense of how widely this
24 was discussed, so it is not just you as a junior
25 Registrar, who else you are sharing this information

33

1 units in the hospital?

2 **A.** No, not in the hospital. So I spoke with
3 a doctor who didn't work at the hospital, just in an
4 anonymous way, just to express my concerns.

5 **Q.** When did you do that, what month roughly?

6 **A.** I think that was more towards the end, towards
7 the end of my placement.

8 **Q.** So I don't want the name of the person, you
9 did it anonymously anyway, was it a mentor or someone
10 else that you trusted or someone more senior, what was
11 the connection?

12 **A.** No, a medic that I trusted.

13 **Q.** A medic you trusted. So you took it on
14 yourself to speak with a medic you trusted on the phone
15 or meet with the, or? On the phone?

16 **A.** No, no, I met with them.

17 **Q.** You met with them. Tell us how that
18 conversation went?

19 **A.** So it was -- because it was something that was
20 playing on my mind a lot, that I spoke with him just to
21 not necessarily ask advice, but just to speak about my
22 concerns and as -- he is a medic but he is not
23 a paediatrician and he was able to appreciate that it
24 was an unusual series of events and was asking, you
25 know, what -- what is happening? Are you -- making sure

35

1 with and discussing with? So you are saying nurses on
2 the neonatal unit shared some of these concerns?

3 **A.** Yes.

4 **Q.** Who else? You say you spoke to someone out of
5 the unit once as well, another doctor that wasn't on the
6 unit?

7 **A.** Yes, so I certainly remember within the
8 hospital -- within our team at handover it was a regular
9 topic of conversation, at handover for a day or
10 a nightshift I remember on more than one occasion almost
11 the heartsink feeling of: oh, gosh, what's going to
12 happen today?

13 The unit felt -- I don't know if busier is the
14 right way to describe it but it felt different and there
15 was almost an air of anticipation of what's going to
16 happen.

17 **Q.** Were you doing night shifts mainly?

18 **A.** No, no, I was on a normal rota.

19 **Q.** But you say it was at nights?

20 **A.** I think I just gave that as an example.

21 **Q.** Okay, so you hadn't made a connection between
22 night shifts and what's happening in the day at all, it
23 is just --

24 **A.** Not at that point, no.

25 **Q.** Okay. So nurses on the ward, doctors in other

34

1 that I was raising concerns. It was more an ear to
2 speak to because it was -- it was a very significant
3 series of events in my lifetime.

4 **Q.** Did the prospect of the police becoming
5 involved --

6 **A.** At the very end of my placement, I do recall
7 having a conversation with him saying: it doesn't sound
8 like we are getting to the bottom of this, and they are
9 carrying on. We did discuss the it felt like
10 a hypothetical possibility that, yes, at some point we
11 might be needing to get the police involved. If we
12 can't suddenly find that there is a virus or there's
13 some contaminant or something, you know, we are getting
14 to the point where we might need to be considering
15 speaking to the police. That was more towards the end
16 of my placement.

17 **Q.** Was that with this person that you trusted
18 that you had that conversation?

19 **A.** Yes.

20 **Q.** So you didn't have that with Consultants in
21 the hospital?

22 **A.** No.

23 **Q.** Just the person you trusted to go to with your
24 worries?

25 **A.** Yes, it was very much a hypothetical

36

1 conversation of, you know: This is continuing to be
2 really unusual and I am very uncomfortable, as is
3 everyone else I am working with, rather than: this weird
4 thing happened and now it settled. It was persisting.

5 But again I need to stress that I was very aware
6 that everybody was talking about it and the Consultants
7 were listening and reporting back -- well, not reporting
8 back, but like Dr Newby coming to speak to me, there was
9 to and fro conversation.

10 **Q.** Do you remember when, if at all, when you were
11 there if Letby was mentioned by name?

12 **A.** Not to me, no.

13 **Q.** Who -- did you hear her name via somebody
14 else, someone else in the --

15 **A.** The first I was aware -- I don't recall when
16 that was first mentioned to me other than it was after
17 I had left so I believe it was when I was contacted by
18 the police to give a statement. Certainly I am very
19 clear that when I left in September, other than seeing
20 the nurses huddled overlooking at a rota it was never --
21 it was not suggested to me that it could be a single
22 person and the name Lucy Letby was not mentioned to me.

23 **Q.** Did you stay in touch with anyone that was
24 still working there who filled you in later on down the
25 road about anything or not?

37

1 and serious and that they were persisting and that at
2 that time we couldn't explain what was happening but
3 there was full appreciation that we needed to look into
4 what was causing these events, so this was not something
5 that could be dismissed.

6 **Q.** In your role, did you have any dealing with
7 the parents of Babies A and B or C, generally, to talk
8 about these events or not; would that have been somebody
9 else who spoke with them?

10 **A.** I don't recall specific conversations. From
11 memory, Child B's collapse was so acute and so unusual,
12 my normal practice would be to have called the parents
13 in. I haven't documented the notes that I spoke to them
14 so I can't recall and it could easily have been that
15 I was so busy that I delegated that to somebody else.

16 I am pretty certain the daytime Consultant spoke to
17 them. The Consultant I called in overnight might well
18 have spoken to them, I can't recall. My normal policy
19 would have been to involve them. I tended to involve
20 parents quite frequently.

21 **Q.** You have described the unit as being busy on
22 a couple of occasions. Did that affect communication
23 either with parents or across teams of professionals --
24 nurses, doctors -- or not as far as you are concerned?

25 **A.** I am sure it would have at time to time as it

39

1 **A.** Yes, there was one other Registrar who had
2 left before I had and I remember speaking to him many,
3 many months later, I cannot even recall if we overlapped
4 but he had worked at Chester. But no, I didn't keep in
5 touch with anyone in particular from Chester.

6 **Q.** And in 2015, you didn't hear any names about
7 Letby or anybody making comments about her in
8 a derogatory way?

9 **A.** Whilst I was working on the unit?

10 **Q.** Mm-hm.

11 **A.** No.

12 **Q.** But you are clear that there was discussion
13 about the unthinkable and looking for somebody as
14 a common denominator between --

15 **A.** Only amongst the nursing staff on this
16 particular period. I don't -- I don't recall
17 a conversation amongst the doctors or a suggestion that
18 it was one particular person by the time I left in
19 September 2015, no.

20 **Q.** So where did their concerns start and end by
21 the time you left in 2015, how would you summarise it
22 amongst the doctors? Concerns about unexpected events
23 and not knowing why they happened?

24 **A.** Yes, there was established concerns that there
25 were a series of events that were unusual and unexpected

38

1 would in any unit, unfortunately particularly with
2 parents. So again as a doctor I would always have to
3 prioritise the needs of the baby or the child in front
4 of me. Even if I very much wanted to speak to parents,
5 it would be wrong of me to prioritise that over an
6 acutely unwell child, and there are times when you have
7 to do that. But I would always make a concerted effort
8 to either ask somebody else to speak to them at the
9 time, ask them to wait, or get back to them as soon as
10 possible.

11 The same with speaking to other medics. If you --
12 on occasion you might miss a handover, if there's
13 an acute resuscitation, you might send one of your
14 colleagues to hand over and get secondhand information
15 that way. But it's something that would always try and
16 be avoided if at all possible. But you simply had to
17 prioritise the needs of the children in front of you.

18 **Q.** Did you have any dealing with any of the
19 managers when you were the Registrar?

20 **A.** No.

21 **Q.** From what you say, that would be typical for
22 your role --

23 **A.** In my experience, yes, in my experience for my
24 stage of training that was quite normal.

25 **Q.** Did you hear the Consultants or anyone else

40

1 talking about management in any way?

2 **A.** No.

3 **Q.** So nothing negative, nothing positive. It
4 just didn't feature in your daily --

5 **A.** No.

6 **Q.** -- life on the wards?

7 **A.** No.

8 **Q.** Reflections. You offer various reflections in
9 your statement of events now. One of the issues you
10 were asked about was CCTV and you say a number of things
11 including:

12 "... I am not sure I would like to work in that
13 arena. I would be concerned it may negatively affect
14 doctors' and nurses' actions and how they interact with
15 staff, colleagues and families."

16 Of course, the police now wear body cameras when
17 they go into emergency scenes and they can provide very
18 useful information and material for later scrutiny of
19 events. Do you think that could become normalised in
20 the same way it has had to be for officers if --

21 **A.** I think a lot of that will depend on the
22 outcome of this Inquiry. I would be very interested to
23 see what the recommendations are. It certainly is
24 something we could consider.

25 I think the way it's used in the police force is

41

1 or environs wouldn't be seen, would they, until they
2 came close to the baby or were handling the baby?

3 **A.** Yes, I think it's something that I can
4 understand why it's being considered and I can certainly
5 see the positives. I think it's something that would
6 need to be thought of -- just the logistics of it would
7 need to be thought out very carefully again.

8 Particularly for the impact it would have on the
9 parents, I would be most worried about.

10 **Q.** This Inquiry has heard evidence from the
11 parents of the babies who were post-caesarean section
12 not able to get to the neonatal unit to see their babies
13 at all --

14 **A.** Yes.

15 **Q.** -- and to be on another unit, having sight of
16 your baby would be very comforting, wouldn't it?

17 **A.** Yes.

18 **Q.** So I see for the mother who is able to be next
19 to the baby breastfeeding, there are other issues that
20 presumably --

21 **A.** Yes.

22 **Q.** -- can be dealt with but for these mothers
23 separated from a baby on a unit it would be a positive
24 advantage, wouldn't it, to be able to see them in
25 the way that --

43

1 very or my impression, because I don't have direct
2 experience of it, might be quite different. If it was
3 a case that we were wearing CCTV that you could then
4 turn on in a certain circumstance and you had control
5 over that, personally, I can only speak for myself,
6 I would be quite happy and comfortable. I'd need to get
7 used to it, but I would be happy to do that.

8 But the notion of having a camera constantly
9 recording in an environment where you have women who
10 have just given birth, fathers who are new fathers, you
11 are breastfeeding, you are encouraging kangaroo care
12 where you are having direct skin-to-skin contact, I do
13 worry significantly that having a camera there all the
14 time would negatively impact that.

15 It's also important that people are -- feel
16 confident to speak freely and openly and a neonatal unit
17 can be a very heated circumstance, both between medics
18 and families, and it's important that everyone is happy
19 to be open. That might be a case of just getting used
20 to having CCTV but I think the way it's used in the
21 police force is somewhat different to having a camera
22 fixed in the unit all the time.

23 **Q.** If there was somebody in the incubator, so
24 it's effectively the baby that's monitored in the
25 incubator, of course the staff in the surrounding areas

42

1 **A.** Absolutely.

2 **Q.** -- parents --

3 **A.** If it's used in that way, then I can
4 definitely see a lot of positives. I just worry about
5 the negatives as well.

6 **Q.** You say the most:

7 "Reflecting on the whole case I feel the most
8 effective way to have prevented Letby from harming as
9 many children as she did would have been for the
10 hospital management team to have acknowledged and acted
11 on the significant and exceptional concerns repeatedly
12 raised by the NNU Consultant body."

13 Pausing there before we go to that. The first area
14 of course is for the doctors to express those concerns
15 in a unified way, isn't it --

16 **A.** Yes.

17 **Q.** -- to link the medical facts together in the
18 way that you say they were by the end of September when
19 you left, discussing --

20 **A.** That's the impression I had.

21 **Q.** That's the impression you had.

22 **A.** Yes. Like I say, I wasn't present at those
23 meetings so I don't know firsthand what was said by whom
24 to whom. But my impression very much was that the
25 Consultants were aware, understood our concerns and

44

1 shared those concerns.

2 **Q.** You say:

3 "All the staff on the NNU that I discussed these
4 cases with at the time uniformly agreed that something
5 exceptional was happening, with severe consequences."

6 **A.** Yes.

7 **Q.** And you are clear about that?

8 **A.** Yes.

9 **Q.** You also refer in the same paragraph to the
10 discussion you had with the non-paediatric doctor
11 anonymously:

12 "~... and we both theorised that a police
13 investigation may need to be considered if the current
14 events could not be explained by a number of
15 possibilities including environmental toxin or rare
16 infections."

17 So that was being considered, this pseudomonas,
18 what else might have been going on in the hospital,
19 those things were being looked at?

20 **A.** From -- well, from the conversations I had
21 I knew they were being considered because I personally
22 had raised them and I'm aware other colleagues of mine
23 had.

24 As to whether -- what investigations were actively
25 being undertaken, I don't know. I wasn't party to that

45

1 my colleagues, and acknowledged and shared those
2 concerns and were escalating them and I had faith in the
3 hospital process that it would be escalated
4 appropriately and I didn't -- I had no idea that that
5 was not the case.

6 **MS LANGDALE:** Yes, thank you. My Lady, I have no
7 further questions.

8 **LADY JUSTICE THIRLWALL:** Thank you, Ms Langdale.
9 Dr Lambie, may I just take you back to one
10 document. I hope I have got the reference right. It is
11 0008894, which is the report to the Coroner. Thank you.

12 I have understood your evidence correctly, I think,
13 that this was April 2016 when you were asked to do this.

14 **A.** (Nods).

15 **LADY JUSTICE THIRLWALL:** And you left the Countess
16 of Chester in September.

17 **A.** '15.

18 **LADY JUSTICE THIRLWALL:** 2015.

19 **A.** Yes.

20 **LADY JUSTICE THIRLWALL:** Do you know why you were
21 asked to do this?

22 **A.** I don't know for certain other than I was one
23 of the clinicians named. So during the resuscitation
24 one of the -- it's usually one of the more junior
25 doctors or one of the nurses is usually asked to scribe.

47

1 information.

2 **Q.** Did you talk much with Eirian Powell about
3 investigations?

4 **A.** No.

5 **Q.** Did you have much of a -- much to do with
6 Eirian Powell.

7 **A.** No.

8 **Q.** You say:

9 "During the court case, I became aware of the
10 significant difficulties the neonatal Consultants had
11 faced in raising and escalating their concerns ...
12 I felt upset and angry as I had relied on trusted the
13 wider management of the hospital to follow an
14 appropriate process once I had raised my concerns with
15 the Consultants."

16 Would you like to expand upon that, what you heard,
17 what your view is about that?

18 **A.** So yes, I wasn't aware of the difficulties
19 that the Consultants were having at raising their
20 concerns and continuing to escalate them until much
21 later and closer to the court case. Certainly at the
22 time, I wasn't aware that they were having difficulties.

23 From my perspective, as a trainee, I had concerns,
24 I had escalated them appropriately to the Consultants,
25 I was very confident that they were listening to me and

46

1 **LADY JUSTICE THIRLWALL:** To write everything down.

2 **A.** And I am aware that the house officer at the
3 time wrote my name. I wasn't -- I didn't write in the
4 patient's notes at the time so the only documented
5 evidence that I had attended was my colleague writing my
6 name and then I was asked to provide details of my
7 involvement.

8 I have written here, "I have been asked to prepare
9 a statement detailing my involvement."

10 I can only assume it's because I wasn't able to
11 write in the notes at the time but I don't recall
12 exactly why I was asked to, no.

13 **LADY JUSTICE THIRLWALL:** And you weren't there
14 throughout the incident, were you?

15 **A.** No, I was there at the very end.

16 **LADY JUSTICE THIRLWALL:** Yes. So it seems a
17 slightly unusual choice of person to ask because you
18 were the one -- you came in and assisted very near the
19 end.

20 **A.** (Nods).

21 **LADY JUSTICE THIRLWALL:** You didn't make any notes.
22 I think, was it Dr Harkness who was there?

23 **A.** Dr Harkness was the lead, so I didn't make any
24 clinical decisions.

25 **LADY JUSTICE THIRLWALL:** No.

48

1 A. He led the resus and I helped.
 2 **LADY JUSTICE THIRLWALL:** Yes. One of the things
 3 that we have been looking at in the course of your
 4 evidence is the nature of collapses and you have
 5 described them as unusual, unexpected and serious. But
 6 that doesn't come across in relation to Child A in this
 7 report. Is the reason, there could be a number of
 8 reasons for that.
 9 Presumably if you come in later you only know it's
 10 unexpected if someone tells you that afterwards?
 11 A. Yes and it looks like I was asked to prepare
 12 a statement detailing my involvement specifically.
 13 **LADY JUSTICE THIRLWALL:** Yes.
 14 A. So I would have replied with my involvement
 15 was literally I arrived, I helped with the CPR, whatever
 16 else I did, Dr Jayaram the Consultant then stopped the
 17 resuscitation and then I left to continue my shift and
 18 that -- the answer to the question, that was my
 19 involvement.
 20 **LADY JUSTICE THIRLWALL:** Yes.
 21 A. I wouldn't have then reflected on the nature
 22 of the collapse because that would have been
 23 Dr Harkness's involvement.
 24 **LADY JUSTICE THIRLWALL:** Yes, thank you. We are
 25 just being reminded of Part 2. I think you agree that

49

1 **LADY JUSTICE THIRLWALL:** Ms Browne.
 2 **MS BROWNE:** Yes, my Lady, if we could call
 3 Dr Neame, please.
 4 **DR MATTHEW NEAME (Affirmed)**
 5 **Questioned by MS BROWNE**
 6 **LADY JUSTICE THIRLWALL:** Do sit down, Dr Neame.
 7 **MS BROWNE:** Could you please give your full name.
 8 A. Matthew Thomas Neame.
 9 Q. And, Dr Neame, you have been provided
 10 a witness statement to the Inquiry dated 23 June 2024
 11 and is that statement true to the best of your knowledge
 12 and belief?
 13 A. Yes.
 14 Q. Dr Neame, I am going to start just briefly by
 15 going through your career. You graduated with a medical
 16 degree from the University of Liverpool in 2008?
 17 A. Yes.
 18 Q. You gained full membership of the Royal
 19 College of Paediatrics and Child Health in 2014?
 20 A. Yes.
 21 Q. I think your medical foundation training was
 22 completed at the Royal Liverpool University Hospital
 23 between 2008 and 2010?
 24 A. That's correct.
 25 Q. Having then progressed on from foundation

51

1 it was a perfunctory statement in the sense that --
 2 A. Yes.
 3 **LADY JUSTICE THIRLWALL:** -- you said everything you
 4 knew but that wasn't all that much in the circumstances.
 5 A. No.
 6 **LADY JUSTICE THIRLWALL:** Thank you very much
 7 indeed, Dr Lambie. Is there anything else you want to
 8 ask?
 9 **MS LANGDALE:** No thank you, my Lady.
 10 **LADY JUSTICE THIRLWALL:** In that case, that
 11 completes your evidence. Thank you very much for
 12 coming, you are free to go.
 13 As for the rest of us, we will take a break and
 14 start again at 11.15.
 15 **MS LANGDALE:** My Lady, I was going to suggest if we
 16 start at 11.30? All of the witnesses today I think will
 17 be less than an hour. All have been timetabled in
 18 different ways so it may be an opportunity to take
 19 a slightly longer break.
 20 **LADY JUSTICE THIRLWALL:** I don't think anyone is
 21 going to complain about that, so we will start again at
 22 11.30.
 23 **(10.59 am)**
 24 **(A short break)**
 25 **(11.30 am)**

50

1 training to your specialist paediatric training, you
 2 spent, as was usual, six month rotations at a number of
 3 hospitals and that included Alder Hey, Liverpool Women's
 4 Hospital, Arrowe Park and the Countess of Chester?
 5 A. Yes.
 6 Q. If you could just explain, Dr Neame, did that
 7 mean that when we are looking at the doctors at the
 8 Countess of Chester on the paediatric and neonatal unit
 9 below Consultant level, they would, like you, generally
 10 have been there on a six-month rotation period?
 11 A. Usually, yes.
 12 Q. Currently you are a Consultant general
 13 paediatrician at Alder Hey Children's NHS Foundation
 14 Trust?
 15 A. That's correct.
 16 Q. When did you commence that role?
 17 A. Two years ago, August 22.
 18 Q. And I think it is the case that in your
 19 current role as a Consultant general paediatrician, that
 20 does not encompass neonatology now?
 21 A. That's correct, yes.
 22 Q. If I can turn now to the period that you spent
 23 at the Countess of Chester during your paediatric
 24 training. You in fact undertook three periods of your
 25 paediatric training at the Countess of Chester,

52

1 six months from August 2012 to February 2013 right at
2 the start of your training when your clinical supervisor
3 was Dr Saladi; is that correct?

4 **A.** Yes.

5 **Q.** Then you returned for six months,
6 September 2015 to March 2016, with under the clinical
7 supervision of Dr Gibbs and that's obviously the period
8 we are going to be looking at in some more detail.

9 Then you returned for a third time, I think this
10 time working not full time but on the 60% contract in
11 2021 from March to September and on that occasion your
12 clinical supervisor was Dr Brearey?

13 **A.** Yes.

14 **Q.** Dr Neame, was it an active choice on your part
15 to return to Chester on three occasions for your
16 rotations?

17 **A.** Yes, I applied to work there again. It is
18 close to where I live.

19 **Q.** Other than geography, was it a rotation you
20 actively chose because you had a positive experience or
21 was there another reason why you chose to return three
22 times to the Countess of Chester?

23 **A.** I had had a very positive experience during my
24 first placement there which I think encouraged me to
25 list it as a preference for a subsequent placement and

53

1 general paediatric children's ward, help them with
2 admissions of new patients and assessments of previously
3 admitted patients and covering the neonatal unit, the
4 postnatal ward and the delivery suite as well.

5 **Q.** In that split of your duties insofar as you
6 are able, if you are able, what was the percentage of
7 time or the approximate split between the time you would
8 spend on the paediatric wards and the time you would
9 spend on the neonatal unit?

10 **A.** Obviously it depended on the clinical need at
11 the time. Typically, on a typical shift, particularly
12 out of hours, the majority of time would be spent on the
13 children's paediatric side, managing new admissions
14 which would happen quite frequently.

15 **Q.** So would it be the case that generally you
16 would be called in to the neonatal unit from the
17 paediatric ward?

18 **A.** Yes, more usually out of regular office hours
19 that would usually be the case.

20 **Q.** Just to put in context your time at Chester,
21 the previous six months before commencing at Chester in
22 2015, you had spent six months I think on a neonatology
23 rotation at the Liverpool Women's Hospital under the
24 supervision of Dr Yoxall?

25 **A.** That's correct.

55

1 I think the third occasion was for practical reasons,
2 primarily.

3 **Q.** You said you had a very positive on your first
4 occasion. Was that not the case with your second
5 six months?

6 **A.** Well, it was more challenging and I don't have
7 happy memories of that placement.

8 **Q.** Yes, and obviously we will go through that in
9 detail. Just looking at the level of experience you had
10 when you went in 2015 to 2016, you were an ST5. Can you
11 just explain how many years' experience in paediatric
12 and neonatal practice that meant when you were at the
13 hospital in 2015?

14 **A.** So I had had by that point four years of
15 primarily paediatric experience with two six-month
16 placements in the Liverpool Women's Hospital where I was
17 just working in neonatology.

18 **Q.** Just to make clear, so four years of
19 specialist training but of course you would have had
20 your few years foundation training. I think you did an
21 many additional year as well prior to that?

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

23 **Q.** What were your responsibilities as a Registrar
24 at the hospital?

25 **A.** Primarily to undertake clinical work on the

54

1 **Q.** The Liverpool Women's Hospital was a Level 3
2 unit. Could you just explain the significance in terms
3 of the babies cared for and how that differed to the
4 Countess as a Level 2 unit?

5 **A.** So the team at the Women's Hospital would
6 admit more unwell babies, they would accept babies who
7 had been born earlier in the gestation, so more
8 premature than the babies admitted to the Countess of
9 Chester.

10 **Q.** And at Liverpool, my understanding is your
11 rotation was purely neonatology so you would have come
12 to Chester having had six months purely dealing with
13 very premature babies and babies who needed neonatal
14 care?

15 **A.** That's correct.

16 **Q.** And you have talked about your split of time
17 spending time on the paediatric ward and then being
18 called into the neonatal unit as required. What was
19 your experience of Consultant rounds on the neonatal
20 unit, how often do you recall they took place?

21 **A.** I think they were scheduled for twice weekly
22 during the week and possibly one of the weekend days.
23 I may have misremembered the precise number.

24 **Q.** And would that be part of your regular duties
25 if you were there at the time of Consultant round that

56

1 you would assist in that?

2 **A.** Yes.

3 **Q.** Just looking at the comparison with the
4 Liverpool Women's Hospital a little further. You say in
5 your statement at paragraph 11:

6 "I would describe the culture on the Neonatal Unit
7 at the Countess of Chester as being slightly more
8 informal than at the Liverpool Women's Tertiary Neonatal
9 Unit ..."

10 You did give some explanation in your statement but
11 could you just expand a little on what you meant by
12 "slightly more informal"?

13 **A.** So an example would be that the ward rounds at
14 the Women's would be conducted by the team who had been
15 working overnight or led by that team of Registrars and
16 SHOs. There would be an expectation that each baby on
17 the unit would be presented by the night team to the
18 Consultant working that day with a full explanation of
19 the management of that baby overnight and the full
20 summary of that baby's care prior to that point.

21 That -- those processes were conducted on a daily
22 basis and it was a very regular, routinised way of
23 conducting the department.

24 **Q.** Did you consider that the informality that you
25 observed, did you consider that impacted on the standard

57

1 get the sense that the culture or standard practice had
2 changed significantly between the two periods.

3 **Q.** Setting aside the incidents we are going to be
4 dealing with today, but in terms of the babies who were
5 being admitted, were you aware of any reason for this
6 why you say that you were conscious of babies being
7 particularly unwell?

8 **A.** No, I wasn't aware of any reason.

9 **Q.** In terms of pressure on nursing staff or on
10 doctors, how did that contrast or did it contrast at the
11 Countess of Chester compared to other hospitals where
12 you had worked? I think you had been at quite a number
13 by now: you had been at Alder Hey, Wrexham Maelor,
14 Arrows Park, for example, as well as Liverpool?

15 **A.** I thought the staffing pressures were very
16 typical of the pressures that I have encountered at
17 other organisations, I don't think it is unusual to --
18 to feel those pressures.

19 **Q.** Turning now to the relationships between
20 staff. How would you describe the relationships between
21 nurses and doctors on the neonatal unit in 2015 to 2016?

22 **A.** I didn't notice anything unremarkable about
23 those relationships or interactions during my time
24 there.

25 **Q.** So nothing particularly good but nothing

59

1 of care in any way?

2 **A.** I thought it was typical of the way that care
3 had been provided in the district general hospitals that
4 I had worked in, it didn't feel abnormal or
5 inappropriate but it felt on reflection different to the
6 way things were conducted at the Level 3 unit.

7 **Q.** But did you have at the time, or indeed on
8 reflection, any concerns about the care the sort of
9 babies the Countess was caring for, did you have any
10 concerns about the standard of care they were receiving?

11 **A.** Not the general standard of clinical care.
12 There were times where I felt that we were managing
13 babies who were more unwell than I might have expected
14 to or where we managed babies who had deteriorations and
15 then were not necessarily transferred off the unit in
16 the way I might have expected them to be.

17 **Q.** When you say about caring for babies who are
18 particularly unwell, was that something that you
19 observed was a difference from when you had been working
20 on the unit in 2012 to 2013, did you observe there to be
21 a difference or had that always been the case?

22 **A.** I don't think the processes or culture had
23 necessarily changed but I think there were more --
24 a greater number of unwell babies during my second
25 placement so perhaps it was more noticeable but I didn't

58

1 particularly bad, do I take from that?

2 **A.** Yes, that's correct.

3 **Q.** Were you aware of any sense of resentment from
4 nurses on the neonatal unit that the doctors were
5 perhaps less present on the neonatal ward and spent
6 perhaps more time on their paediatric duties?

7 **A.** I wasn't aware of that.

8 **Q.** In terms specifically of relationships, I have
9 been talking about relationships between nurses and
10 doctors, I was thinking of doctors in your -- of your
11 level of seniority. But the relationship between nurses
12 and Consultants, did you see that as a positive
13 relationship or again was it -- I think you used the
14 expression "unremarkable"?

15 **A.** Yes, I didn't notice anything unusual or
16 remarkable about that.

17 **Q.** Again, just reflecting back to your earlier
18 period in 2012/2013. Any difference in the
19 relationships between nurses and doctors between those
20 two periods?

21 **A.** No.

22 **Q.** Just very briefly, you returned of course in
23 2021, this time Letby had been charged with murder.
24 Were there differences then in the relationships between
25 nurses and doctors that you were conscious of?

60

1 A. No, I don't think so. The atmosphere was,
2 particularly for me, I found it slightly unusual working
3 there but not in terms of unusual relationships between
4 colleagues.

5 Q. Turning then to the relationship between
6 midwives and doctors and nurses. You say in paragraph 6
7 of your statement that you -- part of your duties
8 included attending high risk obstetric deliveries. Can
9 you just give an indication of the sort of extent of
10 involvement you would have had with midwives and those
11 working on the obstetric unit in terms of a proportion
12 of your time? How frequently would you be involved
13 working on the obstetric unit or with midwives?

14 A. So I would suggest that on most shifts we
15 would be called to at least one or two deliveries where
16 it was anticipated there may have been some challenges
17 or committee cases and probably similarly called to the
18 postnatal ward once or twice per shift to review a baby.

19 Q. When we are looking at being called out then
20 you are talking about how often you were called to the
21 obstetric -- how often can you relate that to the
22 neonatal unit, how often as a general rule would you be
23 called there?

24 A. Much more usual to be called to a neonatal
25 unit, but that would be typical in any setting I have

61

1 Q. And how many doctors were there approximately
2 in your six-month intake? Paediatric trainees, that is?

3 A. I think perhaps seven.

4 Q. And sort of aimable professional
5 relationships, would you discuss your cases, seek advice
6 from those at similar levels of seniority?

7 A. Yes, we would have regular discussions and
8 handovers about care.

9 Q. Dr Lambie ended her six-month rotation at the
10 start of September just when you were starting. Was
11 there a system of handover, did you have a handover from
12 Dr Lambie or have any contact with her or would that
13 have been normal?

14 A. No, I wasn't fully aware of who had preceded
15 us on the rotation.

16 Q. So there wasn't a settle-in day where you
17 spoke to the Registrars who had been there for the
18 six-month period before?

19 A. There is an induction but it is provided by
20 the Consultant and nursing teams, not by training
21 doctors.

22 Q. You say in paragraph 8 of your statement.
23 "Colleagues seemed supportive during more
24 challenging periods, for example following episodes
25 where babies had become unwell or collapsed or had sadly

63

1 worked in.

2 Q. So several times in a shift, would you be
3 expecting -- in every shift, would you spend some time
4 on the neonatal unit, for example?

5 A. Yes, usually.

6 Q. And what was your perception of the
7 relationships between nurses and midwives or indeed
8 between midwives and doctors on the neonatal unit, did
9 you have any observations about those particular
10 relationships?

11 A. No. I wasn't aware of any difficulties or
12 challenges.

13 Q. We have just heard evidence that Dr Lambie
14 experienced some she described as hostility from
15 midwifery staff towards medical staff. Was that
16 something that you were aware of?

17 A. It is not something I experienced.

18 Q. Looking now at the relationships between your
19 fellow doctors, so those at a similar level of you who
20 are completing their paediatric training. What were the
21 relationships that you had or you felt were usual
22 between the other doctors also undergoing their
23 training?

24 A. I think I would describe them as aimable,
25 productive, healthy working relationships.

62

1 died."

2 In practical terms, how were your colleagues
3 supportive?

4 A. In sort of typical human ways, I suppose,
5 checking in and acknowledging that those situations are
6 difficult and being friendly and open to further
7 discussion.

8 Q. So would it be normal to have a discussion
9 with one of your fellow Registrars if you had had to
10 experience a baby dying or collapsing having to
11 undertake a resuscitation?

12 A. Perhaps not extensive discussions but
13 certainly to acknowledge it as a difficult situation.

14 Q. And did you personally seek that support, do
15 you recall those sorts of conversations with colleagues
16 after the collapses of H or the collapse or indeed the
17 death of Child I, both of which you were involved with?

18 A. I don't think I sought those conversations or
19 support, but I am sure I discussed those, you know,
20 challenging episodes with colleagues informally at
21 times.

22 Q. But do you have any specific recollections of
23 discussions you would have had about those incidents
24 with anyone in particular?

25 A. I recall during the week that Child I had had

64

1 a number of episodes having a discussion, I think it was
2 a morning handover just reflecting on the fact that it
3 had been a difficult challenging week and in many ways
4 had been more -- far more challenging than a typical
5 week on a neonatal unit.

6 **Q.** We are going to go through that in a little
7 bit more detail now.

8 As part of those discussions, those sort of
9 supportive discussions, I have asked you about
10 specifics, Child H and Child I. Were there any
11 discussions that you had with any of your colleagues,
12 whether at your own level or more senior, about concerns
13 you had about the number of collapses or deaths that
14 were occurring?

15 **A.** Only in very general terms similar to the way
16 I have described it just now, just reflecting on the
17 fact that it was more that that week in October when
18 Child I had a number of collapses in particular was
19 busier and more challenging than I had expected.

20 **Q.** You have said when you alluded to the period
21 overall, the six months you spent 2015 to 2016 to being
22 a difficult period. Was it your impression not only for
23 you but for others working on the unit at that time that
24 they too would have said this was a period where there
25 were an unusual number of collapses or deaths and that

65

1 **A.** I felt that I had good relationships with
2 them. I felt that they were approachable and
3 supportive.

4 **Q.** So had you had any concerns or difficulties,
5 concerns about procedures or concerns about a particular
6 case you were dealing with, was that something you felt
7 freely able to raise with a Consultant?

8 **A.** Yes.

9 **Q.** Did you ever go to your supervisor, Dr Gibbs,
10 with specific concerns or queries, either in relation to
11 Child H or Child I or indeed just the number of
12 collapses that were occurring at this period?

13 **A.** No, I didn't raise any specific concerns.

14 **Q.** Why was that? Was there any inhibitor in you
15 going to speak to Dr Gibbs or was it something that you
16 felt they were aware of, he was already aware of? We
17 have heard Dr Lambie did raise those concerns, was that
18 something you considered?

19 **A.** I didn't feel that there was anything
20 preventing me from doing that. I think I was focused
21 on, you know, the possible clinical reasons for
22 deteriorations that I had noted and focused on my
23 clinical performance and I don't think I was sort of
24 thinking far beyond that in terms of the broader or
25 systemic factors on the unit.

67

1 was something that was known and was affecting those
2 working in the unit?

3 **A.** Yes, I think that was acknowledged informally
4 by the doctors I was working with.

5 **Q.** Can you give a little bit more detail in terms
6 of that would have been discussed at breaks or whether
7 you recall any meetings where that was specifically
8 raised?

9 **A.** I -- I don't recall specific detail around
10 those conversations and I certainly don't recall any
11 sort of formal acknowledgement or processes for
12 reflecting upon that general observation.

13 **Q.** But your experience of this being a difficult
14 six months when there was an unusual level of collapse
15 or deaths was something that you would have felt was
16 commonly held by those who were at your level --

17 **A.** I think it was understood that it had been
18 a surprisingly busy period.

19 **Q.** By "busy" you mean a surprising number of
20 babies collapsing or dying?

21 **A.** Correct, yes.

22 **Q.** Just looking at the relationship with
23 Consultants. How would you describe the relationship
24 between trainee doctors such as yourself and the
25 Consultants?

66

1 **Q.** Just so that we can understand how the
2 relationship with the clinical supervisor worked, would
3 you be -- would you have a scheduled regular meeting
4 where you would raise any concerns or would it be an
5 ad hoc situation where if you had a concerns you could
6 go to them?

7 **A.** So both -- we would have regular scheduled
8 supervision meetings and I would use my clinical
9 supervisor as a first point of contact if I had other
10 specific issues that I wanted to discuss between those
11 episodes.

12 **Q.** Do you recall discussing Child I or Child H in
13 any of those supervision meetings with Dr Gibbs or
14 indeed any of the other Consultants that you may have
15 spoken to?

16 **A.** No. I possibly would have completed some
17 reflections or some supervision discussions with
18 Consultants around the management, but I think that
19 would have been from a sort of clinical learning
20 perspective, not from a concerns about practice on unit
21 perspective.

22 **Q.** Obviously one of the hierarchies that exist in
23 hospitals is that when a Registrar feels the situation
24 warrants it they will call out a Consultant. Was that
25 something you felt very freely able to do?

68

1 A. Yes, I did do that freely.
 2 Q. And you didn't feel there was any inhibition
 3 on calling a Consultant when that was --
 4 A. No.
 5 Q. Their level of expertise was needed?
 6 A. No, no inhibition.
 7 Q. In terms of relationship with managers, did
 8 you have any interaction at all with managers at the
 9 hospital whilst you were there in 2015/16?
 10 A. Not that I recall.
 11 Q. And just so that we can get a feel of that,
 12 would you for example have known, recognised, Ian Harvey
 13 the Medical Director or the Chief Executive, would you
 14 have known who they were?
 15 A. No, I don't think so.
 16 Q. The Board of Directors, as far as you are
 17 aware, did they ever come on the unit, did you have any
 18 contact with any of those individuals, even if not to
 19 speak to them, but aware of their presence?
 20 A. Not that I was aware of at that time.
 21 Q. So it would be fair to say, would it, that as
 22 far as you were concerned, they weren't visible to you
 23 working on the unit?
 24 A. Yes, I wasn't aware of them. They weren't
 25 visible to me.

69

1 detailed as that in terms of memories I have of --
 2 Q. I am just going to put a suggestion to you and
 3 you can either say that seems right or that you simply
 4 have no recollection, we know now that four babies died
 5 in under two months between early June and early
 6 August 2015 and we have heard from Dr Lambie that those
 7 issues were being discussed at the Countess of Chester,
 8 so that would have been the August, the month -- your
 9 last month at Liverpool before you moved to Countess of
 10 Chester.
 11 Does that seem about right in terms of when you
 12 were hearing these reports of the bad time?
 13 A. Possibly, or I think one of my colleagues in
 14 the Registrar group had been working in Chester prior to
 15 me starting there, so possibly from him. I'm afraid
 16 I just have a sense of being aware that episodes may
 17 have happened, but it's not more specific.
 18 Q. You say you were you had heard reports.
 19 How widespread was your impression that those
 20 reports were amongst the community, for example at the
 21 Liverpool Women's Hospital, was it something that was
 22 being generally discussed?
 23 A. I don't recall it being discussed there. I am
 24 not sure if it was amongst trainees or possibly when
 25 I started at Chester that I became aware of it. I just

71

1 Q. Just before we turn on to another topic,
 2 finishing off the issue of relationships between staff.
 3 We have said and looked at the way training worked
 4 going through rotations of a number of hospitals. Is
 5 there anything you want to add, I think your evidence is
 6 that it was relatively unremarkable but how the Countess
 7 compared in terms of relationships between doctors
 8 nurses and midwives to other places you had worked?
 9 A. Just very typical of a district general
 10 hospital.
 11 Q. Thank you.
 12 Turning to the issues of what you had had in terms
 13 of reports before you started at the Countess.
 14 You say in your statement to the Inquiry, this is
 15 paragraph 12:
 16 "Prior to starting my role on the Countess of
 17 Chester's neonatal unit in September 2015 I had heard
 18 reports of the neonatal team having 'a bad time'. My
 19 understanding was that this was a reference to episodes
 20 where babies had either died or required unexpected
 21 escalations of care or transfer to tertiary Neonatal
 22 Units."
 23 Can you recall approximately when you were hearing
 24 these reports?
 25 A. No, I -- I can't, I'm afraid, it's about as

70

1 recall having a sense of being aware of that but no
 2 details, I'm afraid.
 3 Q. So you are not able to assist as to who you
 4 heard these reports from, was it colleagues at your own
 5 level or was it from nursing or Consultant level?
 6 A. I -- my sense is it would have been from
 7 discussions with colleagues at my level.
 8 Q. You have said that when you were at Liverpool,
 9 you were under Dr Yoxall. Was it, as far as you know,
 10 something that he was aware of or that you ever
 11 discussed with him as a concern as your current
 12 supervisor about to go on to Chester, did you discuss
 13 with him that you had heard these reports and that was
 14 causing you any concern?
 15 A. No, not as I recall.
 16 Q. You say in terms of the reports they were
 17 having what you had heard was they were having a bad
 18 time. Just to go into that a little further.
 19 As a doctor, presumably there would be some
 20 speculation as to the cause of babies dying or
 21 collapsing. What is your recollection that people were
 22 speculating or discussing as being the cause of the bad
 23 time that was being experienced at Chester?
 24 A. I don't recall any speculation about the
 25 cause. I think the assumption, or certainly my

72

1 assumption, would have been that that was bad luck and
2 a bad -- a bad run I have no recollection of discussion
3 of a cause for those.

4 **Q.** So just in case this prompts your memory, no
5 discussion of infections, concerns about the standard of
6 care?

7 **A.** No, I don't, not aware of anyone expressing
8 those concerns.

9 **Q.** Just to look at a wider historical situation.
10 We know that in May 2015 there had been a nurse at
11 Stepping Hill who had been sentenced for murdering
12 patients by the admission of insulin. Was there ever
13 a sense when you heard "a bad time" that there were
14 discussions even only speculation or rumour that there
15 might be someone involved in criminal action?

16 **A.** No.

17 **Q.** Once you arrived at the Countess of Chester,
18 and I think you are unsure -- you say prior to starting
19 the role you had heard the "bad time", whether that was
20 at Liverpool or in fact whether just as you were
21 arriving at the Countess of Chester, do you have any
22 clearer recollection of what was being talked about in
23 terms of increased mortality or concerns once you
24 arrived at Chester in September 2015?

25 **A.** No. We weren't briefed or I don't think it

73

1 the first month of you starting --

2 **A.** (Nods)

3 **Q.** -- at the Countess of Chester.

4 The first occasion you were bleeped at 2051 and
5 attended Nursery 1 and on that occasion -- we don't need
6 to go in the details but on that occasion, a breathing
7 tube was replaced and Child H stabilised quite quickly?

8 **A.** Yes.

9 **Q.** Then turning to the second occasion. You were
10 called out then a second time at 1.30 in the morning and
11 if we go to paragraph 16 of your statement where you
12 deal with this, you say:

13 "I reported that in relation to the second episode
14 there was 'a sense of being more concerned on this
15 occasion [as compared to an early deterioration] because
16 it wasn't completely clear while she [Child H] had
17 deteriorated. There wasn't as clear an explanation'."

18 What did that make you feel, the lack of
19 explanation, what was your response to that?

20 **A.** That she needed some further assessment and
21 further investigations in order to try to identify the
22 cause.

23 **Q.** You called I think Dr Saladi, the Consultant,
24 at home?

25 **A.** (Nods)

75

1 was addressed specifically at any point.

2 **Q.** So you might have not been briefed about it,
3 but was it something that -- amongst your seven or so
4 trainees who were all starting together, was it
5 something that was a topic of discussion between you?

6 **A.** I don't think in any more detail than the
7 general sense that I tried to convey in my statement.
8 Certainly I don't recall any discussions about specific
9 clinical cases or circumstances around those, those
10 deaths or episodes.

11 **Q.** Because the impression that Dr Lambie gave,
12 obviously she was there at an early period and had been
13 involved in some child deaths which I appreciate was not
14 the case of you in September, but that impression was of
15 it very much being discussed on the unit and something
16 that was being discussed at Consultant and indeed at
17 Registrar level.

18 Was that an impression you had when you started in
19 September or not?

20 **A.** No, that's not my impression and not my
21 recollection.

22 **Q.** In relation to Child H, I think you have had
23 an opportunity to review the medical notes and you refer
24 to two collapses of Child H that occurred during the
25 night of 26 and 27 September 2015, so this was within

74

1 **Q.** You had to do chest compressions and I think
2 adrenaline was administered?

3 **A.** That is correct.

4 **Q.** Can you give an indication of how unusual that
5 was to have to call out a Consultant from home, chest
6 compressions, administration of adrenaline? You had
7 obviously been there only under a month at this time but
8 was that something you had experienced before, was that
9 a very infrequent occurrence having to call the
10 Consultant in in those circumstances, just so that we
11 can have a feel of how unusual that was as an incident,
12 let alone the fact that this one you say you were unsure
13 as to the cause, but as an event how unusual was that?

14 **A.** So I wouldn't describe it as being unusual to
15 have to call the Consultant for advice or further
16 support. I would say that it's relatively unusual to
17 need to use adrenaline as part of resuscitation of
18 a neonate.

19 **Q.** Insofar as you can recall, and I appreciate
20 you won't have gone over every medical note of every
21 child you saw, was that the first time as far as you
22 recall that had happened since you started at the
23 beginning of September?

24 **A.** Yes.

25 **Q.** Looking back, for example over the period you

76

1 spent in Chester in 2012/13, can you recall that sort of
2 incident having occurred then?

3 **A.** I -- I can't recall, I'm afraid, and I think
4 I would have been working at a much more junior level
5 where I wouldn't have been as involved in episodes like
6 that one.

7 **Q.** But it is fair to say this was sufficiently
8 unusual that it very much stuck in your mind, the
9 administration of adrenaline with Child H?

10 **A.** I don't think I can recall every episode where
11 I have used adrenaline in my career, it is not unheard
12 of.

13 **Q.** Yes.

14 **A.** In the -- difficult to quantify.

15 **Q.** You say in your statement at paragraph 19:
16 "My reaction to Child H's collapse episodes was
17 that they were challenging and unexpected episodes of
18 deterioration."

19 What would you have done in that situation at the
20 handover, what discussion would have taken place
21 regarding the collapse of H, given as you say the
22 challenging nature the unexpected episode, and it not
23 being clear to you why Child H had deteriorated? What
24 discussions would flow over that at handover or indeed
25 beyond handover?

77

1 a transfer so I think I felt satisfied that the episode
2 was understood.

3 **Q.** If I could just turn you to paragraph 20 of
4 your statement.

5 You say there:

6 "In a witness statement provided in relation to the
7 investigation of Child H's collapse episode I reported
8 being 'surprised by how many poorly babies there were
9 (at the Countess of Chester Hospital) but I did not
10 think it was suspicious'. I do recall having
11 a subjective sense there had been a higher than expected
12 frequency of episodes where babies required
13 stabilisation or resuscitation during my time at the
14 Countess of Chester Hospital."

15 So you seem there to be linking in some way
16 Child H's collapses and your subjective sense that there
17 was a higher than expected frequency?

18 **A.** Yes, I don't think that statement refers to
19 that period in time, I think that's possibly further on
20 in my placement.

21 **Q.** So at the stage of H's collapse, your concerns
22 there hadn't developed to the point and we will go on to
23 deal with Child I in a moment?

24 **A.** I would agree with that.

25 **Q.** In relation to H, you were -- there were also

79

1 **A.** So it would be a discussion of her previous
2 medical care, her background and then a summary of the
3 events and then a recommendation in terms of ongoing
4 assessments or investigations and ongoing management.

5 **Q.** You have told us that you had heard
6 discussions of the bad time before you started. You are
7 now in a situation where you have been involved in what
8 you describe as an unexpected episode of deterioration
9 for which there wasn't a clear explanation.

10 Did you make an association with what you had heard
11 and what was in fact now happening to you and feel that
12 was something that you needed to raise with those senior
13 to you raise with the Consultant body?

14 **A.** No, I didn't see those events as being
15 associated.

16 **Q.** That translates I think to being that that
17 wasn't something you would have discussed with other
18 doctors and nurses, you didn't raise it with Consultants
19 but was that a concern that you raised with your fellow
20 Registrars?

21 **A.** No, I don't think so. I had called Dr Saladi
22 early in the second episode so I was confident that one
23 of the Consultant team was -- was aware and it would
24 have been handed over to colleagues in the morning in
25 terms of the plan and I think the plan was for

78

1 going on at this period unexpected collapses of Child G
2 that had happened in advance of Child H. Were you aware
3 of that, was that something that was being discussed?

4 **A.** I am sure I would have had or I suspect
5 I would have had awareness through handover processes
6 and those discussions. But I -- I couldn't recall
7 details of those episodes.

8 **Q.** Did you ever consider at this stage -- just on
9 H, we will come later to Child I -- that there was any
10 safeguarding issue and that concerns for the child
11 themselves meant that you should be reporting the matter
12 to anyone other than discussing it at the handover,
13 which I think is your evidence, that it was discussed at
14 the handover?

15 **A.** No, I didn't.

16 **Q.** You say in your statement at paragraph 21:
17 "I do not recall attending a formal debrief or
18 discussion between doctors and other medical staff in
19 respect of the collapses that Child H experienced on
20 26th to 27th ..."

21 You have said that it was an unexpected episode and
22 in paragraph 18, you have described some of the steps
23 that were taken to investigate potential causes, x-rays,
24 blood test, ultrasound.

25 Do you think on reflection that there should have

80

1 been a debrief if only from a learning perspective for
2 you and others involved as to what had occurred and what
3 was the cause of the collapse of Child H?

4 **A.** Well, I certainly think there could have been
5 I suspect -- her, as I understand it, prompt recovery
6 may have a factor in that not happening.

7 **Q.** But would you say that was usual at the time
8 that there was not a debrief. Were you surprised there
9 was no debrief in the case of Child H?

10 **A.** No, that didn't surprise me and I think that's
11 probably because, as I understand things, she made
12 a good recovery soon after that episode.

13 **Q.** And we have heard that debriefs tended to be
14 more common in a situation where a child died. Would
15 that be your experience too?

16 **A.** Yes.

17 **Q.** Paragraph 22 you say:

18 "... I did not have any concerns that Child H's
19 collapse had a suspicious cause. I was not aware of any
20 colleagues who may have had suspicions about the cause
21 of Child H's collapse."

22 Is it right that you weren't conscious then of the
23 sort of anxiety about working on night shifts that we
24 were hearing from Dr Lambie?

25 **A.** So I think night shifts as a trainee are

81

1 that, but I don't recall how.

2 **Q.** What would be your normal practice where there
3 is a collapse in terms of looking at notes, would you --
4 would you examine the notes to look back and see their
5 past history?

6 **A.** Yes.

7 **Q.** After this unusual collapse on the 13th, was
8 that something that was discussed at the handover as
9 I understand it, is that correct?

10 **A.** It certainly would have been raised at
11 handover. I don't recall that discussion.

12 **Q.** But did you consider it should be raised in
13 any other forum or did you -- having had the experience
14 of Child H which was now unexplained and now a further
15 unusual collapse, did you feel this was something that
16 you should now be raising at Consultant level?

17 **A.** Well, I think I was confident -- well, I was
18 confident that Consultants knew about the episodes as
19 I had called Dr Newby in and she was there. I think
20 similarly I was quite focused on the potential clinical
21 explanations and ...

22 **Q.** Did Dr Newby or indeed any other Consultants
23 discuss with you concerns they had, wider concerns
24 beyond that specific collapse of Child I?

25 **A.** No.

83

1 always more challenging. You are less well staffed and
2 less well immediately supported, I felt supported in
3 terms of being able to access Consultant colleagues, but
4 they weren't in the building so I think most trainees
5 experience anxiety about working night shifts.

6 **Q.** But the situation with H, as far as you were
7 concerned, didn't lead to particular heightened anxiety
8 either your own or others who were discussing that
9 situation?

10 **A.** No, not that I am aware of.

11 **Q.** Turning then to Child I. I think you knew
12 Child I because you had been working at Liverpool
13 Women's Hospital when Child I was born?

14 **A.** Yes.

15 **Q.** On 13 October, you were bleeped to attend
16 Child I, chest compressions were needed and Dr Newby was
17 called in as a Consultant?

18 **A.** (Nods)

19 **Q.** And you say at paragraph 24 of your statement
20 talking about the collapse on 13th that it was unusual
21 for a baby to deteriorate so quickly.

22 **A.** Yes.

23 **Q.** Were you aware at that stage that Child I had
24 previously collapsed unexpectedly on 30 September?

25 **A.** I suspect I would have had some awareness of

82

1 **Q.** On the following night, 14 October, Child I
2 collapsed again and on this occasion Dr Jayaram was
3 called out and again chest compressions commenced and
4 adrenaline was given?

5 **A.** (Nods)

6 **Q.** Again, Dr Neame, can you indicate or give some
7 indication of how unusual it was in your experience to
8 have that experience of consecutive collapses on
9 consecutive nights requiring chest compressions of
10 a severity that Consultants needed to be called in?

11 **A.** Well, I think it that's slightly more
12 challenging from a clinical perspective because I think
13 there are cases where babies are unstable due to
14 an underlying clinical condition and that might
15 precipitate further events, that was certainly my
16 interpretation of what was happening by that stage.

17 So using adrenaline in a resuscitation situation in
18 a district general hospital was unusual but managing
19 very unwell children and seeing complications of
20 further -- of periods of instability represented by
21 further periods of instability felt plausible
22 clinically.

23 **Q.** If I could take you to paragraph 26 of your
24 statement, you say there:

25 "... I recall formal discussions ([for example]

84

1 during ward rounds and during discussions with
2 colleagues from tertiary neonatal centres and the
3 Alder Hey surgical team) and informal discussions
4 amongst the clinical team relating to the unusual course
5 of Child I's presentation."

6 Then you go on to say:

7 "My recollection is that although Child I's death
8 was surprising and unexplained there would be an ongoing
9 attempt to try to identify the cause through
10 a postmortem assessment."

11 So was it your understanding that indeed matters
12 were being looked into in relation to Child I?

13 **A.** Yes, that was my perception through that
14 period, was that we, the team, were searching for
15 a clinical explanation for her instability and episode.

16 **Q.** Thank you, Dr Neame. If we just could put up
17 INQ0000536. This is tab 8, my Lady, in your bundle.
18 That is the witness statement of Dr Rachel Chang who was
19 a Registrar and if we can just go down towards the
20 bottom of the page.

21 It says there in the last paragraph talking about
22 this period on the handover of the 15 October:

23 "Matt Neame was having a really difficult stretch
24 of nights with Child I as she had been very ill. Night
25 after night he was really shattered. He was glad to be

85

1 Liverpools Women's Hospital's NNU which cares for some
2 the sickest neonates in the Northwest. He returned to
3 the NNU at the Countess of Chester earlier and has made
4 comment that he had used more adrenaline during these
5 night shifts than he did in six months at the Liverpool
6 Women's. He again made a comment along the lines of
7 'it's always Lucy that ends up with these babies too'.
8 Again, there was no further discussions or him
9 suggesting anything was with intent."

10 So that's one additional aspect to the pattern. We
11 have looked at the fact that these were deteriorations
12 that happened at night, that Child I then seemed to
13 recover during the day, and then we are adding to that
14 that you had observed that Letby was on duty at the same
15 time. Did you draw any conclusions from that or did you
16 have any concerns arising out of that?

17 **A.** No.

18 **Q.** We have heard from Dr Lambie back in September
19 that there was a suggestion of nurses huddling and
20 looking at who was on duty on a rota. Was that
21 something that you were aware of, other nurses or
22 anybody suggesting to you that should be considered of
23 who was on duty when these collapses occurred?

24 **A.** No, I wasn't aware of any of those
25 discussions.

87

1 finishing nights, I think, but I can't remember any
2 comment or concerns from him about the three nights he
3 had looked after her. He was just very glad to be
4 finished as it had been so understandably stressful".

5 Then if we could turn over to page 7. Scroll down
6 to page 7 and we see there in the penultimate paragraph:

7 "Matt Neame had been resuscitating poor Child I
8 every night shift, then every morning at handover
9 I would be like 'Oh my God, poor Child I and poor you',
10 then we would have a day shift of where we would say,
11 'Oh she's not been too bad' as she had seemingly
12 recovered quite quickly."

13 So what Dr Chang seems to be saying is that there
14 was an apparent pattern where Child I would deteriorate
15 at night, bounce back to some extent into the day and
16 you were involved in those episodes?

17 **A.** (Nods)

18 **Q.** If we can go now to 0099075 at page 12 and
19 this is tab 10, my Lady, in your bundle. So that's
20 0099075 and page 12. At paragraph 36, this is the
21 statement of Nurse ZC that's been given to the Inquiry.

22 She says:

23 "The second instance was with Dr Matthew Neame who
24 similarly had a run of bad shifts. My understanding was
25 he had in fact previously completed a rotation at

86

1 **Q.** The Inquiry are considering an issue of
2 whether there was an instruction that was given on the
3 afternoon of 14 October, so after the second of the
4 consecutive collapses, experienced by Child I that Letby
5 be taken off caring for Baby I.

6 Did you have any knowledge that Letby was or there
7 was a suggestion that Letby should be taken off caring
8 for Baby I?

9 **A.** No.

10 **Q.** Just staying again with Baby I. It appears
11 that it was the death of Child I and indeed the -- which
12 happened on 23 October, I think you weren't involved on
13 that occasion; is that correct?

14 **A.** That's correct.

15 **Q.** But the death of Child I and indeed the
16 previous collapses that raised Dr Brearey's concern, and
17 indeed to some extent Dr Gibbs's concerns we heard
18 yesterday, at about this time, too.

19 Do you have any recollection of either Dr Brearey
20 or indeed of any Consultant coming to you and asking you
21 for your views as the doctor involved in these collapses
22 as to your views on the reason or any concerns you had?

23 **A.** No, I don't recall that.

24 **Q.** I think it follows, but I must ask you, did
25 anyone come to you and ask you about who were the nurses

88

1 who had been on duty during those collapses?

2 **A.** No.

3 **Q.** In the case of Child H and Child I, they were
4 significant collapses, where the child required
5 resuscitation. Did you consider making a Datix entry
6 for any of those collapses?

7 **A.** No, I didn't.

8 **Q.** Why was that?

9 **A.** I think at that time my perception of the
10 Datix would have been that it would be used if there had
11 been a mistake or a clinical error or a problem with the
12 equipment and I didn't perceive that to be the case
13 during those episodes.

14 **Q.** Maybe you can help. Had you felt there was
15 a reason for a Datix would that be something that you
16 would have been filling in or would that be something
17 that would be generally done by the nursing staff?

18 **A.** Often there would be a discussion about who
19 had identified it and who had the most useful
20 information about the incidents but certainly it is
21 something I would have felt comfortable and confident to
22 do.

23 **Q.** But it was nothing that either occurred to you
24 or was suggested by anyone that a Datix should be
25 entered for any of those episodes, the Child H or the

89

1 and had frequent clinical signs that could have
2 subsequently caused a deterioration.

3 I think they were still surprising in terms of how
4 severe they were. But, I hope that's a fair way of
5 expressing it.

6 **Q.** We see in the paragraph in the middle box
7 "Discussions and learning from the case".

8 There is no discussion about the collapses. Were
9 those meetings meetings where there was a free
10 discussion about any concerns? I'm trying to understand
11 why there was nothing in that discussion and learning in
12 relation to the collapses.

13 **A.** So I don't have a clear recollection of this
14 Morbidity and Mortality Meeting. Other mortality
15 meetings that I have a sort of vague recollection of at
16 Chester I think were quite Consultant-led perhaps and
17 quite focused on presenting key events without input
18 from junior colleagues. That -- that's a vague
19 recollection of some meetings that I had attended at my
20 time there.

21 **Q.** So just to interpret that if I can. That --
22 was that a meeting, would it have been led by
23 Dr Brearey, first of all, would that be your
24 recollection?

25 **A.** Well, the only meeting that I am certain I can

91

1 Child I collapses we have been discussing?

2 **A.** No, it wasn't suggested as far as I recall.

3 **Q.** If we could now look at 000526, page 10, which
4 is tab 7. Sorry, no, I'm afraid that's an incorrect
5 reference.

6 It's 0003288001. This is a neonatal mortality
7 meeting that you attended in relation to Child I. We
8 see your name there "Attendees" at the top.

9 Do you have any recollection of this meeting?

10 **A.** I don't think I recall that meeting. I think
11 I recall an informal debrief discussing Child I, but
12 I don't think I recall a formal mortality meeting.

13 **Q.** Because we see there, certainly in the middle
14 of the page, we see a summary of the case and we see
15 there that the collapses on the 13th and the 14th are
16 recorded there and obviously that was something that you
17 would have had direct evidence about?

18 **A.** (Nods).

19 **Q.** And I think it's correct, is it, Dr Neame,
20 that you had concerns and didn't have an explanation as
21 to why those arrests had occurred at this stage?

22 **A.** I think certainly the immediacy of the first
23 episode was very surprising. As I tried to express
24 earlier, I think the subsequent episodes were less
25 unexpected in that Child I was less stable by that point

90

1 remember to do with Child I was a quite informal debrief
2 and discussion amongst the team around her course on the
3 unit. But I -- I don't recall that as being a formal
4 Morbidity and Mortality Meeting with an in-depth
5 discussion of the clinical course.

6 **Q.** So you, as far as you are aware, can't recall
7 this neonatal mortality meeting that would be
8 discussing, as is apparent from it, the period
9 from August to October and the deaths that had occurred
10 in that period. That's not a meeting that you recall?

11 **A.** I don't recall it, no.

12 **Q.** Thank you. If we could just turn, while we
13 are looking at the recording of incidents, to 000526 and
14 page 10 of that and this is tab 7, my Lady, in the
15 bundle.

16 Dr Neame, this is an extract from a statement that
17 you gave to the police and if you could go to page 10
18 and you deal here with some of the note-taking in
19 relation to Child I. We see there, are we on page 10,
20 yes, that you were called to attend Child I and that's
21 at the top of that paragraph and that's relating to --
22 it's not immediately apparent from this page -- but
23 that's relating to 15 October and then going down the
24 page, we see:

25 "My next note was then 19 October at 09:50 hours."

92

1 And if we could go to the next page, please, we see
2 that's dealing with the note, the continuation of the
3 note that you were filling on 19 October and it says:

4 "I discussed her [that's Child I] with the surgical
5 team at Alder Hey and the Registrar there who had
6 discussed her with the on-call Consultant. There was
7 a query about arranging another investigation for her to
8 have a barium x-ray of her tummy to see if there was any
9 explanation for her tummy problems. A barium x-ray can
10 give a clearer picture of any blockages in the bowel."

11 Then at the bottom of that page, your next notes
12 were on 22 October at 11:30 and then if we can go on one
13 more page, so this is still the note of 22 October, you
14 say there at the end of the first paragraph:

15 "The plan was to chase up the previous
16 investigations, the contrast enema and keep her nil by
17 mouth until then."

18 Were you aware, Dr Neame -- obviously sadly
19 Child I died the following day, but were you aware why
20 these tests that you were chasing up had not taken place
21 prior to that?

22 **A.** My recollection is that during that period it
23 was very -- it had been very difficult to get her
24 transferred over to Alder Hey to have a further
25 assessment and to have those investigations completed.

93

1 by the more senior cohort of medical and nursing
2 colleagues, and in part this was because I held the
3 assumption that the episodes were related to unexplained
4 or unexpected medical factors rather than being caused
5 by factors related to deliberate harm or incompetence."

6 Just looking at that, you say you were confident
7 that observations had been noted by a more senior
8 cohort. What was the basis of that confidence?

9 **A.** The fact that I had, you know, been escalating
10 the concerns directly to Consultant colleagues as they
11 arose. They were often present as I was managing the
12 challenging clinical situations and I felt confident
13 that they would have found them, you know, challenging
14 as I did and my perception was that they were a, you
15 know, relatively close coherent group who would be
16 familiar with how much pressure the unit was
17 experiencing.

18 **Q.** And then you, just looking at the expression
19 you use there, "unexplained or unexpected medical
20 factors". In effect, that means that simply there was
21 no explanation for these. That's what that's saying,
22 isn't it, there was unexplained or unexpected, is that
23 correct?

24 **A.** Well, it's saying that my perception was that
25 they weren't immediately explainable, but that with

95

1 **Q.** You say then at the bottom of the page:

2 "I don't recall ever there being a good explanation
3 or understanding of Child I as to why she had episodes
4 where she became unwell so quickly and sadly died."

5 Does that accurately set out your view?

6 **A.** That's a good summary of the overall feeling
7 I have about her care. I think there were episodes
8 where I felt there was certainly a plausible clinical
9 explanation. But I think reflecting on the overall, you
10 know, on her care and her course overall I think that's
11 a fair summary.

12 **Q.** And if we could go just to paragraph 40 of
13 your statement. I think if we could put that up on
14 screen, that's INQ0102351 at page 10, and again this is
15 somewhat of a summary really of your evidence -- of your
16 witness statement:

17 "I recall developing a subjective sense of concern
18 about the number of deaths and unexpected deteriorations
19 on the Neonatal Unit during my placement there in
20 2015-2016. I recall discussing these concerns
21 informally with colleagues, for example highlighting
22 that shifts had been unexpectedly busy at Consultant
23 handover meetings but I did not raise these concerns
24 formally. In part, I believe this is because I was
25 confident that these observations had already been noted

94

1 further assessment or investigation that we would
2 identify medical causes.

3 **Q.** Do you now considering, looking at this with
4 hindsight, was that a situation where there should have
5 been consideration of whether there was a non-medical
6 factor, either deliberate harm or negligence, for why
7 those were happening? Is that something that should
8 have been within the range of possibilities that was
9 considered?

10 **A.** Well, I think absolutely it -- it should have
11 been and I think it's hard to know when, when that
12 threshold should have been met.

13 But, yes, I think it's difficult to disagree with
14 that given everything we know now of course.

15 **Q.** But at that stage for you, Dr Neame, you
16 hadn't reached a point where you were considering
17 non-medical explanations, is that correct?

18 **A.** No, that's correct.

19 **Q.** Then just dealing briefly with safeguarding.

20 What was the training that you had received in
21 relation to safeguarding training either at the Countess
22 of Chester or indeed prior to that?

23 **A.** So I can't remember precise details of the
24 training I had undertaken. But I remember clearly that
25 by that stage of my training, I was required to have

96

1 a good understanding, well, have a clear understanding
2 of the typical presentations that might indicate that
3 a child had been subject to deliberate harm or
4 a non-accidental injury.

5 That would have included reflecting on clinical
6 cases, discussing them with senior colleagues and also
7 attending training courses designed to promote the
8 recognition and response to -- to child protection
9 issues.

10 **Q.** Did you at any stage in this, particularly by
11 the stage towards the end of your period in February
12 when you had dealt with the issues of the collapses of
13 Child I, did you at any point consider that there was
14 a safeguarding issue that was developing here?

15 **A.** No.

16 **Q.** Turning finally then to your reflections and,
17 Dr Neame, you set out in your witness statement your
18 reflections which will of course be considered.

19 But I just wanted to look at one of those that you
20 deal with at paragraph 6 and you say that you would like
21 the Inquiry to recommend that: neonatal units should aim
22 to enable the parents of babies to stay with their
23 babies around the clock and that you think more contact
24 between babies and families would make it harder for
25 staff to perpetrate criminal actions and that closer

97

1 Chester?

2 **A.** I think that's something I have reflected on
3 since being involved in this case.

4 **MS BROWNE:** Thank you very much. You may have some
5 further questions from my Lady.

6 **LADY JUSTICE THIRLWALL:** No, I have no questions
7 for you. Thank you very much indeed, Dr Neame, and in
8 particular for your reflections which are extremely
9 helpful. I know that you have made a number of
10 statements including the ones we have been looking at
11 today. Thank you for all of that and you are now free
12 to go.

13 **A.** Thank you.

14 **LADY JUSTICE THIRLWALL:** I think, Ms Browne, the
15 next witness is attending by videolink.

16 **MS BROWNE:** Yes.

17 **LADY JUSTICE THIRLWALL:** So that is fixed for
18 2 o'clock. So if everyone could be back in the room
19 just before 2 o'clock so we can get started on time.

20 **(12.43 pm)**

21 **(The luncheon adjournment)**

22 **(2.00 pm)**

23 **MS LANGDALE:** My Lady, may I call the next witness
24 Dr Mayberry who is giving evidence over the link and
25 needs to be sworn.

99

1 contact between family members improves clinical
2 outcomes.

3 Is that something you just want to expand upon very
4 briefly as to why you feel that is so important with
5 your additional experience obviously now as a Consultant
6 paediatrician?

7 **A.** I just think that's not just my experience.

8 I think there's evidence that babies have -- experience
9 better outcomes when they spend more time with their
10 caregivers.

11 With respect to the particular issues in this, this
12 case, I think it would have made it much harder for
13 a medical professional to behave abnormally or with --
14 cause harm if there was a parent with the child.

15 I think the neonatal settings that I have worked in
16 previously have not been well set up in terms of the
17 sort of architecture or layout in terms of making it
18 easy for families to spend large amounts of time with
19 their children. I think efforts are made with
20 comfortable chairs and so on, but that's very different
21 to, you know, being able to stay with your child which
22 would be the norm in a paediatric ward or a children's
23 hospital.

24 **Q.** And the lack of that was something that you
25 were conscious of when you were at the Countess of

98

1 **LADY JUSTICE THIRLWALL:** Welcome, Dr Mayberry the
2 next voice you will hear will be from my clerk who is
3 going to administer the affirmation.

4 **THE WITNESS:** Sure.

5 **DR HUW MAYBERRY (affirmed)**
6 **(Evidence via videolink)**

7 **Questioned by MS LANGDALE**

8 **MS LANGDALE:** Can you give us your name and
9 qualifications, please?

10 **A.** Sure so my name is Dr Huw Francis Mayberry,
11 I hold a Certificate of Completion of Training in
12 Paediatrics (Paediatric Intensive Care) from the General
13 Medical Council. I have also completed
14 a Special Interest Module, or a SPIN, in Paediatric
15 Cardiology. I am a member of the Royal College of
16 Paediatrics and Child Health. I have held memberships
17 with the Paediatric Critical Care Society and the
18 European Society for Paediatric and Neonatal Intensive
19 Care.

20 My degree is an MUDr awarded by Charles University
21 in Prague in 2011.

22 **LADY JUSTICE THIRLWALL:** Just pause there,
23 Dr Mayberry. Can everyone hear sufficiently well? No.
24 I wonder if you could move forward, I gather there is
25 a problem with the sound so if you can move forward,

100

1 that might be the best thing to do.

2 **MS LANGDALE:** Shall we try that? (Pause) That
3 sounds better.

4 If you can't hear me, Dr Mayberry, at any point
5 just raise your hand and I will do the same for you so
6 we don't keep speaking into a vacuum of people not
7 hearing us.

8 **A.** That sounds good.

9 **Q.** Thank you.

10 You have provided helpfully the Inquiry with
11 a statement dated 9 April 2024. Can you confirm for us
12 that the contents are true and accurate as far as you
13 are concerned?

14 **A.** As far as I am aware yes, the contents are
15 true and accurate.

16 **Q.** You have it with you, I believe, Dr Mayberry,
17 so I can take you through it today?

18 **A.** Yes, I do yes.

19 **Q.** Can I ask you a couple of questions before
20 I do. We know from your CV that you were working at the
21 Countess of Chester between March 2016 and
22 September 2016 in specialist paediatrics; yes?

23 **A.** Yes.

24 **Q.** Did you know Dr Ogden or Dr Lambie, those who
25 had come before you, in Dr Ogden's case March

101

1 **A.** Yes.

2 **Q.** We can't see you while you are looking at it
3 but I will take it down as soon as I can, Dr Mayberry.

4 If you look at paragraph 32, Dr Ogden says when she
5 was at the Countess:

6 "I do recall finding the numbers of collapses or
7 deaths on the unit at that time as unusual and
8 concerning. I am unsure specifically when this appeared
9 to me as unusual but it is likely to be around the time

10 of several of those collapses/deaths that occurred
11 within a few weeks of each other in June 2015. Whilst

12 I do not recall that I specifically approached any

13 Consultant in particular to raise specific concerns

14 I believe the whole department was discussing this

15 informally as being unusual and that the senior

16 Consultant team were raising this and investigating what
17 could have caused this."

18 That can come down from the screen, Dr Mayberry.

19 **A.** Sure.

20 **Q.** I can tell you that we heard from Dr Lambie
21 this morning that in the same period in around June, she
22 says she does:

23 "... recall being aware of increasing levels of
24 anxiety following the death of Child A and collapse of
25 Child B soon afterwards largely due to the unexpected

103

1 to September 2015 and the same I think for Dr Lambie?

2 **A.** I haven't met Dr Lambie to the best of my
3 recollection. Dr Ogden is somebody who I have met in
4 other contexts. I can't remember if I knew Dr Ogden
5 before the Countess, before I worked at the Countess,
6 but I am -- I do know who she is and I have met her on
7 other occasions.

8 **Q.** I notice it is obviously not uncommon as
9 Registrars or trainees you move around. Arrowse Park, in
10 your case, Alder Hey, Countess of Chester and also
11 Liverpool Women's. So presumably there is sometimes
12 overlap or connection or communication between
13 Registrars rotating in their roles?

14 **A.** Yes, there can be. To the best of my
15 recollection, I don't think I worked with Dr Ogden
16 before I worked at the Countess of Chester.

17 **Q.** Dr Ogden, I will ask for it to be put on the
18 screen so you can see it Dr Mayberry, she in here
19 statement -- the reference number is INQ0102019, page 8.
20 It is paragraph 32 of her statement. It doesn't refer
21 to you, Dr Mayberry, but I want to draw to your
22 attention what she says at paragraph 32 on page 8.

23 **A.** I don't have that on screen currently.

24 **Q.** You will shortly, don't worry, I think it
25 should be coming. Can you see it now?

102

1 and similar natures of their collapses and the
2 appearance of the unusual rash.

3 "As further babies become unexpectedly seriously
4 ill, (collapsed) or died, I recall medical and nursing
5 staff reporting to each other they were nervous at the
6 start of their shifts. I personally recall being
7 nervous at the start of a set of night shifts towards
8 the end of my placement as I was almost expecting
9 something bad to happen".

10 When you arrive, were you aware of that concern or
11 discussions, sense of unease that both have described in
12 their statements?

13 **A.** I think on arrival it wasn't something I was
14 particularly aware of. As I have written later on
15 during my statement Dr Brearey did tell me that
16 historically the Countess had had a low mortality rate,
17 that that had increased over the period before I had
18 arrived and that they had started asking for other
19 people to be involved with that.

20 I don't recall exactly when that conversation took
21 place. It was an informal conversation. But I wasn't
22 aware of a growing sense of unease at the time.

23 **Q.** I think it is paragraph 12 of your statement,
24 Dr Mayberry, you set that out, you say:

25 "As time went on I do recall growing anxiety about

104

1 the mortality rate. From what I understood Chester
2 traditionally had a low mortality rate compared to the
3 rest of the region and it wasn't understood why that had
4 changed."

5 **A.** Yes.

6 **Q.** So you can anchor yourself and everyone in the
7 room can, Dr Mayberry, when you were there we know that
8 L, M, N and Q suffered deteriorations and O and P died.

9 So when you were there, O and P, the triplets which
10 we will come to later, died, but you say nevertheless
11 you were aware from Dr Brearey some growing anxiety
12 about the mortality rates. I just want to unpack that.

13 When you say "mortality rates", does that mean
14 simply death rate or did you have any sense or unease
15 about unexpected death rate or discussion about that?

16 **A.** Sure. To the best of my recollection, all
17 that was referred to was the mortality rate as opposed
18 to anything unusual about the deaths.

19 **Q.** So it was the crude indicator, a mortality
20 rate full stop and the number?

21 **A.** Yes.

22 **Q.** You understood from Dr Brearey that that was
23 being investigated because it was higher?

24 **A.** Yes.

25 **Q.** Or it had changed?

105

1 **Q.** But nobody ever spoke to you about what it
2 might represent or anything like that?

3 **A.** No, I think Dr Brearey said they didn't
4 understand why it had gone up and that's why they had
5 sought external opinions and advice.

6 **Q.** What external opinion did you think that they
7 were getting?

8 **A.** So I thought that they were getting a Network
9 review, so a review from the Neonatal Network, and then
10 later on a review from the Royal College of Paediatrics
11 and Childcare.

12 **LADY JUSTICE THIRLWALL:** I'm sorry to ask, would
13 you mind just keeping your voice up a little bit more
14 and a bit closer to the microphone, thank you.

15 **A.** Sure, sorry, so my understanding was that it
16 was a Network review, so a review from the Neonatal
17 Network in the area and a review from the -- later on
18 from the Royal College of Paediatrics and Child Health.

19 **Q.** And in what context did Dr Brearey give you
20 this information, was it in a passing conversation, in
21 an informal discussion, what kind of set-up was it where
22 you learned this?

23 **A.** I believe it was an informal discussion but
24 I can't remember too much more context to it, sorry.

25 **Q.** Informal discussions, presumably they take

107

1 **A.** Yes, it increased, yes.

2 **Q.** Was he a supervisor of yours or a -- I don't
3 know what you would call it?

4 **A.** He was my -- he was a Consultant so he is
5 somebody I guess would supervise me in the sense he was
6 the most senior person on-call or on a number of
7 occasions. My designated supervisor was Dr Gibbs
8 though.

9 **Q.** Did Dr Gibbs ever say anything to you about
10 mortality rates?

11 **A.** If I am honest, I don't fully recall.

12 A conversation I recall most clearly was the one with
13 Dr Brearey.

14 **Q.** Was that soon after you arrived, later on?
15 I mean, you arrived in March 2016?

16 **A.** Yes.

17 **Q.** When did that conversation roughly take place
18 with Dr Brearey?

19 **A.** I think it probably would have been within the
20 first couple of months but I find it hard to be more
21 specific than that.

22 **Q.** Fair enough, but you knew soon after your
23 arrival there was concern about that number and what it
24 represented?

25 **A.** Yes.

106

1 place between doctors, doctors and nurses and people all
2 the time walking around a hospital? When you catch
3 a moment, you catch someone, you have a conversation, is
4 that how it is?

5 **A.** Yes, you do have informal conversations.

6 **Q.** Did you have any discussion with fellow
7 Registrars about the mortality rate?

8 **A.** No, not really. The -- I am getting a lot of
9 feedback, does everyone -- are you having trouble
10 hearing me?

11 **Q.** We are not having trouble hearing you. I'm
12 sorry that you are getting feedback. Can you hear me?

13 **A.** Yes, I can hear you.

14 So I didn't have a conversation with other
15 Registrars, to the best of my recollection about it was
16 quite low on the number of Registrars on the rota and by
17 its very nature I think at times we were down to 3.5
18 working equivalent Registrars on an eight Registrar
19 rota. You wouldn't necessarily see the other Registrars
20 on a very regular basis.

21 **Q.** Did you ever ask "what are the numbers" when
22 you were told there was an investigation or
23 consideration, I should say, into the mortality rate,
24 did you say, "Well, how many is it usually, what's it
25 now?" or ask any questions out of curiosity. I am not

108

1 saying you should have done, but were you curious what
2 that was about?

3 **A.** No. At this point this was my first year of
4 being a Registrar and it was my first job working in
5 a designated neonatal unit as a Registrar and I think
6 I was probably focused largely on making sure my own
7 practice was as good as it could be and up to date and
8 I understood that there were processes taking place in
9 the background to look into what had happened and why it
10 had happened.

11 **Q.** Understood. At that stage in your career,
12 Dr Mayberry, did you know whether and if so there was
13 a difference between what should happen when a child
14 dies in hospital and when a child unexpectedly or
15 without explanation dies in a hospital, would you have
16 known that or been aware of that important distinction
17 then?

18 **A.** I think I would have had some awareness of it
19 but probably I would have had some awareness but not as
20 extensive perhaps as I do now.

21 **Q.** Sure. What's given you a greater awareness
22 now: training, knowledge, experience?

23 **A.** I think probably a combination of all of those
24 things.

25 **Q.** Did you, at the time you were at the Countess
109

1 would think about on a day-to-day basis and there were
2 a number of other things which were more likely to
3 affect and -- affect children and put their lives at
4 risk.

5 **Q.** We asked you, Dr Mayberry, about the culture
6 and atmosphere of the neonatal unit in 2016. You tell
7 us Dr Gibbs was your assigned supervisor and was
8 responsible for helping you with any difficulties you
9 might face. Did you find Consultants, particularly
10 Dr Gibbs, helpful to you in their capacity as
11 Consultants? Were the relationships good and harmonious
12 as far as you are concerned?

13 **A.** Yes, I didn't have any problem or any issue
14 with any Consultants there. When I was on-call and
15 I needed help, the Consultants would often come in even
16 middle of the night they would happily come into help.
17 I didn't have any problems.

18 **Q.** That was a super clear answer, Dr Mayberry, so
19 wherever you are sitting now is a good place to be. It
20 was very audible, thank you.

21 You also say in your statement at paragraph 8:

22 "... Consultants didn't really discuss the
23 interactions with management with junior members of
24 staff."

25 You are a junior doctor, you are setting out on
111

1 and generally, know very much, if at all, about the case
2 of Beverley Allitt the nurse in Grantham Hospital who
3 had been convicted of murdering patients? Did you know
4 anything about that case when you started medical
5 training?

6 **A.** I knew historically just from general sort of
7 news about some of Beverley Allitt's case but it's
8 something that didn't come through training or anything
9 like that. It was more a from sort of general news.

10 **Q.** And in general, would that heighten any
11 awareness in you or colleagues generally or do you think
12 it was sort of consigned to the past and just a case or
13 what do you think?

14 **A.** I think it's something that you did sort of
15 think of in -- as something to be aware of in the
16 background. I am not sure it's something that came into
17 day-to-day thinking, though.

18 **Q.** So background knowledge but not day-to-day
19 thinking because that seems unthinkable, or how would
20 you define thinking about a nurse murdering patients?

21 **A.** I think because it's -- potentially it was
22 more historic, it was something that was relatively --
23 well, it was rare in its nature, and I guess they are
24 probably the main -- the main things that it was
25 historic and it was rare and so it's not something you
110

1 your career at this time. What role did management
2 play, if any, in your understanding of your career and
3 your future ahead, what did you make of the role of
4 management and how the Consultants got on with them?

5 **A.** So I didn't hear a great deal about how the
6 Consultants got on with management. I think what I did
7 hear was probably limited to their attempts to increase
8 the number of Registrars on the rota and that seemed to
9 be the extent of my interaction, my knowledge of
10 management interaction with Consultants.

11 **Q.** That they did increase the number?

12 **A.** No, that the Consultants were trying to get
13 more Registrars on that rota and that they were
14 approaching HR and management to try and do that.

15 **Q.** Did you think that would be a good thing, to
16 have more Registrars?

17 **A.** Absolutely, yes.

18 **Q.** What was your shift pattern like?

19 **A.** My shift pattern in itself was fairly
20 standard, I recall. Having said that, what you needed
21 to do on a shift was much more difficult and hectic than
22 you would have had to do in another district general
23 hospital and I think that was down to the fact that they
24 were so short on numbers of people on that grade rota
25 with there only being 3.5 working time equivalents on an
112

1 eight -- what would normally be eight doctors fulfilling
2 this role and the Countess was a busy hospital.
3 It had a large range of services to cover as
4 a paediatric trainee and it meant that you had to do
5 what would be expected normally of eight Registrars with
6 3.5, so it was busy.

7 **Q.** You were going into the children's unit,
8 neonatal unit and A&E as well?

9 **A.** A&E and other clinics, yes.

10 **Q.** You say the interactions you experienced
11 between medical, nursing and midwifery groups were
12 always friendly and professional. Did you ever sense
13 tension anywhere between midwives and doctors, nurses
14 and doctors, or not?

15 **A.** Not -- not really, no.

16 **Q.** You say:

17 "From a medical perspective ... Dr Brearey was the
18 lead and would promote the latest and most up-to-date
19 neonatal medicine, encouraging trainees to read and
20 follow the ... (British Association of Perinatal
21 Medicine) guidance."

22 So did he encourage best practice in individual
23 sessions with you or just generally signpost what was
24 going on or how did what work?

25 **A.** He did it in a variety of ways. He would
113

1 atmosphere that people were encouraging in terms of
2 development of junior staff and would try and promote
3 up-to-date guidance and help push things forward.

4 **Q.** You say the Consultant body were known to be
5 clinically sound, supportive towards juniors and
6 pleasant to work with.

7 So there was no sense, was there, from your
8 perspective of arrogance or they know best and not
9 listening to concerns or voices around them?

10 **A.** No, not at the time I worked there. No.

11 **Q.** Did you ever witness them being dismissive or
12 not concerned about matters raised by nurses or patients
13 or anyone else?

14 **A.** It's not something I recall witnessing, no.

15 **Q.** You say you had little direct interaction with
16 senior management but you did attend a corporate
17 induction. Can you tell us about the corporate
18 induction and what you say at paragraph 15 you were
19 taught about?

20 **A.** Yes. So my memory of corporate inductions has
21 become a little bit more hazy but one of the things that
22 stuck out to me was -- one of the things that stood out
23 was the importance of not losing your handover sheets.

24 Now, every doctor knows that your handover sheet
25 has a lot of important information for patients on it
115

1 often discuss changes in guidance. In terms of things
2 like individual practice he would also help with that as
3 well. I think at the time for example one of the things
4 was around UVC incision, the umbilical venous catheters.
5 BAPM had changed what they suggested in terms of how you
6 insert them and how you secure them and he was saying,
7 you know, we should -- if you do it like this, then
8 that's a bit of an older practice. We should try and do
9 it in this new way with the BAPM guidance, so he would
10 provide individual feedback as well as promoting good
11 practice in general.

12 **Q.** You say that the nurses, you had a good
13 relationship with the nurses, they were friendly and
14 professional, your interaction was good with them?

15 **A.** Yes, I believe it was, yes.

16 **Q.** You also say that the culture in the Countess
17 compared very well to other hospitals you have worked in
18 that's Arrowe Park, Leighton Hospital, and you also say
19 it had a good reputation. What was it about the
20 Countess of Chester that had a good reputation as far as
21 trainees who wanted to apply to work in those units were
22 concerned?

23 **A.** I think it had a -- what was known to be
24 a very supportive Consultant body, people who would help
25 you with help and guidance and it had a fairly friendly
114

1 and that you would never want to lose that because you
2 don't want to breach confidentiality of a patient.

3 But one of the things that came up was the fines
4 that the Countess would go through if you -- if you lost
5 a handover sheet, however much money that was and that
6 this was unacceptable.

7 I thought that was very unusual. Everyone at
8 induction goes through, like, make sure you don't lose
9 confidential information and Caldicott guidelines and
10 things like that, but no one in any other corporate
11 induction I had attended had mentioned the cost of fines
12 and I thought that to be very unusual.

13 **Q.** Was this in 2016, so was this early on
14 in March, the beginning or a bit later on in your ...

15 **A.** At the beginning.

16 **Q.** So your induction very much told you about the
17 importance of handovers. Can I just understand at that
18 time, were the handovers written and on paper, you know,
19 was there something you could physically take?

20 **A.** Yes. So normally, handover consisted of two
21 things. You would have a piece of paper which would
22 have a short summary of the most important points about
23 why a patient was there and what jobs they needed --
24 what investigations they had had done and what jobs they
25 needed doing and that's fairly standard at the time
116

1 across all the NHS Trusts.

2 That would allow you to also write additional notes
3 next to it to help structure your day and help make sure
4 that you did everything that the patient needed to have
5 done.

6 There was also accompanied with that a verbal
7 handover from the junior doctors with the Consultants
8 present to say what was going on with each patient and
9 potentially patients who were due to come in as well.

10 **Q.** At the criminal trial it was made clear,
11 Dr Mayberry, that Letby had handover sheets for a number
12 of children in plastic bags under her bed at home; in
13 fact kept 231 handover sheets.

14 At the induction was it being highlighted that if
15 you took them, there was a fine and would you have
16 expected as a doctor working there that someone would
17 notice when you have taken a handover sheet or not, are
18 you not looking retrospectively or how does it work?

19 **A.** So the handover sheet, normally the way it
20 worked is the handover sheet gets printed, you write
21 your stuff down on it and then at the end of the day
22 there is a confidential waste bin where your handover
23 goes in to, then that is taken securely it is in the
24 sort of waste bin of it and shredded and destroyed so
25 that patient confidentiality is kept, you know, safe.

117

1 confidential waste properly.

2 **LADY JUSTICE THIRLWALL:** Thank you very much.
3 Sorry, Ms Langdale.

4 **MS LANGDALE:** Thank you.

5 In that induction, either that one or any other,
6 did you have any safeguarding advice about who to speak
7 to if you were concerned about a child, concerned
8 potentially because of a member of staff's treatment or
9 family members; anything, concerns for a child, child
10 protection, was there a generalised induction around
11 that?

12 **A.** Yes. There was an induction around child
13 protection, I think it was one of the community
14 paediatricians who did it.

15 **Q.** Would you have known the name of the community
16 paediatrician or the person to go to if you had
17 a safeguarding concern?

18 **A.** So safeguarding concerns out of hours at the
19 Countess of Chester I believe were discussed with the
20 duty Consultant paediatrician.

21 **Q.** Did you have any discussion at any time around
22 Datixes and what the importance of a Datix was after any
23 event and what type of event?

24 **A.** I think there were some discussions around
25 Datix and that if you saw things which you thought were

119

1 It's not that every handover sheet is necessarily
2 tracked in some sort of a way. If it were that you
3 ended up, you know, taking them home I am not sure
4 somebody would -- it would be a good way of tracking
5 that based on the --

6 **Q.** Don't worry, I am not asking about tracking
7 it. It was more that the hospital are telling you there
8 are fines for it because of patient confidentiality and
9 you were not expecting that. Have you had that kind of
10 induction anywhere else since?

11 **A.** Yes. In terms of -- not in terms of fines
12 specifically but everybody knows that you should be
13 getting rid of your handover sheets and disposing of
14 them in the secure, you know, bins where you throw them
15 away.

16
17 **LADY JUSTICE THIRLWALL:** Dr Mayberry, can I just
18 ask you, I didn't quite hear and I am not sure that the
19 transcriber did either: when you were talking about the
20 induction, and that everyone is aware of the guidelines,
21 did you say "Caldicott Guidelines" or some other sort of
22 guideline?

23 **A.** So yes, Caldicott and information about how to
24 how to make sure that you -- only the right people have
25 the right information and you dispose of any

118

1 a risk to patients, or -- not or -- or caused patient
2 harm then you should fill out Datix forms to make sure
3 that those concerns could be addressed and followed up
4 with.

5 **Q.** You tell us, going back to the topic of
6 management, you briefly interacted with management about
7 the cap on locums for junior doctors at a significantly
8 reduced rate.

9 Can you tell us about that?

10 **A.** So in terms of the Registrar rota and some of
11 the Level 1 rotas, so the rota below the Registrars,
12 there were a lot of gaps obviously because there is
13 designed for eight people and only 3.5 people were at
14 times running on that rota.

15 The -- at the time I think or it might have been
16 a bit before this there was a cap put on locum fees with
17 the aim of trying to -- I don't know, trying get
18 expenditure and things down.

19 It became clear that the cap across the region
20 wasn't working and people weren't going to work for
21 a reduced rate and most hospitals in the region lifted
22 that cap and went back to the rates that they had
23 traditionally paid people.

24 At the Countess, that approach wasn't taken during
25 certainly the early part while I was there and they

120

1 remained steadfastly holding on to that cap. It meant
2 that people in other parts of the region when locums
3 came up were being offered significantly more money to
4 go and work in another hospital, like Alder Hey or
5 Arrowse Park, and so people -- if you had a choice of
6 where to work, people weren't taking up the locum offers
7 at the Countess of Chester.

8 **Q.** Did you raise that with other doctors or
9 managers individually?

10 **A.** Yes. So that was raised with a number of
11 different Consultants who knew about it. As I said,
12 I didn't really have a relationship with the managers so
13 I didn't have somebody I could really speak to about
14 that on a management level and the Consultants assured
15 me that they were pushing hard to fill the gaps on the
16 rota and had also asked for the cap to be raised.

17 **Q.** We are aware there was a medical staff
18 committee, was that something you were aware of or would
19 have had any relevance here or not?

20 **A.** No, it's not something I was aware of.

21 **Q.** Okay. Moving now, if I may, to Child N in
22 paragraph 19 of your statement. Looking at your Inquiry
23 statement and your police statement, I don't need you to
24 go to your police statement, it is clear that you are
25 speaking about events on 15 June 2016, at paragraph 19.

121

1 Child N's oxygen levels had dropped to 44% and 3ml of
2 blood had been aspirated from the nasogastric tube
3 beforehand. I can't remember which member of staff
4 initiated the call. I used an airway manoeuvre and
5 a NeoPuff device ventilated Child N until their oxygen
6 saturations were 100% and I requested the crash bleep to
7 Dr Saladi, given that the previous Registrar had had
8 a lot of difficulty in attempting intubation. Whilst
9 awaiting the arrival of Dr Saladi, I instrumented the
10 airway and saw a large swelling at the end of the
11 epiglottis only just see the bottom of the vocal chords
12 which is the area where you would normally put
13 a breathing tube in.

14 At this point Dr Saladi arrived and given the
15 difficulty with the airway, I handed over Child N's care
16 to him. I don't remember much more about who was
17 present and what was happening as my sole focus was to
18 improve the oxygen levels in the critically unwell
19 child.

20 **Q.** Did you discuss what you saw at the back of
21 the throat at the time then with anyone?

22 **A.** Yes, I did. I can't remember if I discussed
23 it with Dr Saladi at that point when he came. I did
24 later on discuss it when I came back to the neonatal
25 unit later on, and there was a Consultant anaesthetist

123

1 We now know of course that Letby has been convicted
2 of the attempted murder of Baby N with inflicted trauma
3 to the throat. Taking yourself back to the evening
4 obviously you didn't know that then, but can you set out
5 for us your involvement with Baby N as you set it out
6 here?

7 **A.** Sorry?

8 **Q.** As you set it out here, I don't need the pages
9 of your police statement, just what you set out here.

10 **A.** So I think most of my involvement was with
11 Child N. I believe it was in the afternoon, actually,
12 and I was holding the emergency bleep for the neonatal
13 unit. To the best of my recollection I wasn't assigned
14 to the neonatal unit, but I think --

15 **Q.** Sorry, we lost you there, Dr Mayberry. To the
16 best of your recollection, you weren't assigned to
17 Baby N?

18 **A.** Sorry, I wasn't assigned to the neonatal unit.

19 **Q.** To the neonatal unit.

20 **A.** I covered the bleep for a brief period of time
21 from one of the doctors who was assigned to the neonatal
22 unit that day and I believe I was assigned to the
23 paediatric ward.

24 Whilst holding the bleep, the emergency crash bleep
25 went off and there was a call to the unit because

122

1 present who was Dr Campbell, who I wanted -- who
2 I discussed it with because I hadn't seen anything like
3 this before and I was wondering as somebody who is more
4 experienced with airways what her thoughts on it were
5 and if there was anything else that I could do in the
6 future to improve my practice if I came across the
7 situation such as that.

8 She told me that the view on the airway was
9 a Grade 4 which is the most difficult grade of
10 intubation and that she had been unable to intubate the
11 child. I believe an ENT team and a paediatric intensive
12 care team were mobilised from Alder Hey and they did not
13 find any difficulty in intubating the child.

14 At some point I asked Dr Gibbs about what they
15 found and he told me it was a Grade 1 airway and that
16 they hadn't had any difficulty in intubating the child.

17 **Q.** You say:

18 "I do not recall attending a debrief for Child N."

19 Was there any informal discussion between doctors
20 and nurses who had been present that day or at that time
21 about Child N?

22 **A.** There was obviously that informal conversation
23 that I have referred to.

24 **Q.** You and the anaesthetist?

25 **A.** Yes, and with Dr Gibbs subsequently. But

124

1 I don't recall a debrief. There may have been one but

2 I don't recall it.

3 **Q.** The Inquiry is aware that Dr Brearey had sent
4 an email to Eirian Powell and his fellow Consultants on
5 11 May 2016 saying:

6 "If you come across a baby who deteriorates
7 suddenly or unexpectedly or needs resuscitation on NNU
8 please could you let me and Eirian know. We will keep
9 a record of these cases and review them as soon as
10 practicable".

11 As far as you were aware, were you invited or asked
12 to say what your involvement was or what you had seen or
13 what you may have been concerned about at any review?

14 **A.** No.

15 **Q.** Child O. At paragraph 23, you tell us you
16 were working nights. Tell us of your involvement with
17 Child O and when you learned of Child O's death and how
18 you felt about that?

19 **A.** So for Child O I was on the night of
20 22 June 2016 and I was working as a middle grade doctor,
21 so on the Registrar rota.

22 "At some point in the night, I don't remember the
23 exact time, Sophie Ellis, who was the nurse looking
24 after Child O, requested a review of Child O's abdomen
25 because it was mildly distended. Although she was not
125

1 **Q.** Sorry, we are losing you there a bit. You say
2 you returned, you learned there was a concern?

3 **A.** About NEC, and that the child had deteriorated
4 very quickly.

5 **Q.** And you say at paragraph 26:

6 "... I had a brief conversation with Sophie where
7 I expressed my shock at what had happened. Sophie also
8 agreed that he had been fine for the rest of the
9 previous shift and she stated she was also shocked at
10 what had happened'."

11 **A.** Yes.

12 **Q.** You can't recollect further details other than
13 what you have said previously to the police and what you
14 have repeated in part now. So can you remember how you
15 were shocked or why you were shocked?

16 **A.** I was shocked because nothing seemed unusual
17 on that nightshift and with the initial concern about
18 NEC that wouldn't normally fit in that kind of timeline.

19 **Q.** You then go on in your statement to speak
20 about Child P and your involvement with him on that next
21 night. Tell us about that.

22 **A.** So in terms of my involvement with Child P,
23 received a call from one of the nurses in the neonatal
24 unit but I don't recall who it was. There was a concern
25 about a large amount of milk being aspirated from the
127

1 worried about him, she felt he looked slightly

2 uncomfortable. When examining Child O I could feel that
3 his abdomen was soft although it was slightly distended,
4 he wasn't uncomfortable. This would be a common finding
5 in a child on high flow nasal cannula oxygen and
6 I wasn't particularly concerned about him. As
7 I finished examining Child O and left his nursery, the
8 emergency bleep went off and I had to immediately attend
9 to that. I realised that I didn't have time to document
10 my findings and so I quickly told Sophie what I had
11 found and asked her to document the information in her
12 notes, ie what I had found, and then I left to attend to
13 the emergency."

14 I subsequently found out about Child O coming back
15 for the following shift the next evening, I did
16 originally believe that that was with a -- with --

17 **Q.** You weren't sure who told you about it
18 originally, were you?

19 **A.** No.

20 **Q.** So, leaving aside who told you about it, what
21 were you told when you came back on shift to -- how did
22 you learn about it, what did they say?

23 **A.** So what I was told was that Child O had
24 deteriorated during the day and suddenly there was
25 a concern about NEC and that the child --
126

1 nasogastric tube. This was a relatively common
2 occurrence normally. There was no other concern about
3 Child P at the time.

4 But given what had happened to Child O and that
5 these were triplets, I thought that the best thing to do
6 was stop all the feed and start some intravenous fluids
7 to replace that.

8 Upon arrival in the neonatal unit, my crash bleep
9 went off indicating an emergency was taking place and as
10 I was standing in the corridor I checked with the nurse
11 who was there at the time to see how the triplets were
12 doing and they told me that apart from the aspirate,
13 they were otherwise fine in themselves and I knew that
14 I didn't have time to review them so I asked them to put
15 in place the IV fluids.

16 **Q.** So did you have any cause to be clinically
17 concerned about Child P that night?

18 **A.** With the exception of what had happened with
19 Child P's sibling, no. The -- and the child was
20 otherwise well and checking back during the night,
21 I think I called from Resus to the neonatal unit, things
22 seemed to be going okay since and everything had been
23 settled and blood gases had been fine up to that point.
24 So no, I didn't have a reason beyond that to be
25 concerned. I think Dr Gibbs to the best of my
128

1 recollection had started antibiotics which would be the
2 other -- the other thing to think about, but that was
3 already covered.

4 **Q.** When did you learn Child P had died?

5 **A.** Again coming back on the next nightshift
6 I learned that Child P had passed away, had died.

7 **Q.** Are you all right, Dr Mayberry?

8 **A.** Yes.

9 **Q.** So paragraph 34, you say:

10 "I felt devastated, shocked and bewildered. I felt
11 and still feel deep sadness for the two babies involved
12 and their parents. I had only been doing two and a half
13 years of paediatrics but I hadn't come across anything
14 like this. Triplets are rare and I thought they must
15 have had some sort of common genetic or gut problem.

16 "I remember those present being in a state of
17 shock, deep sadness and bewilderment."

18 Who did you speak with on the day of learning of
19 P's death when you say you remember shock and
20 bewilderment? The Inquiry has heard evidence from a
21 number of people in written form and orally, but who
22 were you talking to about that?

23 **A.** I spoke to Jess Birkett I remember about it
24 and she was probably the main person I spoke to at the
25 time about it. I don't recall who else I spoke to but

129

1 at the point where I asked them further and people went
2 to look for them, they said that they had gone to the
3 Coroners already and I believe I discussed it again at
4 a later point with Dr Brearey in person, not via email
5 and to say I have tried to get hold of the notes but
6 they don't -- we don't have them and I think his -- at
7 the time he said I think it's very unlikely that you
8 were likely to be called about this given that you
9 weren't there at the point where they deteriorated, so
10 not to worry too much about it.

11 **Q.** Were you aware at that time whether there were
12 suspicions or not about a particular member of staff
13 being involved in causing deliberate harm to babies?

14 **A.** No.

15 **Q.** How well did you get on with all of the nurses
16 on the unit?

17 **A.** I got on well with all of the nurses, I didn't
18 have, as far as I am aware, any problems with any of the
19 nurses.

20 **Q.** On 30 June 2016, we know from a text message
21 sent from Dr U to Letby -- sorry, from Letby to Dr U.
22 Letby says:

23 "Had a nice chat with Huw, said I should go for
24 a Band 6 and take the unit forward, I am one the nicest
25 nurses he has worked with."

131

1 I remember the atmosphere in the handover room was
2 distinctly different to how it normally was. People
3 were normally fairly chatty and bubbly but there was
4 a lot of quiet and a lot of upset.

5 **Q.** Can we have document, please, Ms Killingback
6 of INQ0004891, page 1. This is an email from Dr Brearey
7 to you, Dr Mayberry:

8 "You reviewed the triplets' care and I think at
9 least Child O and probably Child P will go to an
10 inquest. You may be asked to produce a statement for
11 the inquest. It is probably best to get it ready now
12 rather than wait six months when they ask you and it is
13 not fresh in your memory. I can help with format
14 et cetera if you need help. Dr V and Dr U are doing the
15 same and have the notes. I can let you know when they
16 are finished with them."

17 Did you ever get the notes -- that can come down
18 now, Ms Killingback, thank you -- and did you ever do
19 a statement?

20 **A.** I didn't receive the notes. So I was aware
21 that Dr U and Dr V -- sorry, from what I recall, had the
22 notes at the time and they were the people who were
23 preparing a statement.

24 I was also keen to prepare a statement but the
25 notes never appeared. I did ask for the notes again but

130

1 Can you remember saying that to Letby at any point,
2 encouraging her in her career and saying she is one the
3 nicest nurses you have worked with?

4 **A.** I don't -- I don't recall specifics at this
5 point in time. She wasn't somebody who outwardly --
6 outwardly she appeared to be a competent nurse who when
7 you asked for things, you know, she did them and she
8 wasn't somebody who appeared, you know, incompetent and
9 she generally had a fairly friendly demeanour towards
10 other members of staff.

11 **Q.** Did you ever have any suspicions or concerns
12 yourself about her?

13 **A.** No.

14 **Q.** Were you aware whether others did?

15 **A.** I don't -- I think I have written in my
16 statement about the only other occasions. One was --
17 sorry, I just need to make sure I refer to them by the
18 right acronym -- Nurse ZC who worked in the paediatric
19 ward who had told me that Lucy Letby had been her
20 student and that she hadn't seemed particularly engaged,
21 I think was the -- was the term that she used and she
22 asked me how she was getting on. I guess the only other
23 conversation was the deputy ward manager in the
24 paediatric ward had mentioned, and I think this was
25 after -- I can't remember the exact time but I believe

132

1 it was after the issue with the triplets, that
2 Dr Brearey had thought that Lucy Letby was a bit odd and
3 that the fact that both the triplets had died was a bit
4 odd.

5 That's the extent of everything that I recall being
6 said.

7 **Q.** So what's the name of the deputy ward manager,
8 can you remember who you are talking about there?

9 **A.** I -- I don't know if they have an acronym
10 which I should refer to as in a -- the name, am
11 I allowed to say their name in full, as in I don't know
12 if they have -- if they have an anonymity.

13 **Q.** If you -- you can let us have the name
14 afterwards, okay, so we can take the name from you via
15 email.

16 So the deputy ward manager, someone spoke to you,
17 but this looks as though that was after O and P had died
18 because it's a reference to what Dr Brearey said, yes?

19 **A.** Yes.

20 **Q.** What about Nurse ZC, was that at an earlier
21 stage that she said as a student Letby hadn't seemed
22 engaged and what did you think of her in effect.

23 When was that conversation with Nurse ZC?

24 **A.** The truth is I can't remember the exact time
25 it was. I believe it was probably earlier than that,

133

1 Are you talking historically when you say you
2 hadn't had any training on child death reviews or now?
3 Just expand on that paragraph, if you can.

4 **A.** Predominantly historically at that point in
5 time.

6 **Q.** When you say you have now had training on the
7 Sudden Death in Infancy process but you don't think it
8 is sufficient to deal with the situation, in what way
9 was it lacking?

10 **A.** I think much of the Sudden Death in Infancy
11 process is focused externally. Much of it is focused on
12 children who die in the community and come into hospital
13 either moribund and about to arrest or arrested and
14 dead.

15 There doesn't appear to be a sufficient --
16 a significant proportion of much of the SUDIc process
17 which is associated with what if a child dies
18 unexpectedly as an inpatient in hospital.

19 **Q.** In terms of that not just with your experience
20 at the Countess of Chester, how comfortable would it
21 feel to express concerns about a colleague that they are
22 causing deliberate harm in some way?

23 **A.** I think in my experience that's probably
24 changing a lot over -- over the course of my career and
25 training.

135

1 but I couldn't tell you an exact time, sorry.

2 **Q.** You tell us in your statement at paragraph 46:

3 "In terms of investigations, neonatal deaths were
4 not investigated by doctors at my level."

5 You weren't invited to provide a statement or
6 comment, just for internal review about the deaths of
7 O and P. So was the first time you provided anything in
8 writing to the police?

9 **A.** Sorry, could you repeat the last part?

10 **Q.** Was the first time you provided anything in
11 writing about your care of the babies to the police when
12 you did a police statement? Had you written anything
13 before then?

14 **A.** No.

15 **Q.** Nothing. Because we have seen Dr Brearey say
16 while it's fresh in your mind, write stuff down. But
17 that for one reason or another didn't happen.

18 **A.** Yes.

19 **Q.** Paragraph 59 of your statement, "Speaking up
20 and notification of police and other external bodies".

21 You have had some training on the Sudden Death in
22 Infancy process but you say:

23 "I do not think it was sufficient to deal with the
24 situation which arose at the Countess. I did not
25 receive any training on Child Death Reviews."

134

1 I think that -- I think it's becoming more common
2 to speak up and to voice concerns as -- as things go on.
3 I think that is -- is changing as a process.

4 **Q.** In what way?

5 **A.** I think it's -- it's encouraged more now to
6 than ever to speak up for when you see things which
7 aren't right or if you are worried about a process. And
8 I think people of my level, as in my experience and
9 below, feel more empowered and encouraged than before to
10 speak up when you are not happy with a situation.

11 **Q.** I mean it sounds from what you said about
12 Nurse ZC she was trying to do exactly that; just check
13 in with you if you had any concerns. She just says,
14 "I didn't find her engaged. What do you think?"

15 Did that conversation, as it took place, feel an
16 appropriate conversation, someone just sharing concerns
17 or did it feel something out of the comfort zone what
18 you were being asked there. How did you receive that?

19 **A.** I think it was somebody who was wondering
20 about how somebody who was their trainee had progressed
21 and whether they were somebody who had become more
22 engaged with time and as they got more interest in the
23 job and took on more. I think that was probably the
24 context in which I took it.

25 **Q.** So you didn't think it was a deeper request,

136

1 "Are you worried about anything else?" Just if they are
2 engaged properly?

3 **A.** Yes.

4 **Q.** We asked everybody including you, Dr Mayberry,
5 thank you for providing them, for reflections and
6 comments.

7 On CCTV, you say effectively you don't think it
8 would have been effective or halt what she did,
9 paragraph 64 and 65, and you don't think CCTV would
10 necessarily be effective.

11 **A.** I think -- so there is a number of aspects to
12 the CCTV question. One is I am not sure it would have
13 dealt with a lot of the ways in which she killed people
14 and it may have given false reassurance that things were
15 right and I think in my statement I particularly
16 reference the point of her injecting air into -- into
17 children's bloodstreams. I think --

18 **Q.** What you say there, just to make that clear
19 for those who haven't seen that paragraph, you say --
20 well, expand on that because it's hard to tell. You
21 wouldn't be able to tell looking.

22 **A.** I think -- so -- so in terms of if you look at
23 syringes that are used to give children medications, one
24 of the common syringes is a 1ml syringe, which is often
25 made out of glass, and at the point where that is filled

137

1 who can do those investigations who have the time and
2 I think having safe staffing has got to be an
3 integral --

4 **Q.** Sorry, I missed that. Have a safe ~...?

5 **A.** Having safe staffing, sorry.

6 **Q.** Safe staffing.

7 **A.** It's got to be an integral part of making sure
8 hospitals and units are safe and you will be able to do
9 further investigating and more safety checks when you
10 have sufficient staffing.

11 **Q.** What sort of staffing for babies in intensive
12 care? Do you think one-to-one nursing is enough or it
13 should be two-to-one, two nurses to every patient?

14 **A.** I am probably -- I am probably -- I think
15 one-to-one is the ratio that has normally been used in
16 both neonates and paediatric intensive care units.

17 Part of it is about -- so you should always ensure
18 I think that there is a minimum of one-to-one as best
19 you can.

20 But it's also not just about the numbers alone.
21 I think it's about having experienced people who are
22 present and experienced people who can look and say:
23 wait, what's going on there? And: what are you doing
24 there? And wondering, and -- and can raise suspicions
25 from that point of view.

139

1 with fluid sometimes it can be really hard to tell

2 looking directly at it is there fluid in this or, you
3 know, is it misfilled with air?

4 So part of my job in what I do now as a paediatric
5 intensivist is that sometimes I have to provide
6 anaesthetics for children having procedures done on the
7 unit and I'm responsible for administering those
8 medications.

9 So I would always check that you could see that
10 there was -- that you could push fluid to the end of the
11 syringe and coming out of the top of it before you --
12 before you gave that medication to a child to make sure
13 that it was all okay and that there wasn't any air in
14 it.

15 But I am not sure if you would be able to tell from
16 a digital image further away in the same way that you,
17 you know -- if you are doing that check because if you
18 are looking at it really closely you still might not be
19 able to tell whether there is air or fluid there.

20 I think the other thing that has crossed my mind
21 since I wrote that statement is that at the time when
22 all of this happened the Countess was very short-staffed
23 on the medical rota and in order to provide, undoubtedly
24 what needs to happen is further oversight and overview
25 in some way. But you also need to have staff present

138

1 When you are continually stretched as a service, as
2 this service was I think back then, it's increasingly
3 hard to pick up on smaller things which are happening
4 which may be untoward.

5 **Q.** Are you aware whether some of the neighbouring
6 hospitals had advanced neonatal nurse practitioners
7 operating on the intensive care units and is that
8 something that you are referring to when you say greater
9 experience of people?

10 **A.** I think -- I think neonatal nurse
11 practitioners are very helpful in that they have a lot
12 of experience in neonates and they are somebody who is
13 there as a constant on a unit. Doctors will often
14 rotate round to build up their experience in different
15 hospitals and different areas.

16 But having a member of staff who's there
17 constantly, who knows the practices of the hospital
18 inside out and has that experience over time in the
19 unit, would be helpful.

20 **Q.** So stability and consistency within a unit?

21 **A.** Yes.

22 **Q.** You set out at 67 a number of recommendations
23 you think would be beneficial.

24 Your first is a broad cultural change within the
25 Ministry of Health and executive boards mandating that

140

1 concerns of senior clinicians are listened to and that
2 patient safety is prioritised over all else.

3 Would you like to expand on that?

4 **A.** Yes, sure. I think with regard to that
5 comment what -- maybe what I haven't said explicitly
6 there is that the level, firstly, the level of staffing
7 wasn't sufficient; certainly at a Registrar level and
8 that while it seemed from my level like the Consultants
9 were trying to improve that situation how much
10 engagement there was further up, I am not entirely sure
11 and that's probably a question I guess for them.

12 Certainly the thing about locum caps and things
13 like that it wasn't a particularly safe initiative to --
14 to drive down the supply of doctors looking -- looking
15 for locums.

16 And I think the last thing I am referring to in it
17 is probably whether it's been broadly publicised now of
18 Consultants raising their concerns at an earlier point
19 in time. From what I can tell in what's been written in
20 the media felt that that wasn't addressed in sufficient
21 time.

22 **Q.** You also say:

23 "In cases where clinicians feel they are not being
24 listened to by the board, they should be encouraged to
25 'break the glass' and contact police directly"?

141

1 **Q.** Characteristics that people might need to be
2 more vigilant about?

3 **A.** Yes.

4 **Q.** You also say:

5 "Consideration should be given to mandating the
6 presence of security systems relating to drug access in
7 neonatal units."

8 What are you particularly referring to there?

9 **A.** I think a lot of units now have electronic
10 security systems relating to dispensation of drugs, so
11 that you know who is accessing those drugs and they have
12 to provide their, you know, thumbprint or whatever to
13 get access to the drugs.

14 I think in terms of things like, you know, insulin
15 and -- which Lucy Letby was convicted of putting into
16 TPN bags that that would have provided more evidence
17 if -- if that was something that had had to be released
18 from -- from an electronic system.

19 **Q.** Dr Mayberry, those are all my questions.

20 Is there anything else you would like to add or
21 supplement to your evidence thus far?

22 **A.** So there is nothing I think from an evidence
23 point of view. Just I would like to express my deep
24 sorrow to the families who were involved and I can't
25 imagine what they have had to go through.

143

1 **A.** Yes.

2 **Q.** You say things are changing. Do you think the
3 culture now as a doctor, would you feel able or unable
4 to do that if you were sufficiently concerned or
5 suspicious of the conduct of another member of staff?

6 **A.** I think the GMC in its guidance does say that
7 people should be protected in terms of raising concerns.
8 I think it probably now has shifted more and more
9 towards people being -- feeling like they are more
10 protected if they do raise concerns.

11 **Q.** You say there should be education for staff on
12 how to spot concerns where another member of staff is
13 harming patients. What kind of education are you
14 referring to there? Something different from medicine
15 training, which obviously you all have. What is it?

16 **A.** I think that there is some guidance into
17 I don't know whether -- I think that there is some
18 guidance into how people can pick up on things which are
19 untoward with other staff members in terms of them doing
20 other things. If there is some learning that can come
21 out of this Inquiry and other things of things that you
22 can -- might be identifiable in those patients then that
23 should be widely disseminated.

24 **Q.** So heighten awareness of other attributes?

25 **A.** Yes.

142

Questioned by LADY JUSTICE THIRLWALL

2 **LADY JUSTICE THIRLWALL:** Thank you very much
3 indeed, Dr Mayberry. We can see how much you have
4 thought about this over a long time and thank you.

5 There was just one point I just wanted to clarify
6 with you if I may, when you were talking about the
7 possibility of having some training so that people could
8 pick up signs in relation -- and you spoke a lot
9 about -- in a few sentences about things that may be
10 untoward with other staff members.

11 Then you went on to say if there is some learning
12 that comes out of this Inquiry or other things that you
13 might be able to identify in patients then that should
14 be widely disseminated, and I just wanted to make sure
15 that I had understood that correctly.

16 So, on the one hand, flagging behaviours by staff,
17 for example, but then did you mean to say something
18 about patients?

19 **A.** Staff. Sorry, I -- I think staff was probably
20 what I was referring to.

21 **LADY JUSTICE THIRLWALL:** No, I completely
22 understand. We all use the wrong word, some of us quite
23 frequently.

24 But anyway, thank you very much indeed, also for
25 your other reflections and for being with us this

144

1 afternoon.

2 Thank you. You are free to switch us off.

3 **THE WITNESS:** Thank you.

4 **LADY JUSTICE THIRLWALL:** Thank you.

5 **MS LANGDALE:** My Lady, can we resume at 3.35? We

6 will still complete the evidence in good time this

7 afternoon.

8 **LADY JUSTICE THIRLWALL:** All right. So we will

9 rise now until 3.35.

10 (3.08 pm)

11 (A short break)

12 (3.36 pm)

13 **LADY JUSTICE THIRLWALL:** Ms Langdale.

14 **MS LANGDALE:** May I call the next witness.

15 **DR CASSANDRA BARRETT (affirmed)**

16 **Questioned by MS LANGDALE**

17 **MS LANGDALE:** Can you give us your name and

18 qualifications, please.

19 **A.** My name is Cassandra Barrett. I am

20 a paediatric general paediatric Consultant. I gained my

21 CCT last year in the summertime. I have a special

22 interest in respiratory medicine.

23 **Q.** Dr Barrett, you provided us with a statement

24 dated 28 June 2024. Have you got that with you?

25 **A.** I do, yes.

145

1 Dr Lambie or Dr Ogden?

2 **A.** I did not know Dr Lambie, I had met Dr Ogden

3 at a previous placement I had done.

4 **Q.** So did you know Dr Ogden at the time when you

5 were working at the Countess or did you know her

6 subsequently?

7 **A.** I think I had met her before but she wasn't

8 somebody I was in regular contact with.

9 **Q.** I won't take you to the same bit, you have

10 heard me read out how Dr Ogden says in June 2015, that

11 she had found:

12 "... the numbers of collapses or deaths on the unit

13 at that time as unusual and concerning. I am unsure

14 specifically when this appeared to me as unusual but it

15 is likely to be around the time of several of those

16 collapses/deaths that occurred within a few weeks of

17 each other in June 2015. Whilst I do not recall that

18 I specifically approached any Consultant in particular

19 to raise specific concerns I believe the whole

20 department was discussing this informally as being

21 unusual and that the senior Consultant team were raising

22 this and investigating what could have caused this."

23 Did you ever have a chat with Dr Ogden or did she

24 ever say anything to you about that?

25 **A.** No, I hadn't spoken to Dr Ogden about it. All

147

1 **Q.** Can you confirm if the contents are true and

2 accurate as far as you are concerned?

3 **A.** Yes.

4 **Q.** We see from this that you worked at the

5 Countess of Chester between March 2016 and

6 September 2016 as an ST1?

7 **A.** I did, yes.

8 **Q.** You followed that -- you then went on to

9 Liverpool Women's Hospital and your supervisor there was

10 Dr Yoxall?

11 **A.** That's correct.

12 **Q.** You are the last of four Registrars to give

13 evidence today. I think you have heard the evidence of

14 the last two?

15 **A.** (Nods)

16 **Q.** Can you just briefly tell us, what stage were

17 you at at the ST1 stage?

18 **A.** So this was the first year of my paediatric

19 training, so although it's termed an ST1, this is often

20 called a SHO, so a senior house officer. So I had done

21 a placement in paediatric A&E at Alder Hey Children's

22 Hospital and then rotated to Chester Hospital.

23 **Q.** So just got going?

24 **A.** Just got going.

25 **Q.** You probably -- I don't know, did you know

146

1 the feedback I had had from other trainees was very
2 positive about the department.

3 **Q.** So when you went there so in March 2016, had
4 you had feedback then from other trainees?

5 **A.** Just when you told people what placement you
6 were going to next they would say: oh, that's a lovely
7 place to work, you will have a really good experience.

8 **Q.** Is that the medical grapevine, people who have
9 just qualified and know each other?

10 **A.** Yes.

11 **Q.** Or the people still working there or were they
12 round and about in the vicinity?

13 **A.** This was the people that I was working with at
14 that time, so different levels of doctors who had worked
15 there before.

16 **Q.** When you went on to go to Liverpool Women's
17 Hospital, what were the differences you noticed between
18 the two hospitals, if any, and particularly their
19 neonatal units?

20 **A.** So the neonatal unit at Liverpool Women's
21 Hospital is significantly bigger. They have got many
22 more cot spaces. As it is an intensive care department
23 they have more staff, you just solely cover the neonatal
24 unit and not cross covering between paediatrics and
25 neonates.

148

1 Q. When you say "more staff" how does that work
2 for the baby? So in the neonatal intensive care set-up
3 how many nurses would be looking after a baby at
4 Liverpool and how many in Chester?

5 A. I believe it was one to one and then there
6 would be a shift leader as well that would have an
7 oversight of the unit too.

8 Q. So in Liverpool one to one shift leader. What
9 about in Chester when you got there?

10 A. I can't remember fully because I have only
11 worked there for six months, whereas I had done a whole
12 year at Liverpool Women's and that was more recently.
13 I believe in the higher intensity room it would have
14 been one to one but I don't know for definite.

15 Q. And a shift leader as well or you don't know?
16 Best to ask the nurses?

17 A. I don't remember that, sorry.

18 Q. You heard Dr Mayberry giving evidence earlier
19 about the position for registrars and locums and
20 Chester's approach to that. Did you hear that evidence?

21 A. I did, yes.

22 Q. Does that accord with your experience when you
23 were there in 2016, that it would have been helpful to
24 have more Registrars?

25 A. I think I remember that there was a shortage
149

1 A. Not that I recall.

2 Q. Were you aware of that? It is clear from
3 Dr Ogden and Dr Lambie and Dr Mayberry people were being
4 made aware of a raised mortality rate or concerns about
5 that. Were you ever made aware of it?

6 A. That wasn't something that was discussed
7 amongst the SHO body that I was part of.

8 Q. Okay. Did you have discussions with nurses or
9 anyone about that?

10 A. No, not that I can recall.

11 Q. You heard Dr Lambie say again she was more
12 senior than you, wasn't she, but she had seen nurses in
13 a group and had a discussion with them about that issue.
14 Did you ever have such a discussion with nurses or
15 Consultants or anyone else?

16 A. Not that I can recall.

17 Q. You said the medical professionals appeared to
18 have a good working relationship with all members of the
19 MDT. Does that mean multi-disciplinary team?

20 A. Yes.

21 Q. So who is in the multi-disciplinary team?

22 A. So that would be the doctors, nurses
23 pharmacists, any of the ward clerks and cleaners.
24 Everybody that is on the wards at the time.

25 Q. Okay. You say you had no contact with the
151

1 of Registrars but we had a good group of Registrars that
2 were very supportive. I don't remember there being
3 a shortage on the rota that I was on, the SHO rota.

4 Q. You don't know whether there was an issue of
5 getting good locums, it is not something you were
6 sighted on anyway --

7 A. No.

8 Q. Culture and atmosphere. You say at
9 paragraph 8 of your statement the lead Consultant during
10 your period working there was Dr Brearey. How did you
11 get on with him?

12 A. I would say we had a good working
13 relationship. He appeared to have a very detailed
14 knowledge of neonates and it was clear he was the lead
15 and his presence was often felt or requested at times.

16 Q. Dr Mayberry said he encouraged learning via
17 the materials that were available to you all. Did you
18 do that?

19 A. Yes, he did. I think Dr Mayberry probably had
20 a closer relationship with him as the paediatric
21 Registrar that would have been doing lots of the
22 procedures, at times I was more there observing.

23 Q. Dr Brearley also had a conversation with
24 Dr Mayberry, you heard, about the mortality rates. Did
25 he have that conversation with you at any point?
150

1 managers. Did you know who they were? Would you know
2 who the board was or the managers?

3 A. No, no.

4 Q. Did you get much patient contact?

5 A. On the neonatal unit?

6 Q. Yes. So our shifts were slightly different to
7 the Registrars so we covered either a long day or short
8 day on the children's ward in A&E and then there was the
9 neonatal unit, but we would go to the deliveries and
10 call for a Registrar if needed and spent a lot of time
11 on the postnatal ward doing newborn baby checks. So we
12 would aim to be on the neonatal ward round alongside the
13 Consultants and the Registrars.

14 Q. And how frequently were the Consultants doing
15 the ward rounds, as far as you remember?

16 A. I can't recall this. I do remember that on
17 a weekend they didn't go every day because they were
18 covering paediatrics and neonates and I didn't think
19 that they were there every day on the neonatal unit
20 either.

21 Q. But in the week you think so?

22 A. I don't recall them doing a ward round every
23 day on the neonatal unit.

24 Q. So who did you go to if you were particularly
25 concerned about a patient then?
152

1 A. The paediatric Registrar.
 2 Q. Then the paediatric Registrar can contact
 3 a Consultant if they wanted to?
 4 A. Yes, yes.
 5 Q. Were you ever aware of that system failing and
 6 not getting hold of a Consultant?
 7 A. No, that was never something that I had seen
 8 witnessed on my shifts.
 9 Q. You set out at paragraph 15 your involvement
 10 in the care of Child M on Saturday, 9 April and as you
 11 know Letby was convicted of the attempted murder of
 12 Child M and his twin brother, L, on 9 April.
 13 Can you tell us, as you do there, you set out your
 14 involvement with Child M?
 15 A. So I had been upstairs on the postnatal ward
 16 and remember coming down and using the computer and as
 17 I was on the computer I heard a shout from Nursery 1 for
 18 help and as I entered the room the child was in full
 19 cardiac arrest receiving full resuscitation.
 20 My role was then to assist with the resuscitation
 21 whilst Dr Ukoh, the paediatric Registrar, was leading
 22 the situation and Dr Ravi Jayaram arrived after he had
 23 been called from home.
 24 Q. You say in your statement:
 25 "I didn't have any concerns about M's deterioration
 153

1 record any errors that had happened, whether that be
 2 a prescription error or the wrong drug being given to
 3 the wrong patient, and any potential near misses as well
 4 as that -- any breaches of confidentiality too for the
 5 case to be reviewed.
 6 Q. Would you have thought any unexplained event
 7 should go on a Datix just because you didn't know what
 8 had happened or not? Would that fall into the category?
 9 A. I don't think that would have fallen into the
 10 category for me at that time, whereas now it definitely
 11 would.
 12 Q. Now it would?
 13 A. Now it would.
 14 Q. What's your understanding now as you sit here
 15 about the importance of Datix or what's supposed to be
 16 recorded there?
 17 A. So now as a paediatric Consultant we have --
 18 all of the Datixes in our Trusts are sent to us so
 19 therefore we attend the meetings where these cases are
 20 discussed. It's useful to pick up any learning points
 21 and to see if there is anything that can be changed or
 22 made different and to get input from all the different
 23 members of the multi-disciplinary team that attend that
 24 meeting. But it picks up on themes.
 25 Q. Did you ever, when you were at the Countess of
 155

1 as I had not been involved in Child M's care that day
 2 prior to the deterioration."
 3 So you didn't have any understanding of what was
 4 happening?
 5 A. No.
 6 Q. You were a responder in that situation?
 7 A. That's correct.
 8 Q. And with others more senior than you taking
 9 the lead?
 10 A. Yes. So Dr Ukoh had done the paediatric ward
 11 round that day so he had already seen the baby and knew
 12 the case, so he was leading.
 13 Q. Are you aware whether there was any
 14 consideration of completing a Datix in relation to this
 15 event or not?
 16 A. I didn't hear it mentioned.
 17 Q. Did you know at that time what a Datix was?
 18 A. Yes, I did know what a Datix was.
 19 I think my understanding of a Datix and when to
 20 complete is has probably increased throughout my
 21 training, but it is something that even at our very
 22 junior levels we do know about.
 23 Q. What did you, at that time, think a Datix form
 24 was about?
 25 A. I thought it was there to document, well, to
 154

1 Chester, see a nurse or a doctor or anyone fill in
 2 a Datix or hear them talking about that?
 3 A. Not that I can recall.
 4 Q. No. Did you have -- we heard again
 5 Dr Mayberry talking about induction. Did you have
 6 induction at the beginning of your training on any
 7 issues?
 8 A. So we would have been at the same paediatric
 9 induction.
 10 Q. Okay. So you had the same warning of a fine
 11 for the handover note?
 12 A. I actually don't recall that, but obviously
 13 Dr Mayberry does.
 14 Q. What do you recall being trained about?
 15 A. I have been to so many inductions that I can't
 16 specifically say what was in that induction.
 17 Q. Do you think child protection or safeguarding
 18 was one of the topics, can you remember now?
 19 A. I can't remember now, but it often is. On
 20 every rotation that we do it's part of it.
 21 Q. Do you share Dr Mayberry's observation that it
 22 would be useful to know as a doctor what might assist
 23 you to spot when those around you might be deliberately
 24 harming children?
 25 A. Yes. So I think at the paediatric ST1 level
 156

1 I was, I didn't have any knowledge about
2 Beverley Allitt. So I think if -- if that was openly
3 discussed and themes came out that were -- and how they
4 picked it up and what she was doing that might then help
5 to trigger us to think about it in complex situations.

6 **Q.** So by the time you were working there, you
7 didn't know about that case or the misuse of insulin and
8 all of --

9 **A.** No.

10 **Q.** -- the other things the Beverley Allitt case
11 tells us about?

12 **A.** No.

13 **Q.** When did you first learn about that case?

14 **A.** I think it was after Lucy Letby's case came to
15 the press.

16 **Q.** One of the recommendations that followed the
17 Beverley Allitt case, there was an Inquiry into that,
18 and one of the recommendations was that there should be
19 a heightened awareness of that case and what the nurse
20 had done in that case. From what you are saying, that
21 doesn't seem to have translated through to the NHS, does
22 it, at --

23 **A.** No.

24 **Q.** -- your time of working?

25 **A.** No.

157

1 **A.** I can't remember exactly, but I think it might
2 have been the days after the second triplet had died
3 when I had been allocated the neonatal unit to cover.

4 At the time of saying that, I didn't have any
5 awareness about the suspicions amongst the Consultant
6 body with regards to Lucy Letby actively causing harm.
7 Never did I think the unthinkable, as we have mentioned
8 earlier in the day, that somebody would be going to work
9 to actively harm babies that we were going to work to
10 help.

11 **Q.** What association had you made about her though
12 to say "Nurse Death is on again"?

13 **A.** I had noticed that she was there at a couple
14 of the unexplained collapse and child deaths.

15 **Q.** So O and P.

16 **A.** P.

17 **Q.** Or others?

18 **A.** Not sure about O, and the baby that we
19 discussed earlier. So I had noticed she was there, but
20 I thought that was more of bad luck rather than her
21 being the causative agent.

22 **Q.** Was that the first time you said that to
23 someone in the hospital?

24 **A.** Yes.

25 **Q.** Had you been thinking that before because --

159

1 **Q.** You were at the hospital when Babies O and P
2 were -- died and Letby subsequently found guilty of
3 their murder.

4 Can you remember when you were first told about the
5 death of O and P?

6 **A.** I was on shift the day that Baby P died but
7 I wasn't covering the neonatal unit. So that's how
8 I had heard about it happening.

9 **Q.** How many people expressed surprise or upset?
10 Tell us what the atmosphere was.

11 **A.** I think generally after the death of any
12 child, expected or unexpected, there is often a feeling
13 of sadness amongst the team and it would be evident that
14 something had happened to upset the team.

15 **Q.** Nurse Lightfoot, as you know, says that she
16 recalled when there was a set of triplets and two of the
17 siblings died on consecutive days:

18 "I cannot be date specific but I walked past
19 Dr Barrett in the corridor and she spoke directly to me
20 and said words to the effect of 'Nurse Death's on
21 again.'"

22 You tell us you did say that.

23 **A.** I did say that at the --

24 **Q.** Do you know when you said that, which day or
25 what --

158

1 **A.** Not --

2 **Q.** That she was associated with events that were
3 concerning?

4 **A.** Not that I can recall. I think having to go
5 to the neonatal that day I was -- the neonatal unit,
6 I was anxious and it was a comment that I made but it
7 wasn't something that I was regularly saying.

8 **Q.** I think another nurse and Nurse Lightfoot says
9 that Nurse ZC may have been involved in that discussion
10 with you, but you don't remember that?

11 **A.** No.

12 **Q.** Do you remember saying it to Nurse Lightfoot?

13 **A.** Yes.

14 **Q.** Were you saying it to her or did she hear you
15 saying it?

16 **A.** Yes.

17 **Q.** Was it a direct conversation with her?

18 **A.** A direct conversation.

19 **Q.** You are confident about that?

20 **A.** Yes.

21 **Q.** And what was her response to you when you said
22 that?

23 **A.** She didn't respond.

24 **Q.** Did anyone after that come and speak to you --
25 anyone, Dr Brearey, a manager, anyone -- and say, "You

160

1 shouldn't be saying that about a colleague."
 2 **A.** No.
 3 **Q.** "And we know that you've said it", or not?
 4 **A.** Not that I can recall.
 5 **Q.** And it's not something you said to other
 6 doctors or you generally spread about the unit, if I can
 7 put it that way?
 8 **A.** No.
 9 **Q.** Did you know the number of deaths on the
 10 neonatal unit between 2015 and 2016?
 11 **A.** No.
 12 **Q.** Did you know how many unexpected or
 13 unexplained deaths had happened on the unit?
 14 **A.** No.
 15 **Q.** How many deteriorations or collapses of babies
 16 were you aware of? You were obviously aware of O and P,
 17 you have told us that, but they are babies murdered.
 18 What about babies that had collapsed or
 19 deteriorated, did you know about any of those other
 20 than M?
 21 **A.** So I can remember being on night shifts
 22 particularly with Dr Mayberry where there would be an
 23 unexpected collapse. But I had never done neonates
 24 before to know whether that was normal or not normal to
 25 happen.

161

1 at Liverpool about what had happened?
 2 **A.** So as part -- every placement that we start
 3 with our new clinical supervisor, we would have
 4 a meeting and they discuss where you had been on your
 5 last placement and obviously he had an understanding at
 6 that point of the increased number of deaths and
 7 unexplained collapse. So he just acknowledged that
 8 I had been in Chester and that it had been a difficult
 9 time.
 10 **Q.** So he's taking -- you are coming to the
 11 hospital, he is your supervisor, and he says, "I know
 12 you have had a difficult time, there has been collapses
 13 and deaths at Chester"?
 14 **A.** Yes.
 15 **Q.** He says that at the beginning
 16 in September 2016, does he, when you first go there?
 17 **A.** Yes.
 18 **Q.** So you understand him to be aware of what is
 19 going on in Chester at that point?
 20 **A.** Yes.
 21 **Q.** Did you speak of the earlier collapse that you
 22 say you knew about in the night of those sorts of events
 23 to anyone in the children's unit or elsewhere?
 24 **A.** Not that I can recall.
 25 **Q.** There must have been conversations though,

163

1 **Q.** Was that the one he was talking about today?
 2 **A.** I don't know because I've not seen the notes,
 3 sorry.
 4 **Q.** Right. So you had been present for another
 5 night shift unexpected collapse?
 6 **A.** (Nods).
 7 **Q.** And you had learnt of the deaths of O and P?
 8 **A.** Yes.
 9 **Q.** Did you know, as Dr Mayberry knew, that there
 10 were described as investigations but the RCPCH
 11 completing a report in relation to the unit, did you
 12 know about that?
 13 **A.** I think I learnt about it after I had left the
 14 neonatal unit.
 15 **Q.** Who told you about it after you left?
 16 **A.** I am not sure whether it was Bill Yoxall, who
 17 was then my clinical supervisor at Liverpool Women's
 18 Hospital.
 19 **Q.** Yes. So he was your supervisor as we
 20 highlighted earlier in September 2016 to March 2017.
 21 Did Dr Yoxall when you were working at Chester, did
 22 he go between the hospitals at all? Did you see him in
 23 both hospitals or just when you were --
 24 **A.** No, I never saw him at Chester Hospital.
 25 **Q.** So what did he say to you when you were there

162

1 mustn't there, between the wards about what was going
 2 on? These are upsetting events, aren't they? We can
 3 see that.
 4 **A.** Yes.
 5 **Q.** So normal conversation might lead one to relay
 6 what's happened the night before or the day before?
 7 **A.** Yes, and I think there were those
 8 conversations and, like we have heard earlier, you know,
 9 within handovers you would find out what had happened
 10 the day before. Because overnight and on an evening,
 11 the doctors would cross-cover paediatrics and neonates.
 12 The nurses might have said on the neonatal side, "Oh,
 13 the doctors were busy last night on paediatrics" or
 14 vice versa.
 15 **Q.** You heard Dr Lambie this morning -- it may
 16 seem a long time ago now -- was saying that
 17 by September 2015, the thought of someone causing
 18 deliberate harm had crossed her mind. Indeed she was
 19 speaking with somebody who she trusted outside of the
 20 hospital.
 21 When did that thought cross your mind? Don't worry
 22 about comments and what they might have meant or not.
 23 Just honestly reflect. When did you think about that?
 24 **A.** When Lucy Letby was taken off clinical shifts
 25 and we noticed a difference.

164

1 Q. So when she was moved from the ward to working
2 in the risk units.
3 Are you okay?
4 A. (Nods).
5 Q. You noticed a difference. Do you want to
6 expand on that?
7 A. It became evident that there was less
8 deteriorations and less cardiac arrests.
9 Q. Did you discuss that with colleagues at that
10 point?
11 A. (Shakes head).
12 Q. You just held that view?
13 A. Yes.
14 Q. Had you been told not to discuss her with
15 colleagues? Was there any sense that you couldn't do
16 that because there was other stuff going on, you know,
17 she was being moved around the hospital?
18 A. I don't think we were specifically told not to
19 discuss it. I think the Consultants recognised that it
20 was a difficult time for everybody that had been
21 involved, but I don't recall them asking us not to
22 discuss it.
23 Q. Did you know what the managers' involvement
24 was, if any, at this time or that was nothing to do with
25 you?

165

1 You know, maybe they'd put the long line in the wrong
2 place, maybe they had done something different. Was
3 that the atmosphere, that people got very worried about
4 everything?
5 A. I think naturally as doctors we always worry
6 if we have done everything possible that we can. So
7 yes, it was, you know, it was --
8 Q. A tense time?
9 A. Yes, yes.
10 Q. You tell us:
11 "As a senior house officer, I was the most junior
12 team member and I was not aware of the investigation
13 process for deaths in the neonatal unit and what
14 happened following the deaths or when postmortems were
15 being requested."
16 I don't think you're alone there, Dr Barrett, at
17 any age. But, what did you think at the time? Was
18 there a discussion about that?
19 A. I do remember the Coroners being discussed
20 and -- but I wouldn't know which patients were being
21 referred to the Coroner.
22 Now I have a much better understanding of the
23 SUDiC, Sudden Unexplained Death pathway and it's
24 something that I have to use within my role. I don't
25 remember that ever being discussed or used for these

167

1 A. No, nothing.
2 Q. That was the consultants?
3 A. Yes.
4 Q. You tell us in your statement at paragraph 42
5 when you were at Countess of Chester you did notice
6 there were frequent deaths on the neonatal unit:
7 "~... but this was my first exposure to neonates
8 and therefore I didn't realise that the deaths were
9 beyond what would be expected."
10 Were you aware at the time it wasn't that there
11 were deaths; that they were unexpected deaths and people
12 were surprised by them? What sense of that did you get
13 when you were there; that these weren't babies that
14 people thought were going to die?
15 A. I think it was clear that they were unexpected
16 because people would often afterwards be sat down trying
17 to think about any potential causes, looking solely for
18 medical causes.
19 I specifically remember with the triplets everybody
20 was thinking of different metabolic conditions, how they
21 are inherited, could there be any genetic predisposition
22 for those babies as well.
23 But you could tell people were surprised.
24 Q. And people, no doubt we've seen evidence of
25 this, started worrying if they had done something wrong.

166

1 babies.
2 Q. And at the time, did you understand that an
3 unexpected death in hospital is an unexpected death the
4 same as anywhere else and it triggers various referrals
5 or was that just not something that seemed to be
6 appreciated?
7 A. I don't think I appreciated that at the time.
8 Q. You say you don't recall attending any
9 debriefs or discussions following clinical events for
10 the babies named on the indictment.
11 Do you think there should have been debriefs or
12 discussions between all those involved in the care to
13 share observations and see what people thought?
14 A. Yes. I think debriefs have a really important
15 role, not only for the kind of psychological well-being
16 of all the staff that have been involved in these
17 traumatic events but to try and pick up on any common
18 themes or pattern recognition and look at how we can
19 improve care for the future.
20 Q. You tell us you didn't turn to any
21 professional body for advice with regards to events at
22 the Countess. Did you feel supported by the Consultants
23 there and generally did you feel like you needed help or
24 advice from anyone else?
25 A. Yes, so the Consultants were very supportive.

168

1 I didn't turn to anybody particularly at the time
 2 because I didn't feel I needed any extra support than
 3 what they were already giving us.

4 **Q.** We have asked people about reflections or
 5 potential recommendations. You have heard me discuss
 6 a number of them today. One of them is CCTV perhaps in
 7 the incubators for newborn babies in neonatal units.

8 What do you think about that as an option?

9 **A.** So I think initially when I had read about the
 10 CCTV I thought it would be a CCTV camera within the room
 11 and I share the same feelings as Dr Lambie as, you know,
 12 with the families and breastfeeding, expressing milk, it
 13 felt like an invasion of their privacy but I think if it
 14 was in the incubator that seems like a good idea to me.

15 But like Dr Mayberry commented as well, it's
 16 difficult even on those cameras as to whether you would
 17 be able to see there was air in syringes or that it was
 18 insulin being given, not the saline flush.

19 **Q.** Do you have any other reflections about how
 20 the healthcare environment could be improved to avoid
 21 what's happened at the Countess of Chester happening
 22 again?

23 **A.** I think as I said before I had no
 24 understanding about the Beverley Allitt cases. So
 25 I think education around that and picking out any common

1 **(The Inquiry adjourned until 10.00 am,**
 2 **on Thursday, 3 October 2024)**

3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 themes that have come up from -- from previous Inquiries
 2 and education even in medical school. During paediatric
 3 training we have a lot of safeguarding training but
 4 a lot of it is about parents causing harm to their child
 5 and we are very much skilled at recognising that but
 6 I don't feel like we are trained in how to recognise
 7 that another healthcare professional that you trust has
 8 been causing harm.

9 **MS LANGDALE:** Yes, thank you, Dr Barrett, those are
 10 my questions.

11 **LADY JUSTICE THIRLWALL:** Thank you very much
 12 indeed, Dr Barrett. It's a good job we didn't take
 13 a break because now you are finished.

14 Thank you for coming and in particular for your
 15 reflections as to what might help and also the way you
 16 have thought through, first of all, what a CCTV camera
 17 might do and also what it might be very useful for.
 18 Thank you very much indeed and you are free to go now.

19 **A.** Thank you.

20 **MS LANGDALE:** My Lady, that concludes the evidence
 21 for today and we have three Consultants giving evidence
 22 tomorrow.

23 **LADY JUSTICE THIRLWALL:** Very well. So we will
 24 rise now and we will start tomorrow at 10 o'clock.

25 **(4.07 pm)**

I N D E X

1		
2	DR RACHEL LAMBIE (affirmed)	1
3	Questioned by MS LANGDALE	1
4	DR MATTHEW NEAME (Affirmed)	51
5	Questioned by MS BROWNE	51
6	DR HUW MAYBERRY (affirmed)	100
7	Questioned by MS LANGDALE	100
8	Questioned by LADY JUSTICE THIRLWALL	144
9	DR CASSANDRA BARRETT (affirmed)	145
10	Questioned by MS LANGDALE	145
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		

11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

LADY JUSTICE THIRLWALL: [37] 1/3 1/8 5/25 47/8 47/15 47/18 47/20 48/1 48/13 48/16 48/21 48/25 49/2 49/13 49/20 49/24 50/3 50/6 50/10 50/20 51/1 51/6 99/6 99/14 99/17 100/1 100/22 107/12 118/17 119/2 144/2 144/21 145/4 145/8 145/13 170/11 170/23 MS BROWNE: [4] 51/2 51/7 99/4 99/16 MS LANGDALE: [15] 1/5 1/10 6/4 47/6 50/9 50/15 99/23 100/8 101/2 119/4 145/5 145/14 145/17 170/9 170/20 THE WITNESS: [2] 100/4 145/3	100 [1] 123/6 11 [1] 57/5 11 May 2016 [1] 125/5 11.15 [1] 50/14 11.30 [3] 50/16 50/22 50/25 11:30 [1] 93/12 12 [6] 9/16 9/16 70/15 86/18 86/20 104/23 12.43 [1] 99/20 13 [1] 77/1 13 October [1] 82/15 13th [3] 82/20 83/7 90/15 14 [1] 11/14 14 days [2] 18/19 18/25 14 October [2] 84/1 88/3 14th [1] 90/15 15 [3] 12/19 115/18 153/9 15 June [1] 121/25 15 October [2] 85/22 92/23 16 [2] 69/9 75/11 18 [3] 14/21 15/18 80/22 19 [3] 77/15 121/22 121/25 19 October [2] 92/25 93/3 1ml [1] 137/24	2016 [25] 3/9 24/7 24/11 47/13 53/6 54/10 59/21 65/21 94/20 101/21 101/22 106/15 111/6 116/13 121/25 125/5 125/20 131/20 146/5 146/6 148/3 149/23 161/10 162/20 163/16 2017 [1] 162/20 2021 [2] 53/11 60/23 2024 [6] 1/1 1/15 51/10 101/11 145/24 171/2 2051 [1] 75/4 21 [1] 80/16 22 [3] 26/8 52/17 81/17 22 June 2016 [1] 125/20 22 October [2] 93/12 93/13 23 [2] 27/9 125/15 23 June [1] 19/10 23 June 2024 [1] 51/10 23 October [1] 88/12 231 [1] 117/13 24 [1] 82/19 24 hours [1] 25/16 25 [1] 30/12 26 [3] 74/25 84/23 127/5 26th [1] 80/20 27 [1] 31/9 27 April 2015 [1] 2/17 27 September 2015 [1] 74/25 27th [1] 80/20 28 June 2024 [2] 1/15 145/24 29 June [1] 22/14 29th [1] 23/18	4 4.07 [1] 170/25 40 [1] 94/12 42 [1] 166/4 44 [1] 123/1 46 [1] 134/2 5 59 [1] 134/19 6 60 [1] 53/10 64 [1] 137/9 65 [1] 137/9 67 [1] 140/22 8 8 June [1] 10/2 9 9 April [2] 153/10 153/12 9 April 2024 [1] 101/11 A A's [2] 9/18 11/3 A,B [1] 29/21 abdomen [2] 125/24 126/3 able [22] 21/6 22/1 30/16 35/23 43/12 43/18 43/24 48/10 55/6 55/6 67/7 68/25 72/3 82/3 98/21 137/21 138/15 138/19 139/8 142/3 144/13 169/17 abnormal [1] 58/4 abnormally [1] 98/13 about [229] above [1] 17/1 absolutely [4] 12/23 44/1 96/10 112/17 accept [1] 56/6 access [3] 82/3 143/6 143/13 accessing [1] 143/11 accidental [1] 97/4 accompanied [1] 117/6 accord [1] 149/22 account [1] 25/21 accurate [4] 1/19 101/12 101/15 146/2 accurately [1] 94/5 acknowledge [1] 64/13 acknowledged [4] 44/10 47/1 66/3 163/7 acknowledgement [1] 66/11 acknowledging [1] 64/5	acronym [2] 132/18 133/9 across [7] 39/23 49/6 117/1 120/19 124/6 125/6 129/13 acted [1] 44/10 action [2] 18/1 73/15 actions [3] 29/11 41/14 97/25 active [2] 13/25 53/14 actively [5] 4/2 45/24 53/20 159/6 159/9 actually [2] 122/11 156/12 acute [6] 7/3 23/7 31/15 31/16 39/11 40/13 acutely [2] 12/14 40/6 ad [1] 68/5 ad hoc [1] 68/5 add [2] 70/5 143/20 adding [1] 87/13 additional [4] 54/21 87/10 98/5 117/2 addressed [3] 74/1 120/3 141/20 adequacy [1] 25/1 adjourned [1] 171/1 adjournment [1] 99/21 administer [1] 100/3 administered [1] 76/2 administering [1] 138/7 administration [2] 76/6 77/9 admission [1] 73/12 admissions [2] 55/2 55/13 admit [1] 56/6 admitted [3] 55/3 56/8 59/5 adrenaline [8] 76/2 76/6 76/17 77/9 77/11 84/4 84/17 87/4 advance [1] 80/2 advanced [1] 140/6 advantage [1] 43/24 adverse [1] 30/12 advice [7] 35/21 63/5 76/15 107/5 119/6 168/21 168/24 affect [4] 39/22 41/13 111/3 111/3 affecting [1] 66/1 affirmation [1] 100/3 affirmed [8] 1/6 51/4 100/5 145/15 172/2 172/4 172/6 172/9 afraid [5] 70/25 71/15 72/2 77/3 90/4
'15 [1] 47/17 'a [2] 70/18 75/14 'a bad [1] 70/18 'a sense [1] 75/14 'break [1] 141/25 'I [1] 127/6 'I had [1] 127/6 'it's [1] 87/7 'Nurse [1] 158/20 'Oh [2] 86/9 86/11 'surprised [1] 79/8	2 2 July [2] 30/13 31/6 2 o'clock [2] 99/18 99/19 2 October 2024 [1] 1/1 2.00 pm [1] 99/22 20 [2] 16/21 79/3 2008 [2] 51/16 51/23 2010 [1] 51/23 2011 [1] 100/21 2012 [2] 53/1 58/20 2012/13 [1] 77/1 2012/2013 [1] 60/18 2013 [3] 53/1 58/20 60/18 2014 [1] 51/19 2015 [26] 2/17 2/17 3/9 27/10 28/21 38/6 38/19 38/21 47/18 53/6 54/10 54/13 55/22 59/21 65/21 70/17 71/6 73/10 73/24 74/25 102/1 103/11 147/10 147/17 161/10 164/17 2015-2016 [1] 94/20 2015/16 [1] 69/9	3 3 October 2024 [1] 171/2 3.08 [1] 145/10 3.35 [2] 145/5 145/9 3.36 [1] 145/12 3.5 [4] 108/17 112/25 113/6 120/13 30 June 2016 [1] 131/20 30 September [1] 82/24 32 [3] 102/20 102/22 103/4 34 [1] 129/9 36 [1] 86/20 3ml [1] 123/1	1 1 September 2015 [1] 2/17 1.30 in [1] 75/10 10 [9] 18/19 18/24 86/19 90/3 92/14 92/17 92/19 94/14 170/24 10.00 [2] 1/2 171/1 10.59 [1] 50/23	

A	131/15 131/17 138/13 138/22 141/2 142/15 143/19 144/22 145/8 147/25 150/17 151/18 155/18 155/22 157/8 162/22 168/12 168/16 170/16 all of [1] 157/8 Allitt [6] 29/2 110/2 157/2 157/10 157/17 169/24 Allitt's [1] 110/7 allocated [1] 159/3 allow [1] 117/2 allowed [1] 133/11 alluded [1] 65/20 almost [9] 5/22 7/7 18/7 33/5 33/7 33/21 34/10 34/15 104/8 alone [3] 76/12 139/20 167/16 along [1] 87/6 alongside [1] 152/12 already [11] 8/24 18/25 19/1 27/15 30/24 67/16 94/25 129/3 131/3 154/11 169/3 also [40] 2/13 2/14 3/15 11/11 12/15 14/2 14/2 16/8 18/5 18/11 21/1 22/7 23/21 25/18 25/21 42/15 45/9 62/22 79/25 97/6 100/13 102/10 111/21 114/2 114/16 114/18 117/2 117/6 121/16 127/7 127/9 130/24 138/25 139/20 141/22 143/4 144/24 150/23 170/15 170/17 although [5] 17/22 85/7 125/25 126/3 146/19 always [17] 4/3 4/14 4/21 5/24 7/9 12/13 22/3 40/2 40/7 40/15 58/21 82/1 87/7 113/12 138/9 139/17 167/5 am [55] 1/2 1/12 8/10 17/23 18/20 19/6 19/23 20/6 20/11 21/22 27/23 31/4 31/7 31/14 31/19 37/2 37/3 37/18 39/16 39/25 41/12 48/2 50/23 50/25 51/14 64/19 71/2 71/23 80/4 82/10 91/25 100/15 101/14 102/6 103/8 106/11 108/8 108/25 110/16 118/3 118/6 118/18 131/18 131/24 133/10	137/12 138/15 139/14 139/14 141/10 141/16 145/19 147/13 162/16 171/1 amongst [14] 2/19 16/23 32/5 38/15 38/17 38/22 71/20 71/24 74/3 85/4 92/2 151/7 158/13 159/5 amount [1] 127/25 amounts [1] 98/18 anaesthetics [1] 138/6 anaesthetist [2] 123/25 124/24 anatomical [1] 25/20 anchor [1] 105/6 And: [1] 139/23 And: what [1] 139/23 angry [1] 46/12 Ann [1] 20/20 Ann Murphy [1] 20/20 anonymity [1] 133/12 anonymous [1] 35/4 anonymously [2] 35/9 45/11 another [15] 9/6 20/6 34/5 43/15 53/21 70/1 93/7 112/22 121/4 134/17 142/5 142/12 160/8 162/4 170/7 answer [3] 21/20 49/18 111/18 antibiotics [1] 129/1 anticipate [1] 13/11 anticipated [2] 21/8 61/16 anticipation [1] 34/15 anxiety [7] 8/1 81/23 82/5 82/7 103/24 104/25 105/11 anxious [2] 19/1 160/6 any [133] 5/16 5/16 7/23 9/22 10/10 11/2 18/1 29/1 31/16 32/12 32/25 38/6 39/6 40/1 40/18 40/18 41/1 48/21 48/23 58/1 58/8 58/9 59/5 59/8 60/3 60/18 61/25 62/9 62/11 63/12 64/22 65/10 65/11 66/7 66/10 67/4 67/13 67/14 68/4 68/13 68/14 69/2 69/8 69/17 69/18 72/14 72/24 73/21 74/1 74/6 74/8 80/9 81/18 81/19 83/13 83/22 86/1 87/15 87/16 87/24 88/6 88/19 88/20	88/22 89/6 89/25 90/9 91/10 93/8 93/10 97/10 97/13 101/4 103/12 105/14 108/6 108/25 110/10 111/8 111/13 111/13 111/14 111/17 112/2 116/10 118/25 119/5 119/6 119/21 119/21 119/22 121/19 124/13 124/16 124/19 125/13 128/16 131/18 131/18 132/1 132/11 134/25 135/2 136/13 138/13 147/18 148/18 150/25 151/23 153/25 154/3 154/13 155/1 155/3 155/4 155/6 155/20 156/6 157/1 158/11 159/4 161/19 165/15 165/24 166/17 166/21 167/17 168/8 168/17 168/20 169/2 169/19 169/25 anybody [4] 14/4 38/7 87/22 169/1 anyone [22] 13/18 13/24 28/13 37/23 38/5 40/25 50/20 64/24 73/7 80/12 88/25 89/24 115/13 123/21 151/9 151/15 156/1 160/24 160/25 160/25 163/23 168/24 anything [28] 22/17 26/4 27/4 28/15 28/16 37/25 50/7 59/22 60/15 67/19 70/5 87/9 105/18 106/9 107/2 110/4 110/8 119/9 124/2 124/5 129/13 134/7 134/10 134/12 137/1 143/20 147/24 155/21 anyway [4] 21/9 35/9 144/24 150/6 anywhere [3] 113/13 118/10 168/4 apart [1] 128/12 apparent [3] 86/14 92/8 92/22 appear [1] 135/15 appearance [2] 8/4 104/2 appeared [7] 103/8 130/25 132/6 132/8 147/14 150/13 151/17 appears [1] 88/10 applied [1] 53/17 apply [1] 114/21 appreciate [3] 35/23 74/13 76/19 appreciated [2] 168/6 168/7 appreciation [1] 39/3	approach [3] 33/5 120/24 149/20 approachable [1] 67/2 approached [2] 103/12 147/18 approaching [1] 112/14 appropriate [2] 46/14 136/16 appropriately [3] 22/24 46/24 47/4 approximate [1] 55/7 approximately [2] 63/1 70/23 April [7] 2/17 24/7 24/11 47/13 101/11 153/10 153/12 architecture [1] 98/17 are [143] 1/18 1/19 1/21 1/22 1/25 4/18 5/13 6/24 17/22 18/10 19/7 19/8 20/17 22/10 22/16 26/17 27/3 27/25 28/12 29/11 31/1 31/10 31/11 31/11 31/12 31/13 33/25 34/1 35/25 36/8 36/8 36/13 38/12 39/24 40/6 41/23 42/10 42/11 42/11 42/12 42/15 43/19 45/7 49/24 50/12 52/7 52/12 53/8 55/6 55/6 58/17 59/3 61/19 61/20 62/20 64/5 65/6 69/16 72/3 73/18 78/6 81/25 82/1 84/13 84/13 87/13 88/1 90/15 92/6 92/13 92/19 98/19 99/8 99/11 101/12 101/13 101/14 103/2 108/9 108/11 108/12 108/21 110/23 111/12 111/19 111/25 111/25 117/17 118/7 118/8 121/17 121/24 127/1 129/7 129/14 130/14 130/16 133/8 135/1 135/21 136/7 136/10 137/1 137/1 137/23 138/17 138/18 139/8 139/21 139/23 140/1 140/3 140/5 140/8 140/11 140/12 141/1 141/23 142/2 142/9 142/13 142/18 143/8 143/19 145/2 146/1 146/2 146/12 154/13 155/18 155/19 157/20 160/19 161/17 163/10 164/2 165/3 166/21 170/5
----------	--	---	--	--

A	125/11 126/11 128/14 130/10 131/1 132/7 132/22 136/18 137/4 169/4 asking [9] 5/20 6/6 13/19 14/3 35/24 88/20 104/18 118/6 165/21 aspect [1] 87/10 aspects [1] 137/11 aspirate [1] 128/12 aspirated [2] 123/2 127/25 assessment [4] 75/20 85/10 93/25 96/1 assessments [2] 55/2 78/4 assigned [6] 111/7 122/13 122/16 122/18 122/21 122/22 assist [7] 8/25 30/17 30/19 57/1 72/3 153/20 156/22 assistance [1] 6/7 assisted [1] 48/18 assisting [1] 9/3 associated [3] 78/15 135/17 160/2 association [3] 78/10 113/20 159/11 assume [1] 48/10 assumption [3] 72/25 73/1 95/3 assured [1] 121/14 at [352] atmosphere [8] 3/8 61/1 111/6 115/1 130/1 150/8 158/10 167/3 attempt [2] 4/21 85/9 attempted [2] 122/2 153/11 attempting [1] 123/8 attempts [1] 112/7 attend [15] 4/14 11/21 19/19 19/24 19/25 20/5 20/10 20/13 82/15 92/20 115/16 126/8 126/12 155/19 155/23 attended [10] 8/24 9/11 9/24 19/22 30/21 48/5 75/5 90/7 91/19 116/11 Attendees [1] 90/8 attending [7] 20/2 61/8 80/17 97/7 99/15 124/18 168/8 attention [1] 102/22 attributes [1] 142/24 audible [1] 111/20 August [5] 52/17 53/1 71/6 71/8 92/9	August 2015 [1] 71/6 August 22 [1] 52/17 available [2] 21/5 150/17 avoid [1] 169/20 avoided [1] 40/16 awaiting [1] 123/9 awarded [1] 100/20 aware [81] 7/25 11/25 16/24 21/13 22/16 27/3 29/2 29/4 30/14 30/20 30/24 31/2 31/8 32/2 32/3 32/4 37/5 37/15 44/25 45/22 46/9 46/18 46/22 48/2 59/5 59/8 60/3 60/7 62/11 62/16 63/14 67/16 67/16 69/17 69/19 69/20 69/24 71/16 71/25 72/1 72/10 73/7 78/23 80/2 81/19 82/10 82/23 87/21 87/24 92/6 93/18 93/19 101/14 103/23 104/10 104/14 104/22 105/11 109/16 110/15 118/20 121/17 121/18 121/20 125/3 125/11 130/20 131/11 131/18 132/14 140/5 151/2 151/4 151/5 153/5 154/13 161/16 161/16 163/18 166/10 167/12 awareness [9] 80/5 82/25 109/18 109/19 109/21 110/11 142/24 157/19 159/5 away [6] 4/17 13/24 14/4 118/15 129/6 138/16 awful [2] 27/24 28/18	baby [34] 4/20 7/5 8/14 8/16 8/17 23/19 24/8 24/12 30/25 40/3 42/24 43/2 43/2 43/16 43/19 43/23 57/16 57/19 61/18 64/10 82/21 88/5 88/8 88/10 122/2 122/5 122/17 125/6 149/2 149/3 152/11 154/11 158/6 159/18 Baby A [5] 8/14 8/16 8/17 24/8 24/12 Baby B [2] 23/19 30/25 Baby I [3] 88/5 88/8 88/10 Baby N [3] 122/2 122/5 122/17 Baby P [1] 158/6 baby's [1] 57/20 back [25] 8/11 19/12 21/23 22/3 33/14 37/7 37/8 40/9 47/9 60/17 76/25 83/4 86/15 87/18 99/18 120/5 120/22 122/3 123/20 123/24 126/14 126/21 128/20 129/5 140/2 background [6] 25/17 25/18 78/2 109/9 110/16 110/18 bad [16] 6/12 33/21 60/1 70/18 71/12 72/17 72/22 73/1 73/2 73/2 73/13 73/19 78/6 86/24 104/9 159/20 bad' [1] 86/11 bag [1] 27/7 bags [2] 117/12 143/16 Band [1] 131/24 BAPM [2] 114/5 114/9 barium [2] 93/8 93/9 BARRETT [8] 145/15 145/19 145/23 158/19 167/16 170/9 170/12 172/9 based [1] 118/5 basis [4] 57/22 95/8 108/20 111/1 be [200] became [7] 9/10 33/16 46/9 71/25 94/4 120/19 165/7 because [49] 11/7 12/21 17/16 18/6 19/1 23/20 24/4 33/3 35/19 36/2 42/1 45/21 48/10 48/17 49/22 53/20 74/11 75/15 81/11 82/12 84/12 90/13 94/24 95/2 105/23	110/19 110/21 116/1 118/8 119/8 120/12 122/25 124/2 125/25 127/16 133/18 134/15 137/20 138/17 149/10 152/17 155/7 159/25 162/2 164/10 165/16 166/16 169/2 170/13 become [8] 8/6 12/14 29/14 41/19 63/25 104/3 115/21 136/21 becomes [1] 27/7 becoming [2] 36/4 136/1 bed [1] 117/12 been [140] 2/8 2/10 2/12 4/13 4/17 7/7 8/18 8/20 11/25 11/25 14/22 16/18 19/21 19/24 19/25 22/9 23/14 23/14 23/23 24/17 30/16 30/16 30/21 30/22 30/23 31/7 31/18 33/1 33/7 39/8 39/14 39/19 44/9 45/18 48/8 49/3 49/22 50/17 51/9 52/10 56/7 57/14 58/3 58/19 58/21 59/12 59/13 60/9 60/23 61/16 63/13 63/17 65/3 65/4 66/6 66/17 68/19 71/8 71/14 72/6 73/1 73/10 73/11 74/2 74/12 76/7 77/4 77/5 78/7 78/24 79/11 81/1 81/4 82/12 83/10 85/24 86/4 86/7 86/11 86/21 89/1 89/10 89/11 89/16 90/1 91/22 93/23 94/22 94/25 95/7 95/9 96/5 96/8 96/11 96/12 97/3 98/16 99/10 106/19 109/16 110/3 120/15 122/1 123/2 124/10 124/20 125/1 125/13 127/8 128/22 128/23 129/12 132/19 137/8 139/15 141/17 141/19 149/14 149/23 150/21 153/15 153/23 154/1 156/8 156/15 159/2 159/3 159/25 160/9 162/4 163/4 163/8 163/8 163/12 163/25 165/14 165/20 168/11 168/16 170/8 before [35] 10/10 11/10 18/23 18/25 27/17 38/2 44/13 55/21 63/18 70/1 70/13 71/9 76/8 78/6 99/19 101/19 101/25 102/5 102/5 102/16
----------	--	---	---	---

B	139/18 149/16 better [3] 98/9 101/3 167/22 between [54] 3/12 3/14 3/16 5/7 5/20 6/3 6/3 6/22 14/7 14/23 26/12 30/18 34/21 38/14 42/17 51/23 55/7 59/2 59/19 59/20 60/9 60/11 60/19 60/19 60/24 61/3 61/5 62/7 62/8 62/18 62/22 66/24 68/10 70/2 70/7 71/5 74/5 80/18 97/24 98/1 101/21 102/12 108/1 109/13 113/11 113/13 124/19 146/5 148/17 148/24 161/10 162/22 164/1 168/12 between March 2016 [2] 101/21 146/5 Beverley [7] 29/2 110/2 110/7 157/2 157/10 157/17 169/24 Beverley Allitt [4] 157/2 157/10 157/17 169/24 bewildered [1] 129/10 bewilderment [2] 129/17 129/20 beyond [5] 67/24 77/25 83/24 128/24 166/9 bigger [1] 148/21 Bill [1] 162/16 Bill Yoxall [1] 162/16 bin [2] 117/22 117/24 bins [1] 118/14 Birkett [1] 129/23 birth [1] 42/10 bit [15] 5/2 7/21 21/4 65/7 66/5 107/13 107/14 114/8 115/21 116/14 120/16 127/1 133/2 133/3 147/9 bleep [8] 11/21 122/12 122/20 122/24 122/24 123/6 126/8 128/8 bleeped [2] 75/4 82/15 blockages [1] 93/10 blood [3] 80/24 123/2 128/23 bloodstreams [1] 137/17 blotchy [1] 12/6 blue [1] 10/1 board [3] 69/16 141/24 152/2 boards [1] 140/25 bodies [1] 134/20 body [8] 41/16 44/12	78/13 114/24 115/4 151/7 159/6 168/21 born [2] 56/7 82/13 both [14] 2/24 2/25 3/5 3/24 11/7 15/21 42/17 45/12 64/17 68/7 104/11 133/3 139/16 162/23 bottom [5] 36/8 85/20 93/11 94/1 123/11 bounce [1] 86/15 bowel [1] 93/10 box [1] 91/6 breach [1] 116/2 breaches [1] 155/4 break [5] 50/13 50/19 50/24 145/11 170/13 breaks [1] 66/6 Brearey [20] 19/13 30/13 53/12 88/19 91/23 104/15 105/11 105/22 106/13 106/18 107/19 113/17 125/3 130/6 131/4 133/2 133/18 134/15 150/10 160/25 Brearey's [1] 88/16 Brearley [2] 107/3 150/23 breastfeeding [3] 42/11 43/19 169/12 breathing [5] 11/23 11/24 13/9 75/6 123/13 brief [5] 14/3 24/10 25/4 122/20 127/6 briefed [2] 73/25 74/2 briefly [6] 51/14 60/22 96/19 98/4 120/6 146/16 British [1] 113/20 broad [1] 140/24 broader [1] 67/24 broadly [1] 141/17 brother [1] 153/12 Browne [4] 51/1 51/5 99/14 172/5 bubbly [1] 130/3 build [1] 140/14 building [1] 82/4 bundle [3] 85/17 86/19 92/15 busier [2] 34/13 65/19 busy [9] 21/20 39/15 39/21 66/18 66/19 94/22 113/2 113/6 164/13 but [204]	43/11 Caldicott [3] 116/9 118/21 118/23 call [22] 1/5 2/15 2/24 3/1 8/19 9/7 11/21 51/2 68/24 76/5 76/9 76/15 93/6 99/23 106/3 106/6 111/14 122/25 123/4 127/23 145/14 152/10 called [30] 2/21 4/17 5/23 7/3 7/4 8/15 9/11 12/5 39/12 39/17 55/16 56/18 61/15 61/17 61/19 61/20 61/23 61/24 75/10 75/23 78/21 82/17 83/19 84/3 84/10 92/20 128/21 131/8 146/20 153/23 calling [2] 7/18 69/3 calls [1] 6/22 came [16] 10/1 16/13 16/15 17/15 17/17 43/2 48/18 110/16 116/3 121/3 123/23 123/24 124/6 126/21 157/3 157/14 camera [8] 13/16 13/19 14/5 42/8 42/13 42/21 169/10 170/16 cameras [2] 41/16 169/16 Campbell [1] 124/1 can [118] 1/10 1/18 1/20 1/23 5/13 6/9 7/15 7/16 8/15 9/13 9/14 11/17 12/4 17/10 17/11 19/14 20/2 20/19 21/25 24/9 24/14 25/19 26/3 26/14 29/6 29/7 41/17 42/5 42/17 43/3 43/4 43/22 44/3 48/10 52/22 54/10 61/8 61/21 66/5 68/1 69/11 70/23 71/3 76/4 76/11 76/19 77/1 77/10 84/6 85/19 86/18 89/14 91/21 91/25 93/9 93/12 99/19 100/8 100/23 100/25 101/11 101/17 101/19 102/14 102/18 102/25 103/3 103/18 103/20 105/6 105/7 108/12 108/13 115/17 116/17 118/17 120/9 122/4 127/14 130/5 130/13 130/15 130/17 132/1 133/8 133/13 133/14 135/3 138/1 139/1 139/19 139/22 139/24 141/19 142/18 142/20 142/22	144/3 145/5 145/17 146/1 146/16 151/10 151/16 153/2 153/13 155/21 156/3 156/18 158/4 160/4 161/4 161/6 161/21 163/24 164/2 167/6 168/18 can't [36] 4/11 7/17 7/19 8/25 11/6 13/22 13/25 15/2 15/2 15/10 26/7 27/17 27/22 36/12 39/14 39/18 70/25 77/3 86/1 92/6 96/23 101/4 102/4 103/2 107/24 123/3 123/22 127/12 132/25 133/24 143/24 149/10 152/16 156/15 156/19 159/1 cannot [2] 38/3 158/18 cannula [1] 126/5 cap [6] 120/7 120/16 120/19 120/22 121/1 121/16 capacity [1] 111/10 caps [1] 141/12 cardiac [3] 9/1 153/19 165/8 Cardiology [1] 100/15 cardiopulmonary [1] 8/23 care [36] 3/21 4/20 7/13 7/23 11/15 27/18 42/11 56/14 57/20 58/1 58/2 58/8 58/10 58/11 63/8 70/21 73/6 78/2 94/7 94/10 100/12 100/17 100/19 123/15 124/12 130/8 134/11 139/12 139/16 140/7 148/22 149/2 153/10 154/1 168/12 168/19 care and [1] 130/8 cared [1] 56/3 career [7] 51/15 77/11 109/11 112/1 112/2 132/2 135/24 carefully [1] 43/7 caregivers [1] 98/10 cares [1] 87/1 caring [4] 58/9 58/17 88/5 88/7 carried [1] 15/21 carrying [1] 36/9 case [45] 5/24 12/16 13/13 20/9 25/17 26/20 29/2 29/9 42/3 42/19 44/7 46/9 46/21 47/5 50/10 52/18 54/4 55/15 55/19 58/21 67/6 73/4 74/14 81/9
----------	--	--	--	---

C	Chang [2] 85/18 86/13	29/25 30/13 31/18 39/11 40/3 40/6 49/6	65/10 80/9 82/11 82/12 82/16 83/24	clarify [1] 144/5
case... [21] 89/3 89/12 90/14 91/7 98/12 99/3 101/25 102/10 110/1 110/4 110/7 110/12 154/12 155/5 157/7 157/10 157/13 157/14 157/17 157/19 157/20	change [2] 13/17 140/24	51/19 64/17 64/25 65/10 65/10 65/18 67/11 67/11 68/12 68/12 74/13 74/22 74/24 75/7 75/16 76/21 77/9 77/16 77/23 79/7 79/16 79/23 80/1 80/2 80/9 80/10 80/19 81/3 81/9 81/14 81/18 81/21 82/11 82/12 82/13 82/16 82/23 83/14 83/24 84/1 85/5 85/7 85/12 85/24 86/7 86/9 86/14 87/12 88/4 88/11 88/15 89/3 89/3 89/4 89/25 90/1 90/7 90/11 90/25 92/1 92/19 92/20 93/4 93/19 94/3 97/3 97/8 97/13 98/14 98/21 100/16 103/24 103/25 107/18 109/13 109/14 119/7 119/9 119/9 119/12 121/21 122/11 123/1 123/5 123/15 123/19 124/11 124/13 124/16 124/18 124/21 125/15 125/17 125/17 125/19 125/24 125/24 126/2 126/5 126/7 126/14 126/23 126/25 127/3 127/20 127/22 128/3 128/4 128/17 128/19 128/19 129/4 129/6 130/9 130/9 134/25 135/2 135/17 138/12 153/10 153/12 153/14 153/18 154/1 156/17 158/12 159/14 170/4	84/1 85/12 89/3 90/7 90/11 92/19 93/4 97/13	cleaners [1] 151/23 clear [19] 5/15 37/19 38/12 45/7 54/18 75/16 75/17 77/23 78/9 91/13 97/1 111/18 117/10 120/19 121/24 137/18 150/14 151/2 166/15
cases [10] 45/4 61/17 63/5 74/9 84/13 97/6 125/9 141/23 155/19 169/24	changes [1] 114/1	Child I and [4] 86/9 88/11 88/15 92/20	Child I had [3] 64/25 65/18 82/23	clearer [2] 73/22 93/10
CASSANDRA [3] 145/15 145/19 172/9	changing [3] 135/24 136/3 142/2	Child I as [1] 94/3	Child I in [1] 79/23	clearly [5] 21/8 24/19 32/1 96/24 106/12
catch [2] 108/2 108/3	channels [1] 26/23	Child I or [2] 67/11 68/12	Child I that [1] 88/4	clerk [1] 100/2
category [2] 155/8 155/10	Characteristics [1] 143/1	Child I then [1] 87/12	Child I was [3] 82/13 90/25 92/1	clerks [1] 151/23
catheters [1] 114/4	charged [1] 60/23	Child I would [1] 86/14	Child I would [1] 86/14	clinical [29] 48/24 53/2 53/6 53/12 54/25 55/10 58/11 67/21 67/23 68/2 68/8 68/19 74/9 83/20 84/12 84/14 85/4 85/15 89/11 91/1 92/5 94/8 95/12 97/5 98/1 162/17 163/3 164/24 168/9
causative [1] 159/21	Charles [1] 100/20	Child I's [2] 85/5 85/7	child it [1] 21/8	clinically [3] 84/22 115/5 128/16
cause [12] 72/20 72/22 72/25 73/3 75/22 76/13 81/3 81/19 81/20 85/9 98/14 128/16	chase [1] 93/15	Child M [3] 153/10 153/12 153/14	Child M's [1] 154/1	clinicians [4] 5/8 47/23 141/1 141/23
caused [5] 91/2 95/4 103/17 120/1 147/22	chasing [1] 93/20	Child N [5] 121/21 122/11 123/5 124/18 124/21	Child N's [2] 123/1 123/15	clinicians' [2] 20/17 23/18
causes [5] 26/12 80/23 96/2 166/17 166/18	chat [2] 131/23 147/23	Child O [9] 125/15 125/17 125/19 125/24 126/2 126/7 126/14 126/23 128/4	Child O's [2] 125/17 125/24	clinics [1] 113/9
causing [9] 29/10 39/4 72/14 131/13 135/22 159/6 164/17 170/4 170/8	chatty [1] 130/3	Child P [6] 127/20 127/22 128/3 128/17 129/4 129/6	Child P's [1] 128/19	clock [1] 97/23
CCT [1] 145/21	check [5] 16/4 18/19 136/12 138/9 138/17	Child P's [1] 127/20 127/22 128/3 128/17 129/4 129/6	Childcare [1] 107/11	clocking [1] 15/7
CCTV [10] 41/10 42/3 42/20 137/7 137/9 137/12 169/6 169/10 169/10 170/16	checked [2] 32/20 128/10	children [22] 2/12 3/4 11/11 12/5 12/12 12/16 13/10 15/21 21/18 23/4 23/11 23/17 40/17 44/9 84/19 98/19 111/3 117/12 135/12 137/23 138/6 156/24	children's [14] 3/2 3/3 3/20 3/22 20/21 52/13 55/1 55/13 98/22 113/7 137/17 146/21 152/8 163/23	close [7] 8/20 11/11 15/20 27/1 43/2 53/18 95/15
CCT [1] 145/21	checking [3] 30/9 64/5 128/20	Child A [14] 8/1 14/13 14/23 15/7 15/9 18/18 18/25 19/1 20/2 23/12 29/25 30/13 49/6 103/24	choice [3] 48/17 53/14 121/5	closer [5] 23/24 46/21 97/25 107/14 150/20
CCTV [10] 41/10 42/3 42/20 137/7 137/9 137/12 169/6 169/10 169/10 170/16	checks [2] 139/9 152/11	Child A's [1] 9/18	chose [2] 53/20 53/21	coffee [1] 16/14
centres [1] 85/2	chest [5] 76/1 76/5 82/16 84/3 84/9	Child B [11] 8/2 11/5 11/15 11/22 14/9 14/11 14/23 15/3 15/14 17/18 103/25	chords [1] 123/11	coherent [1] 95/15
certain [6] 16/5 31/11 39/16 42/4 47/22 91/25	Chester [64] 2/8 2/16 2/22 3/25 4/4 6/15 6/16 23/24 24/7 32/8 32/12 33/4 38/4 38/5 47/16 52/4 52/8 52/23 52/25 53/15 53/22 55/20 55/21 56/9 56/12 57/7 59/11 71/7 71/10 71/14 71/25 72/12 72/23 73/17 73/21 73/24 75/3 77/1 79/9 79/14 87/3 91/16 96/22 99/1 101/21 102/10 102/16 105/1 114/20 119/19 121/7 135/20 146/5 146/22 149/4 149/9 156/1 162/21 162/24 163/8 163/13 163/19 166/5 169/21	Child B's [1] 15/12	circumstance [3] 13/24 42/4 42/17	cohort [2] 95/1 95/8
certainly [27] 10/11 10/21 11/7 15/11 21/17 21/21 23/24 24/4 34/7 37/18 41/23 43/4 46/21 64/13 66/10 72/25 74/8 81/4 83/10 84/15 89/20 90/13 90/22 94/8 120/25 141/7 141/12	Chester's [2] 70/17 149/20	Child G [1] 80/1	circumstances [3] 50/4 74/9 76/10	collapse [27] 8/1 11/8 13/15 14/23 15/12 39/11 49/22 64/16 66/14 77/16 77/21 79/7 79/21 81/3 81/19 81/21 82/20 83/3 83/7 83/15 83/24 103/24 159/14 161/23 162/5 163/7 163/21
Certificate [1] 100/11	Chief [1] 69/13	Child H [16] 65/10 67/11 68/12 74/22 74/24 75/7 75/16 77/9 77/23 80/2 80/19 81/3 81/9 83/14 89/3 89/25	citizen [1] 29/5	collapsed [9] 8/7 11/5 12/20 15/4 63/25 82/24 84/2 104/4 161/18
cetera [2] 24/23 130/14	Chief Executive [1] 69/13	Child H's [5] 77/16 79/7 79/16 81/18 81/21		collapses [33] 8/3 17/18 26/10 49/4 64/16 65/13 65/18 65/25 67/12 74/24 79/16 80/1 80/19 84/8 87/23 88/4 88/16 88/21 89/1 89/4 89/6
chairs [1] 98/20	child [165] 4/20 8/1 8/2 9/9 9/18 11/3 11/5 11/15 11/22 12/1 12/12 14/9 14/11 14/13 14/23 14/23 15/3 15/7 15/9 15/12 15/14 17/18 18/18 18/18 18/25 19/1 20/2 21/8 23/12 25/18	Child I [15] 64/17		
challenges [2] 61/16 62/12				
challenging [13] 7/21 54/6 63/24 64/20 65/3 65/4 65/19 77/17 77/22 82/1 84/12 95/12 95/13				

<p>C</p> <p>collapses... [12] 90/1 90/15 91/8 91/12 97/12 103/6 103/10 104/1 147/12 147/16 161/15 163/12</p> <p>collapses/deaths [2] 103/10 147/16</p> <p>collapsing [3] 64/10 66/20 72/21</p> <p>colleague [7] 8/25 9/8 10/14 14/25 48/5 135/21 161/1</p> <p>colleagues [27] 16/24 16/25 40/14 41/15 45/22 47/1 61/4 63/23 64/2 64/15 64/20 65/11 71/13 72/4 72/7 78/24 81/20 82/3 85/2 91/18 94/21 95/2 95/10 97/6 110/11 165/9 165/15</p> <p>colleagues' [1] 30/20</p> <p>College [4] 51/19 100/15 107/10 107/18</p> <p>colour [1] 13/17</p> <p>combination [1] 109/23</p> <p>come [23] 8/11 10/11 21/6 49/6 49/9 56/11 69/17 80/9 88/25 101/25 103/18 105/10 110/8 111/15 111/16 117/9 125/6 129/13 130/17 135/12 142/20 160/24 170/1</p> <p>comes [1] 144/12</p> <p>comfort [1] 136/17</p> <p>comfortable [4] 42/6 89/21 98/20 135/20</p> <p>comforting [1] 43/16</p> <p>coming [13] 1/9 2/1 16/12 37/8 50/12 88/20 102/25 126/14 129/5 138/11 153/16 163/10 170/14</p> <p>commence [1] 52/16</p> <p>commenced [1] 84/3</p> <p>commencing [1] 55/21</p> <p>comment [7] 26/5 86/2 87/4 87/6 134/6 141/5 160/6</p> <p>commented [1] 169/15</p> <p>comments [3] 38/7 137/6 164/22</p> <p>committee [2] 61/17 121/18</p> <p>common [13] 6/14 21/15 26/19 27/8 38/14 81/14 126/4 128/1 129/15 136/1</p>	<p>137/24 168/17 169/25</p> <p>commonality [1] 30/17</p> <p>commonly [2] 5/19 66/16</p> <p>communication [4] 6/18 7/21 39/22 102/12</p> <p>community [6] 1/13 31/14 71/20 119/13 119/15 135/12</p> <p>compared [5] 59/11 70/7 75/15 105/2 114/17</p> <p>comparison [1] 57/3</p> <p>competent [1] 132/6</p> <p>complain [1] 50/21</p> <p>complete [2] 145/6 154/20</p> <p>completed [6] 2/2 51/22 68/16 86/25 93/25 100/13</p> <p>completely [3] 10/1 75/16 144/21</p> <p>completes [1] 50/11</p> <p>completing [3] 62/20 154/14 162/11</p> <p>Completion [1] 100/11</p> <p>complex [1] 157/5</p> <p>complications [1] 84/19</p> <p>compressions [5] 76/1 76/6 82/16 84/3 84/9</p> <p>computer [4] 27/19 28/11 153/16 153/17</p> <p>concern [16] 8/12 15/1 22/21 72/11 72/14 78/19 88/16 94/17 104/10 106/23 119/17 126/25 127/2 127/17 127/24 128/2</p> <p>concerned [29] 1/19 11/8 12/20 14/22 15/19 17/17 18/11 22/16 22/22 26/10 31/1 39/24 41/13 69/22 75/14 82/7 101/13 111/12 114/22 115/12 119/7 119/7 125/13 126/6 128/17 128/25 142/4 146/2 152/25</p> <p>concerning [3] 103/8 147/13 160/3</p> <p>concerns [77] 11/12 16/7 16/25 17/3 17/4 17/8 18/2 18/5 18/6 26/21 30/20 32/1 32/25 33/8 34/2 35/4 35/22 36/1 38/20 38/22 38/24 44/11 44/14 44/25 45/1</p>	<p>46/11 46/14 46/20 46/23 47/2 58/8 58/10 65/12 67/4 67/5 67/5 67/10 67/13 67/17 68/4 68/5 68/20 73/5 73/8 73/23 79/21 80/10 81/18 83/23 83/23 86/2 87/16 88/17 88/22 90/20 91/10 94/20 94/23 95/10 103/13 115/9 119/9 119/18 120/3 132/11 135/21 136/2 136/13 136/16 141/1 141/18 142/7 142/10 142/12 147/19 151/4 153/25</p> <p>concerted [1] 40/7</p> <p>concludes [1] 170/20</p> <p>conclusions [1] 87/15</p> <p>condition [2] 12/5 84/14</p> <p>conditions [1] 166/20</p> <p>conduct [1] 142/5</p> <p>conducted [3] 57/14 57/21 58/6</p> <p>conducting [1] 57/23</p> <p>confidence [1] 95/8</p> <p>confident [12] 7/15 7/16 42/16 46/25 78/22 83/17 83/18 89/21 94/25 95/6 95/12 160/19</p> <p>confidential [3] 116/9 117/22 119/1</p> <p>confidentiality [4] 116/2 117/25 118/8 155/4</p> <p>confirm [3] 1/18 101/11 146/1</p> <p>confirming [1] 24/11</p> <p>connection [3] 34/21 35/11 102/12</p> <p>conscious [4] 59/6 60/25 81/22 98/25</p> <p>consecutive [4] 84/8 84/9 88/4 158/17</p> <p>consequences [2] 25/20 45/5</p> <p>consider [7] 41/24 57/24 57/25 80/8 83/12 89/5 97/13</p> <p>consideration [4] 96/5 108/23 143/5 154/14</p> <p>considered [8] 43/4 45/13 45/17 45/21 67/18 87/22 96/9 97/18</p> <p>considering [4] 36/14 88/1 96/3 96/16</p> <p>consigned [1] 110/12</p>	<p>consisted [1] 116/20</p> <p>consistency [1] 140/20</p> <p>constant [1] 140/13</p> <p>constantly [2] 42/8 140/17</p> <p>Consultant [68] 1/13 2/9 2/10 4/2 4/7 9/4 9/10 15/24 16/2 16/6 16/24 21/3 21/7 23/21 24/2 25/11 31/12 31/14 31/15 31/17 31/19 32/18 39/16 39/17 44/12 49/16 52/9 52/12 52/19 56/19 56/25 57/18 63/20 67/7 68/24 69/3 72/5 74/16 75/23 76/5 76/10 76/15 78/13 78/23 82/3 82/17 83/16 88/20 91/16 93/6 94/22 95/10 98/5 103/13 103/16 106/4 114/24 115/4 119/20 123/25 145/20 147/18 147/21 150/9 153/3 153/6 155/17 159/5</p> <p>Consultant-led [1] 91/16</p> <p>consultants [61] 2/15 3/15 3/19 4/25 5/6 9/4 17/2 17/5 17/14 18/4 19/13 20/19 21/6 21/11 26/11 30/24 31/1 32/4 33/3 33/5 33/11 36/20 37/6 40/25 44/25 46/10 46/15 46/19 46/24 60/12 66/23 66/25 68/14 68/18 78/18 83/18 83/22 84/10 111/9 111/11 111/14 111/15 111/22 112/4 112/6 112/10 112/12 117/7 121/11 121/14 125/4 141/8 141/18 151/15 152/13 152/14 165/19 166/2 168/22 168/25 170/21</p> <p>contact [12] 21/23 42/12 63/12 68/9 69/18 97/23 98/1 141/25 147/8 151/25 152/4 153/2</p> <p>contacted [1] 37/17</p> <p>contaminant [1] 36/13</p> <p>contamination [3] 13/3 15/23 27/6</p> <p>contents [4] 1/18 101/12 101/14 146/1</p> <p>context [5] 25/1 55/20 107/19 107/24 136/24</p>	<p>contexts [1] 102/4</p> <p>continually [1] 140/1</p> <p>continuation [1] 93/2</p> <p>continue [1] 49/17</p> <p>continues [1] 9/25</p> <p>continuing [2] 37/1 46/20</p> <p>contract [1] 53/10</p> <p>contrast [3] 59/10 59/10 93/16</p> <p>control [2] 13/9 42/4</p> <p>conversation [28] 16/15 18/3 18/7 34/9 35/18 36/7 36/18 37/1 37/9 38/17 104/20 104/21 106/12 106/17 107/20 108/3 108/14 124/22 127/6 132/23 133/23 136/15 136/16 150/23 150/25 160/17 160/18 164/5</p> <p>conversations [8] 39/10 45/20 64/15 64/18 66/10 108/5 163/25 164/8</p> <p>convey [1] 74/7</p> <p>convicted [4] 110/3 122/1 143/15 153/11</p> <p>corner [1] 27/19</p> <p>Coroner [8] 24/8 25/2 25/7 25/9 25/14 32/2 47/11 167/21</p> <p>Coroner's [1] 25/13</p> <p>Coroners [2] 131/3 167/19</p> <p>corporate [4] 115/16 115/17 115/20 116/10</p> <p>correct [19] 51/24 52/15 52/21 53/3 54/22 55/25 56/15 60/2 66/21 76/3 83/9 88/13 88/14 90/19 95/23 96/17 96/18 146/11 154/7</p> <p>correctly [2] 47/12 144/15</p> <p>corridor [2] 128/10 158/19</p> <p>cost [1] 116/11</p> <p>cot [1] 148/22</p> <p>could [53] 5/2 5/8 12/21 12/24 13/4 13/4 14/9 15/20 15/22 37/21 39/5 39/14 41/19 41/24 42/3 45/14 49/7 51/2 51/7 52/6 56/2 57/11 68/5 79/3 81/4 84/23 85/16 86/5 90/3 91/1 92/12 92/17 93/1 94/12 94/13 99/18 100/24 103/17 109/7 116/19 120/3 121/13 124/5 125/8 126/2 134/9</p>
---	--	--	---	--

C	curiosity [1] 108/25 curious [1] 109/1 current [3] 45/13 52/19 72/11 currently [3] 19/11 52/12 102/23 CV [1] 101/20	167/23 168/3 168/3 Death's [1] 158/20 deaths [40] 17/18 22/8 22/15 22/18 23/19 23/20 25/16 26/10 26/16 28/8 30/5 30/11 30/13 31/9 65/13 65/25 66/15 74/10 74/13 92/9 94/18 103/7 103/10 105/18 134/3 134/6 147/12 147/16 159/14 161/9 161/13 162/7 163/6 163/13 166/6 166/8 166/11 166/11 167/13 167/14 debate [1] 21/4 debrief [14] 23/3 23/4 23/8 23/11 23/12 23/15 80/17 81/1 81/8 81/9 90/11 92/1 124/18 125/1 debriefs [5] 22/11 81/13 168/9 168/11 168/14 decide [1] 26/20 decisions [1] 48/24 deep [3] 129/11 129/17 143/23 deeper [1] 136/25 define [1] 110/20 definite [1] 149/14 definitely [2] 44/4 155/10 degree [2] 51/16 100/20 delay [1] 7/18 delegated [1] 39/15 deliberate [6] 95/5 96/6 97/3 131/13 135/22 164/18 deliberately [2] 29/10 156/23 delivered [1] 7/13 deliveries [3] 61/8 61/15 152/9 delivery [1] 55/4 demeanour [1] 132/9 denominator [1] 38/14 department [6] 2/11 57/23 103/14 147/20 148/2 148/22 depend [1] 41/21 depended [1] 55/10 dependent [1] 21/20 depends [3] 25/21 30/19 32/18 depth [1] 92/4 deputy [3] 132/23 133/7 133/16 derogatory [1] 38/8 describe [12] 5/9 6/4 6/9 12/4 16/19 34/14	57/6 59/20 62/24 66/23 76/14 78/8 described [10] 18/1 29/21 30/22 39/21 49/5 62/14 65/16 80/22 104/11 162/10 designated [3] 9/7 106/7 109/5 designed [2] 97/7 120/13 destroyed [1] 117/24 detail [10] 10/7 11/14 31/24 31/25 53/8 54/9 65/7 66/5 66/9 74/6 detailed [3] 25/17 71/1 150/13 detailing [2] 48/9 49/12 details [8] 9/19 18/13 48/6 72/2 75/6 80/7 96/23 127/12 deteriorate [5] 12/21 13/2 13/5 82/21 86/14 deteriorated [7] 13/13 75/17 77/23 126/24 127/3 131/9 161/19 deteriorates [1] 125/6 deterioration [11] 22/21 22/22 22/23 23/7 25/16 75/15 77/18 78/8 91/2 153/25 154/2 deteriorations [7] 58/14 67/22 87/11 94/18 105/8 161/15 165/8 devastated [1] 129/10 developed [2] 26/15 79/22 developing [2] 94/17 97/14 development [1] 115/2 device [1] 123/5 diagnosis [3] 12/7 12/24 26/18 did [178] didn't [75] 4/3 5/15 10/2 10/16 12/7 12/10 12/17 12/19 12/22 12/25 15/11 17/24 19/24 20/5 25/4 29/16 33/6 35/3 36/20 38/4 38/6 41/4 47/4 48/3 48/21 48/23 58/4 58/25 59/22 60/15 67/13 67/19 69/2 78/14 78/18 80/15 81/10 82/7 89/7 89/12 90/20 107/3 108/14 110/8 111/13 111/17	111/22 112/5 118/18 121/12 121/13 122/4 126/9 128/14 128/24 130/20 131/17 134/17 136/14 136/25 152/17 152/18 153/25 154/3 154/16 155/7 157/1 157/7 159/4 160/23 166/8 168/20 169/1 169/2 170/12 die [3] 10/3 135/12 166/14 died [19] 8/7 9/21 64/1 70/20 71/4 81/14 93/19 94/4 104/4 105/8 105/10 129/4 129/6 133/3 133/17 158/2 158/6 158/17 159/2 dies [3] 109/14 109/15 135/17 differed [1] 56/3 difference [6] 58/19 58/21 60/18 109/13 164/25 165/5 differences [2] 60/24 148/17 different [28] 3/13 4/4 5/16 5/16 6/17 16/3 24/18 31/15 32/12 32/17 32/18 34/14 42/2 42/21 50/18 58/5 98/20 121/11 130/2 140/14 140/15 142/14 148/14 152/6 155/22 155/22 166/20 167/2 differential [1] 26/18 difficult [18] 5/9 5/19 22/1 64/6 64/13 65/3 65/22 66/13 77/14 85/23 93/23 96/13 112/21 124/9 163/8 163/12 165/20 169/16 difficulties [6] 46/10 46/18 46/22 62/11 67/4 111/8 difficulty [6] 6/3 11/23 123/8 123/15 124/13 124/16 digital [1] 138/16 direct [7] 24/20 42/1 42/12 90/17 115/15 160/17 160/18 directed [1] 5/10 directly [4] 95/10 138/2 141/25 158/19 Director [1] 69/13 Directors [1] 69/16 disagree [1] 96/13 disappointed [1] 6/6 disciplinary [3] 151/19 151/21 155/23 discuss [19] 11/12
	D			
	D's [1] 22/15 daily [2] 41/4 57/21 date [5] 24/16 109/7 113/18 115/3 158/18 dated [4] 1/15 51/10 101/11 145/24 dates [1] 24/23 Datix [15] 89/5 89/10 89/15 89/24 119/22 119/25 120/2 154/14 154/17 154/18 154/19 154/23 155/7 155/15 156/2 Datixes [2] 119/22 155/18 day [48] 2/15 4/9 4/10 4/10 4/12 4/13 9/12 9/17 9/24 10/3 10/10 10/13 11/3 18/7 22/4 34/9 34/22 57/18 63/16 86/10 86/15 87/13 93/19 110/17 110/17 110/18 110/18 111/1 111/1 117/3 117/21 122/22 124/20 126/24 129/18 152/7 152/8 152/17 152/19 152/23 154/1 154/11 158/6 158/24 159/8 160/5 164/6 164/10 days [7] 11/7 16/13 18/19 18/25 56/22 158/17 159/2 daytime [4] 2/23 16/6 21/19 39/16 dead [1] 135/14 deal [7] 75/12 79/23 92/18 97/20 112/5 134/23 135/8 dealing [8] 8/14 39/6 40/18 56/12 59/4 67/6 93/2 96/19 dealt [4] 17/8 43/22 97/12 137/13 death [37] 8/1 9/18 10/2 10/16 10/20 11/3 18/11 18/14 23/5 23/7 25/22 25/25 26/1 29/24 29/25 31/18 31/22 64/17 85/7 88/11 88/15 103/24 105/14 105/15 125/17 129/19 134/21 134/25 135/2 135/7 135/10 158/5 158/11 159/12	167/23 168/3 168/3 Death's [1] 158/20 deaths [40] 17/18 22/8 22/15 22/18 23/19 23/20 25/16 26/10 26/16 28/8 30/5 30/11 30/13 31/9 65/13 65/25 66/15 74/10 74/13 92/9 94/18 103/7 103/10 105/18 134/3 134/6 147/12 147/16 159/14 161/9 161/13 162/7 163/6 163/13 166/6 166/8 166/11 166/11 167/13 167/14 debate [1] 21/4 debrief [14] 23/3 23/4 23/8 23/11 23/12 23/15 80/17 81/1 81/8 81/9 90/11 92/1 124/18 125/1 debriefs [5] 22/11 81/13 168/9 168/11 168/14 decide [1] 26/20 decisions [1] 48/24 deep [3] 129/11 129/17 143/23 deeper [1] 136/25 define [1] 110/20 definite [1] 149/14 definitely [2] 44/4 155/10 degree [2] 51/16 100/20 delay [1] 7/18 delegated [1] 39/15 deliberate [6] 95/5 96/6 97/3 131/13 135/22 164/18 deliberately [2] 29/10 156/23 delivered [1] 7/13 deliveries [3] 61/8 61/15 152/9 delivery [1] 55/4 demeanour [1] 132/9 denominator [1] 38/14 department [6] 2/11 57/23 103/14 147/20 148/2 148/22 depend [1] 41/21 depended [1] 55/10 dependent [1] 21/20 depends [3] 25/21 30/19 32/18 depth [1] 92/4 deputy [3] 132/23 133/7 133/16 derogatory [1] 38/8 describe [12] 5/9 6/4 6/9 12/4 16/19 34/14	57/6 59/20 62/24 66/23 76/14 78/8 described [10] 18/1 29/21 30/22 39/21 49/5 62/14 65/16 80/22 104/11 162/10 designated [3] 9/7 106/7 109/5 designed [2] 97/7 120/13 destroyed [1] 117/24 detail [10] 10/7 11/14 31/24 31/25 53/8 54/9 65/7 66/5 66/9 74/6 detailed [3] 25/17 71/1 150/13 detailing [2] 48/9 49/12 details [8] 9/19 18/13 48/6 72/2 75/6 80/7 96/23 127/12 deteriorate [5] 12/21 13/2 13/5 82/21 86/14 deteriorated [7] 13/13 75/17 77/23 126/24 127/3 131/9 161/19 deteriorates [1] 125/6 deterioration [11] 22/21 22/22 22/23 23/7 25/16 75/15 77/18 78/8 91/2 153/25 154/2 deteriorations [7] 58/14 67/22 87/11 94/18 105/8 161/15 165/8 devastated [1] 129/10 developed [2] 26/15 79/22 developing [2] 94/17 97/14 development [1] 115/2 device [1] 123/5 diagnosis [3] 12/7 12/24 26/18 did [178] didn't [75] 4/3 5/15 10/2 10/16 12/7 12/10 12/17 12/19 12/22 12/25 15/11 17/24 19/24 20/5 25/4 29/16 33/6 35/3 36/20 38/4 38/6 41/4 47/4 48/3 48/21 48/23 58/4 58/25 59/22 60/15 67/13 67/19 69/2 78/14 78/18 80/15 81/10 82/7 89/7 89/12 90/20 107/3 108/14 110/8 111/13 111/17	

D	9/3 9/19 10/4 10/21 10/25 11/4 13/10 13/18 13/22 14/1 15/14 16/20 18/4 20/7 22/23 23/1 23/9 24/9 25/8 28/5 31/12 32/20 33/8 33/9 33/9 33/10 35/5 36/6 37/10 40/7 41/19 42/7 42/12 46/5 47/13 47/20 47/21 51/6 56/20 60/1 64/14 64/22 68/12 68/25 69/1 73/21 76/1 79/10 80/17 80/25 88/19 89/22 90/9 92/1 96/3 101/1 101/5 101/18 101/20 102/6 103/6 103/12 104/25 108/5 109/20 110/11 110/13 112/14 112/21 112/22 113/4 114/7 114/8 124/5 124/18 128/5 130/18 134/23 136/12 136/14 138/4 139/1 139/8 139/12 142/2 142/4 142/10 145/25 147/17 150/18 152/16 153/13 154/22 156/14 156/17 156/20 156/21 158/24 160/12 165/5 165/15 165/24 167/19 168/11 169/8 169/19 170/17	117/18 142/6 149/1 149/22 151/19 156/13 157/21 163/16 doesn't [6] 24/22 36/7 49/6 102/20 135/15 157/21 doing [18] 1/25 4/1 5/3 27/20 34/17 67/20 116/25 128/12 129/12 130/14 138/17 139/23 142/19 150/21 152/11 152/14 152/22 157/4 don't [117] 9/21 10/6 12/14 13/21 14/3 15/4 15/4 15/6 15/9 15/11 18/3 18/13 19/21 23/3 23/12 23/23 24/3 24/18 24/20 28/6 28/9 28/10 28/13 28/16 30/8 31/16 32/23 33/1 34/13 35/8 37/15 38/16 38/16 39/10 42/1 44/23 45/25 47/22 48/11 50/20 54/6 58/22 59/17 61/1 64/18 66/9 66/10 67/23 69/15 71/23 72/24 73/7 73/25 74/6 74/8 75/5 77/10 78/21 79/18 83/1 83/11 88/23 90/10 90/12 91/13 92/3 92/11 94/2 101/6 102/15 102/23 102/24 104/20 106/2 106/11 116/2 116/8 118/6 120/17 121/23 122/8 123/16 125/1 125/2 125/22 127/24 129/25 131/6 131/6 132/4 132/4 132/15 133/9 133/11 135/7 137/7 137/9 142/17 146/25 149/14 149/15 149/17 150/2 150/4 152/22 155/9 156/12 160/10 162/2 164/21 165/18 165/21 167/16 167/24 168/7 168/8 170/6 done [18] 17/23 22/10 22/16 77/19 89/17 109/1 116/24 117/5 138/6 146/20 147/3 149/11 154/10 157/20 161/23 166/25 167/2 167/6 door [1] 8/21 doubt [1] 166/24 down [24] 1/8 6/21 6/23 9/6 9/16 16/14 21/7 37/24 48/1 51/6 85/19 86/5 92/23 103/3 103/18 108/17 112/23 117/21 120/18	130/17 134/16 141/14 153/16 166/16 Dr [201] Dr Barrett [5] 145/23 158/19 167/16 170/9 170/12 Dr Brearey [20] 19/13 30/13 53/12 88/19 91/23 104/15 105/11 105/22 106/13 106/18 107/19 113/17 125/3 130/6 131/4 133/2 133/18 134/15 150/10 160/25 Dr Brearey's [1] 88/16 Dr Campbell [1] 124/1 DR CASSANDRA [2] 145/15 172/9 Dr Chang [1] 86/13 Dr Gibbs [14] 17/9 17/25 19/10 53/7 67/9 67/15 68/13 106/7 106/9 111/7 111/10 124/14 124/25 128/25 Dr Gibbs's [2] 17/13 88/17 Dr Harkness [9] 9/5 10/15 10/19 10/21 11/1 11/5 15/14 23/16 48/23 Dr Harkness who [1] 48/22 Dr Harkness's [1] 49/23 Dr Huw [1] 100/10 DR HUW MAYBERRY [2] 100/5 172/6 Dr Jayaram [4] 9/5 9/10 49/16 84/2 Dr Lambie [26] 1/5 1/8 1/14 9/18 17/13 19/13 47/9 50/7 62/13 63/9 63/12 67/17 71/6 74/11 81/24 87/18 101/24 102/1 102/2 103/20 147/1 147/2 151/3 151/11 164/15 169/11 DR MATTHEW [3] 51/4 86/23 172/4 Dr Mayberry [31] 99/24 100/1 100/23 101/4 101/16 102/18 102/21 103/3 103/18 104/24 105/7 109/12 111/5 111/18 117/11 118/17 122/15 129/7 130/7 137/4 143/19 144/3 149/18 150/16 150/19 150/24 156/5 156/13 161/22 162/9	169/15 Dr Mayberry's [1] 156/21 Dr Mittal [1] 32/24 Dr Neame [14] 51/3 51/6 51/9 51/14 52/6 53/14 84/6 85/16 90/19 92/16 93/18 96/15 97/17 99/7 Dr Newby [13] 16/2 16/3 16/8 16/9 16/9 16/12 16/22 31/4 31/6 37/8 82/16 83/19 83/22 Dr Ogden [14] 9/13 101/24 102/3 102/4 102/15 102/17 103/4 147/1 147/2 147/4 147/10 147/23 147/25 151/3 Dr Ogden's [2] 9/14 101/25 DR RACHEL [4] 1/6 1/12 85/18 172/2 Dr Ravi [1] 153/22 Dr Saladi [9] 16/6 16/8 53/3 75/23 78/21 123/7 123/9 123/14 123/23 Dr Ukoh [1] 154/10 Dr V [1] 130/21 Dr Yoxall [4] 55/24 72/9 146/10 162/21 draw [2] 87/15 102/21 drive [1] 141/14 dropped [1] 123/1 drug [2] 143/6 155/2 drugs [3] 143/10 143/11 143/13 due [6] 8/2 10/11 14/24 84/13 103/25 117/9 during [32] 2/21 2/23 2/24 4/18 14/18 21/16 21/19 46/9 47/23 52/23 53/23 56/22 58/24 59/23 63/23 64/25 74/24 79/13 85/1 85/1 87/4 87/13 89/1 89/13 93/22 94/19 104/15 120/24 126/24 128/20 150/9 170/2 duties [4] 55/5 56/24 60/6 61/7 duty [6] 14/15 87/14 87/20 87/23 89/1 119/20 dying [3] 64/10 66/20 72/20
			E	
			each [12] 8/8 11/12	

E	126/13 128/9	47/3	170/21	95/17
each... [10] 15/20 17/5 27/22 33/18 57/16 103/11 104/5 117/8 147/17 148/9	empowered [1] 136/9	escalating [3] 46/11 47/2 95/9	evident [2] 158/13 165/7	expertise [2] 6/13 69/5
ear [1] 36/1	enable [1] 97/22	escalations [1] 70/21	exact [4] 125/23	explain [7] 14/21 26/23 27/17 39/2 52/6 54/11 56/2
earlier [19] 18/11 18/14 18/16 19/7 22/21 22/23 56/7 60/17 87/3 90/24 133/20 133/25 141/18 149/18 159/8 159/19 162/20 163/21 164/8	encompass [1] 52/20	established [1] 38/24	132/25 133/24 134/1	explainable [1] 95/25
early [7] 71/5 71/5 74/12 75/15 78/22 116/13 120/25	encountered [1] 59/16	et [2] 24/23 130/14	exactly [9] 4/12 9/19 11/6 12/10 17/23 48/12 104/20 136/12 159/1	explained [1] 45/14
early June [1] 71/5	encourage [2] 19/18 113/22	et cetera [2] 24/23 130/14	European [1] 100/18	explanation [11] 57/10 57/18 75/19 78/9 85/15 90/20 93/9 94/2 94/9 95/21 109/15
easily [1] 39/14	encouraged [6] 21/17 53/24 136/5 136/9 141/24 150/16	even [10] 6/12 33/6 38/3 40/4 69/18 73/14 111/15 154/21 169/16 170/2	examine [1] 83/4	explaining [3] 24/25 126/2 126/7
easy [1] 98/18	encouraging [4] 42/11 113/19 115/1 132/2	evening [3] 122/3 126/15 164/10	example [16] 2/25 7/18 13/23 14/1 34/20 57/13 59/14 62/4 63/24 69/12 71/20 76/25 84/25 94/21 114/3 144/17	express [5] 35/4 44/14 90/23 135/21 143/23
education [4] 142/11 142/13 169/25 170/2	ended [2] 63/9 118/3	event [11] 1/22 9/9 10/12 12/24 19/2 19/4 76/13 119/23 119/23 154/15 155/6	examples [2] 5/13 21/10	expressed [2] 127/7 158/9
effect [3] 95/20 133/22 158/20	ends [1] 87/7	events [32] 9/6 18/8 22/25 26/9 26/16 26/24 29/13 29/16 30/6 30/12 30/23 31/22 35/24 36/3 38/22 38/25 39/4 39/8 41/9 41/19 45/14 78/3 78/14 84/15 91/17 121/25 160/2 163/22 164/2 168/9 168/17 168/21	exception [1] 128/18	expressing [4] 18/5 73/7 91/5 169/12
effective [3] 44/8 137/8 137/10	enema [1] 93/16	ever [23] 19/20 67/9 69/17 72/10 73/12 80/8 94/2 106/9 107/1 108/21 113/12 115/11 130/17 130/18 132/11 136/6 147/23 147/24 151/5 151/14 153/5 155/25 167/25	exceptional [3] 13/23 44/11 45/5	expression [2] 60/14 95/18
effectively [2] 42/24 137/7	engaged [5] 132/20 133/22 136/14 136/22 137/2	every [18] 4/9 4/10 7/6 18/7 62/3 76/20 76/20 77/10 86/8 86/8 115/24 118/1 139/13 152/17 152/19 152/22 156/20 163/2	executive [2] 69/13 140/25	extensive [2] 64/12 109/20
effort [1] 40/7	engagement [1] 141/10	everybody [6] 37/6 118/12 137/4 151/24 165/20 166/19	exist [1] 68/22	extent [6] 26/15 61/9 86/15 88/17 112/9 133/5
efforts [1] 98/19	enough [3] 21/3 106/22 139/12	everyone [9] 26/22 37/3 42/18 99/18 100/23 105/6 108/9 116/7 118/20	expand [9] 5/13 29/7 46/16 57/11 98/3 135/3 137/20 141/3 165/6	external [3] 107/5 107/6 134/20
eight [5] 108/18 113/1 113/1 113/5 120/13	ensure [1] 139/17	everything [10] 10/9 12/25 48/1 50/3 96/14 117/4 128/22 133/5 167/4 167/6	expect [3] 6/24 10/2 23/8	externally [1] 135/11
Eirian [7] 20/23 21/1 21/9 46/2 46/6 125/4 125/8	ENT [1] 124/11	evidence [27] 1/23 13/14 43/10 47/12 48/5 49/4 50/11 62/13 70/5 80/13 90/17 94/15 98/8 99/24 100/6 129/20 143/16 143/21 143/22 145/6 146/13 146/13 149/18 149/20 166/24 170/20	expectation [1] 57/16	extra [1] 169/2
Eirian Powell [4] 20/23 46/2 46/6 125/4	entered [2] 89/25 153/18	every [18] 4/9 4/10 7/6 18/7 62/3 76/20 76/20 77/10 86/8 86/8 115/24 118/1 139/13 152/17 152/19 152/22 156/20 163/2	expected [17] 4/12 4/16 7/1 20/10 20/13 23/14 23/15 23/23 58/13 58/16 65/19 79/11 79/17 113/5 117/16 158/12 166/9	extract [1] 92/16
either [20] 2/23 11/2 14/4 16/17 32/9 39/23 40/8 67/10 70/20 71/3 82/8 88/19 89/23 96/6 96/21 118/19 119/5 135/13 152/7 152/20	entirely [1] 141/10	every [18] 4/9 4/10 7/6 18/7 62/3 76/20 76/20 77/10 86/8 86/8 115/24 118/1 139/13 152/17 152/19 152/22 156/20 163/2	expedition [1] 57/16	extremely [1] 99/8
electronic [2] 143/9 143/18	entry [1] 89/5	environment [4] 15/22 27/2 42/9 169/20	expand [9] 5/13 29/7 46/16 57/11 98/3 135/3 137/20 141/3 165/6	face [1] 111/9
Ellis [1] 125/23	environmental [1] 45/15	environs [1] 43/1	expecting [4] 33/21 62/3 104/8 118/9	faced [1] 46/11
else [29] 4/19 9/21 13/18 22/17 27/5 32/25 33/25 34/4 35/10 37/3 37/14 37/14 39/9 39/15 40/8 40/25 45/18 49/16 50/7 115/13 118/10 124/5 129/25 137/1 141/2 143/20 151/15 168/4 168/24	epiglottis [1] 123/11	episode [11] 75/13 77/10 77/22 78/8 78/22 79/1 79/7 80/21 81/12 85/15 90/23	expenditure [1] 120/18	fact [13] 22/7 52/24 65/2 65/17 73/20 76/12 78/11 86/25 87/11 95/9 112/23 117/13 133/3
elsewhere [2] 19/23 163/23	episodes [20] 63/24 64/20 65/1 68/11 70/19 71/16 74/10 77/5 77/16 77/17 79/12 80/7 83/18 86/16 89/13 89/25 90/24 94/3 94/7 95/3	equipment [1] 89/12	experience [42] 3/5 4/3 5/10 5/18 6/2 6/5 6/14 7/23 21/14 22/2 23/4 31/16 32/19 40/23 40/23 42/2 53/20 53/23 54/9 54/11 54/15 56/19 64/10 66/13 81/15 82/5 83/13 84/7 84/8 98/5 98/7 98/8 109/22 135/19 135/23 136/8 140/9 140/12 140/14 140/18 148/7 149/22	factor [2] 81/6 96/6
email [7] 17/9 17/13 19/13 125/4 130/6 131/4 133/15	equivalent [1] 108/18	equivalent [1] 108/18	extract [1] 92/16	facts [2] 24/23 44/17
emergency [6] 41/17 122/12 122/24 126/8	equivalent [1] 112/25	error [2] 89/11 155/2	failure [3] 5/22 5/25 6/10	fair [5] 69/21 77/7 91/4 94/11 106/22

F	137/25	format [1] 130/13	gather [2] 22/24 100/24	170/21
familiar [2] 31/19 95/16	filling [2] 89/16 93/3	forms [1] 120/2	gave [6] 9/12 13/9 34/20 74/11 92/17 138/12	glad [2] 85/25 86/3
families [8] 21/19 21/25 41/15 42/18 97/24 98/18 143/24 169/12	final [1] 24/1	forum [2] 19/19 83/13	general [20] 5/5 25/12 52/12 52/19 55/1 58/3 58/11 61/22 65/15 66/12 70/9 74/7 84/18 100/12 110/6 110/9 110/10 112/22 114/11 145/20	glass [1] 137/25
family [2] 98/1 119/9	finally [1] 97/16	forward [4] 100/24 100/25 115/3 131/24	genetically [2] 129/15 166/21	glass' [1] 141/25
far [23] 1/19 29/21 31/1 31/7 39/24 65/4 67/24 69/16 69/22 72/9 76/21 82/6 90/2 92/6 101/12 101/14 111/12 114/20 125/11 131/18 143/21 146/2 152/15	find [11] 5/15 16/12 16/13 16/15 21/25 36/12 106/20 111/9 124/13 136/14 164/9	found [12] 3/16 5/18 10/16 20/16 61/2 95/13 124/15 126/11 126/12 126/14 147/11 158/2	genetic [2] 129/15 166/21	GMC [1] 142/6
fashioned [1] 2/3	finding [2] 103/6 126/4	foundation [4] 51/21 51/25 52/13 54/20	generally [15] 21/4 31/23 32/10 39/7 52/9 55/15 71/22 89/17 110/1 110/11 113/23 132/9 158/11 161/6 168/23	go [53] 3/7 4/20 13/2 15/11 17/10 17/11 19/11 19/12 24/10 26/19 32/22 32/23 33/6 33/10 36/23 41/17 44/13 50/12 54/8 65/6 67/9 68/6 72/12 72/18 75/6 75/11 79/22 85/6 85/19 86/18 92/17 93/1 93/12 94/12 99/12 116/4 119/16 121/4 121/24 127/19 130/9 131/23 136/2 143/25 148/16 152/9 152/17 152/24 155/7 160/4 162/22 163/16 170/18
fathers [2] 42/10 42/10	findings [1] 126/10	four [4] 54/14 54/18 71/4 146/12	geographically [1] 15/19	God [1] 86/9
fearful [1] 5/3	fine [5] 117/15 127/8 128/13 128/23 156/10	four years [2] 54/14 54/18	geography [1] 53/19	goes [2] 116/8 117/23
feature [1] 41/4	finer [4] 116/3 116/11 118/8 118/11	Francis [1] 100/10	gestation [1] 56/7	going [42] 5/4 8/10 13/1 19/1 19/6 22/10 23/6 27/16 27/21 33/14 34/11 34/15 45/18 50/15 50/21 51/14 51/15 53/8 59/3 65/6 67/15 70/4 71/2 80/1 92/23 100/3 113/7 113/24 117/8 120/5 120/20 128/22 139/23 146/23 146/24 148/6 159/8 159/9 163/19 164/1 165/16 166/14
February [2] 53/1 97/11	finished [4] 86/4 126/7 130/16 170/13	free [6] 21/7 50/12 91/9 99/11 145/2 170/18	get [29] 6/23 13/16 13/19 14/5 21/10 22/3 23/24 32/9 33/23 36/11 40/9 40/14 42/6 43/12 59/1 69/11 93/23 99/19 112/12 120/17 130/11 130/17 131/5 131/15 143/13 150/11 152/4 155/22 166/12	gone [5] 5/22 7/8 76/20 107/4 131/2
feed [2] 27/6 128/6	finishing [3] 23/25 70/2 86/1	freely [4] 42/16 67/7 68/25 69/1	gets [1] 117/20	good [26] 1/3 59/25 67/1 81/12 94/2 94/6 97/1 101/8 109/7 111/11 111/19 112/15 114/10 114/12 114/14 114/19 114/20 118/4 145/6 148/7 150/1 150/5 150/12 151/18 169/14 170/12
feedback [5] 108/9 108/12 114/10 148/1 148/4	first [28] 8/10 15/13 21/1 37/15 37/16 44/13 53/24 54/3 68/9 75/1 75/4 76/21 90/22 91/23 93/14 106/20 109/3 109/4 134/7 134/10 140/24 146/18 157/13 158/4 159/22 163/16 166/7 170/16	frequency [2] 79/12 79/17	getting [12] 21/3 36/8 36/13 42/19 107/7 107/8 108/8 108/12 118/13 132/22 150/5 153/6	gosh [1] 34/11
feeding [1] 27/5	firsthand [2] 16/19 44/23	frequent [4] 5/9 6/4 91/1 166/6	Gibbs [16] 17/9 17/25 18/20 19/10 20/20 53/7 67/9 67/15 68/13 106/7 106/9 111/7 111/10 124/14 124/25 128/25	got [17] 18/7 32/23 32/25 33/8 47/10 112/4 112/6 131/17 136/22 139/2 139/7 145/24 146/23 146/24 148/21 149/9 167/3
feel [26] 7/12 22/9 42/15 44/7 58/4 59/18 67/19 69/2 69/11 75/18 76/11 78/11 83/15 98/4 126/2 129/11 135/21 136/9 136/15 136/17 141/23 142/3 168/22 168/23 169/2 170/6	firstly [2] 1/23 141/6	fresh [2] 130/13 134/16	Gibbs's [2] 17/13 88/17	grade [8] 2/7 23/22 32/15 112/24 124/9 124/9 124/15 125/20
feeling [7] 6/6 6/10 7/7 34/11 94/6 142/9 158/12	fit [2] 12/7 127/18	friendly [5] 64/6 113/12 114/13 114/25 132/9	give [15] 1/10 21/23 37/18 51/7 57/10 61/9 66/5 76/4 84/6 93/10 100/8 107/19 137/23 145/17 146/12	graduated [1] 51/15
feelings [1] 169/11	fixed [2] 42/22 99/17	fro [1] 37/9	given [17] 10/19 11/24 42/10 77/21 84/4 86/21 88/2 96/14 109/21 123/7 123/14 128/4 131/8 137/14 143/5 155/2 169/18	Grantham [2] 29/3 110/2
feels [1] 68/23	flagging [1] 144/16	front [2] 40/3 40/17	giving [6] 1/23 13/1 99/24 149/18 169/3	
fees [1] 120/16	flow [2] 77/24 126/5	fulfilling [1] 113/1 113/11 153/18 153/19		
fellow [6] 17/14 62/19 64/9 78/19 108/6 125/4	fluid [4] 138/1 138/2 138/10 138/19	fully [5] 12/19 30/20 63/14 106/11 149/10		
felt [33] 3/11 7/22 21/2 22/11 26/22 33/5 34/13 34/14 36/9 46/12 58/5 58/12 62/21 66/15 67/1 67/2 67/6 67/16 68/25 79/1 82/2 84/21 89/14 89/21 94/8 95/12 125/18 126/1 129/10 129/10 141/20 150/15 169/13	fluids [3] 27/6 128/6 128/15	fungus [1] 26/25		
few [7] 8/22 11/7 24/23 54/20 103/11 144/9 147/16	flush [1] 169/18	furnish [1] 24/8		
fill [3] 120/2 121/15 156/1	focus [3] 23/15 23/20 123/17	further [25] 9/22 33/16 47/7 57/4 64/6 72/18 75/20 75/21 76/15 79/19 83/14 84/15 84/20 84/21 87/8 93/24 96/1 99/5 104/3 127/12 131/1 138/16 138/24 139/9 141/10		
filled [2] 37/24	follow [2] 46/13 113/20	future [3] 112/3 124/6 168/19		
	followed [3] 120/3 146/8 157/16	G		
	following [13] 8/1 11/4 11/19 15/24 22/4 30/5 63/24 84/1 93/19 103/24 126/15 167/14 168/9	gained [2] 51/18 145/20		
	follows [1] 88/24	gaps [2] 120/12 121/15		
	force [2] 41/25 42/21	gases [1] 128/23		
	form [3] 15/22 129/21 154/23			
	formal [11] 16/14 22/11 23/3 23/4 23/11 23/12 66/11 80/17 84/25 90/12 92/3			

G	14/19 24/3 25/22 37/4 38/23 71/17 76/22 80/2 87/12 88/12 109/9 109/10 127/7 128/4 128/18 138/22 155/1 155/8 158/14 161/13 163/1 164/6 164/9 167/14 169/21	10/15 10/16 17/21 19/14 35/22 35/22 35/23 38/4 49/1 67/16 72/10 85/25 85/25 86/2 86/3 86/25 87/2 87/4 87/5 87/6 106/2 106/4 106/4 106/4 106/5 113/22 113/25 113/25 114/2 114/6 114/9 123/23 124/15 126/1 126/4 127/8 131/7 131/25 150/13 150/14 150/16 150/19 150/25 153/22 154/11 154/12 162/1 162/19 162/22 162/25 163/5 163/7 163/11 163/11 163/15 163/16	111/10 140/11 140/19 149/23 helpfully [2] 1/14 101/10 helping [1] 111/8 her [52] 11/24 12/2 13/2 13/5 13/6 13/7 13/9 13/9 13/12 16/22 37/13 38/7 63/9 63/12 78/1 78/2 81/5 85/15 86/3 92/2 93/4 93/6 93/7 93/8 93/9 93/16 93/23 94/7 94/10 94/10 102/6 102/20 117/12 124/4 126/11 126/11 132/2 132/2 132/12 132/19 133/22 136/14 137/16 147/5 147/7 159/11 159/20 160/14 160/17 160/21 164/18 165/14	honest [1] 106/11 honestly [3] 15/2 26/7 164/23 hope [2] 47/10 91/4 hospital [59] 24/18 25/22 25/23 31/15 31/16 32/6 32/10 32/12 34/8 35/1 35/2 35/3 36/21 44/10 45/18 46/13 47/3 51/22 52/4 54/13 54/16 54/24 55/23 56/1 56/5 57/4 69/9 70/10 71/21 79/9 79/14 82/13 84/18 98/23 108/2 109/14 109/15 110/2 112/23 113/2 114/18 118/7 121/4 135/12 135/18 140/17 146/9 146/22 146/22 148/17 148/21 158/1 159/23 162/18 162/24 163/11 164/20 165/17 168/3 Hospital's [1] 87/1 hospitals [14] 6/15 52/3 58/3 59/11 68/23 70/4 114/17 120/21 139/8 140/6 140/15 148/18 162/22 162/23 hostility [9] 5/10 5/14 6/5 6/7 6/8 7/1 7/2 7/7 62/14 hour [1] 50/17 hours [5] 25/16 55/12 55/18 92/25 119/18 house [7] 2/3 2/4 2/13 32/16 48/2 146/20 167/11 how [78] 1/24 4/7 5/3 12/25 17/23 21/20 23/23 25/2 30/9 31/9 31/11 33/23 35/17 38/21 41/14 54/11 56/3 56/20 59/10 59/20 61/12 61/20 61/21 61/22 63/1 64/2 66/23 68/1 70/6 71/19 76/4 76/11 76/13 79/8 83/1 84/7 91/3 95/16 108/4 108/24 110/19 112/4 112/5 113/24 114/5 114/6 117/18 118/23 118/24 125/17 126/21 127/14 128/11 130/2 131/15 132/22 135/20 136/18 136/20 141/9 142/12 142/18 144/3 147/10 149/1 149/3 149/4 150/10 152/14 157/3 158/7 158/9 161/12 161/15 166/20 168/18 169/19
grapevine [1] 148/8 great [1] 112/5 greater [3] 58/24 109/21 140/8 group [6] 5/5 28/7 71/14 95/15 150/1 151/13 groups [1] 113/11 growing [3] 104/22 104/25 105/11 guess [4] 106/5 110/23 132/22 141/11 guidance [8] 113/21 114/1 114/9 114/25 115/3 142/6 142/16 142/18 guideline [1] 118/22 guidelines [3] 116/9 118/20 118/21 guilty [1] 158/2 gut [1] 129/15	happened' [1] 127/10 happening [14] 21/11 34/22 35/25 39/2 45/5 78/11 81/6 84/16 96/7 123/17 140/3 154/4 158/8 169/21 happily [1] 111/16 happy [9] 30/21 30/22 33/5 33/7 42/6 42/7 42/18 54/7 136/10 hard [6] 96/11 106/20 121/15 137/20 138/1 140/3 harder [2] 97/24 98/12 Harkness [11] 9/5 9/8 10/15 10/19 10/21 11/1 11/5 15/14 23/16 48/22 48/23 Harkness's [1] 49/23 harm [13] 29/10 95/5 96/6 97/3 98/14 120/2 131/13 135/22 159/6 159/9 164/18 170/4 170/8 harming [3] 44/8 142/13 156/24 harmonious [1] 111/11 Harvey [1] 69/12 has [19] 10/7 20/16 25/22 41/20 43/10 87/3 115/20 115/25 122/1 129/20 131/25 138/20 139/2 139/15 140/18 142/8 154/20 163/12 170/7 have [361] haven't [4] 39/13 102/2 137/19 141/5 having [35] 11/22 11/23 31/17 36/7 42/8 42/12 42/13 42/20 42/21 43/15 46/19 46/22 51/25 56/12 64/10 65/1 70/18 72/1 72/17 72/17 76/9 77/2 79/10 83/13 85/23 108/9 108/11 112/20 138/6 139/2 139/5 139/21 140/16 144/7 160/4 hazy [1] 115/21 he [59] 9/9 9/20 9/25	head [2] 20/20 165/11 Health [4] 51/19 100/16 107/18 140/25 healthcare [2] 169/20 170/7 healthy [1] 62/25 hear [15] 37/13 38/6 40/25 100/2 100/23 101/4 108/12 108/13 112/5 112/7 118/18 149/20 154/16 156/2 160/14 heard [32] 6/19 16/17 43/10 46/16 62/13 67/17 70/17 71/6 71/18 72/4 72/13 72/17 73/13 73/19 78/5 78/10 81/13 87/18 88/17 103/20 129/20 146/13 147/10 149/18 150/24 151/11 153/17 156/4 158/8 164/8 164/15 169/5 hearing [6] 70/23 71/12 81/24 101/7 108/10 108/11 heartsink [1] 34/11 heated [1] 42/17 hectic [1] 112/21 heighten [2] 110/10 142/24 heightened [2] 82/7 157/19 held [5] 30/12 66/16 95/2 100/16 165/12 help [19] 6/23 7/5 55/1 89/14 111/15 111/16 114/2 114/24 114/25 115/3 117/3 117/3 130/13 130/14 153/18 157/4 159/10 168/23 170/15 helped [2] 49/1 49/15 helpful [5] 99/9	here [11] 24/10 28/23 48/8 92/18 97/14 102/18 121/19 122/6 122/8 122/9 155/14 Hey [10] 52/3 52/13 59/13 85/3 93/5 93/24 102/10 121/4 124/12 146/21 hierarchies [1] 68/22 high [2] 61/8 126/5 higher [4] 79/11 79/17 105/23 149/13 highlighted [3] 12/1 117/14 162/20 highlighting [1] 94/21 Hill [1] 73/11 him [19] 10/2 32/25 35/20 36/7 38/2 71/15 72/11 72/13 86/2 87/8 123/16 126/1 126/6 127/20 150/11 150/20 162/22 162/24 163/18 hindsight [1] 96/4 his [9] 10/2 10/14 17/13 125/4 126/3 126/7 131/6 150/15 153/12 historic [2] 110/22 110/25 historical [1] 73/9 historically [4] 104/16 110/6 135/1 135/4 history [1] 83/5 hm [1] 38/10 hoc [1] 68/5 hold [3] 100/11 131/5 153/6 holding [3] 121/1 122/12 122/24 home [5] 75/24 76/5 117/12 118/3 153/23	
H				
H's [6] 77/16 79/7 79/16 79/21 81/18 81/21 had [312] hadn't [10] 34/21 79/22 96/16 124/2 124/16 129/13 132/20 133/21 135/2 147/25 half [1] 129/12 halt [1] 137/8 hand [3] 40/14 101/5 144/16 handed [4] 10/9 10/12 78/24 123/15 handling [1] 43/2 handover [40] 8/19 9/12 9/17 9/20 9/22 10/5 10/6 26/11 34/8 34/9 40/12 63/11 63/11 65/2 77/20 77/24 77/25 80/5 80/12 80/14 83/8 83/11 85/22 86/8 94/23 115/23 115/24 116/5 116/20 117/7 117/11 117/13 117/17 117/19 117/20 117/22 118/1 118/13 130/1 156/11 handovers [5] 9/23 63/8 116/17 116/18 164/9 happen [12] 10/23 12/11 23/5 33/21 34/12 34/16 55/14 104/9 109/13 134/17 138/24 161/25 happened [29] 10/8 10/9 12/22 14/12				

H	42/5 43/3 43/4 44/3 48/10 52/22 77/10 91/21 91/25 101/17 103/3 103/20 108/13 130/13 130/15 141/19 151/10 151/16 156/3 160/4 161/4 161/6 161/21 163/24	19/21 23/3 23/12 23/23 24/3 24/18 24/20 28/9 28/13 28/16 30/8 31/16 33/1 34/13 35/8 37/15 38/16 38/16 39/10 42/1 44/23 45/25 47/22 48/11 50/20 54/6 58/22 59/17 61/1 64/18 66/9 67/23 69/15 71/23 72/24 73/25 74/6 74/8 77/10 79/18 83/1 83/11 88/23 90/10 90/12 91/13 92/3 92/11 94/2 102/15 102/23 104/20 106/2 106/11 120/17 121/23 122/8 123/16 125/1 125/2 125/22 127/24 129/25 132/4 132/4 132/15 133/9 133/11 142/17 146/25 149/14 149/17 150/2 152/22 155/9 162/2 165/18 165/21 167/16 167/24 168/7 170/6	7/20 17/22 18/22 21/9 27/15 31/18 32/25 33/8 47/6 47/10 47/12 48/8 48/8 59/16 60/8 61/25 65/9 65/16 71/1 73/2 77/11 91/15 94/7 98/15 99/2 99/6 102/3 102/6 104/14 124/23 131/5 132/15 138/5 145/21 149/10 156/15 167/22 167/24	I probably [1] 33/2 I raised [1] 17/4 I realised [1] 126/9 I recall [24] 3/19 8/7 14/11 15/23 16/12 26/11 27/17 29/19 64/25 69/10 72/15 84/25 90/2 90/10 90/11 90/12 94/17 94/20 104/4 106/12 112/20 115/14 130/21 133/5 I refer [1] 132/17 I remember [11] 14/18 27/14 28/16 30/10 34/10 38/2 96/24 129/16 129/23 130/1 149/25 I reported [2] 75/13 79/7 I requested [1] 123/6 I said [2] 121/11 169/23 I saw [1] 15/9 I say [1] 44/22 I screened [1] 13/6 I see [1] 43/18 I should [3] 108/23 131/23 133/10 I sought [1] 64/18 I speak [1] 33/9 I specifically [3] 103/12 147/18 166/19 I spoke [8] 18/21 31/4 35/2 35/20 39/13 129/23 129/24 129/25 I started [1] 71/25 I subsequently [1] 126/14 I suppose [1] 64/4 I suspect [4] 15/11 80/4 81/5 82/25 I take [2] 22/14 60/1 I tended [1] 39/19 I think [160] 7/19 10/15 15/4 17/15 18/10 20/20 26/14 26/22 34/20 35/6 41/21 41/25 42/20 43/3 43/5 47/12 48/22 49/25 51/21 52/18 53/9 53/24 54/1 54/20 55/22 56/21 58/23 59/12 60/13 62/24 63/3 65/1 66/3 66/17 67/20 68/18 70/5 71/13 72/25 73/18 74/22 75/23 76/1 77/3 78/16 78/25 79/1 79/19 80/13 81/10 81/25 82/4 82/11 83/19 84/11 84/12 86/1 88/12 88/24 89/9 90/10 90/19 90/22
I	26/15 156/19 159/1 I cannot [2] 38/3 158/18 I certainly [5] 15/11 24/4 34/7 66/10 81/4 I checked [1] 128/10 I clearly [1] 24/19 I completely [1] 144/21 I could [6] 12/24 79/3 84/23 121/13 124/5 126/2 I couldn't [2] 80/6 134/1 I covered [1] 122/20 I delegated [1] 39/15 I did [18] 7/12 49/16 69/1 79/9 81/18 94/23 95/14 112/6 123/22 123/23 126/15 130/25 134/24 146/7 147/2 149/21 154/18 158/23 I didn't [35] 5/15 10/2 17/24 19/24 20/5 47/4 48/3 48/23 58/25 59/22 60/15 67/19 78/14 89/12 108/14 111/13 111/17 112/5 118/18 121/12 121/13 126/9 128/14 128/24 130/20 131/17 136/14 152/18 153/25 154/16 157/1 159/4 166/8 169/1 169/2 I discussed [6] 45/3 64/19 93/4 123/22 124/2 131/3 I do [25] 1/17 9/3 11/4 15/14 16/20 18/4 33/9 36/6 42/12 79/10 80/17 101/18 101/20 102/6 103/6 103/12 104/25 109/20 124/18 134/23 138/4 145/25 147/17 152/16 167/19 I don't [91] 9/21 10/6 14/3 15/4 15/4 15/9 15/11 18/3 18/13	21/22 27/23 31/4 31/7 31/14 31/19 37/3 37/18 39/16 39/25 41/12 48/2 51/14 64/19 71/2 71/23 80/4 82/10 91/25 100/15 101/14 102/6 103/8 106/11 108/8 108/25 110/16 118/3 118/6 118/18 131/18 131/24 137/12 138/15 139/14 139/14 141/10 141/16 145/19 147/13 162/16 I appreciate [2] 74/13 76/19 I appreciated [1] 168/7 I arrived [1] 49/15 I ask [2] 9/13 101/19 I asked [4] 27/19 124/14 128/14 131/1 I attended [2] 8/24 19/22 I became [2] 46/9 71/25 I believe [18] 16/5 16/13 20/4 37/17 94/24 101/16 103/14 107/23 119/19 122/11 122/22 124/11 131/3 132/25 133/25 147/19 149/5 149/13 I call [3] 1/5 99/23 145/14 I called [2] 39/17 128/21 I came [2] 123/24 124/6 I can [30] 1/20 6/9 7/16 12/4 21/25 24/9	7/20 17/22 18/22 21/9 27/15 31/18 32/25 33/8 47/6 47/10 47/12 48/8 48/8 59/16 60/8 61/25 65/9 65/16 71/1 73/2 77/11 91/15 94/7 98/15 99/2 99/6 102/3 102/6 104/14 124/23 131/5 132/15 138/5 145/21 149/10 156/15 167/22 167/24 I haven't [3] 39/13 102/2 141/5 I heard [1] 153/17 I held [1] 95/2 I helped [2] 49/1 49/15 I hold [1] 100/11 I honestly [2] 15/2 26/7 I hope [2] 47/10 91/4 I instrumented [1] 123/9 I just [16] 25/10 26/15 30/8 34/20 44/4 47/9 71/16 71/25 97/19 98/7 105/12 116/17 118/17 132/17 144/5 144/14 I knew [5] 15/3 45/21 102/4 110/6 128/13 I know [2] 99/9 163/11 I learned [1] 129/6 I learnt [1] 162/13 I left [8] 10/2 24/17 27/14 27/17 37/19 38/18 49/17 126/12 I live [1] 53/18 I made [2] 13/8 160/6 I may [4] 8/11 56/23 121/21 144/6 I mean [6] 24/19 25/15 28/18 33/2 106/15 136/11 I met [1] 35/16 I might [3] 4/19 58/13 58/16 I must [2] 15/4 88/24 I need [1] 37/5 I needed [3] 12/2 111/15 169/2 I never [1] 162/24 I not [1] 23/10 I notice [1] 102/8 I particularly [2] 3/25 137/15 I perceived [1] 6/10 I personally [6] 5/21 7/2 30/2 33/19 45/21 104/6 I possibly [1] 68/16 I presume [3] 19/16 19/22 20/5	

I	47/22 48/6 48/12 49/11 50/15 54/16 60/10 66/4 67/20 67/23 69/20 81/19 83/17 83/17 83/20 94/24 95/11 96/25 104/8 104/13 109/6 111/14 120/25 121/20 122/12 122/22 124/3 125/19 125/20 126/23 127/16 128/10 130/20 130/24 144/20 147/8 148/13 150/3 150/22 151/7 153/17 157/1 158/6 160/5 160/6 160/7 167/11 167/12 I wasn't [17] 20/5 21/14 44/22 45/25 46/22 48/3 48/10 59/8 60/7 62/11 63/14 87/24 104/21 122/13 122/18 126/6 158/7 I will [5] 21/23 32/24 101/5 102/17 103/3 I won't [1] 147/9 I wonder [1] 100/24 I worked [4] 102/5 102/15 102/16 115/10 I would [48] 2/10 4/11 4/12 4/16 4/20 4/22 8/18 8/19 8/22 10/9 10/12 13/22 14/1 16/4 18/19 23/8 23/10 23/15 24/17 30/22 33/4 33/7 40/2 40/7 41/12 41/13 41/22 42/6 42/7 43/9 49/14 57/6 61/14 62/24 68/8 76/16 77/4 79/24 80/4 80/5 82/25 86/9 89/21 109/18 109/19 138/9 143/23 150/12 I wouldn't [7] 7/1 23/13 23/22 49/21 76/14 77/5 167/20 I wrote [1] 138/21 I'd [1] 42/6 I'm [10] 45/22 70/25 71/15 72/2 77/3 90/4 91/10 107/12 108/11 138/7 I'm afraid [5] 70/25 71/15 72/2 77/3 90/4 I's [2] 85/5 85/7 I've [1] 162/2 Ian [1] 69/12 Ian Harvey [1] 69/12 idea [2] 47/4 169/14 identifiable [1] 142/22 identified [1] 89/19 identify [4] 75/21 85/9 96/2 144/13 ie [1] 126/12	if [139] 2/9 3/7 3/25 4/16 4/18 5/2 5/20 6/11 7/3 7/3 8/11 9/13 13/2 13/7 15/8 15/20 17/11 19/11 19/12 20/24 21/5 21/8 22/5 23/7 23/8 23/12 24/3 24/8 24/10 26/15 28/13 28/15 30/7 31/3 33/6 34/13 36/11 37/10 37/11 38/3 40/4 40/11 40/12 40/16 41/20 42/2 42/23 44/3 45/13 49/9 49/10 50/15 51/2 52/6 52/22 55/6 56/25 64/9 68/5 68/9 69/18 71/24 75/11 79/3 81/1 84/23 85/16 85/19 86/5 86/18 89/10 90/3 91/21 92/12 92/17 93/1 93/8 93/12 94/12 94/13 98/14 99/18 100/24 100/25 101/4 102/4 103/4 106/11 109/12 110/1 112/2 114/7 116/4 116/4 117/14 118/2 119/7 119/16 119/25 121/5 121/21 123/22 124/5 124/6 125/6 130/14 133/9 133/12 133/12 133/13 135/3 135/17 136/7 136/13 137/1 137/22 138/15 138/17 138/17 142/4 142/10 142/20 143/17 143/17 144/6 144/11 146/1 148/18 152/10 152/24 153/3 155/21 157/2 157/2 161/6 165/24 166/25 167/6 169/13 ill [5] 8/6 12/14 33/17 85/24 104/4 image [1] 138/16 image [2] 21/25 143/25 immediacy [1] 90/22 immediate [1] 27/2 immediately [8] 2/9 8/21 18/24 22/2 82/2 92/22 95/25 126/8 impact [2] 42/14 43/8 impacted [4] 7/12 7/19 7/22 57/25 importance [4] 115/23 116/17 119/22 155/15 important [7] 42/15 42/18 98/4 109/16 115/25 116/22 168/14 impression [14] 5/21 17/7 31/3 32/5 42/1 44/20 44/21 44/24	65/22 71/19 74/11 74/14 74/18 74/20 improve [4] 123/18 124/6 141/9 168/19 improved [1] 169/20 improves [1] 98/1 inappropriate [1] 58/5 incident [15] 4/19 16/17 16/18 18/16 18/17 18/21 18/22 19/8 22/21 22/22 23/6 29/22 48/14 76/11 77/2 incidents [4] 59/3 64/23 89/20 92/13 incision [1] 114/4 included [3] 52/3 61/8 97/5 including [5] 10/10 41/11 45/15 99/10 137/4 incompetence [1] 95/5 incompetent [1] 132/8 incorrect [1] 90/4 increase [2] 112/7 112/11 increased [6] 26/9 73/23 104/17 106/1 154/20 163/6 increasing [2] 7/25 103/23 increasingly [1] 140/2 incubator [3] 42/23 42/25 169/14 incubators [1] 169/7 indeed [26] 13/18 17/9 22/20 25/2 33/10 50/7 58/7 62/7 64/16 67/11 68/14 74/16 77/24 83/22 85/11 88/11 88/15 88/17 88/20 96/22 99/7 144/3 144/24 164/18 170/12 170/18 indicate [2] 84/6 97/2 indicating [1] 128/9 indication [3] 61/9 76/4 84/7 indicator [1] 105/19 indictment [4] 6/20 18/10 18/14 168/10 individual [3] 113/22 114/2 114/10 individually [1] 121/9 individuals [1] 69/18 induction [17] 32/11 63/19 115/17 115/18 116/8 116/11 116/16 117/14 118/10 118/20 119/5 119/10 119/12	156/5 156/6 156/9 156/16 inductions [2] 115/20 156/15 Infancy [3] 134/22 135/7 135/10 infants [1] 17/19 infection [4] 13/3 13/7 15/21 26/25 infections [2] 45/16 73/5 inflicted [1] 122/2 informal [12] 57/8 57/12 85/3 90/11 92/1 104/21 107/21 107/23 107/25 108/5 124/19 124/22 informality [1] 57/24 informally [5] 64/20 66/3 94/21 103/15 147/20 information [16] 24/20 25/2 25/5 25/9 25/14 33/25 40/14 41/18 46/1 89/20 107/20 115/25 116/9 118/23 118/25 126/11 informed [4] 9/17 11/22 32/3 32/3 infrequent [1] 76/9 inherited [1] 166/21 inhibition [2] 69/2 69/6 inhibitor [1] 67/14 initial [1] 127/17 initially [1] 169/9 initiated [1] 123/4 initiative [1] 141/13 injecting [1] 137/16 injury [1] 97/4 inpatient [1] 135/18 input [2] 91/17 155/22 INQ0000536 [1] 85/17 INQ0004891 [1] 130/6 INQ0036166 [1] 20/18 INQ0102019 [1] 102/19 INQ0102351 [1] 94/14 inquest [2] 130/10 130/11 Inquiries [1] 170/1 Inquiry [19] 1/14 10/20 20/16 25/1 41/22 43/10 51/10 70/14 86/21 88/1 97/21 101/10 121/22 125/3 129/20 142/21 144/12 157/17 171/1 insert [1] 114/6
----------	--	--	---	--

I	108/22 167/12	J	JUSTICE [2] 144/1 172/8	88/6 109/22 110/18 112/9 150/14 157/1
inside [1] 140/18	investigations [10] 45/24 46/3 75/21 78/4 93/16 93/25 116/24 134/3 139/1 162/10	Jayaram [6] 9/5 9/10 20/19 49/16 84/2 153/22	K	known [10] 2/7 32/24 33/2 66/1 69/12 69/14 109/16 114/23 115/4 119/15
insofar [2] 55/5 76/19	invited [9] 19/20 19/25 20/7 20/10 23/14 23/23 24/2 125/11 134/5	Jayaram arrived [1] 153/22	kangaroo [1] 42/11	knows [3] 115/24 118/12 140/17
instability [3] 84/20 84/21 85/15	involve [2] 39/19 39/19	Jess [1] 129/23	keen [3] 13/5 16/18 130/24	
instance [2] 7/17 86/23	involved [27] 16/18 23/17 24/5 25/18 31/18 36/5 36/11 61/12 64/17 73/15 74/13 77/5 78/7 81/2 86/16 88/12 88/21 99/3 104/19 129/11 131/13 143/24 154/1 160/9 165/21 168/12 168/16	job [4] 109/4 136/23 138/4 170/12	keep [4] 38/4 93/16 101/6 125/8	L
instruction [1] 88/2	involvement [19] 11/15 23/13 24/12 48/7 48/9 49/12 49/14 49/19 49/23 61/10 122/5 122/10 125/12 125/16 127/20 127/22 153/9 153/14 165/23	jobs [2] 116/23 116/24	keeping [1] 107/13	L,M [1] 105/8
instrumented [1] 123/9	is [225]	join [1] 32/12	kept [2] 117/13 117/25	lack [2] 75/18 98/24
insulin [4] 73/12 143/14 157/7 169/18	isn't [6] 6/5 12/11 23/20 26/20 44/15 95/22	joined [1] 13/15	key [2] 25/24 91/17	lacking [1] 135/9
intake [1] 63/2	issue [12] 21/2 21/12 21/13 22/7 70/2 80/10 88/1 97/14 111/13 133/1 150/4 151/13	July [2] 30/13 31/6	killed [1] 137/13	Lady [15] 1/5 24/25 47/6 50/9 50/15 51/2 85/17 86/19 92/14 99/5 99/23 144/1 145/5 170/20 172/8
integral [2] 139/3 139/7	issues [10] 25/24 41/9 43/19 68/10 70/12 71/7 97/9 97/12 98/11 156/7	June [14] 1/15 10/2 19/10 22/14 51/10 71/5 103/11 103/21 121/25 125/20 131/20 145/24 147/10 147/17	Killingback [5] 9/13 17/10 24/9 130/5 130/18	Lambie [31] 1/5 1/6 1/8 1/12 1/14 9/18 13/16 17/13 17/15 19/13 47/9 50/7 62/13 63/9 63/12 67/17 71/6 74/11 81/24 87/18 101/24 102/1 102/2 103/20 147/1 147/2 151/3 151/11 164/15 169/11 172/2
intensity [1] 149/13	it [438]	junior [17] 2/2 3/14 3/17 4/25 16/25 26/12 33/24 47/24 77/4 91/18 111/23 111/25 115/2 117/7 120/7 154/22 167/11	kind [7] 6/25 21/13 107/21 118/9 127/18 142/13 168/15	large [4] 98/18 113/3 123/10 127/25
intensive [9] 27/18 100/12 100/18 124/11 139/11 139/16 140/7 148/22 149/2	it's [54] 6/8 13/21 20/18 28/18 32/20 40/15 41/25 42/15 42/18 42/20 42/24 43/3 43/4 43/5 44/3 47/24 48/10 49/9 70/25 71/17 76/16 90/6 90/19 92/22 95/24 96/11 96/13 110/7 110/14 110/16 110/21 110/25 115/14 118/1 121/20 131/7 133/18 134/16 136/1 136/5 136/5 137/20 139/7 139/20 139/21 140/2 141/17 146/19 155/20 156/20 161/5 167/23 169/15 170/12	just [115] 15/6 18/1 24/16 24/22 25/10 25/12 26/15 27/21 27/25 29/6 29/7 29/24 30/8 33/3 33/24 34/20 34/23 35/3 35/4 35/20 35/21 36/23 41/4 42/10 42/19 43/6 44/4 47/9 49/25 51/14 52/6 54/9 54/11 54/17 54/18 55/20 56/2 57/3 57/11 60/17 60/22 61/9 62/13 63/10 65/2 65/16 65/16 66/22 67/11 68/1 69/11 70/1 70/9 71/2 71/16 71/25 72/18 73/4 73/9 73/20 76/10 79/3 80/8 85/16 85/19 86/3 88/10 91/21 92/12 94/12 95/6 95/18 96/19 97/19 98/3 98/7 98/7 99/19 100/22 101/5 105/12 107/13 110/6 110/12 113/23 116/17 118/17 122/9 123/11 132/17 134/6 135/3 135/19 136/12 136/13 136/16 137/1 137/18 139/20 143/23 144/5 144/5 144/14 146/16 146/23 146/24 148/5 148/9 148/23 155/7 162/23 163/7 164/23 165/12 168/5	knew [15] 15/3 30/24 33/3 45/21 50/4 82/11 83/18 102/4 106/22 110/6 121/11 128/13 154/11 162/9 163/22	last [10] 14/19 71/9 85/21 134/9 141/16 145/21 146/12 146/14 163/5 164/13
intensivist [1] 138/5	its [4] 14/6 108/17 110/23 142/6	just when [1] 162/23	know [113] 9/12 10/14 12/22 12/25 16/3 23/12 23/23 24/3 25/8 25/17 25/20 27/2 27/16 28/9 28/10 28/14 28/17 30/8 31/22 32/21 32/22 32/23 33/1 33/6 33/8 34/13 35/25 36/13 37/1 44/23 45/25 47/20 47/22 49/9 64/19 67/21 71/4 72/9 73/10 94/10 95/9 95/13 95/15 96/11 96/14 98/21 99/9 101/20 101/24 102/6 105/7 106/3 109/12 110/1 110/3 114/7 115/8 116/18 117/25 118/3 118/14 120/17 122/1 122/4 125/8 130/15 131/20 132/7 132/8 133/9 133/11 138/3 138/17 142/17 143/11 143/12 143/14 146/25 146/25 147/2 147/4 147/5 148/9 149/14 149/15 150/4 152/1 152/1 153/11 154/17 154/18 154/22 155/7 156/22 157/7 158/15 158/24 161/3 161/9 161/12 161/19 161/24 162/2 162/9 162/12 163/11 164/8 165/16 165/23 167/1 167/7 167/20 169/11	largely [3] 8/2 103/25 109/6
intent [1] 87/9	itself [1] 112/19		knowing [1] 38/23	learn [3] 126/22 129/4 157/13
interact [1] 41/14	IV [1] 128/15		knowledge [7] 51/11	learned [4] 107/22 125/17 127/2 129/6
interacted [1] 120/6				learning [10] 22/24 68/19 81/1 91/7 91/11 129/18 142/20 144/11 150/16 155/20
interaction [6] 6/25 69/8 112/9 112/10 114/14 115/15				
interactions [3] 59/23 111/23 113/10				
interest [5] 6/25 25/8 100/14 136/22 145/22				
interested [3] 18/10 25/9 41/22				
internal [1] 134/6				
interpret [1] 91/21				
interpretation [1] 84/16				
into [26] 15/12 17/22 18/8 19/1 25/21 39/3 41/17 56/18 72/18 85/12 86/15 101/6 108/23 109/9 110/16 111/16 113/7 135/12 137/16 137/16 142/16 142/18 143/15 155/8 155/9 157/17				
intravenous [1] 128/6				
intubate [1] 124/10				
intubating [2] 124/13 124/16				
intubation [2] 123/8 124/10				
invasion [1] 169/13				
investigate [1] 80/23				
investigated [4] 31/10 31/11 105/23 134/4				
investigating [3] 103/16 139/9 147/22				
investigation [6] 45/13 79/7 93/7 96/1				

L	141/13 142/9 143/14 143/20 143/23 164/8 168/23 169/13 169/14 169/15 170/6 likely [5] 8/20 103/9 111/2 131/8 147/15 limited [1] 112/7 line [1] 167/1 lines [1] 87/6 link [5] 14/22 15/21 28/23 44/17 99/24 linking [3] 27/5 30/5 79/15 liquid [1] 27/5 list [1] 53/25 listened [2] 141/1 141/24 listening [4] 17/7 37/7 46/25 115/9 literally [1] 49/15 little [10] 7/21 23/13 57/4 57/11 65/6 66/5 72/18 107/13 115/15 115/21 live [1] 53/18 Liverpool [25] 51/16 51/22 52/3 54/16 55/23 56/1 56/10 57/4 57/8 59/14 71/9 71/21 72/8 73/20 82/12 87/5 102/11 146/9 148/16 148/20 149/4 149/8 149/12 162/17 163/1 Liverpools [1] 87/1 lives [1] 111/3 locum [3] 120/16 121/6 141/12 locums [5] 120/7 121/2 141/15 149/19 150/5 logistics [1] 43/6 long [5] 24/6 144/4 152/7 164/16 167/1 longer [1] 50/19 look [18] 2/12 12/10 19/22 20/24 20/24 22/5 29/12 39/3 73/9 83/4 90/3 97/19 103/4 109/9 131/2 137/22 139/22 168/18 looked [6] 45/19 70/3 85/12 86/3 87/11 126/1 looking [37] 1/22 17/19 17/22 22/17 24/16 24/20 27/25 28/8 28/12 38/13 49/3 52/7 53/8 54/9 57/3 61/19 62/18 66/22 76/25 83/3 87/20 92/13 95/6 95/18 96/3 99/10 103/2 117/18 121/22 125/23 137/21 138/2 138/18 141/14	141/14 149/3 166/17 looks [6] 15/12 23/18 24/6 24/22 49/11 133/17 lose [2] 116/1 116/8 losing [2] 115/23 127/1 lost [3] 23/19 116/4 122/15 lot [17] 35/20 41/21 44/4 108/8 115/25 120/12 123/8 130/4 130/4 135/24 137/13 140/11 143/9 144/8 152/10 170/3 170/4 lots [2] 12/17 150/21 lovely [1] 148/6 low [3] 104/16 105/2 108/16 luck [2] 73/1 159/20 Lucy [9] 14/3 37/22 87/7 132/19 133/2 143/15 157/14 159/6 164/24 Lucy Letby [3] 143/15 159/6 164/24 Lucy Letby's [1] 157/14 luncheon [1] 99/21	manager [4] 132/23 133/7 133/16 160/25 managers [7] 40/19 69/7 69/8 121/9 121/12 152/1 152/2 managers' [1] 165/23 managing [4] 55/13 58/12 84/18 95/11 mandating [2] 140/25 143/5 mandatory [2] 32/11 32/19 manoeuvre [1] 123/4 many [16] 38/2 38/3 44/9 54/11 54/21 63/1 65/3 79/8 108/24 148/21 149/3 149/4 156/15 158/9 161/12 161/15 March [9] 53/6 53/11 101/21 101/25 106/15 116/14 146/5 148/3 162/20 material [1] 41/18 materials [1] 150/17 Matt [2] 85/23 86/7 matter [2] 25/8 80/11 matters [2] 85/11 115/12 MATTHEW [4] 51/4 51/8 86/23 172/4 may [33] 1/5 8/11 14/22 21/7 25/10 26/4 30/3 33/1 41/13 45/13 47/9 50/18 56/23 61/16 68/14 71/16 73/10 81/6 81/20 99/4 99/23 121/21 125/1 125/5 125/13 130/10 137/14 140/4 144/6 144/9 145/14 160/9 164/15 maybe [6] 21/23 28/22 89/14 141/5 167/1 167/2 Mayberry [35] 99/24 100/1 100/5 100/10 100/23 101/4 101/16 102/18 102/21 103/3 103/18 104/24 105/7 109/12 111/5 111/18 117/11 118/17 122/15 129/7 130/7 137/4 143/19 144/3 149/18 150/16 150/19 150/24 151/3 156/5 156/13 161/22 162/9 169/15 172/6 Mayberry's [1] 156/21 MDT [1] 151/19 me [53] 2/14 12/1 13/24 14/12 14/18 16/10 16/12 16/13	16/15 16/15 16/19 16/19 16/23 17/15 20/17 21/21 28/12 29/6 29/8 37/8 37/12 37/16 37/21 37/22 40/4 40/5 46/25 53/24 61/2 67/20 69/25 71/15 81/10 101/4 103/9 104/15 106/5 108/10 108/12 115/22 121/15 124/8 124/15 125/8 128/12 132/19 132/22 147/10 147/14 155/10 158/19 169/5 169/14 mean [17] 6/7 10/25 14/8 22/15 23/1 24/19 25/15 28/18 30/19 33/2 52/7 66/19 105/13 106/15 136/11 144/17 151/19 means [1] 95/20 meant [7] 12/25 54/12 57/11 80/11 113/4 121/1 164/22 media [1] 141/20 medic [4] 35/12 35/13 35/14 35/22 medical [37] 5/11 5/21 6/6 8/7 9/24 15/16 16/5 18/20 25/17 33/17 44/17 51/15 51/21 62/15 69/13 74/23 76/20 78/2 80/18 95/1 95/4 95/19 96/2 96/5 96/17 98/13 100/13 104/4 110/4 113/11 113/17 121/17 138/23 148/8 151/17 166/18 170/2 medication [1] 138/12 medications [2] 137/23 138/8 medicine [4] 113/19 113/21 142/14 145/22 medics [3] 6/11 40/11 42/17 meet [1] 35/15 meeting [23] 19/16 20/4 20/17 20/19 21/11 22/12 23/18 23/21 30/14 30/25 68/3 90/7 90/9 90/10 90/12 91/14 91/22 91/25 92/4 92/7 92/10 155/24 163/4 meetings [13] 24/2 24/3 24/5 44/23 66/7 68/8 68/13 91/9 91/9 91/15 91/19 94/23 155/19 member [8] 100/15 119/8 123/3 131/12
	M			
	M's [2] 153/25 154/1 made [20] 6/22 7/21 11/25 12/8 13/8 29/1 34/21 81/11 87/3 87/6 98/12 98/19 99/9 117/10 137/25 151/4 151/5 155/22 159/11 160/6 Maelor [1] 59/13 main [3] 110/24 110/24 129/24 mainly [1] 34/17 majority [1] 55/12 make [21] 5/15 10/7 12/17 13/5 27/21 40/7 48/21 48/23 54/18 75/18 78/10 97/24 112/3 116/8 117/3 118/24 120/2 132/17 137/18 138/12 144/14 making [6] 35/25 38/7 89/5 98/17 109/6 139/7 managed [1] 58/14 management [18] 24/2 32/7 41/1 44/10 46/13 57/19 68/18 78/4 111/23 112/1 112/4 112/6 112/10 112/14 115/16 120/6 120/6 121/14 management-led [1] 24/2			

M	164/18 164/21 mine [1] 45/22 minimum [1] 139/18 Ministry [1] 140/25 minutes [2] 8/22 19/22 misfilled [1] 138/3 misremembered [1] 56/23 miss [1] 40/12 missed [1] 139/4 misses [1] 155/3 mistake [1] 89/11 misuse [1] 157/7 Mittal [1] 32/24 Mm [1] 38/10 Mm-hm [1] 38/10 mobilised [1] 124/12 Module [1] 100/14 moment [3] 21/22 79/23 108/3 Monday [1] 22/14 money [2] 116/5 121/3 monitored [2] 32/20 42/24 month [12] 20/11 35/5 52/2 52/10 54/15 63/2 63/9 63/18 71/8 71/9 75/1 76/7 monthly [1] 20/11 months [14] 38/3 53/1 53/5 54/5 55/21 55/22 56/12 65/21 66/14 71/5 87/5 106/20 130/12 149/11 Morbidity [2] 91/14 92/4 more [86] 2/3 5/8 7/21 13/11 23/5 23/7 23/15 23/16 24/2 26/16 26/21 26/23 34/10 35/6 35/10 36/1 36/15 47/24 53/8 54/6 55/18 56/6 56/7 57/7 57/12 58/13 58/23 58/25 60/6 61/24 63/23 65/4 65/4 65/7 65/12 65/17 65/19 66/5 71/17 74/6 75/14 77/4 81/14 82/1 84/11 87/4 93/13 95/1 95/7 97/23 98/9 106/20 107/13 107/24 110/9 110/22 111/2 112/13 112/16 112/21 115/21 118/7 121/3 123/16 124/3 136/1 136/5 136/9 136/21 136/22 136/23 139/9 142/8 142/8 142/9 143/2 143/16 148/22 148/23 149/1 149/12 149/24 150/22 151/11 154/8	159/20 moribund [1] 135/13 morning [13] 1/3 9/22 9/23 10/22 11/4 15/24 17/15 65/2 75/10 78/24 86/8 103/21 164/15 morphine [1] 13/10 mortality [20] 19/16 73/23 90/6 90/12 91/14 91/14 92/4 92/7 104/16 105/1 105/2 105/12 105/13 105/17 105/19 106/10 108/7 108/23 150/24 151/4 most [17] 2/10 8/20 8/22 43/9 44/6 44/7 61/14 82/4 89/19 106/6 106/12 113/18 116/22 120/21 122/10 124/9 167/11 mother [2] 6/23 43/18 mothers [1] 43/22 mould [1] 26/25 mouth [1] 93/17 move [3] 100/24 100/25 102/9 moved [4] 2/4 71/9 165/1 165/17 moving [4] 12/11 14/2 27/4 121/21 Ms [19] 1/4 1/7 9/13 17/10 24/9 47/8 51/1 51/5 99/14 100/7 119/3 130/5 130/18 145/13 145/16 172/3 172/5 172/7 172/10 Ms Browne [2] 51/1 99/14 Ms Killingback [4] 9/13 17/10 24/9 130/5 Ms Langdale [6] 1/4 47/8 119/3 145/13 145/16 172/10 much [48] 5/1 6/13 7/3 7/20 8/24 13/13 17/6 23/6 26/17 27/24 36/25 40/4 44/24 46/2 46/5 46/5 46/20 50/4 50/6 50/11 61/24 74/15 77/4 77/8 95/16 98/12 99/4 99/7 107/24 110/1 112/21 116/5 116/16 119/2 123/16 131/10 135/10 135/11 135/16 141/9 144/2 144/3 144/24 152/4 167/22 170/5 170/11 170/18 MUDr [1] 100/20 multi [3] 151/19 151/21 155/23 multi-disciplinary [3]	151/19 151/21 155/23 murder [4] 60/23 122/2 153/11 158/3 murdered [1] 161/17 murdering [3] 73/11 110/3 110/20 murders [1] 29/2 Murphy [1] 20/20 must [4] 15/4 88/24 129/14 163/25 mustn't [1] 164/1 my [149] 1/5 1/12 2/8 2/12 4/3 5/18 6/1 6/2 6/8 7/16 7/23 8/17 8/25 9/4 9/8 17/4 18/5 21/14 21/17 22/2 23/4 24/25 30/20 30/20 31/3 32/5 33/4 33/20 35/4 35/7 35/20 35/21 36/3 36/6 36/16 39/12 39/18 40/23 40/23 40/23 42/1 44/24 46/14 46/23 47/1 47/6 48/3 48/5 48/5 48/6 48/9 49/12 49/14 49/17 49/18 50/9 50/15 51/2 53/23 56/10 58/24 59/23 67/22 68/8 70/16 70/18 71/13 72/6 72/7 72/25 74/7 74/20 74/20 77/11 77/16 79/13 79/20 84/15 85/7 85/13 85/17 86/9 86/19 86/24 89/9 91/19 92/14 92/25 93/22 94/19 95/14 95/24 96/25 98/7 99/5 99/23 100/2 100/10 100/20 102/2 102/14 104/8 104/15 105/16 106/4 106/7 107/15 108/15 109/3 109/4 109/6 112/9 112/9 112/19 115/20 122/10 122/13 123/17 124/6 126/10 127/7 127/22 128/8 128/25 132/15 134/4 135/23 135/24 136/8 136/8 137/15 138/4 138/20 141/8 143/19 143/23 145/5 145/19 145/20 146/18 153/8 153/20 154/19 154/20 162/17 166/7 167/24 170/10 170/20 my Lady [12] 1/5 24/25 47/6 50/9 50/15 51/2 85/17 86/19 92/14 99/5 99/23 145/5 myself [2] 23/1 42/5	N N's [2] 123/1 123/15 name [20] 1/10 1/12 35/8 37/11 37/13 37/22 48/3 48/6 51/7 90/8 100/8 100/10 119/15 133/7 133/10 133/11 133/13 133/14 145/17 145/19 named [3] 6/19 47/23 168/10 names [1] 38/6 nasal [1] 126/5 nasogastric [2] 123/2 128/1 naturally [2] 26/19 167/5 nature [11] 10/12 11/3 11/8 15/16 29/23 30/1 49/4 49/21 77/22 108/17 110/23 natures [2] 8/3 104/1 Neame [20] 51/3 51/4 51/6 51/8 51/9 51/14 52/6 53/14 84/6 85/16 85/23 86/7 86/23 90/19 92/16 93/18 96/15 97/17 99/7 172/4 near [2] 48/18 155/3 NEC [3] 126/25 127/3 127/18 necessarily [7] 23/14 35/21 58/15 58/23 108/19 118/1 137/10 need [19] 16/4 18/19 21/5 25/20 36/14 37/5 42/6 43/6 43/7 45/13 55/10 75/5 76/17 121/23 122/8 130/14 132/17 138/25 143/1 needed [16] 12/2 39/3 56/13 69/5 75/20 78/12 82/16 84/10 111/15 112/20 116/23 116/25 117/4 152/10 168/23 169/2 needing [1] 36/11 needs [5] 40/3 40/17 99/25 125/7 138/24 negative [2] 7/10 41/3 negatively [2] 41/13 42/14 negatives [1] 44/5 negligence [1] 96/6 neighbouring [1] 140/5 neither [1] 11/9 neonatal [82] 3/9 3/22 3/24 6/21 6/22 8/20 17/18 21/2 22/8 28/4 28/5 31/10 34/2
----------	--	--	--	---

N	nicest [2] 131/24 132/3	nobody [1] 107/1	122/1 127/14 130/11	3/20 5/8 5/11 8/7
neonatal... [69] 42/16 43/12 46/10 52/8	night [34] 9/24 10/10 11/2 11/19 11/19	Nods [13] 8/13 20/22 47/14 48/20 75/2	130/18 135/2 135/6	15/15 16/25 27/13
54/12 55/3 55/9 55/16	11/20 14/19 33/20	75/25 82/18 84/5	136/5 138/4 141/17	33/17 38/15 59/9
56/13 56/18 56/19	34/17 34/22 57/17	86/17 90/18 146/15	142/3 142/8 143/9	63/20 72/5 89/17 95/1
57/6 57/8 59/21 60/4	74/25 81/23 81/25	162/6 165/4	145/9 155/10 155/12	104/4 113/11 139/12
60/5 61/22 61/24 62/4	82/5 84/1 85/24 85/25	non [4] 45/10 96/5	155/13 155/14 155/17	
62/8 65/5 70/17 70/18	86/8 86/15 87/5 87/12	96/17 97/4	156/18 156/19 164/16	O
70/21 85/2 90/6 92/7	104/7 111/16 125/19	non-medical [1]	167/22 170/13 170/18	o'clock [3] 99/18
94/19 97/21 98/15	125/22 127/21 128/17	96/17	170/24	99/19 170/24
100/18 107/9 107/16	128/20 161/21 162/5	non-paediatric [1]	number [37] 1/21 4/4	O's [2] 125/17 125/24
109/5 111/6 113/8	163/22 164/6 164/13	45/10	17/5 18/4 26/9 41/10	observation [2]
113/19 122/12 122/14	nights [7] 11/19	norm [1] 98/22	45/14 49/7 52/2 56/23	66/12 156/21
122/18 122/19 122/21	34/19 84/9 85/24 86/1	normal [15] 4/1 4/22	58/24 59/12 65/1	observations [4]
123/24 127/23 128/8	86/2 125/16	26/22 26/23 32/6	65/13 65/18 65/25	62/9 94/25 95/7
128/21 134/3 140/6	nightshift [5] 2/25	34/18 39/12 39/18	66/19 67/11 70/4	168/13
140/10 143/7 148/19	8/17 34/10 127/17	40/24 63/13 64/8 83/2	94/18 99/9 102/19	observe [1] 58/20
148/20 148/23 149/2	129/5	161/24 161/24 164/5	105/20 106/6 106/23	observed [3] 57/25
152/5 152/9 152/12	nil [1] 93/16	normalised [1] 41/19	108/16 111/2 112/8	58/19 87/14
152/19 152/23 158/7	NUU [6] 7/13 44/12	normally [12] 9/23	112/11 117/11 121/10	observing [1] 150/22
159/3 160/5 160/5	45/3 87/1 87/3 125/7	10/8 113/1 113/5	129/21 137/11 140/22	obstetric [4] 61/8
161/10 162/14 164/12	no [137] 2/9 7/1 7/14	116/20 117/19 123/12	161/9 163/6 169/6	61/11 61/13 61/21
166/6 167/13 169/7	7/17 7/23 13/21 14/3	127/18 128/2 130/2	numbers [5] 103/6	obstetrics [1] 7/4
neonate [2] 3/4 76/18	14/19 15/9 15/9 18/16	130/3 139/15	108/21 112/24 139/20	obvious [2] 12/23
neonates [10] 2/23	20/4 21/14 21/14	Northwest [1] 87/2	147/12	27/8
87/2 139/16 140/12	22/19 22/19 23/17	not [177]	nurse [25] 10/18	obviously [18] 5/23
148/25 150/14 152/18	24/16 24/21 25/7 25/8	note [7] 76/20 92/18	10/18 10/19 14/11	53/7 54/8 55/10 68/22
161/23 164/11 166/7	28/6 29/18 31/24	92/25 93/2 93/3 93/13	73/10 86/21 110/2	74/12 76/7 90/16
neonatology [4]	32/12 34/18 34/18	156/11	110/20 125/23 128/10	93/18 98/5 102/8
52/20 54/17 55/22	34/24 35/2 35/12	note-taking [1] 92/18	132/6 132/18 133/20	120/12 122/4 124/22
56/11	35/16 35/16 36/22	noted [3] 67/22 94/25	133/23 136/12 140/6	142/15 156/12 161/16
NeoPuff [1] 123/5	37/12 38/4 38/11	95/7	140/10 156/1 157/19	163/5
nervous [5] 8/8 33/18	38/19 40/20 41/2 41/5	notes [20] 16/5 24/12	158/15 159/12 160/8	occasion [13] 4/17
33/19 104/5 104/7	41/7 46/4 46/7 47/4	39/13 48/4 48/11	160/8 160/9 160/12	34/10 40/12 53/11
Network [4] 107/8	47/6 48/12 48/15	48/21 74/23 83/3 83/4	Nurse Death [1]	54/1 54/4 75/4 75/5
107/9 107/16 107/17	48/25 50/5 50/9 59/8	93/11 117/2 126/12	159/12	75/6 75/9 75/15 84/2
never [9] 18/22 31/18	60/21 61/1 62/11	130/15 130/17 130/20	Nurse Lightfoot [3]	88/13
37/20 116/1 130/25	63/14 67/13 68/16	130/22 130/25 130/25	158/15 160/8 160/12	occasions [6] 21/16
153/7 159/7 161/23	69/4 69/6 69/6 69/15	131/5 162/2	Nurse ZC [6] 86/21	39/22 53/15 102/7
162/24	70/25 71/4 72/1 72/15	nothing [13] 12/8	132/18 133/20 133/23	106/7 132/16
nevertheless [1]	73/2 73/4 73/7 73/16	22/9 41/3 41/3 59/25	136/12 160/9	occurred [10] 26/16
105/10	73/25 74/20 78/14	59/25 89/23 91/11	nursery [3] 75/5	74/24 77/2 81/2 87/23
new [6] 5/3 42/10	78/21 80/15 81/9	127/16 134/15 143/22	126/7 153/17	89/23 90/21 92/9
55/2 55/13 114/9	81/10 82/10 83/25	165/24 166/1	Nursery 1 [2] 75/5	103/10 147/16
163/3	87/8 87/17 87/24 88/9	notice [5] 59/22	153/17	occurrence [2] 76/9
newborn [2] 152/11	88/23 89/2 89/7 90/2	60/15 102/8 117/17	nurses [55] 4/2 14/15	128/2
169/7	90/4 91/8 92/11 95/21	166/5	14/17 19/18 21/6	occurring [2] 65/14
Newby [15] 16/2 16/3	96/18 97/15 99/6 99/6	noticeable [1] 58/25	21/10 21/24 26/12	67/12
16/8 16/9 16/9 16/12	100/23 107/3 108/8	noticed [5] 148/17	27/18 27/20 28/1 28/2	October [14] 1/1
16/22 16/22 20/19	109/3 112/12 113/15	159/13 159/19 164/25	28/4 28/5 28/7 28/12	65/17 82/15 84/1
31/4 31/6 37/8 82/16	115/7 115/10 115/10	165/5	29/11 34/1 34/25	85/22 88/3 88/12 92/9
83/19 83/22	115/14 116/10 121/20	notification [1]	37/20 39/24 47/25	92/23 92/25 93/3
news [3] 29/5 110/7	125/14 126/19 128/2	134/20	59/21 60/4 60/9 60/11	93/12 93/13 171/2
110/9	128/19 128/24 131/14	notion [1] 42/8	60/19 60/25 61/6 62/7	odd [2] 133/2 133/4
next [17] 8/21 9/12	132/13 134/14 144/21	now [57] 1/25 31/12	70/8 78/18 87/19	off [10] 10/15 58/15
9/17 11/3 43/18 92/25	147/25 150/7 151/10	31/13 37/4 41/9 41/16	87/21 88/25 108/1	70/2 88/5 88/7 122/25
93/1 93/11 99/15	151/25 152/3 152/3	52/20 52/22 59/13	113/13 114/12 114/13	126/8 128/9 145/2
99/23 100/2 117/3	153/7 154/5 156/4	59/19 62/18 65/7	115/12 124/20 127/23	164/24
126/15 127/20 129/5	157/9 157/12 157/23	65/16 71/4 78/7 78/11	131/15 131/17 131/19	offer [2] 6/13 41/8
145/14 148/6	157/25 160/11 161/2	83/14 83/14 83/16	131/25 132/3 139/13	offered [1] 121/3
NHS [3] 52/13 117/1	161/8 161/11 161/14	86/18 90/3 96/3 96/14	149/3 149/16 151/8	offers [1] 121/6
157/21	162/24 166/1 166/24	98/5 99/11 102/25	151/12 151/14 151/22	office [2] 17/16 55/18
nice [1] 131/23	169/23	108/25 109/20 109/22	164/12	officer [6] 2/4 2/4
		111/19 115/24 121/21	nurses' [1] 41/14	32/17 48/2 146/20
			nursing [18] 3/16	167/11

<p>O</p> <p>officers [2] 2/14 41/20</p> <p>often [18] 19/25 20/13 23/5 56/20 61/20 61/21 61/22 89/18 95/11 111/15 114/1 137/24 140/13 146/19 150/15 156/19 158/12 166/16</p> <p>Ogden [14] 9/13 101/24 102/3 102/4 102/15 102/17 103/4 147/1 147/2 147/4 147/10 147/23 147/25 151/3</p> <p>Ogden's [2] 9/14 101/25</p> <p>oh [6] 14/18 15/12 28/17 34/11 148/6 164/12</p> <p>okay [11] 26/8 34/21 34/25 121/21 128/22 133/14 138/13 151/8 151/25 156/10 165/3</p> <p>old [1] 2/3</p> <p>old-fashioned [1] 2/3</p> <p>older [1] 114/8</p> <p>on [302]</p> <p>on high [1] 126/5</p> <p>on-call [5] 2/15 2/24 93/6 106/6 111/14</p> <p>once [8] 4/10 4/12 4/13 34/5 46/14 61/18 73/17 73/23</p> <p>one [77] 1/21 2/23 4/5 7/19 14/15 14/17 16/3 20/2 20/7 20/16 22/6 24/25 25/24 27/20 27/22 28/11 34/10 38/1 38/18 40/13 41/9 47/9 47/22 47/24 47/24 47/25 48/18 49/2 56/22 61/15 64/9 68/22 71/13 76/12 77/6 78/22 87/10 93/12 97/19 106/12 114/3 115/21 115/22 116/3 116/10 119/5 119/13 122/21 125/1 127/23 131/24 132/2 132/16 134/17 137/12 137/23 139/12 139/12 139/13 139/15 139/15 139/18 139/18 144/5 144/16 149/5 149/5 149/8 149/8 149/14 149/14 156/18 157/16 157/18 162/1 164/5 169/6</p> <p>ones [2] 28/5 99/10</p> <p>ongoing [3] 78/3 78/4 85/8</p>	<p>only [26] 7/16 12/4 17/16 18/10 23/19 24/4 38/15 42/5 48/4 48/10 49/9 65/15 65/22 73/14 76/7 81/1 91/25 112/25 118/24 120/13 123/11 129/12 132/16 132/22 149/10 168/15</p> <p>open [4] 3/15 3/17 42/19 64/6</p> <p>openly [3] 4/25 42/16 157/2</p> <p>operating [1] 140/7</p> <p>opinion [2] 4/2 107/6</p> <p>opinions [2] 3/20 107/5</p> <p>opportunity [2] 50/18 74/23</p> <p>opposed [1] 105/17</p> <p>option [1] 169/8</p> <p>or [306]</p> <p>orally [1] 129/21</p> <p>order [2] 75/21 138/23</p> <p>organisations [1] 59/17</p> <p>originally [2] 126/16 126/18</p> <p>other [74] 2/24 5/17 6/15 8/8 9/20 11/12 15/15 15/20 23/16 23/17 29/22 33/18 34/25 37/16 37/19 38/1 40/11 43/19 45/22 47/22 53/19 59/11 59/17 62/22 68/9 68/14 70/8 78/17 80/12 80/18 83/13 83/22 87/21 91/14 102/4 102/7 103/11 104/5 104/18 108/14 108/19 111/2 113/9 114/17 116/10 118/21 119/5 121/2 121/8 127/12 128/2 129/2 129/2 132/10 132/16 132/22 134/20 138/20 142/19 142/20 142/21 142/24 144/10 144/12 144/25 147/17 148/1 148/4 148/9 157/10 161/5 161/19 165/16 169/19</p> <p>others [7] 18/6 65/23 81/2 82/8 132/14 154/8 159/17</p> <p>otherwise [2] 128/13 128/20</p> <p>our [11] 6/13 17/7 20/15 32/14 32/15 34/8 44/25 152/6 154/21 155/18 163/3</p> <p>out [45] 4/5 8/14 8/19</p>	<p>10/1 14/25 25/22 27/10 28/7 34/4 43/7 55/12 55/18 61/19 68/24 75/10 76/5 84/3 87/16 94/5 97/17 104/24 108/25 111/25 115/22 115/22 119/18 120/2 122/4 122/5 122/8 122/9 126/14 136/17 137/25 138/11 140/18 140/22 142/21 144/12 147/10 153/9 153/13 157/3 164/9 169/25</p> <p>outcome [1] 41/22</p> <p>outcomes [2] 98/2 98/9</p> <p>outlined [1] 17/1</p> <p>outside [1] 164/19</p> <p>outwardly [2] 132/5 132/6</p> <p>over [21] 10/9 10/12 27/19 28/11 40/5 40/14 42/5 76/20 76/25 77/24 78/24 86/5 93/24 99/24 104/17 123/15 135/24 135/24 140/18 141/2 144/4</p> <p>overall [5] 4/24 65/21 94/6 94/9 94/10</p> <p>overlap [1] 102/12</p> <p>overlapped [1] 38/3</p> <p>overlooking [1] 37/20</p> <p>overly [1] 31/19</p> <p>overnight [4] 39/17 57/15 57/19 164/10</p> <p>oversight [2] 138/24 149/7</p> <p>overview [1] 138/24</p> <p>own [4] 65/12 72/4 82/8 109/6</p> <p>oxygen [4] 123/1 123/5 123/18 126/5</p>	<p>paediatric-specific [1] 32/15</p> <p>paediatrician [6] 35/23 52/13 52/19 98/6 119/16 119/20</p> <p>paediatricians [1] 119/14</p> <p>paediatrics [13] 2/22 3/1 51/19 100/12 100/16 101/22 107/10 107/18 129/13 148/24 152/18 164/11 164/13</p> <p>page [33] 9/15 9/15 17/11 17/11 17/11 19/11 19/11 19/12 20/18 20/24 24/9 24/10 24/10 85/20 86/5 86/6 86/18 86/20 90/3 90/14 92/14 92/17 92/19 92/22 92/24 93/1 93/11 93/13 94/1 94/14 102/19 102/22 130/6</p> <p>page 1 [7] 17/11 19/11 19/12 20/18 24/9 24/10 130/6</p> <p>page 10 [5] 90/3 92/14 92/17 92/19 94/14</p> <p>page 12 [2] 86/18 86/20</p> <p>page 2 [4] 17/11 17/11 19/11 24/10</p> <p>page 3 [2] 9/15 9/15</p> <p>page 7 [2] 86/5 86/6</p> <p>page 8 [2] 102/19 102/22</p> <p>pages [1] 122/8</p> <p>paid [1] 120/23</p> <p>paper [2] 116/18 116/21</p> <p>paragraph [56] 3/7 3/18 7/24 8/15 9/16 9/16 11/14 12/19 14/21 15/18 16/21 22/5 26/8 27/9 30/12 31/9 45/9 57/5 61/6 63/22 70/15 75/11 77/15 79/3 80/16 80/22 81/17 82/19 84/23 85/21 86/6 86/20 91/6 92/21 93/14 94/12 97/20 102/20 102/22 103/4 104/23 111/21 115/18 121/22 121/25 125/15 127/5 129/9 134/2 134/19 135/3 137/9 137/19 150/9 153/9 166/4</p> <p>paragraph 11 [1] 57/5</p> <p>paragraph 12 [4] 9/16 9/16 70/15</p>	<p>104/23</p> <p>Paragraph 14 [1] 11/14</p> <p>paragraph 15 [3] 12/19 115/18 153/9</p> <p>paragraph 16 [1] 75/11</p> <p>paragraph 18 [3] 14/21 15/18 80/22</p> <p>paragraph 19 [3] 77/15 121/22 121/25</p> <p>paragraph 20 [2] 16/21 79/3</p> <p>paragraph 21 [1] 80/16</p> <p>paragraph 22 [2] 26/8 81/17</p> <p>paragraph 23 [2] 27/9 125/15</p> <p>paragraph 24 [1] 82/19</p> <p>paragraph 25 [1] 30/12</p> <p>paragraph 26 [2] 84/23 127/5</p> <p>paragraph 27 [1] 31/9</p> <p>paragraph 32 [3] 102/20 102/22 103/4</p> <p>paragraph 34 [1] 129/9</p> <p>paragraph 36 [1] 86/20</p> <p>paragraph 40 [1] 94/12</p> <p>paragraph 42 [1] 166/4</p> <p>paragraph 46 [1] 134/2</p> <p>paragraph 5 [1] 3/7</p> <p>Paragraph 59 [1] 134/19</p> <p>paragraph 6 [3] 3/18 61/6 97/20</p> <p>paragraph 64 [1] 137/9</p> <p>paragraph 8 [4] 7/24 63/22 111/21 150/9</p> <p>paragraph 9 [1] 8/15</p> <p>paragraphs [1] 20/25</p> <p>paraphrasing [1] 27/23</p> <p>parent [1] 98/14</p> <p>parents [19] 6/19 21/2 21/5 21/9 21/15 21/16 32/3 39/7 39/12 39/20 39/23 40/2 40/4 43/9 43/11 44/2 97/22 129/12 170/4</p> <p>Park [5] 52/4 59/14 102/9 114/18 121/5</p> <p>part [26] 3/6 4/18 4/22 9/1 20/12 20/14 20/14 29/14 32/12</p>
--	---	--	--	--

P	139/22 140/9 142/7 142/9 142/18 143/1 144/7 148/5 148/8 148/11 148/13 151/3 158/9 166/11 166/14 166/16 166/23 166/24 167/3 168/13 169/4 per [1] 61/18 perceive [1] 89/12 perceived [2] 6/10 7/2 percentage [1] 55/6 perception [8] 6/1 6/8 7/16 62/6 85/13 89/9 95/14 95/24 performance [1] 67/23 perfunctory [2] 24/22 50/1 perhaps [11] 6/6 6/21 17/10 58/25 60/5 60/6 63/3 64/12 91/16 109/20 169/6 Perinatal [3] 19/16 19/20 113/20 period [27] 9/3 13/12 38/16 52/10 52/22 53/7 60/18 63/18 65/20 65/22 65/24 66/18 67/12 74/12 76/25 79/19 80/1 85/14 85/22 92/8 92/10 93/22 97/11 103/21 104/17 122/20 150/10 periods [6] 52/24 59/2 60/20 63/24 84/20 84/21 perpetrate [1] 97/25 persisting [2] 37/4 39/1 person [15] 17/16 28/23 29/10 30/5 30/7 35/8 36/17 36/23 37/22 38/18 48/17 106/6 119/16 129/24 131/4 personal [2] 5/18 18/5 personally [12] 3/13 5/21 7/2 7/17 21/21 29/8 30/2 33/19 42/5 45/21 64/14 104/6 perspective [7] 46/23 68/20 68/21 81/1 84/12 113/17 115/8 pharmacists [1] 151/23 phone [5] 6/21 21/19 21/21 35/14 35/15 photo [2] 13/17 13/20 physically [1] 116/19 pick [5] 140/3 142/18	144/8 155/20 168/17 picked [1] 157/4 picking [1] 169/25 picks [1] 155/24 picture [1] 93/10 piece [1] 116/21 pin [1] 12/25 place [15] 4/8 22/12 56/20 77/20 93/20 104/21 106/17 108/1 109/8 111/19 128/9 128/15 136/15 148/7 167/2 placed [1] 13/8 placement [17] 33/14 33/20 35/7 36/6 36/16 53/24 53/25 54/7 58/25 79/20 94/19 104/8 146/21 147/3 148/5 163/2 163/5 placements [1] 54/16 places [1] 70/8 plan [3] 78/25 78/25 93/15 plastic [1] 117/12 plausible [2] 84/21 94/8 play [1] 112/2 playing [1] 35/20 pleasant [1] 115/6 please [10] 9/13 16/11 19/18 51/3 51/7 93/1 100/9 125/8 130/5 145/18 pm [5] 99/20 99/22 145/10 145/12 170/25 PMM [1] 19/15 point [40] 13/25 19/7 24/18 25/11 25/13 26/21 34/24 36/10 36/14 54/14 57/20 68/9 74/1 79/22 90/25 96/16 97/13 101/4 109/3 123/14 123/23 124/14 125/22 128/23 131/1 131/4 131/9 132/1 132/5 135/4 137/16 137/25 139/25 141/18 143/23 144/5 150/25 163/6 163/19 165/10 pointed [1] 14/25 points [2] 116/22 155/20 police [19] 19/3 36/4 36/11 36/15 37/18 41/16 41/25 42/21 45/12 92/17 121/23 121/24 122/9 127/13 134/8 134/11 134/12 134/20 141/25 policies [1] 32/23 policy [1] 39/18 poor [3] 86/7 86/9	86/9 poorly [1] 79/8 position [1] 149/19 positive [10] 3/11 4/24 17/6 41/3 43/23 53/20 53/23 54/3 60/12 148/2 positives [2] 43/5 44/4 possibilities [2] 45/15 96/8 possibility [2] 36/10 144/7 possible [8] 13/6 13/8 13/13 26/11 40/10 40/16 67/21 167/6 possibly [6] 56/22 68/16 71/13 71/15 71/24 79/19 post [2] 6/23 43/11 post-caesarean [2] 6/23 43/11 postdate [1] 31/4 postmortem [1] 85/10 postmortems [1] 167/14 postnatal [4] 55/4 61/18 152/11 153/15 potential [5] 80/23 83/20 155/3 166/17 169/5 potentially [4] 13/4 110/21 117/9 119/8 Powell [4] 20/23 46/2 46/6 125/4 practicable [1] 125/10 practical [2] 54/1 64/2 practice [12] 21/15 39/12 54/12 59/1 68/20 83/2 109/7 113/22 114/2 114/8 114/11 124/6 practices [1] 140/17 practitioners [2] 140/6 140/11 Prague [1] 100/21 preceded [1] 63/14 precipitate [1] 84/15 precise [2] 56/23 96/23 precisely [1] 27/23 predated [1] 18/18 predisposition [1] 166/21 Predominantly [1] 135/4 preference [1] 53/25 premature [2] 56/8 56/13 prepare [3] 48/8	49/11 130/24 prepared [1] 24/11 preparing [1] 130/23 prescription [1] 155/2 presence [3] 69/19 143/6 150/15 present [15] 9/6 14/17 20/14 21/16 44/22 60/5 95/11 117/8 123/17 124/1 124/20 129/16 138/25 139/22 162/4 presentation [1] 85/5 presentations [1] 97/2 presented [2] 19/25 57/17 presenting [1] 91/17 press [1] 157/15 pressure [2] 59/9 95/16 pressures [3] 59/15 59/16 59/18 presumably [5] 43/20 49/9 72/19 102/11 107/25 presume [3] 19/16 19/22 20/5 pretty [4] 18/20 20/11 24/22 39/16 prevented [1] 44/8 preventing [1] 67/20 previous [8] 55/21 78/1 88/16 93/15 123/7 127/9 147/3 170/1 previously [5] 55/2 82/24 86/25 98/16 127/13 primarily [4] 14/23 54/2 54/15 54/25 printed [1] 117/20 prior [10] 18/24 25/16 54/21 57/20 70/16 71/14 73/18 93/21 96/22 154/2 prioritise [3] 40/3 40/5 40/17 prioritised [1] 141/2 privacy [1] 169/13 privately [1] 19/19 probably [26] 17/20 22/11 33/2 61/17 81/11 106/19 109/6 109/19 109/23 110/24 112/7 129/24 130/9 130/11 133/25 135/23 136/23 139/14 139/14 141/11 141/17 142/8 144/19 146/25 150/19 154/20 problem [4] 89/11 100/25 111/13 129/15
----------	--	---	---	---

P
problems [4] 26/21
93/9 111/17 131/18
procedures [3] 67/5
138/6 150/22
process [9] 46/14
47/3 134/22 135/7
135/11 135/16 136/3
136/7 167/13
processes [8] 29/15
31/20 32/6 57/21
58/22 66/11 80/5
109/8
produce [2] 24/19
130/10
product [1] 15/22
productive [1] 62/25
products [1] 27/6
professional [6] 63/4
98/13 113/12 114/14
168/21 170/7
professionals [2]
39/23 151/17
progressed [2] 51/25
136/20
prolonged [1] 13/11
prominent [1] 4/6
promote [3] 97/7
113/18 115/2
promoting [1] 114/10
prompt [1] 81/5
prompts [1] 73/4
properly [2] 119/1
137/2
proportion [2] 61/11
135/16
prospect [1] 36/4
protected [2] 142/7
142/10
protection [4] 97/8
119/10 119/13 156/17
provide [8] 25/6
41/17 48/6 114/10
134/5 138/5 138/23
143/12
provided [12] 1/14
19/3 25/2 51/9 58/3
63/19 79/6 101/10
134/7 134/10 143/16
145/23
providing [2] 25/3
137/5
proximity [1] 11/11
pseudomonas [1]
45/17
psychological [1]
168/15
public [1] 29/5
publicised [1] 141/17
purely [2] 56/11
56/12
purpura [1] 17/20
purpuric [1] 17/19

push [2] 115/3
138/10
pushing [1] 121/15
put [14] 8/19 25/3
26/3 55/20 71/2 85/16
94/13 102/17 111/3
120/16 123/12 128/14
161/7 167/1
putting [2] 29/17
143/15

Q

qualifications [3]
1/11 100/9 145/18
qualified [1] 148/9
quality [1] 7/12
quantify [1] 77/14
queries [1] 67/10
query [1] 93/7
question [3] 49/18
137/12 141/11
Questioned [10] 1/7
51/5 100/7 144/1
145/16 172/3 172/5
172/7 172/8 172/10
questions [8] 24/25
47/7 99/5 99/6 101/19
108/25 143/19 170/10
quickly [10] 9/11
12/14 12/15 12/21
75/7 82/21 86/12 94/4
126/10 127/4
quiet [1] 130/4
quite [23] 4/1 5/18
19/1 19/23 20/13 22/9
28/17 33/7 39/20
40/24 42/2 42/6 55/14
59/12 75/7 83/20
86/12 91/16 91/17
92/1 108/16 118/18
144/22

R

RACHEL [7] 1/6 1/12
13/16 17/15 17/24
85/18 172/2
raise [15] 26/20 67/7
67/13 67/17 68/4
78/12 78/13 78/18
94/23 101/5 103/13
121/8 139/24 142/10
147/19
raised [18] 15/1
16/25 17/4 21/1 22/7
32/1 44/12 45/22
46/14 66/8 78/19
83/10 83/12 88/16
115/12 121/10 121/16
151/4
raising [10] 16/7 32/5
36/1 46/11 46/19
83/16 103/16 141/18
142/7 147/21
range [2] 96/8 113/3

rare [4] 45/15 110/23
110/25 129/14
rash [22] 8/4 11/9
12/3 12/6 12/10 12/11
14/2 14/6 14/13 14/20
14/24 15/3 15/12
15/13 15/25 16/16
16/19 17/19 17/20
31/2 31/2 104/2
rashes [1] 30/17
rate [12] 104/16
105/1 105/2 105/14
105/15 105/17 105/20
108/7 108/23 120/8
120/21 151/4
rates [5] 105/12
105/13 106/10 120/22
150/24
rather [6] 19/19
22/12 37/3 95/4
130/12 159/20
ratio [1] 139/15
Ravi [1] 153/22
ray [2] 93/8 93/9
rays [1] 80/23
RCPCH [1] 162/10
reached [1] 96/16
react [1] 13/1
reaction [1] 77/16
read [3] 113/19
147/10 169/9
ready [1] 130/11
realise [1] 166/8
realised [1] 126/9
really [15] 6/11 25/4
37/2 85/23 85/25
94/15 108/8 111/22
113/15 121/12 121/13
138/1 138/18 148/7
168/14
reason [9] 23/9 49/7
53/21 59/5 59/8 88/22
89/15 128/24 134/17
reasons [3] 49/8 54/1
67/21
reassurance [1]
137/14
recall [112] 3/19 4/11
7/25 8/7 9/1 9/5 9/19
9/21 10/6 11/4 14/3
14/11 15/2 15/3 15/5
15/10 15/14 15/23
16/12 16/20 16/22
18/3 18/4 23/3 24/18
26/11 27/17 27/23
28/16 29/18 29/19
30/8 33/17 33/19 36/6
37/15 38/3 38/16
39/10 39/14 39/18
48/11 56/20 64/15
64/25 66/7 66/9 66/10
68/12 69/10 70/23
71/23 72/1 72/15
72/24 74/8 76/19

76/22 77/1 77/3 77/10
79/10 80/6 80/17 83/1
83/11 84/25 88/23
90/2 90/10 90/11
90/12 92/3 92/6 92/10
92/11 94/2 94/17
94/20 103/6 103/12
103/23 104/4 104/6
104/20 104/25 106/11
106/12 112/20 115/14
124/18 125/1 125/2
127/24 129/25 130/21
132/4 133/5 147/17
151/1 151/10 151/16
152/16 152/22 156/3
156/12 156/14 160/4
161/4 163/24 165/21
168/8
recalled [1] 158/16
recalling [1] 14/13
receive [3] 130/20
134/25 136/18
received [2] 96/20
127/23
receiving [2] 58/10
153/19
recent [2] 17/18 22/8
recently [1] 149/12
recognise [1] 170/6
recognised [3] 20/14
69/12 165/19
recognising [1]
170/5
recognition [2] 97/8
168/18
recollect [1] 127/12
recollection [21]
8/23 71/4 72/21 73/2
73/22 74/21 85/7
88/19 90/9 91/13
91/15 91/19 91/24
93/22 102/3 102/15
105/16 108/15 122/13
122/16 129/1
recollections [1]
64/22
recommend [1]
97/21
recommendation [1]
78/3
recommendations
[5] 41/23 140/22
157/16 157/18 169/5
record [3] 20/16
125/9 155/1
recorded [2] 90/16
155/16
recording [2] 42/9
92/13
records [1] 18/20
recover [1] 87/13
recovered [1] 86/12
recovery [2] 81/5
81/12

recurrence [1] 14/24
reduced [2] 120/8
120/21
refer [5] 45/9 74/23
102/20 132/17 133/10
reference [8] 9/15
22/15 47/10 70/19
90/5 102/19 133/18
137/16
referrals [2] 31/23
168/4
referred [5] 28/14
29/22 105/17 124/23
167/21
referring [6] 27/12
140/8 141/16 142/14
143/8 144/20
refers [2] 30/25
79/18
reflect [1] 164/23
reflected [2] 49/21
99/2
reflecting [7] 44/7
60/17 65/2 65/16
66/12 94/9 97/5
reflection [3] 58/5
58/8 80/25
reflections [11] 41/8
41/8 68/17 97/16
97/18 99/8 137/5
144/25 169/4 169/19
170/15
refresh [1] 10/4
regard [1] 141/4
regarding [1] 77/21
regards [2] 159/6
168/21
region [4] 105/3
120/19 120/21 121/2
Registrar [31] 1/24
2/1 2/5 2/8 9/8 9/18
12/4 23/22 25/12
32/17 33/25 38/1
40/19 54/23 68/23
71/14 74/17 85/19
93/5 108/18 109/4
109/5 120/10 123/7
125/21 141/7 150/21
152/10 153/1 153/2
153/21
registrars [27] 1/21
1/22 17/17 22/9 57/15
63/17 64/9 78/20
102/9 102/13 108/7
108/15 108/16 108/18
108/19 112/8 112/13
112/16 113/5 120/11
146/12 149/19 149/24
150/1 150/1 152/7
152/13
regular [9] 34/8
55/18 56/24 57/22
63/7 68/3 68/7 108/20
147/8

R	repeating [1] 30/23 replace [1] 128/7 replaced [1] 75/7 replied [2] 27/20 49/14 report [3] 47/11 49/7 162/11 reported [2] 75/13 79/7 reporting [6] 8/8 33/17 37/7 37/7 80/11 104/5 reports [9] 70/13 70/18 70/24 71/12 71/18 71/20 72/4 72/13 72/16 represent [1] 107/2 represented [2] 84/20 106/24 reputation [2] 114/19 114/20 request [2] 24/15 136/25 requested [4] 123/6 125/24 150/15 167/15 required [6] 25/5 56/18 70/20 79/12 89/4 96/25 requiring [1] 84/9 resentment [1] 60/3 respect [2] 80/19 98/11 respiratory [1] 145/22 respond [1] 160/23 responded [1] 12/15 responder [1] 154/6 response [4] 17/6 75/19 97/8 160/21 responsibilities [1] 54/23 responsible [4] 2/13 2/15 111/8 138/7 rest [3] 50/13 105/3 127/8 resume [1] 145/5 resus [2] 49/1 128/21 resuscitating [1] 86/7 resuscitation [16] 8/23 13/19 13/25 14/4 14/18 40/13 47/23 49/17 64/11 76/17 79/13 84/17 89/5 125/7 153/19 153/20 retrospectively [1] 117/18 return [3] 4/21 53/15 53/21 returned [5] 53/5 53/9 60/22 87/2 127/2 review [15] 30/11 30/12 61/18 74/23 107/9 107/9 107/10	107/16 107/16 107/17 125/9 125/13 125/24 128/14 134/6 reviewed [2] 130/8 155/5 reviews [4] 22/10 22/17 134/25 135/2 rid [1] 118/13 right [15] 18/15 34/14 47/10 53/1 71/3 71/11 81/22 118/24 118/25 129/7 132/18 136/7 137/15 145/8 162/4 rise [2] 145/9 170/24 risk [4] 61/8 111/4 120/1 165/2 road [1] 37/25 role [15] 2/8 2/12 2/20 39/6 40/22 52/16 52/19 70/16 73/19 112/1 112/3 113/2 153/20 167/24 168/15 roles [1] 102/13 room [7] 16/14 99/18 105/7 130/1 149/13 153/18 169/10 rota [19] 27/21 28/12 29/12 34/18 37/20 87/20 108/16 108/19 112/8 112/13 112/24 120/10 120/11 120/14 121/16 125/21 138/23 150/3 150/3 rotas [1] 120/11 rotate [2] 2/19 140/14 rotated [1] 146/22 rotating [1] 102/13 rotation [8] 52/10 53/19 55/23 56/11 63/9 63/15 86/25 156/20 rotations [4] 1/24 52/2 53/16 70/4 roughly [2] 35/5 106/17 round [11] 4/1 4/18 4/21 4/22 21/16 56/25 140/14 148/12 152/12 152/22 154/11 rounds [5] 4/8 56/19 57/13 85/1 152/15 routined [1] 57/22 routinely [3] 3/19 13/22 19/25 Royal [5] 51/18 51/22 100/15 107/10 107/18 rule [1] 61/22 rumour [1] 73/14 run [2] 73/2 86/24 running [1] 120/14	S sadly [3] 63/25 93/18 94/4 sadness [3] 129/11 129/17 158/13 safe [8] 13/6 117/25 139/2 139/4 139/5 139/6 139/8 141/13 safeguard [1] 13/12 safeguarding [13] 32/9 32/13 32/15 32/16 80/10 96/19 96/21 97/14 119/6 119/17 119/18 156/17 170/3 safety [2] 139/9 141/2 said [36] 6/16 14/15 20/13 27/15 27/23 28/12 44/23 50/3 54/3 65/20 65/24 70/3 72/8 80/21 107/3 112/20 121/11 127/13 131/2 131/7 131/23 133/6 133/18 133/21 136/11 141/5 150/16 151/17 158/20 158/24 159/22 160/21 161/3 161/5 164/12 169/23 Saladi [10] 16/6 16/8 20/20 53/3 75/23 78/21 123/7 123/9 123/14 123/23 saline [1] 169/18 same [19] 6/5 10/3 12/10 14/12 14/14 40/11 41/20 45/9 87/14 101/5 102/1 103/21 130/15 138/16 147/9 156/8 156/10 168/4 169/11 sat [1] 166/16 satisfied [1] 79/1 saturations [1] 123/6 Saturday [1] 153/10 saw [7] 15/9 30/1 76/21 119/25 123/10 123/20 162/24 say [125] 3/9 3/18 4/23 5/7 6/14 7/11 7/20 7/24 8/5 9/5 12/19 15/18 17/17 17/24 17/25 21/22 22/20 23/6 26/8 27/9 28/15 29/6 30/11 31/10 31/25 32/23 33/11 33/13 33/15 34/4 34/19 40/21 41/10 44/6 44/18 44/22 45/2 46/8 57/4 58/17 59/6 61/6 63/22 69/21 70/14 71/3 71/18 72/16 73/18	75/12 76/12 76/16 77/7 77/15 77/21 79/5 80/16 81/7 81/17 82/19 84/24 85/6 86/10 93/14 94/1 95/6 97/20 104/24 105/10 105/13 106/9 108/23 108/24 111/21 113/10 113/16 114/12 114/16 114/18 115/4 115/15 115/18 117/8 118/21 124/17 125/12 126/22 127/1 127/5 129/9 129/19 131/5 133/11 134/15 134/22 135/1 135/6 137/7 137/18 137/19 139/22 140/8 141/22 142/2 142/6 142/11 143/4 144/11 144/17 147/24 148/6 149/1 150/8 150/12 151/11 151/25 153/24 156/16 158/22 158/23 159/12 160/25 162/25 163/22 168/8 saying [25] 6/24 14/12 14/18 28/16 29/11 30/8 30/10 34/1 36/7 86/13 95/21 95/24 109/1 114/6 125/5 132/1 132/2 157/20 159/4 160/7 160/12 160/14 160/15 161/1 164/16 says [17] 10/21 13/15 17/21 19/14 85/21 86/22 93/3 102/22 103/4 103/22 131/22 136/13 147/10 158/15 160/8 163/11 163/15 scene [2] 13/19 22/10 scenes [1] 41/17 scheduled [3] 56/21 68/3 68/7 school [1] 170/2 screen [6] 9/14 19/12 94/14 102/18 102/23 103/18 screened [1] 13/6 scribe [2] 9/7 47/25 Scroll [2] 9/16 86/5 scrutiny [1] 41/18 searching [1] 85/14 second [11] 11/19 20/24 54/4 58/24 75/9 75/10 75/13 78/22 86/23 88/3 159/2 secondhand [1] 40/14 section [2] 6/23 43/11 secure [2] 114/6
----------	--	--	---	--

S				
secure... [1] 118/14 securely [1] 117/23 security [2] 143/6 143/10	sentences [1] 144/9 separated [1] 43/23 sepsis [3] 12/12 12/13 12/16 September [25] 2/17 27/10 27/15 28/21 37/19 38/19 44/18 47/16 53/6 53/11 63/10 70/17 73/24 74/14 74/19 74/25 76/23 82/24 87/18 101/22 102/1 146/6 162/20 163/16 164/17 September 2015 [3] 27/10 38/19 53/6 September 2016 [2] 101/22 146/6 septicaemia [1] 12/6 series [3] 35/24 36/3 38/25 serious [2] 39/1 49/5 seriously [3] 8/6 33/16 104/3 service [2] 140/1 140/2 services [1] 113/3 sessions [1] 113/23 set [18] 8/14 27/10 33/20 94/5 97/17 98/16 104/7 104/24 107/21 122/4 122/5 122/8 122/9 140/22 149/2 153/9 153/13 158/16 set-up [2] 107/21 149/2 setting [3] 59/3 61/25 111/25 settings [1] 98/15 settle [1] 63/16 settled [2] 37/4 128/23 seven [2] 63/3 74/3 several [3] 62/2 103/10 147/15 severe [2] 45/5 91/4 severity [1] 84/10 Shakes [1] 165/11 Shall [1] 101/2 share [4] 18/2 156/21 168/13 169/11 shared [5] 16/24 17/7 34/2 45/1 47/1 sharing [3] 17/2 33/25 136/16 shattered [1] 85/25 she [79] 10/7 11/25 12/1 12/3 12/15 12/20 12/21 12/25 13/2 13/4 13/8 13/13 13/15 13/15 16/13 16/15 16/17 17/16 20/20 20/21 27/23 44/9 62/14 74/12 75/16	75/20 81/11 83/19 85/24 86/11 86/22 94/3 94/4 102/6 102/18 102/22 103/4 103/21 103/22 124/8 124/10 125/25 126/1 127/9 127/9 129/24 132/2 132/5 132/6 132/7 132/7 132/9 132/20 132/21 132/21 132/22 133/21 136/12 136/13 137/8 137/13 147/7 147/11 147/23 151/11 151/12 151/12 157/4 158/15 158/19 159/13 159/19 160/2 160/14 160/23 164/18 164/19 165/1 165/17 she's [1] 86/11 sheet [6] 115/24 116/5 117/17 117/19 117/20 118/1 sheets [4] 115/23 117/11 117/13 118/13 shift [24] 2/10 4/15 11/20 19/23 20/6 29/19 49/17 55/11 61/18 62/2 62/3 86/8 86/10 112/18 112/19 112/21 126/15 126/21 127/9 149/6 149/8 149/15 158/6 162/5 shifted [1] 142/8 shifts [19] 1/24 8/9 33/19 33/20 34/17 34/22 61/14 81/23 81/25 82/5 86/24 87/5 94/22 104/6 104/7 152/6 153/8 161/21 164/24 SHO [4] 32/17 146/20 150/3 151/7 shock [3] 127/7 129/17 129/19 shocked [6] 28/17 127/9 127/15 127/15 127/16 129/10 short [7] 9/3 50/24 112/24 116/22 138/22 145/11 152/7 short-staffed [1] 138/22 shortage [2] 149/25 150/3 shortly [1] 102/24 SHOs [2] 2/14 57/16 should [37] 21/6 22/11 25/9 31/22 80/11 80/25 83/12 83/16 87/22 88/7 89/24 96/4 96/7 96/10 96/12 97/21 102/25 108/23 109/1 109/13 114/7 114/8 118/12	120/2 131/23 133/10 139/13 139/17 141/24 142/7 142/11 142/23 143/5 144/13 155/7 157/18 168/11 shouldn't [2] 7/9 161/1 shout [1] 153/17 showed [1] 17/19 shredded [1] 117/24 sibling [1] 128/19 siblings [1] 158/17 sick [1] 21/8 sickest [1] 87/2 side [3] 9/2 55/13 164/12 sight [1] 43/15 sighted [1] 150/6 significance [1] 56/2 significant [7] 10/11 29/24 36/2 44/11 46/10 89/4 135/16 significantly [5] 42/13 59/2 120/7 121/3 148/21 signpost [1] 113/23 signs [2] 91/1 144/8 similar [13] 8/3 11/8 14/20 15/13 15/16 15/25 16/17 16/18 31/2 62/19 63/6 65/15 104/1 similarity [1] 15/1 similarly [3] 61/17 83/20 86/24 simply [5] 30/4 40/16 71/3 95/20 105/14 since [6] 18/23 76/22 99/3 118/10 128/22 138/21 single [3] 7/6 12/24 37/21 sit [4] 1/8 16/14 51/6 155/14 sit-down [1] 16/14 sitting [1] 111/19 situation [21] 7/3 12/7 25/15 64/13 68/5 68/23 73/9 77/19 78/7 81/14 82/6 82/9 84/17 96/4 124/7 134/24 135/8 136/10 141/9 153/22 154/6 situations [3] 64/5 95/12 157/5 six [17] 52/2 52/10 53/1 53/5 54/5 54/15 55/21 55/22 56/12 63/2 63/9 63/18 65/21 66/14 87/5 130/12 149/11 six months [11] 53/1 53/5 54/5 55/21 55/22 56/12 65/21 66/14	87/5 130/12 149/11 six-month [4] 54/15 63/2 63/9 63/18 skilled [1] 170/5 skin [2] 42/12 42/12 slightly [13] 21/11 21/19 32/17 32/18 48/17 50/19 57/7 57/12 61/2 84/11 126/1 126/3 152/6 small [1] 27/13 smaller [1] 140/3 so [291] Society [2] 100/17 100/18 soft [1] 126/3 sole [1] 123/17 solely [2] 148/23 166/17 some [51] 5/19 7/7 10/15 15/22 16/20 26/25 34/2 36/10 36/13 53/8 57/10 61/16 62/3 62/14 68/16 68/17 72/19 74/13 75/20 79/15 80/22 82/25 84/6 86/15 87/1 88/17 91/19 92/18 99/4 105/11 109/18 109/19 110/7 118/2 118/21 119/24 120/10 124/14 125/22 128/6 129/15 134/21 135/22 138/25 140/5 142/16 142/17 142/20 144/7 144/11 144/22 somebody [22] 27/22 32/25 37/13 38/13 39/8 39/15 40/8 42/23 102/3 106/5 118/4 121/13 124/3 132/5 132/8 136/19 136/20 136/21 140/12 147/8 159/8 164/19 someone [12] 34/4 35/9 35/10 37/14 49/10 73/15 108/3 117/16 133/16 136/16 159/23 164/17 something [77] 5/3 5/22 7/8 13/4 13/21 18/22 21/22 26/5 27/2 27/16 31/17 33/21 35/19 36/13 39/4 40/15 41/24 43/3 43/5 45/4 58/18 62/16 62/17 66/1 66/15 67/6 67/15 67/18 68/25 71/21 72/10 74/3 74/5 74/15 76/8 78/12 78/17 80/3 83/8 83/15 87/21 89/15 89/16 89/21 90/16 96/7 98/3

S				
<p>something... [30] 98/24 99/2 104/9 104/13 110/8 110/14 110/15 110/16 110/22 110/25 115/14 116/19 121/18 121/20 136/17 140/8 142/14 143/17 144/17 150/5 151/6 153/7 154/21 158/14 160/7 161/5 166/25 167/2 167/24 168/5</p> <p>sometimes [6] 12/5 23/8 32/22 102/11 138/1 138/5</p> <p>somewhat [2] 42/21 94/15</p> <p>somewhere [1] 4/19</p> <p>soon [10] 8/2 11/20 15/16 40/9 81/12 103/3 103/25 106/14 106/22 125/9</p> <p>Sophie [4] 125/23 126/10 127/6 127/7</p> <p>sorrow [1] 143/24</p> <p>sorry [21] 10/25 90/4 107/12 107/15 107/24 108/12 119/3 122/7 122/15 122/18 127/1 130/21 131/21 132/17 134/1 134/9 139/4 139/5 144/19 149/17 162/3</p> <p>sort [22] 26/25 58/8 61/9 63/4 64/4 65/8 66/11 67/23 68/19 77/1 81/23 91/15 98/17 110/6 110/9 110/12 110/14 117/24 118/2 118/21 129/15 139/11</p> <p>sorts [2] 64/15 163/22</p> <p>sought [2] 64/18 107/5</p> <p>sound [3] 36/7 100/25 115/5</p> <p>sounds [5] 25/4 28/21 101/3 101/8 136/11</p> <p>spaces [1] 148/22</p> <p>speak [28] 16/3 16/19 19/10 21/15 21/24 22/1 22/3 31/6 33/9 35/14 35/21 36/2 37/8 40/4 40/8 42/5 42/16 67/15 69/19 119/6 121/13 127/19 129/18 136/2 136/6 136/10 160/24 163/21</p> <p>speaking [10] 11/5 18/4 23/19 36/15 38/2 40/11 101/6 121/25</p>	<p>134/19 164/19</p> <p>special [2] 100/14 145/21</p> <p>specialist [3] 52/1 54/19 101/22</p> <p>specific [18] 18/3 21/10 22/12 29/13 32/15 39/10 64/22 66/9 67/10 67/13 68/10 71/17 74/8 83/24 103/13 106/21 147/19 158/18</p> <p>specifically [20] 3/12 9/21 16/15 25/7 28/2 28/3 30/6 33/6 49/12 60/8 66/7 74/1 103/8 103/12 118/12 147/14 147/18 156/16 165/18 166/19</p> <p>specifics [2] 65/10 132/4</p> <p>speculating [1] 72/22</p> <p>speculation [3] 72/20 72/24 73/14</p> <p>spend [5] 55/8 55/9 62/3 98/9 98/18</p> <p>spending [1] 56/17</p> <p>spent [8] 52/2 52/22 55/12 55/22 60/5 65/21 77/1 152/10</p> <p>SPIN [1] 100/14</p> <p>split [3] 55/5 55/7 56/16</p> <p>spoke [18] 4/25 18/21 26/10 31/4 34/4 35/2 35/20 39/9 39/13 39/16 63/17 107/1 129/23 129/24 129/25 133/16 144/8 158/19</p> <p>spoken [3] 39/18 68/15 147/25</p> <p>spot [3] 12/24 142/12 156/23</p> <p>spread [1] 161/6</p> <p>ST [1] 2/6</p> <p>ST1 [4] 146/6 146/17 146/19 156/25</p> <p>ST5 [1] 54/10</p> <p>ST6 [3] 2/7 23/22 24/4</p> <p>ST8 [2] 23/25 24/1</p> <p>stabilisation [1] 79/13</p> <p>stabilised [1] 75/7</p> <p>stability [1] 140/20</p> <p>stable [1] 90/25</p> <p>staff [44] 3/16 5/8 5/11 5/11 6/22 8/7 15/15 16/25 21/2 21/3 27/13 33/17 38/15 41/15 42/25 45/3 59/9 59/20 62/15 62/15 70/2 80/18 89/17 97/25 104/5 111/24</p>	<p>115/2 121/17 123/3 131/12 132/10 138/25 140/16 142/5 142/11 142/12 142/19 144/10 144/16 144/19 144/19 148/23 149/1 168/16</p> <p>staff's [2] 3/20 119/8</p> <p>staffed [2] 82/1 138/22</p> <p>staffing [7] 59/15 139/2 139/5 139/6 139/10 139/11 141/6</p> <p>stage [14] 40/24 79/21 80/8 82/23 84/16 90/21 96/15 96/25 97/10 97/11 109/11 133/21 146/16 146/17</p> <p>stand [1] 4/4</p> <p>standard [7] 57/25 58/10 58/11 59/1 73/5 112/20 116/25</p> <p>standing [1] 128/10</p> <p>start [16] 8/8 8/17 33/18 33/19 38/20 50/14 50/16 50/21 51/14 53/2 63/10 104/6 104/7 128/6 163/2 170/24</p> <p>started [10] 70/13 71/25 74/18 76/22 78/6 99/19 104/18 110/4 129/1 166/25</p> <p>starting [8] 28/24 29/14 63/10 70/16 71/15 73/18 74/4 75/1</p> <p>state [1] 129/16</p> <p>stated [1] 127/9</p> <p>statement [63] 1/15 3/7 9/14 10/14 11/14 19/3 24/8 24/11 33/14 37/18 41/9 48/9 49/12 50/1 51/10 51/11 57/5 57/10 61/7 63/22 70/14 74/7 75/11 77/15 79/4 79/6 79/18 80/16 82/19 84/24 85/18 86/21 92/16 94/13 94/16 97/17 101/11 102/19 102/20 104/15 104/23 111/21 121/22 121/23 121/23 121/24 122/9 127/19 130/10 130/19 130/23 130/24 132/16 134/2 134/5 134/12 134/19 137/15 138/21 145/23 150/9 153/24 166/4</p> <p>statements [3] 10/19 99/10 104/12</p> <p>stay [3] 37/23 97/22 98/21</p> <p>staying [1] 88/10</p> <p>steadfastly [1] 121/1</p>	<p>step [2] 13/24 14/4</p> <p>Stepping [1] 73/11</p> <p>steps [1] 80/22</p> <p>still [7] 37/24 91/3 93/13 129/11 138/18 145/6 148/11</p> <p>stood [1] 115/22</p> <p>stop [2] 105/20 128/6</p> <p>stopped [1] 49/16</p> <p>strange [1] 17/19</p> <p>stress [1] 37/5</p> <p>stressful [1] 86/4</p> <p>stretch [1] 85/23</p> <p>stretched [1] 140/1</p> <p>structure [1] 117/3</p> <p>stuck [2] 77/8 115/22</p> <p>student [2] 132/20 133/21</p> <p>stuff [3] 117/21 134/16 165/16</p> <p>style [1] 2/3</p> <p>subject [1] 97/3</p> <p>subjective [3] 79/11 79/16 94/17</p> <p>subsequent [2] 53/25 90/24</p> <p>subsequently [6] 10/23 91/2 124/25 126/14 147/6 158/2</p> <p>such [9] 15/21 23/13 24/12 26/24 27/5 33/4 66/24 124/7 151/14</p> <p>sudden [5] 26/10 134/21 135/7 135/10 167/23</p> <p>suddenly [3] 36/12 125/7 126/24</p> <p>SUDic [2] 135/16 167/23</p> <p>suffered [1] 105/8</p> <p>sufficient [6] 134/23 135/8 135/15 139/10 141/7 141/20</p> <p>sufficiently [3] 77/7 100/23 142/4</p> <p>suggest [2] 50/15 61/14</p> <p>suggested [4] 37/21 89/24 90/2 114/5</p> <p>suggesting [2] 87/9 87/22</p> <p>suggestion [4] 38/17 71/2 87/19 88/7</p> <p>suite [1] 55/4</p> <p>summarise [1] 38/21</p> <p>summary [7] 57/20 78/2 90/14 94/6 94/11 94/15 116/22</p> <p>summertime [1] 145/21</p> <p>super [1] 111/18</p> <p>supervise [1] 106/5</p> <p>supervision [5] 53/7 55/24 68/8 68/13</p>	<p>68/17</p> <p>supervisor [14] 53/2 53/12 67/9 68/2 68/9 72/12 106/2 106/7 111/7 146/9 162/17 162/19 163/3 163/11</p> <p>supplement [1] 143/21</p> <p>supply [2] 24/14 141/14</p> <p>support [8] 5/21 6/13 11/23 11/24 64/14 64/19 76/16 169/2</p> <p>supported [3] 82/2 82/2 168/22</p> <p>supportive [10] 3/15 3/17 63/23 64/3 65/9 67/3 114/24 115/5 150/2 168/25</p> <p>suppose [1] 64/4</p> <p>supposed [1] 155/15</p> <p>sure [39] 13/8 17/23 18/20 19/23 20/6 20/11 27/21 31/4 35/25 39/25 41/12 64/19 71/24 80/4 100/4 100/10 103/19 105/16 107/15 109/6 109/21 110/16 116/8 117/3 118/3 118/18 118/24 120/2 126/17 132/17 137/12 138/12 138/15 139/7 141/4 141/10 144/14 159/18 162/16</p> <p>surgical [2] 85/3 93/4</p> <p>surprise [3] 10/20 81/10 158/9</p> <p>surprised [6] 9/19 10/1 23/10 81/8 166/12 166/23</p> <p>surprising [4] 66/19 85/8 90/23 91/3</p> <p>surprisingly [1] 66/18</p> <p>surrounding [1] 42/25</p> <p>suspect [4] 15/11 80/4 81/5 82/25</p> <p>suspicious [5] 81/20 131/12 132/11 139/24 159/5</p> <p>suspicious [2] 81/19 142/5</p> <p>suspicious' [1] 79/10</p> <p>swelling [1] 123/10</p> <p>switch [1] 145/2</p> <p>sworn [1] 99/25</p> <p>syringe [2] 137/24 138/11</p> <p>syringes [3] 137/23 137/24 169/17</p> <p>system [3] 63/11 143/18 153/5</p>

S	158/22 166/4 166/23 167/10 168/20	84/11 86/19 86/21 87/10 88/14 90/4 91/4 91/18 92/10 92/20 92/21 92/23 93/2 93/4 94/6 94/10 94/14 95/21 95/21 96/18 98/7 98/20 99/2 107/4 114/8 114/18 116/25 133/5 135/23 141/11 146/11 148/6 154/7 158/7	107/9 109/17 114/7 117/21 117/23 120/2 122/4 123/21 126/12 127/19 134/13 140/2 142/22 144/11 144/13 144/17 146/8 146/22 148/4 149/5 152/8 152/25 153/2 153/20 157/4 162/17	152/17 152/19 153/3 157/3 161/17 163/4 164/2 164/22 166/11 166/15 166/20 166/25 167/2 169/3
systemic [1] 67/25 systems [2] 143/6 143/10	telling [2] 16/23 118/7 tells [2] 49/10 157/11 tend [2] 12/13 12/13 tended [3] 23/5 39/19 81/13 tends [1] 12/11 tense [1] 167/8 tension [1] 113/13 term [1] 132/21 termed [1] 146/19 terms [40] 22/17 30/11 31/23 56/2 59/4 59/9 60/8 61/3 61/11 64/2 65/15 66/5 67/24 69/7 70/7 70/12 71/1 71/11 72/16 73/23 78/3 78/25 82/3 83/3 91/3 98/16 98/17 114/1 114/5 115/1 118/11 118/11 120/10 127/22 134/3 135/19 137/22 142/7 142/19 143/14 tertiary [3] 57/8 70/21 85/2 test [2] 25/10 80/24 tests [1] 93/20 text [1] 131/20 than [33] 9/20 19/19 22/12 34/10 37/3 37/16 37/19 47/22 50/17 53/19 56/8 57/8 58/13 65/4 65/19 74/6 79/11 79/17 80/12 87/5 95/4 106/21 112/21 127/12 130/12 133/25 136/6 136/9 151/12 154/8 159/20 161/20 169/2 than M [1] 161/20 thank [34] 1/9 17/11 47/6 47/8 47/11 49/24 50/6 50/9 50/11 70/11 85/16 92/12 99/4 99/7 99/11 99/13 101/9 107/14 111/20 119/2 119/4 130/18 137/5 144/2 144/4 144/24 145/2 145/3 145/4 170/9 170/11 170/14 170/18 170/19 that [1017] that's [60] 6/1 6/14 16/22 16/22 17/11 19/16 20/4 23/21 24/10 25/3 28/19 32/19 42/24 44/20 44/21 51/24 52/15 52/21 53/7 54/22 55/25 56/15 60/2 74/20 79/19 81/10	their [39] 4/25 8/3 8/9 10/20 24/15 29/11 29/14 33/18 38/20 43/12 46/11 46/19 60/6 62/20 62/22 69/5 69/19 83/4 97/22 98/9 98/19 102/13 104/1 104/6 104/12 111/3 111/10 112/7 123/5 129/12 133/11 136/20 140/14 141/18 143/12 148/18 158/3 169/13 170/4 them [73] 4/13 5/2 6/5 6/21 11/2 14/18 20/1 21/23 21/24 22/1 22/3 22/3 28/13 28/14 29/23 30/8 30/9 30/10 33/8 35/16 35/17 39/9 39/13 39/17 39/18 39/19 40/8 40/9 40/9 43/24 45/22 46/20 46/24 47/2 49/5 55/1 58/16 62/24 67/2 68/6 69/19 69/24 95/13 97/6 112/4 114/6 114/6 114/14 115/9 115/11 117/15 118/3 118/14 118/14 125/9 128/14 128/14 130/16 131/1 131/2 131/6 132/7 132/17 137/5 141/11 142/19 151/13 152/22 156/2 165/21 166/12 169/6 169/6 themes [4] 155/24 157/3 168/18 170/1 themselves [3] 32/5 80/11 128/13 then [74] 2/4 2/14 4/20 8/11 13/1 13/2 13/13 17/21 22/14 26/19 27/4 27/7 42/3 44/3 48/6 49/16 49/17 49/21 51/25 53/5 53/9 56/17 58/15 60/24 61/5 61/19 75/9 75/10 77/2 78/2 78/3 81/22 82/11 85/6 86/5 86/8 86/10 87/12 87/13 92/23 92/25 93/11 93/12 93/17 94/1 95/18 96/19 97/16	there [277] there's [3] 36/12 40/12 98/8 therefore [2] 155/19 166/8 these [30] 23/3 28/1 29/13 33/8 34/2 39/4 39/8 43/22 45/3 70/24 71/12 72/4 72/13 87/4 87/7 87/11 87/23 88/21 93/20 94/20 94/23 94/25 95/21 125/9 128/5 155/19 164/2 166/13 167/25 168/16 they [137] 3/1 3/25 5/20 6/20 8/8 9/10 11/12 15/19 17/7 17/7 17/8 20/10 20/11 24/15 25/20 27/19 27/20 28/8 28/11 28/14 28/19 28/24 29/16 30/4 30/19 31/7 31/11 33/18 36/8 38/23 39/1 41/14 41/17 41/17 43/1 43/1 44/18 45/21 46/22 46/25 52/9 56/6 56/20 56/21 58/10 65/24 67/2 67/16 68/24 69/14 69/17 69/22 69/24 72/16 72/17 77/17 82/4 83/23 89/3 91/3 91/4 95/10 95/11 95/13 95/14 95/25 98/9 104/5 104/18 107/3 107/4 107/6 107/8 107/25 110/23 111/16 112/11 112/13 112/23 114/5 114/13 115/8 116/23 116/24 116/24 120/22 120/25 121/15 124/12 124/14 124/16 126/22 128/12 128/13 129/14 130/12 130/15 130/22 131/2 131/2 131/6 131/9 133/9 133/12 133/12 135/21 136/21 136/22 137/1 140/11 140/12 141/23 141/24 142/9 142/10 143/11 143/25 148/6 148/11 148/21 148/23 152/1 152/17	they'd [1] 167/1 thing [12] 6/12 14/12 27/24 28/18 37/4 101/1 112/15 128/5 129/2 138/20 141/12 141/16 things [36] 9/2 25/19 41/10 45/19 49/2 58/6 81/11 109/24 110/24 111/2 114/1 114/3 115/3 115/21 115/22 116/3 116/10 116/21 119/25 120/18 128/21 132/7 136/2 136/6 137/14 140/3 141/12 142/2 142/18 142/20 142/21 142/21 143/14 144/9 144/12 157/10 think [227] thinking [14] 15/12 28/17 28/22 28/22 29/6 29/8 29/12 60/10 67/24 110/17 110/19 110/20 159/25 166/20 third [2] 53/9 54/1 THIRLWALL [2] 144/1 172/8 this [137] 7/12 9/7 11/18 12/7 13/3 14/12 14/19 15/12 15/23 16/23 17/15 17/23 17/23 17/24 18/3 19/7 19/19 20/18 21/4 21/10 22/14 24/19 25/1 26/21 26/24 27/12 29/9 29/17 31/3 31/3 31/17 33/23 33/25 36/8 36/17 37/1 37/3 38/15 39/4 41/22 43/10 45/17 47/13 47/13 47/21 49/6 53/9 59/5 60/23 65/24 66/13 67/12 70/14 70/19 73/4 74/25 75/12 75/14 76/7 76/12 77/7 80/1 80/8 83/7 83/15 84/2 85/17 85/22 86/19 86/20 88/18 90/6 90/9 90/21 91/13 92/7 92/14 92/16 92/22 93/13 94/14 94/24 95/2 96/3 97/10 98/11 98/11 99/3 103/8 103/14 103/16 103/17 103/21 107/20 107/22 109/3 109/3 112/1 113/2 114/7 114/9 116/6 116/13 116/13 120/16

T	85/9 85/13 101/17 110/8 116/4 116/8 143/25 157/21 170/16	101/17 146/13 162/1 169/6 170/21	transcriber [1] 118/19	148/18 158/16	
this... [32] 123/14 124/3 126/4 128/1 129/14 130/6 131/8 132/4 132/24 133/17 138/2 138/22 140/2 142/21 144/4 144/12 144/25 145/6 146/4 146/18 146/19 147/14 147/20 147/22 147/22 148/13 152/16 154/14 164/15 165/24 166/7 166/25	throughout [2] 48/14 154/20	together [6] 25/3 26/4 27/1 29/17 44/17 74/4	transfer [2] 70/21 79/1	two months [1] 71/5 Two years [1] 52/17	
Thomas [1] 51/8	throw [1] 118/14	told [19] 9/20 78/5 108/22 116/16 124/8 124/15 126/10 126/17 126/20 126/21 126/23 128/12 132/19 148/5 158/4 161/17 162/15 165/14 165/18	transferred [2] 58/15 93/24	type [1] 119/23 typical [9] 40/21 55/11 58/2 59/16 61/25 64/4 65/4 70/9 97/2	
those [81] 4/7 4/14 6/24 11/12 17/3 20/8 22/23 22/25 24/5 26/14 30/15 44/14 44/22 45/1 45/19 47/1 57/21 59/18 59/23 60/19 61/10 62/9 62/19 63/6 64/5 64/15 64/18 64/19 64/23 65/8 65/8 66/1 66/10 66/16 67/17 68/10 68/13 69/18 71/6 71/19 73/3 73/8 74/9 74/9 76/10 78/12 78/14 80/6 80/7 86/16 87/24 89/1 89/6 89/13 89/25 90/21 91/9 93/25 96/7 97/19 101/24 103/10 109/23 114/21 120/3 129/16 137/19 138/7 139/1 142/22 143/11 143/19 147/15 156/23 161/19 163/22 164/7 166/22 168/12 169/16 170/9	thumbprint [1] 143/12	tomorrow [3] 19/15 170/22 170/24	translated [1] 157/21	Typically [1] 55/11	
though [6] 6/12 106/8 110/17 133/17 159/11 163/25	Thursday [1] 171/2	too [8] 65/24 81/15 86/11 88/18 107/24 131/10 149/7 155/4	translates [1] 78/16	U	
thought [24] 3/13 4/11 29/15 43/6 43/7 58/2 59/15 107/8 116/7 116/12 119/25 128/5 129/14 133/2 144/4 154/25 155/6 159/20 164/17 164/21 166/14 168/13 169/10 170/16	thus [1] 143/21	too' [1] 87/7	trauma [1] 122/2	Ukoh [2] 153/21 154/10	
thoughts [1] 124/4	time [135] 1/22 2/21 7/6 7/19 8/12 9/4 10/15 13/12 14/7 14/8 14/16 15/13 16/20 17/5 21/7 29/1 29/20 33/3 38/18 38/21 39/2 39/25 39/25 40/9 42/14 42/22 45/4 46/22 48/3 48/4 48/11 53/9 53/10 53/10 55/7 55/7 55/8 55/11 55/12 55/20 56/16 56/17 56/25 58/7 59/23 60/6 60/23 61/12 62/3 65/23 69/20 71/12 72/18 72/23 73/13 73/19 75/10 76/7 76/21 78/6 79/13 79/19 81/7 87/15 88/18 89/9 91/20 98/9 98/18 99/19 103/7 103/9 104/22 104/25 108/2 109/25 112/1 112/25 114/3 115/10 116/18 116/25 119/21 120/15 122/20 123/21 124/20 125/23 126/9 128/3 128/11 128/14 129/25 130/22 131/7 131/11 132/5 132/25 133/24 134/1 134/7 134/10 135/5 136/22 138/21 139/1 140/18 141/19 141/21 144/4 145/6 147/4 147/13 147/15 148/14 151/24 152/10 154/17 154/23 155/10 157/6 157/24 159/4 159/22 163/9 163/12 164/16 165/20 165/24 166/10 167/8 167/17 168/2 168/7 169/1	today [10] 1/23 34/12 50/16 59/4 99/11	took [8] 9/1 35/13 56/20 104/20 117/15 136/15 136/23 136/24	traumatic [2] 23/9 168/17	ultrasound [1] 80/24
three [8] 22/8 22/13 30/15 52/24 53/15 53/21 86/2 170/21	time' [1] 70/18	top [3] 90/8 92/21 138/11	triggers [1] 168/4	unable [2] 124/10 142/3	
threshold [1] 96/12	timeline [2] 31/5 127/18	topic [5] 18/6 34/9 70/1 74/5 120/5	triplet [1] 159/2	unacceptable [1] 116/6	
throat [2] 122/3 123/21	times [13] 5/9 7/22 17/5 21/25 40/6 53/22 58/12 62/2 64/21 108/17 120/14 150/15 150/22	topics [1] 156/18	triplets [8] 105/9 128/5 128/11 129/14 133/1 133/3 158/16 166/19	unclear [1] 21/12	
through [24] 26/18 26/23 27/7 27/17 27/21 28/12 29/18 29/19 32/6 32/6 51/15 54/8 65/6 70/4 80/5	timetabled [1] 50/17	touch [2] 37/23 38/5	triplets' [1] 130/8	uncomfortable [3] 37/2 126/2 126/4	
		towards [15] 2/1 5/11 27/14 33/13 33/20 35/6 35/6 36/15 62/15 85/19 97/11 104/7 115/5 132/9 142/9	trouble [2] 108/9 108/11	uncommon [3] 6/2 7/5 102/8	
		tracking [2] 118/4 118/6	true [6] 1/19 17/20 51/11 101/12 101/15 146/1	under [8] 8/24 17/6 53/6 55/23 71/5 72/9 76/7 117/12	
		traditionally [2] 105/2 120/23	trust [2] 52/14 170/7	undergoing [1] 62/22	
		trained [3] 26/18 156/14 170/6	trusted [8] 35/10 35/12 35/13 35/14 36/17 36/23 46/12 164/19	underlying [1] 84/14	
		trainee [5] 46/23 66/24 81/25 113/4 136/20	truth [1] 133/24	understand [13] 12/20 30/3 43/4 68/1 81/5 81/11 83/9 91/10 107/4 116/17 144/22 163/18 168/2	
		trainees [9] 63/2 71/24 74/4 82/4 102/9 113/19 114/21 148/1 148/4	try [9] 22/3 40/15 75/21 85/9 101/2 112/14 114/8 115/2 168/17	understandably [1] 86/4	
		training [49] 2/2 2/3 2/6 3/6 4/24 20/12 20/15 23/25 29/1 29/4 32/9 32/13 32/14 32/15 32/16 40/24 51/21 52/1 52/1 52/24 52/25 53/2 54/19 54/20 62/20 62/23 63/20 70/3 96/20 96/21 96/24 96/25 97/7 100/11 109/22 110/5 110/8 134/21 134/25 135/2 135/6 135/25 142/15 144/7 146/19 154/21 156/6 170/3 170/3	Trusts [2] 117/1 155/18	understanding [15] 56/10 70/19 85/11 86/24 94/3 97/1 97/1 107/15 112/2 154/3 154/19 155/14 163/5 167/22 169/24	
			turn [8] 42/4 52/22 70/1 79/3 86/5 92/12 168/20 169/1	understood [11] 17/2 44/25 47/12 66/17 79/2 105/1 105/3 105/22 109/8 109/11 144/15	
			turning [6] 59/19 61/5 70/12 75/9 82/11 97/16	undertake [2] 54/25 64/11	
			twice [2] 56/21 61/18	undertaken [3] 25/19 45/25 96/24	
			twin [1] 153/12	undertaking [1] 30/4	
			two [19] 6/3 15/17 20/25 27/5 52/17 54/15 59/2 60/20 61/15 71/5 74/24 116/20 129/11 129/12 139/13 139/13 146/14	undertook [1] 52/24	
				undoubtedly [1] 138/23	
				unease [3] 104/11 104/22 105/14	
				unexpected [36] 8/2 10/21 10/24 11/3 25/25 26/1 26/9 29/23 29/25 30/6 31/22 38/22 38/25 49/5 49/10 70/20 77/17 77/22 78/8 80/1 80/21	

<p>U</p> <p>unexpected... [15] 90/25 94/18 95/4 95/19 95/22 103/25 105/15 158/12 161/12 161/23 162/5 166/11 166/15 168/3 168/3</p> <p>unexpectedly [8] 8/6 33/16 82/24 94/22 104/3 109/14 125/7 135/18</p> <p>unexplained [12] 25/25 30/6 83/14 85/8 95/3 95/19 95/22 155/6 159/14 161/13 163/7 167/23</p> <p>unfortunately [1] 40/1</p> <p>unheard [1] 77/11</p> <p>unified [1] 44/15</p> <p>uniformly [1] 45/4</p> <p>unique [1] 6/15</p> <p>unit [104] 3/2 3/3 3/9 3/22 3/22 3/24 5/17 6/21 6/24 8/18 8/20 11/22 13/16 20/21 25/3 27/18 29/19 31/10 34/2 34/5 34/6 34/13 38/9 39/21 40/1 42/16 42/22 43/12 43/15 43/23 52/8 55/3 55/9 55/16 56/2 56/4 56/18 56/20 57/6 57/9 57/17 58/6 58/15 58/20 59/21 60/4 61/11 61/13 61/22 61/25 62/4 62/8 65/5 65/23 66/2 67/25 68/20 69/17 69/23 70/17 74/15 92/3 94/19 95/16 103/7 109/5 111/6 113/7 113/8 122/13 122/14 122/18 122/19 122/22 122/25 123/25 127/24 128/8 128/21 131/16 131/24 138/7 140/13 140/19 140/20 147/12 148/20 148/24 149/7 152/5 152/9 152/19 152/23 158/7 159/3 160/5 161/6 161/10 161/13 162/11 162/14 163/23 166/6 167/13</p> <p>units [15] 2/19 3/5 4/4 35/1 70/22 97/21 114/21 139/8 139/16 140/7 143/7 143/9 148/19 165/2 169/7</p> <p>units should [1] 97/21</p> <p>University [3] 51/16 51/22 100/20</p>	<p>unlikely [1] 131/7</p> <p>unpack [1] 105/12</p> <p>unremarkable [3] 59/22 60/14 70/6</p> <p>unstable [1] 84/13</p> <p>unsure [4] 73/18 76/12 103/8 147/13</p> <p>unthinkable [8] 28/19 28/22 28/25 29/7 29/9 38/13 110/19 159/7</p> <p>until [8] 2/17 9/4 43/1 46/20 93/17 123/5 145/9 171/1</p> <p>untoward [3] 140/4 142/19 144/10</p> <p>unusual [52] 7/6 8/4 11/9 12/3 13/3 14/24 18/22 19/2 21/18 21/21 23/6 26/21 26/23 26/24 26/24 29/23 30/1 35/24 37/2 38/25 39/11 48/17 49/5 59/17 60/15 61/2 61/3 65/25 66/14 76/4 76/11 76/13 76/14 76/16 77/8 82/20 83/7 83/15 84/7 84/18 85/4 103/7 103/9 103/15 104/2 105/18 116/7 116/12 127/16 147/13 147/14 147/21</p> <p>unusualness [1] 14/6</p> <p>unwell [12] 9/10 21/18 40/6 56/6 58/13 58/18 58/24 59/7 63/25 84/19 94/4 123/18</p> <p>up [34] 25/15 85/16 87/7 93/15 93/20 94/13 98/16 107/4 107/13 107/21 109/7 113/18 115/3 116/3 118/3 120/3 121/3 121/6 128/23 134/19 136/2 136/6 136/10 140/3 140/14 141/10 142/18 144/8 149/2 155/20 155/24 157/4 168/17 170/1</p> <p>updated [2] 21/5 21/9</p> <p>updates [1] 21/3</p> <p>upon [5] 5/13 46/16 66/12 98/3 128/8</p> <p>upset [4] 46/12 130/4 158/9 158/14</p> <p>upsetting [2] 10/16 164/2</p> <p>upstairs [1] 153/15</p> <p>urgent [1] 11/21</p> <p>us [51] 1/10 1/18 1/23 2/6 5/23 7/18 8/15 11/9 11/17 15/6 16/11 16/21 18/9</p>	<p>26/14 27/10 29/21 35/17 50/13 63/15 78/5 100/8 101/7 101/11 111/7 115/17 120/5 120/9 122/5 125/15 125/16 127/21 133/13 134/2 144/22 144/25 145/2 145/17 145/23 146/16 153/13 155/18 157/5 157/11 158/10 158/22 161/17 165/21 166/4 167/10 168/20 169/3</p> <p>use [5] 68/8 76/17 95/19 144/22 167/24</p> <p>used [14] 41/25 42/7 42/19 42/20 44/3 60/13 77/11 87/4 89/10 123/4 132/21 137/23 139/15 167/25</p> <p>useful [6] 32/21 41/18 89/19 155/20 156/22 170/17</p> <p>using [2] 84/17 153/16</p> <p>usual [4] 52/2 61/24 62/21 81/7</p> <p>usually [7] 47/24 47/25 52/11 55/18 55/19 62/5 108/24</p> <p>UVC [1] 114/4</p> <hr/> <p>V</p> <p>vacuum [1] 101/6</p> <p>vague [2] 91/15 91/18</p> <p>variety [1] 113/25</p> <p>various [3] 10/18 41/8 168/4</p> <p>venous [1] 114/4</p> <p>ventilated [1] 123/5</p> <p>ventilator [2] 13/8 13/11</p> <p>verbal [1] 117/6</p> <p>versa [1] 164/14</p> <p>very [105] 3/11 3/12 3/15 3/15 3/17 5/1 6/13 7/2 7/20 8/20 8/24 9/3 9/11 10/16 11/7 11/11 11/21 12/3 12/6 13/5 14/3 16/18 17/5 17/6 17/17 18/21 18/21 21/18 23/8 23/13 26/17 27/24 30/21 30/22 30/24 31/15 33/14 36/2 36/6 36/25 37/2 37/5 37/18 40/4 41/17 41/22 42/1 42/17 43/7 43/16 44/24 46/25 48/15 48/18 50/6 50/11 53/23 54/3 56/13 57/22 59/15 60/22 65/15 68/25 70/9</p>	<p>74/15 76/9 77/8 84/19 85/24 86/3 90/23 93/23 93/23 98/3 98/20 99/4 99/7 108/17 108/20 110/1 111/20 114/17 114/24 116/7 116/12 116/16 119/2 127/4 131/7 138/22 140/11 144/2 144/24 148/1 150/2 150/13 154/21 167/3 168/25 170/5 170/11 170/17 170/18 170/23</p> <p>via [5] 37/13 100/6 131/4 133/14 150/16</p> <p>vice [1] 164/14</p> <p>vice versa [1] 164/14</p> <p>vicinity [1] 148/12</p> <p>videolink [2] 99/15 100/6</p> <p>view [8] 25/11 25/13 46/17 94/5 124/8 139/25 143/23 165/12</p> <p>views [3] 3/20 88/21 88/22</p> <p>vigilant [1] 143/2</p> <p>virus [2] 26/24 36/12</p> <p>visible [2] 69/22 69/25</p> <p>vocal [1] 123/11</p> <p>voice [3] 100/2 107/13 136/2</p> <p>voices [1] 115/9</p> <hr/> <p>W</p> <p>wait [3] 40/9 130/12 139/23</p> <p>walked [1] 158/18</p> <p>walking [4] 27/17 29/18 29/19 108/2</p> <p>want [13] 5/15 18/13 26/15 33/23 35/8 50/7 70/5 98/3 102/21 105/12 116/1 116/2 165/5</p> <p>wanted [9] 6/11 40/4 68/10 97/19 114/21 124/1 144/5 144/14 153/3</p> <p>ward [32] 4/1 4/7 4/18 4/21 4/22 8/21 21/16 34/25 55/1 55/4 55/17 56/17 57/13 60/5 61/18 85/1 98/22 122/23 132/19 132/23 132/24 133/7 133/16 151/23 152/8 152/11 152/12 152/15 152/22 153/15 154/10 165/1</p> <p>wards [6] 2/19 3/5 41/6 55/8 151/24 164/1</p> <p>warning [1] 156/10</p> <p>warrants [1] 68/24</p>	<p>was [683]</p> <p>was April 2016 [1] 47/13</p> <p>was certainly [1] 94/8</p> <p>wasn't [58] 6/12 6/15 7/6 7/6 12/23 12/23 12/24 17/20 20/5 20/9 20/9 20/21 21/14 23/10 23/11 24/4 27/22 34/5 44/22 45/25 46/18 46/22 48/3 48/10 50/4 59/8 60/7 62/11 63/14 63/16 69/24 75/16 75/17 78/9 78/17 87/24 90/2 104/13 104/21 105/3 120/20 120/24 122/13 122/18 126/4 126/6 132/5 132/8 138/13 141/7 141/13 141/20 147/7 151/6 151/12 158/7 160/7 166/10</p> <p>waste [3] 117/22 117/24 119/1</p> <p>way [38] 6/9 7/22 8/24 12/4 25/10 34/14 35/4 38/8 40/15 41/1 41/20 41/25 42/20 43/25 44/3 44/8 44/15 44/18 57/22 58/1 58/2 58/6 58/16 65/15 70/3 79/15 91/4 114/9 117/19 118/2 118/4 135/8 135/22 136/4 138/16 138/25 161/7 170/15</p> <p>ways [5] 50/18 64/4 65/3 113/25 137/13</p> <p>we [189]</p> <p>we've [1] 166/24</p> <p>wear [1] 41/16</p> <p>wearing [1] 42/3</p> <p>Wednesday [1] 1/1</p> <p>week [7] 21/5 56/22 64/25 65/3 65/5 65/17 152/21</p> <p>weekend [2] 56/22 152/17</p> <p>weekly [1] 56/21</p> <p>weeks [3] 16/13 103/11 147/16</p> <p>weird [1] 37/3</p> <p>welcome [2] 7/8 100/1</p> <p>welfare [1] 3/21</p> <p>well [50] 3/6 3/17 3/23 3/24 11/25 18/13 18/24 19/4 20/17 27/10 34/5 37/7 39/17 44/5 45/20 54/6 54/21 55/4 59/14 81/4 82/1 82/2 83/17 83/17</p>
---	---	--	---	--

W	140/8 144/6 147/4 147/14 148/3 148/5 148/16 149/1 149/9 149/22 154/19 155/25 156/23 157/13 158/1 158/4 158/16 158/24 159/3 160/21 162/21 162/23 162/25 163/16 164/21 164/23 164/24 165/1 166/5 166/13 167/14 169/9	103/11 122/24 123/8 147/17 153/21 who [111] 9/9 9/11 9/11 9/21 13/10 16/24 21/20 24/14 25/18 30/9 32/22 32/23 33/3 33/6 33/9 33/25 34/4 35/3 37/13 37/24 38/1 39/9 42/9 42/10 43/11 43/18 48/22 56/6 56/13 57/14 58/13 58/14 58/17 59/4 62/19 63/14 63/17 66/16 69/14 72/3 73/11 74/4 81/20 82/8 85/18 86/23 87/20 87/23 88/25 89/1 89/18 89/19 93/5 95/15 99/24 100/2 101/24 102/3 102/6 110/2 114/21 114/24 117/9 119/6 119/14 121/11 122/21 123/16 124/1 124/1 124/1 124/3 124/20 125/6 125/23 126/17 126/20 127/24 128/11 129/18 129/21 129/25 130/22 132/5 132/6 132/8 132/18 132/19 133/8 135/12 136/19 136/20 136/21 137/19 139/1 139/1 139/21 139/22 140/12 140/17 143/11 143/24 148/8 148/14 151/21 152/1 152/2 152/24 162/15 162/16 164/19	103/3 105/10 125/8 130/9 139/8 140/13 145/6 145/8 148/7 170/23 170/24 within [16] 8/22 11/7 29/4 32/14 34/7 34/8 74/25 96/8 103/11 106/19 140/20 140/24 147/16 164/9 167/24 169/10 without [2] 91/17 109/15 witness [9] 51/10 79/6 85/18 94/16 97/17 99/15 99/23 115/11 145/14 witnessed [1] 153/8 witnesses [2] 10/18 50/16 witnessing [1] 115/14 women [1] 42/9 Women's [18] 52/3 54/16 55/23 56/1 56/5 57/4 57/8 57/14 71/21 82/13 87/1 87/6 102/11 146/9 148/16 148/20 149/12 162/17 won't [2] 76/20 147/9 wonder [1] 100/24 wondered [1] 15/20 wondering [3] 124/3 136/19 139/24 word [1] 144/22 words [1] 158/20 work [17] 26/18 28/7 35/3 41/12 53/17 54/25 113/24 114/21 115/6 117/18 120/20 121/4 121/6 148/7 149/1 159/8 159/9 worked [24] 2/16 4/4 5/17 23/24 38/4 58/4 59/12 62/1 68/2 70/3 70/8 98/15 102/5 102/15 102/16 114/17 115/10 117/20 131/25 132/3 132/18 146/4 148/14 149/11 working [43] 24/17 29/20 31/21 33/4 37/3 37/24 38/9 53/10 54/17 57/15 57/18 58/19 61/2 61/11 61/13 62/25 65/23 66/2 66/4 69/23 71/14 77/4 81/23 82/5 82/12 101/20 108/18 109/4 112/25 117/16 120/20 125/16 125/20 147/5 148/11 148/13 150/10 150/12 151/18 157/6 157/24 162/21 165/1 works [1] 1/25	worried [10] 5/3 12/2 19/7 19/8 22/9 43/9 126/1 136/7 137/1 167/3 worried and [1] 22/9 worries [1] 36/24 worry [7] 42/13 44/4 102/24 118/6 131/10 164/21 167/5 worrying [1] 166/25 would [262] wouldn't [16] 6/16 7/1 23/13 23/22 30/17 31/21 43/1 43/16 43/24 49/21 76/14 77/5 108/19 127/18 137/21 167/20 Wrexham [1] 59/13 write [6] 48/1 48/3 48/11 117/2 117/20 134/16 writing [4] 9/6 48/5 134/8 134/11 written [8] 10/7 48/8 104/14 116/18 129/21 132/15 134/12 141/19 wrong [8] 5/23 7/8 40/5 144/22 155/2 155/3 166/25 167/1 wrote [2] 48/3 138/21
	where [57] 4/5 4/17 4/24 7/17 13/25 14/1 17/18 20/2 21/10 25/21 36/14 38/20 42/9 42/12 53/18 54/16 58/12 58/14 59/11 61/15 63/16 63/25 65/24 66/7 68/4 68/5 70/20 75/11 77/5 77/10 78/7 79/12 81/14 83/2 84/13 86/10 86/14 89/4 91/9 94/4 94/8 96/4 96/16 107/21 117/22 118/14 121/6 123/12 127/6 131/1 131/9 137/25 141/23 142/12 155/19 161/22 163/4 whereas [2] 149/11 155/10 wherever [1] 111/19 whether [30] 9/1 9/22 13/2 15/3 15/10 25/22 25/25 26/5 30/25 45/24 65/12 66/6 73/19 73/20 88/2 96/5 109/12 131/11 132/14 136/21 138/19 140/5 141/17 142/17 150/4 154/13 155/1 161/24 162/16 169/16 which [55] 2/7 4/3 5/23 6/5 7/18 8/21 9/14 12/11 12/15 12/25 13/6 13/10 16/2 23/21 24/1 28/5 29/16 31/14 32/18 47/11 53/24 55/14 64/17 74/13 78/9 80/13 83/14 87/1 88/11 90/3 97/18 98/21 99/8 105/9 111/2 116/21 119/25 123/3 123/12 124/9 129/1 133/10 134/24 135/17 136/6 136/24 137/13 137/24 140/3 140/4 142/15 142/18 143/15 158/24 167/20 while [6] 75/16 92/12 103/2 120/25 134/16 141/8 whilst [7] 38/9 69/9	X	x-ray [2] 93/8 93/9 x-rays [1] 80/23	
			Y	
			year [6] 24/1 54/21 109/3 145/21 146/18 149/12 years [5] 52/17 54/14 54/18 54/20 129/13 years' [1] 54/11 yes [180] yesterday [3] 14/13 14/19 88/18 you [1124] you' [1] 86/9 you're [1] 167/16 you've [1] 161/3 your [185] yours [1] 106/2 yourself [7] 15/7 23/2 35/14 66/24 105/6 122/3 132/12 Yoxall [5] 55/24 72/9 146/10 162/16 162/21	
			Z	
			ZC [6] 86/21 132/18 133/20 133/23 136/12 160/9 zone [1] 136/17	