

Monday, 7 October 2024

1
 2 (10.00 am)
 3 **LADY JUSTICE THIRLWALL:** Yes, Mr De La Poer.
 4 **MR DE LA POER:** My Lady, our first witness today is
 5 subject to a Crown Court order. We will be referring to
 6 her as Dr ZA.
 7 **LADY JUSTICE THIRLWALL:** Very good.
 8 **MR DE LA POER:** May I ask her to come forward,
 9 please.
 10 **LADY JUSTICE THIRLWALL:** Yes, please, would you
 11 come forward and take the affirmation or the oath,
 12 whichever it is.
 13 **DR ZA (sworn)**
 14 **LADY JUSTICE THIRLWALL:** Thank you, doctor, please
 15 sit down.
 16 **Questions by MR DE LA POER**
 17 **MR DE LA POER:** Now, Dr ZA, can you confirm for us,
 18 please, that you've provided to the Inquiry a witness
 19 statement dated 23 May 2024.
 20 **A.** Yes.
 21 **Q.** And are the contents of that witness statement
 22 true to the best of your knowledge and belief?
 23 **A.** Yes.
 24 **Q.** We are going to deal necessarily very briefly
 25 with your background. You are a medical doctor; is that

1

1 paediatrics service. How did you find working with both
 2 of those two?
 3 **A.** I'd worked with both of them for a long time,
 4 since my training as a junior doctor, and I had
 5 a positive working relationship with both of them.
 6 I found them very approachable if I had any issues.
 7 **Q.** Now, you speak about the relationship in your
 8 witness statement between the Consultants and the
 9 departmental manager. Could you just help us with who
 10 you meant by departmental manager?
 11 **A.** So at the time I think it was Jackie Blundell
 12 and Jo Moore, they were our sort of department manager
 13 and assistant managers, so sort of the first tier of
 14 hospital management that we dealt with.
 15 **Q.** And was that a positive relationship?
 16 **A.** Yes, we had a good working relationship with
 17 them.
 18 **Q.** What was your view about the relationship
 19 between the Consultants and the junior doctors?
 20 **A.** We generally got on well with our junior
 21 doctors. We were a supportive department. We
 22 consistently got good feedback from the GMC trainee
 23 doctors survey, and the reputation of Chester within the
 24 deanery was one that junior doctors wanted to rotate to,
 25 and certainly that was my experience, having been

3

1 right?
 2 **A.** Yes.
 3 **Q.** And you are a member of the Royal College of
 4 paediatrics in child health?
 5 **A.** Yes.
 6 **Q.** And prior to 2015, you had been a Consultant
 7 at the Countess of Chester Hospital for some years?
 8 **A.** Yes.
 9 **Q.** In terms of your working pattern during the
 10 period we will be focusing on, you were working
 11 part-time; is that right?
 12 **A.** That's correct.
 13 **Q.** Working Mondays to Wednesdays and a share of
 14 out of hours?
 15 **A.** Yes.
 16 **Q.** And in terms of the practical consequences of
 17 that, does that mean that there were certain meetings
 18 throughout the period that we are going to be focused on
 19 which you didn't attend because you weren't at work?
 20 **A.** Yes.
 21 **Q.** I'm going to consider, please, the
 22 relationships between various parties at the Countess of
 23 Chester Hospital.
 24 Firstly, as we have heard, Dr Brearey was the
 25 neonatal lead and Dr Jayaram was the lead for the

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1 a junior doctor several times at Chester, was that it
 2 was a supportive department and that's why I wanted to
 3 go there for my Consultant job because of the positive
 4 experience I'd had.
 5 **Q.** Now, one particular junior doctor, although he
 6 wasn't very junior at the time --
 7 **A.** Yes.
 8 **Q.** -- that we'll be hearing from later today is
 9 Dr U.
 10 **A.** Yes.
 11 **Q.** And obviously Dr U is subject to a Crown Court
 12 order but you know who I mean by that?
 13 **A.** Yes, I do.
 14 **Q.** Dr U was at the final stages of his training
 15 and was at the Countess of Chester between
 16 September 2015 and 2016; okay? He would be described as
 17 a senior middle grade?
 18 **A.** Yes.
 19 **Q.** What was your relationship with Dr U?
 20 **A.** I had worked with him several times throughout
 21 both of our careers, always being slightly senior to
 22 him. He's someone who I felt a positive working
 23 relationship with. I wasn't friends outside of work
 24 with him but I think we had quite a friendly working
 25 relationship.

4

1 Q. We'll come back to Dr U in the course of my
2 questions.

3 Finally, in terms of the relationships on the ward
4 and in the department, what was the relationship, did
5 you think, between the Consultants and the nursing
6 staff?

7 A. I had always thought that the relationship
8 between the Consultants and the nursing staff was again
9 positive and friendly. It was only around 2016 when
10 concerns were being raised about Lucy Letby that that
11 relationship became strained.

12 Q. And we've heard from others that their
13 perception was the strain was because the Consultants
14 took one view of Letby but at least some of the nurses
15 took a different view --

16 A. Yes.

17 Q. -- was that your experience?

18 A. That was my experience.

19 Q. And in terms of the nurses who were taking
20 a different view, we know that the unit manager was
21 Eirian Powell.

22 A. Yes.

23 Q. Was she in that camp?

24 A. Yes.

25 Q. Were there any other senior nurses in that

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1 the trainee junior doctors were doing. So I would
2 disagree that they didn't feel able to challenge us.

3 Q. Turning now to relationships with the senior
4 management, and here I'm talking about those who sit as
5 Executive Directors.

6 What was your impression, before June of 2015,
7 about the senior managers' attitude towards your
8 department?

9 A. I didn't really have much of an impression of
10 the senior management. We didn't really hear from them
11 very much in our day-to-day running. We were very much
12 left to our own devices. If we did try and raise
13 issues, we never really heard anything back from them.

14 So I don't think there was much of a relationship.

15 Q. Now, one of the words that you use in your
16 witness statement about the period 2015 to 2016 was
17 "disinterested". Just can you help us to understand why
18 you used that word?

19 A. I think we were a department that generally
20 got on with things. There were problems that were
21 perceived as being bigger within the Trust, so things
22 with adult medicine and the emergency department, and it
23 felt that when we raised any issues that they just
24 weren't important to the -- the overall hospital because
25 we were a small department who were getting on with

7

1 camp, by which I mean those part of the management
2 structure?

3 A. I'm not sure exactly what position other
4 senior nurses had taken. They weren't very vocal about
5 what they thought in the way that Eirian was, and it
6 became something that we didn't talk about because it
7 caused strained relationships. So I don't know what
8 a lot of nurses' views were because we didn't talk about
9 it.

10 Q. Now -- and I've asked other Consultants about
11 this -- Eirian Powell has, in her witness statement,
12 said that the Consultants would think everyone worked
13 cohesively because everyone did exactly what they said
14 and didn't challenge them.

15 Do you have any comment to make about whether that
16 accords with your experience or not?

17 A. Obviously you only know what people say when
18 you're with them, not what they say when you're not
19 there, but I would disagree that the nurses didn't feel
20 able to challenge us. I think neonatal nurses have
21 al -- have always not been afraid to advocate for their
22 patients, and the nurses were quite about saying when
23 they felt that a management plan wasn't quite what they
24 would have liked. They also were quite happy to ring
25 the Consultants directly if they weren't happy with what

6

1 things.

2 Q. Now, what -- we know that paediatrics had
3 recently been moved into a -- the urgent care
4 directorate --

5 A. Yes.

6 Q. -- whereas obstetrics was in the Planned Care
7 directorate.

8 A. Yes.

9 Q. Do you have a view about whether that made any
10 difference to your department's connection to the senior
11 management of the hospital?

12 A. I think it did because when we were part of
13 a women and children's directorate, we were far less of
14 a small cog in a big machine, we also worked very
15 closely with the obstetricians, so had a lot of similar
16 issues, and once we joined urgent care, which included
17 the emergency department and adult medicine, it was
18 perceived that they had far bigger problems and issues.

19 So we were very much sidelined.

20 Q. I would just like to -- I'm going to jump
21 slightly ahead in --

22 A. Yes.

23 Q. -- our chronology but, while we're dealing
24 with this topic of the word "disinterest" that you used
25 draw your attention to three events around the end of

8

1 2015 into the beginning of 2016.

2 **A.** Yes.

3 **Q.** So this is in a sense in the middle of the
4 first part of our timeline.

5 Firstly, during that period, did you send an email
6 directly to Tony Chambers drawing attention to the
7 staffing and pressure on the paediatric department?

8 **A.** Yes.

9 **Q.** And have you also -- and you were on copy at
10 the time I believe -- seen an email sent at about the
11 same time by your colleague Dr Saladi?

12 **A.** Yes, I've seen that email recently and I also
13 recall receiving it at the time.

14 **Q.** And was that also saying something very
15 similar to what --

16 **A.** Yes, it was --

17 **Q.** -- you were saying?

18 **A.** -- and it rung very true with my own
19 experience of working in the department at that time.

20 **Q.** And if we just bring up a document now on the
21 same theme at about the same time, INQ0017868, please.
22 Now, this is a corporate directors meeting on
23 27 January 2016. You weren't in attendance.

24 **A.** No.

25 **Q.** But if we just look down the list, we can see

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1 that time?

2 **A.** Yes, it does.

3 **Q.** Obviously we're not just seeking here
4 specifically about the neonatal unit, this is the whole
5 paediatric --

6 **A.** This is the whole paediatric department.

7 **Q.** -- the whole paediatric department. Thank you
8 very much, that can come down.

9 Now, Dr ZA, do you have a view about how the
10 pressures that you and your colleagues were under during
11 this period may be relevant to the crimes that
12 Lucy Letby committed?

13 **A.** We were very busy. There weren't enough
14 Consultants for the workloads that we were doing. We
15 also didn't have enough junior doctors, and that meant
16 that we -- it was relatively common that the Consultants
17 would have to act down to cover vacant junior doctors'
18 shifts, which was important to assure the acute safety
19 at that particular time. But that did mean that there
20 was less time for the non-urgent clinical tasks because
21 everything was done to sort of a prioritise that acute
22 safety.

23 But it did mean partly that Lucy could hide what
24 she was doing within people being generally busy. It
25 also meant there was less time for the non-urgent acute

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1 about halfway down the Chair of the medical staffing
2 committee a Consultant Anaesthetist, Mr P Jameson, did
3 attend that meeting, and was Mr Jameson a person who you
4 knew or had any contact with?

5 **A.** Yes. He is -- was one of the Consultant
6 Anaesthetists who specialised in the care of children
7 and did several children's lists, so we had a relatively
8 close working relationship with him. He was also the
9 Chair of the medical staffing committee, which meant he
10 looked after the interests of the permanent medical
11 staff so we knew him in that regard as well.

12 **Q.** So 27 January 2016, about the time that you
13 were sending your email about the time Dr Saladi was
14 sending his email?

15 **A.** Yes.

16 **Q.** If we move forward to page 5, please, please,
17 three quarters of the way down the page, there is a line
18 ending "PJ", being a reference to Mr Jameson.

19 **A.** Yes.

20 **Q.** Do you see that?

21 **A.** Yes.

22 **Q.** "PJ felt the paediatric service was almost at
23 breaking point and needed support before it hits the
24 point of burn out."

25 Does that resonate with your experience at around

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1 things like reviewing the deaths afterwards and
2 reviewing other incidents because we were so busy just
3 trying to cover the acute service.

4 **Q.** Now, I'm going to move on to a topic where we
5 are going to deal with a number of policy matters --

6 **A.** Yes.

7 **Q.** -- before we come to our timeline. But the
8 first is safeguarding. Had you received any
9 safeguarding training on how you should act if you
10 suspected a colleague was harming babies?

11 **A.** No, I'd received a lot of safeguarding
12 training throughout my career about what to do if
13 parents or careers were harming babies but nothing about
14 what to do if other healthcare professionals were.

15 **Q.** Given your experience and looking back, do you
16 regard that as a significant gap in your training?

17 **A.** Yes.

18 **Q.** In terms of your general awareness of
19 circumstances in which colleagues might deliberately
20 harm patients, were you aware of the case of
21 Beverley Allitt?

22 **A.** I was.

23 **Q.** And so you knew that insulin could be used as
24 a deliberate way of harming patients?

25 **A.** I was.

12

1 Q. And were you aware of the nurse at Stepping
2 Hill who had also used insulin in 2011?

3 A. I think I was aware that there was a nurse at
4 Stepping Hill who had harmed patients but I don't think
5 I was aware that they had used insulin to do that.

6 Q. So it was within your knowledge that that kind
7 of terrible behaviour may occur?

8 A. Yes, it was.

9 Q. We'll come back to those two previous cases
10 shortly, but we'll stay with policy, please.

11 You tell us in your witness statement that you
12 consulted the Speak Up Safely policy during 2016 --

13 A. Yes.

14 Q. -- is that correct?

15 A. Yes.

16 Q. Just tell us, why did you consult that policy?

17 A. We felt that we weren't being listened to when
18 we were raising concerns about Lucy Letby, but we'd
19 already had behaviour that strongly implied that our
20 jobs were at risk if we continued to raise those
21 concerns, so we wanted to make sure that we were
22 exhausting the options for raising concerns within the
23 organisation before taking that to outside agencies such
24 as the police.

25 Q. Having conducted that research to check your
13

1 Inquiry in any detail. I know that the wording of the
2 SUDiC policy was very much that it did apply to deaths
3 in hospital, but that wasn't the practice and the
4 culture at the time. It was only really applied to
5 children that died in hospital having been found
6 collapsed outside the hospital and came in with
7 resuscitation ongoing. It wasn't our practice and
8 culture to use that with children that had died in
9 hospital.

10 Q. This might be quite a difficult thing for you
11 to put your finger on --

12 A. Yes.

13 Q. -- but where was that practice and culture
14 coming from? What was driving that?

15 A. I think it was something that hadn't -- that
16 it was felt that that was a very invasive process. The
17 SUDiC protocol involved getting the police involved,
18 getting social care involved, and I think the thinking
19 was that anyone who died in hospital must have had
20 a medical explanation rather than an unnatural
21 explanation because they were obviously ill enough to be
22 in hospital. So I think it was felt that that process
23 was very invasive and not necessary, which obviously we
24 now know is not the case.

25 Q. I would just like it bring up the hospital's
15

1 position, did you establish who it was, if any one
2 person or group of people, that you should be speaking
3 out safely to?

4 A. That it was the higher management within the
5 Trust, the Medical Director and the Chief Executive that
6 we should be bringing those concerns to.

7 Q. And across all the various meetings that you
8 attended, did you ever make reference to the Speak Out
9 Safely policy or the fact that you were speaking out in
10 accordance with it?

11 A. I don't think I ever did. I think that my
12 colleagues did, but I don't have a clear recollection
13 after this time.

14 Q. And so when you spoke to Executive Directors,
15 in particular those two that you've named, was it your
16 view that you were speaking to them in their capacity
17 under the Speak Out Safely policy?

18 A. Yes.

19 Q. The third policy I'd like to ask you about is
20 the SUDiC procedure.

21 A. Yes.

22 Q. Have you followed any of the Inquiry evidence
23 about SUDiC and whether or not it applied to the
24 hospital environment?

25 A. I haven't followed the evidence from the
14

1 own policy, if we can here --

2 A. Yes.

3 Q. -- and just draw your attention to one very
4 small part of it, INQ0003250, and we will go straight to
5 page 33, please.

6 So this is the Safeguarding and Promoting the
7 Welfare of Children internal Countess policy. Page 33.

8 We can see there:

9 "The sudden unexpected death unexpected in 24 hours
10 prior to death of a child under the age of 24 months,
11 irrespective of the place of death, at home or in the
12 community, in the hospital emergency department or
13 ward."

14 So do you agree, that appears to accord with your
15 understanding the wider documents?

16 A. Yes.

17 Q. But that policy specific for the Countess also
18 appears to be in direct tension with what you tell us
19 was the culture and practice in the hospital.

20 A. Yes.

21 Q. Does that surprise you that the hospital's own
22 policy appears to apply SUDiC across all unexpected
23 deaths?

24 A. It doesn't surprise me because I've read these
25 documents as part of preparation for coming today, but
16

1 it certainly wasn't my understanding at the time.

2 **Q.** Thank you, we can take that down. The final
3 area of policy to ask you about is the Datix system.

4 **A.** Yes.

5 **Q.** When did you understand, in 2015/16, it was
6 appropriate to fill in a Datix form?

7 **A.** So a Datix form should be filled in for any
8 clinical incident, which is whenever something happens
9 that either went wrong or could have gone wrong as sort
10 of a near miss.

11 There was a sort of pick list of incidents
12 available on the system which kind of flagged up common
13 things that could be reported like a drug administration
14 error. It was common to report all deaths on the Datix
15 system but any clinical errors or clinical near misses
16 should have been reported using that system.

17 **Q.** So applying to all events, if there was
18 a concern about a clinical issue, that would prompt
19 a Datix form?

20 **A.** Yes.

21 **Q.** But specific to deaths, even if there was no
22 concern about a clinical issue, you would still fill in
23 a Datix form?

24 **A.** Someone on the team would do.

25 **Q.** How about collapses that required

17

1 right?

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

3 **Q.** But did you have some awareness of the fact
4 that there had been three deaths on the neonatal unit in
5 short order?

6 **A.** Yes, I was.

7 **Q.** And were you aware that there was discussion
8 about a rash?

9 **A.** I can't recall whether or not I was involved
10 in that discussion at the time.

11 **Q.** Let me just see if I can assist your
12 recollection. INQ0025743.

13 Now, if we scroll to the next page, but we can
14 leave it on the large page view, my apologies for the
15 quality of the text, but you can see at the top it's
16 23 June 2015 --

17 **A.** Yes.

18 **Q.** -- email from Dr Gibbs. You're included --

19 **A.** Yes.

20 **Q.** -- in the circulation.

21 **A.** Yes.

22 **Q.** And he's there talking about Children A, B, C
23 and D. He's talking, as you can see in the first
24 paragraph, about a "strange purpuric-looking rash".

25 **A.** Yes.

19

1 resuscitation so, in other words, a circumstance where
2 a patient but for outstanding medical care would have
3 died?

4 **A.** That wasn't our practice at the time.

5 **Q.** And, again, looking back on it, do you think
6 it would have been helpful if that had been the
7 practice?

8 **A.** Yes, it would have been.

9 **Q.** And just in a couple of sentences, why do you
10 think that would have been helpful?

11 **A.** I think that we had a change in the neonatal
12 care that we provided over the timeline in question
13 where neonates as a group of patients have always been
14 slightly unpredictable and done slightly unusual things,
15 but gradually over time the rate of these unpredictable
16 and unusual things changed quite dramatically. And
17 I sort of can only liken it to the analogy of putting
18 a frog in boiling water versus a frog being in a pot
19 where you slowly turn the heat up that you don't realise
20 at the time, because it's a gradual increase, how
21 dramatically things are changing, whereas something hard
22 and fast like the Datix system may have flagged that up.

23 **Q.** We are going to move to June 2015, although
24 only deal with it briefly. You weren't involved,
25 yourself, in the care of Children A, B, C or D; is that

18

1 **Q.** And in particular that Dr Lambie has come to
2 him very concerned.

3 **A.** Yes.

4 **Q.** That's the email in a nutshell.

5 **A.** Yes, I do recall this email now.

6 **Q.** So that was -- so is it fair to say that as
7 at, when we come to it, August your colleagues had
8 shared that information with you?

9 **A.** Yes.

10 **Q.** Did you have any conversations with Dr Lambie
11 about her concerns at the time?

12 **A.** I don't think so, no.

13 **Q.** And if we scroll to the next page, again
14 leaving it on the overview page, your colleague
15 Dr Newby, at the bottom agreeing, with Dr Gibbs also
16 talks about Dr Harkness, an other another trainee
17 doctor --

18 **A.** Yes.

19 **Q.** -- coming to speak to her about the concern.

20 So just looking at the position in June what
21 appears to be clear from these emails is at least two of
22 the Registrars were concerned --

23 **A.** Yes.

24 **Q.** -- concerned enough to come and speak to
25 different Consultants separately --

20

1 A. Yes.
 2 Q. -- on the face of it, and you seven
 3 Consultants were discussing the cases between
 4 yourselves.
 5 A. Yes, we were.
 6 Q. So we will just take that down.
 7 So that provides us, I hope, with some context for
 8 when we get to Child E, which we will turn to now.
 9 4 August of 2015 so just about six weeks --
 10 A. Yes.
 11 Q. -- after that discussion. You tell us in your
 12 witness statement that you were present at the time of
 13 Child E's cardiac arrest.
 14 A. Yes.
 15 Q. And your colleague Dr Harkness, so the same
 16 doctor --
 17 A. Yes.
 18 Q. -- mentioned in that email, told you about
 19 discolouration.
 20 A. Yes.
 21 Q. Now, did that prompt any recollection in you
 22 on 4 August about this rash and Dr Harkness, both of
 23 which we can see was being discussed as a matter of
 24 concern just six weeks earlier?
 25 A. No -- Dr Harkness with Child E had talked
 21

1 I was surprised at how quickly he deteriorated, but
 2 I felt that there was an appropriate medical explanation
 3 at that time.
 4 Q. So we will come to that in just a moment.
 5 A. Yes.
 6 Q. But just to try and understand your thought
 7 process, we've heard from other Consultants that this
 8 cluster of deaths was highly unusual --
 9 A. Yes.
 10 Q. -- for the department.
 11 A. Yes.
 12 Q. So it isn't just that Child E's death stands
 13 in isolation, whatever conclusion --
 14 A. Yes.
 15 Q. -- you might reach, it sits very much in the
 16 context of just nine weeks previously three other --
 17 A. Yes.
 18 Q. -- deaths.
 19 Do you think that you were sufficiently curious at
 20 that stage to look closely at Child E's death, given the
 21 earlier ones?
 22 A. I don't think I'd linked Child E's death to
 23 the earlier deaths. I think I was aware that there had
 24 been more deaths than we would expect on the unit, but
 25 I felt there was a medical explanation for E's death at
 23

1 about discolouration of the abdomen, which made me think
 2 of the discolouration which you see with Necrotising
 3 Enterocolitis, or NEC. It didn't remind me of these
 4 emails, and Dr Harkness didn't suggest the link between
 5 the rash he'd seen on the previous babies.
 6 Q. And just to deal with it. In your witness
 7 statement you say you're not aware of the discolouration
 8 seen by colleagues. In fact having seen that email, can
 9 you see it that you were?
 10 A. I can see that I were. It's difficult to
 11 remember the exact order in which things happened with
 12 it being a long time ago.
 13 Q. Well, certainly I think it is the case, Dr ZA,
 14 that it's only relatively recently that you were given
 15 access to that email again --
 16 A. Yes.
 17 Q. -- is that right?
 18 A. Yes.
 19 Q. Now, what you say in your witness statement
 20 about Child E's death is that it was unusual because he
 21 deteriorated so quickly; is that right?
 22 A. That's correct.
 23 Q. And was that something that struck you at the
 24 time?
 25 A. It's something that struck me at the time that
 22

1 that time.
 2 Q. And you thought the most likely presentation
 3 fitted with NEC --
 4 A. Yes.
 5 Q. -- as you've told us.
 6 Now, you also say this in your witness statement
 7 that at the time you didn't realise the significance of
 8 abdominal x-ray not showing signs of NEC.
 9 A. Yes.
 10 Q. I just wanted to understand a little bit more
 11 about that. Just the first question is this, and
 12 I promise you, I'll give you an opportunity to say what
 13 you want to say about it, but did you at the time look
 14 at an abdominal X-ray?
 15 A. I had looked at the abdominal x-ray, which
 16 looked relatively normal, which you do see in NEC. So
 17 having an X-ray that shows signs of NEC confirms the
 18 diagnosis. Having a normal X-ray doesn't exclude the
 19 diagnosis. It was reviewing E's death in hindsight
 20 I thought that if the NEC was severe enough to cause him
 21 to die, then there should have been signs on the X-ray,
 22 but I didn't make that connection at the time.
 23 Q. So really just to go back to my earlier
 24 question, do you -- in terms of your level of curiosity
 25 at that time in the context of what was happening --
 24

1 A. Yes.
 2 Q. -- do you think you should have been more
 3 curious?
 4 A. Yes, I should have been.
 5 Q. And stripping out hindsight, it's a difficult
 6 thing to do I know --
 7 A. Yes.
 8 Q. -- but do you think at the time you should
 9 have noticed that the X-ray was normal and that that may
 10 be -- contra-indicate NEC or in some way cause you to
 11 doubt --
 12 A. It would have made that less likely --
 13 Q. Less likely --
 14 A. -- so I should have been more curious at the
 15 time.
 16 Q. And had you been more curious, what
 17 investigations were available to you at the time to take
 18 that further?
 19 A. I spoke to the Coroner and explained that
 20 I thought the cause of death was NEC, which meant that
 21 the Coroner and I agreed that we should issue a --
 22 I should issue a medical certificate of cause of death
 23 with that as the explanation. Had I not had those
 24 thoughts when I discussed it with the Coroner, then
 25 Child E would have had a postmortem to look for the
 25

1 can help us understand how this form is put together.
 2 So I think it's sometimes referred to as the
 3 Form AB?
 4 A. Yes.
 5 Q. I'm sure you are very familiar with.
 6 It. If we can please move to page 4, and we can
 7 see at the top under the heading "SUDiC", "Death
 8 expected", and then there are four options to check,
 9 "Expected", "Expected but meets exclusion criteria",
 10 "Unexpected NHS commissioning board notification".
 11 The "Unexpected but meets exclusion criteria" box
 12 is checked. Can you just help us to understand what
 13 that means in practical terms?
 14 A. I think that that's because I've discussed it
 15 with the Coroner and we've agreed on a cause of death.
 16 Q. It's difficult, but do you know what the
 17 exclusion criteria are?
 18 A. Not off the top of my head, no.
 19 Q. No, but they sit in your mind with the fact
 20 that you had agreed with the Coroner that the cause of
 21 death could be certified?
 22 A. Yes.
 23 Q. Thank you very much indeed, we can take that
 24 down now.
 25 It may be that you will be asked some questions
 27

1 cause of death.
 2 Q. In fairness to you, I just want to give the
 3 other side of it.
 4 A. Yes.
 5 Q. What was the other side of your thought
 6 process about why you perhaps didn't want a postmortem
 7 to take place?
 8 A. I knew that Child E's parents were already
 9 devastated and didn't like the idea of a postmortem, and
 10 I didn't want to do anything that made what was already
 11 an awful situation for them any harder. So it was the
 12 wrong decision but it was done with the best of
 13 intentions.
 14 Q. Because I'm sure implicit in that is that
 15 although the views of the family are extremely important
 16 and must be dealt with as being something you should
 17 have proper regard to --
 18 A. Yes.
 19 Q. -- in this situation, if a postmortem was
 20 required a postmortem should take place?
 21 A. Yes.
 22 Q. Now you filled in a form --
 23 A. (Nods).
 24 Q. -- about Child E's death, I would like just to
 25 bring that up, please, INQ0012016, just to see if you
 26

1 about interactions with Child E's parents but I'm not
 2 going to ask you about those now. I'm just going to
 3 move forward, please, to the position on the ward and in
 4 particular as between the Consultants and whether or
 5 not, now that there had been four deaths, there was
 6 a Consultant-wide discussion?
 7 A. There was. I can't recall exactly when but
 8 there was a quite a high level of concern that we'd had
 9 four deaths at this stage, and very much a worry about
 10 what were we overlooking in terms of medical care,
 11 environment, why -- why had this happened, what could we
 12 do to try and stop this continuing to happen.
 13 Q. In the course of those discussions, did
 14 anybody say within your hearing that there was concern
 15 that there may have been deliberate harm caused?
 16 A. I can't recall anyone saying it at that stage.
 17 Q. Just so that we time mark that, we are talking
 18 about the period immediately following the death of
 19 Child E.
 20 A. Yes.
 21 Q. In your witness statement, you make a comment
 22 about the level of detail that Letby put in the notes
 23 for Child E --
 24 A. Yes.
 25 Q. -- and that that was something that struck you
 28

1 at the time. Can you just tell us, please, what it was
 2 that caused you to notice that note and what your
 3 observations about it are?
 4 **A.** So I noticed that note while preparing my
 5 witness statement for the police some years later.
 6 There was nothing kind of hard and fast, it just seemed
 7 quite a lot of information about the memory boxes and
 8 taking pictures of E and F together, and it just seemed
 9 more detail than I would have expected but there was
 10 nothing sort of hard and tangible, it was just as part
 11 of that overall picture that we had of Lucy Letby at
 12 that stage.
 13 **Q.** I'll just unpack that a little bit. Obviously
 14 you have huge experience of reading medical and nursing
 15 notes --
 16 **A.** Yes.
 17 **Q.** -- it follows from what you say that the level
 18 of detail about that note didn't strike you at the time.
 19 **A.** I didn't I don't think I saw it at the time.
 20 **Q.** But it, later, at a time when you knew there
 21 was a police investigation, you did see it --
 22 **A.** Yes.
 23 **Q.** -- and it's then that you've made the comments
 24 about it being perhaps slightly inconsistent with what
 25 you usually see in notes.

29

1 to ensure that you could attend the meeting about
 2 Child E's death?
 3 **A.** Probably with hindsight, yes. But that wasn't
 4 how we practised at the time but then we did have
 5 a lesser number of deaths at that time. I was also the
 6 first person in our department to work less than full
 7 time, so that was a relatively new situation for the
 8 department.
 9 **Q.** But it almost always might be the case that
 10 a Dr may not be working --
 11 **A.** Yes.
 12 **Q.** -- when a meeting is scheduled --
 13 **A.** Yes.
 14 **Q.** -- that's just -- that's just how the rota --
 15 **A.** Yes, they may be on annual level --
 16 **Q.** Absolutely.
 17 **A.** -- they may be covering acute things.
 18 **Q.** Absolutely. So it is not at all a question
 19 about the hours that you kept --
 20 **A.** Yes.
 21 **Q.** -- it's more about how things were arranged to
 22 make sure the most important people attend important
 23 meetings.
 24 **A.** Yes.
 25 **Q.** And I think you've agreed that really it

31

1 **A.** Yes.
 2 **Q.** We're just going to stay with Child E here and
 3 move forward in our chronology before coming back to
 4 Child F. But there was a Neonatal Mortality Meeting on
 5 26 November 2015, which you tell us you didn't attend
 6 because it was a non-workday for you.
 7 **A.** Yes.
 8 **Q.** Now, although it was becoming increasingly
 9 more common for deaths to occur on the neonatal unit
 10 they weren't -- it wasn't, as some departments will
 11 experience, a department that had deaths occurring very
 12 often --
 13 **A.** Yes.
 14 **Q.** -- is that fair?
 15 **A.** Yes.
 16 **Q.** And those neonatal mortality meetings are
 17 important.
 18 **A.** Yes.
 19 **Q.** And you shouldn't understand me to be
 20 criticising you at all for not going to work that day --
 21 **A.** Yes.
 22 **Q.** -- I want to look at a different side of it,
 23 which is, do you think, bearing in mind that you were
 24 involved in Child E's care and had signed the death
 25 certificate, that in fact steps should have been taken

30

1 should have been arranged so that you could attend.
 2 **A.** Yes.
 3 **Q.** So Child F -- we go back to the 5 August --
 4 and we know that a -- that Child F was hypoglycemic on
 5 5 August --
 6 **A.** Yes.
 7 **Q.** -- a sample of blood was taken, it went to the
 8 Liverpool laboratory and it came back to the Countess on
 9 13 August 2015 --
 10 **A.** Yes.
 11 **Q.** -- at a time when Child F's condition was
 12 stable.
 13 **A.** Yes.
 14 **Q.** Now, we'll just have a look, please, at the
 15 results as they appear on the notes. It's INQ0000859,
 16 please, and we will go to page 334. I regret to say
 17 that that is a less good quality copy than I believe the
 18 Inquiry holds. But hopefully --
 19 **A.** That's fine I've seen --
 20 **Q.** You've seen this before --
 21 **A.** I've seen it before, yes.
 22 **Q.** -- so I'm not asking unfair questions here.
 23 And the essential point here is that the insulin level
 24 is high whereas the C-peptide level is low.
 25 **A.** Yes.

32

1 Q. And did it form part of your training that
2 that will occur when somebody has administered insulin
3 externally --
4 A. Yes.
5 Q. -- exogenous insulin as opposed to insulin
6 that the body has produced --
7 A. Yes.
8 Q. -- because you would expect a higher C-peptide
9 level?
10 A. Yes.
11 Q. And is this how the results will appear in the
12 notes, presumably more legible, but this is -- this is
13 what will come up when you look at the electronic notes?
14 A. Yes, yes, this is what came up on our
15 electronic results system.
16 Q. And is there another significant issue when
17 interpreting these results, namely the glucose level?
18 A. Yes, you need to know what the glucose level
19 was doing at the time because the body's own amount of
20 insulin and other hormones is a dynamic state and very
21 much depends on what the blood glucose is.
22 Q. So I think, and you'll tell me if I'm wrong
23 about this, if we go to 337, we can see the glucose
24 result. Can you see that?
25 A. That's cerebral spinal fluid rather than blood

33

1 insulin and the C-peptide; is that right?
2 A. Yes, that is correct.
3 Q. Now, let's just bring up your notes, which is
4 the same INQ0000859 and page 39, please.
5 Yes, that's the -- do you recognise that note?
6 A. Yes, I've seen that before.
7 Q. It's at half past 10 --
8 A. Yes.
9 Q. -- on the morning of 13 August. We can see
10 the SHO, Dr Lidden --
11 A. Yes.
12 Q. -- starts the note. We've got the hypo screen
13 results recorded there.
14 A. Yes.
15 Q. I don't think we have the glucose recorded but
16 that was something that you noted at the time, was it?
17 A. Yes, we know that those were done when the
18 glucose was very low --
19 Q. Yes.
20 A. -- I can't remember the exact reading, but it
21 was very low at that time.
22 Q. And you are recorded by Dr Lidden as saying:
23 "Insulin high, C-peptide low, unusual for
24 hypoglycemia as now well and sugar stable for no
25 further ..."

35

1 there.
2 Q. Right. Well, we can take that down for the
3 time being. At all events, did you check the glucose
4 level?
5 A. The reason the bloods were done was because
6 the glucose level was extremely low at that point. The
7 bloods were taken as part of what's called
8 a hypoglycemia screen, and that's when a baby has a very
9 low blood sugar, it's to look for reasons why that may
10 have happened, and it's important that those bloods are
11 done at the time of the low blood sugar because of the
12 importance of interpreting them in the light of the
13 sugar result.
14 Q. This is a hypoglycemic episode.
15 A. Yes.
16 Q. Would you expect the insulin levels to be low
17 or high?
18 A. Low.
19 Q. Low. And on this result, were the insulin
20 levels low or high?
21 A. No, they were high.
22 Q. So that's a first marker that something
23 unexpected is happening?
24 A. Yes.
25 Q. And the second marker is the ratio between the

34

1 What's that last --
2 A. It's an abbreviation for "investigations".
3 I mean, this -- this is quite a short paragraph that
4 sums up what was a sort of much longer discussion. We
5 discussed how the blood results looked as if Child F had
6 been given exogenous insulin, which is an insulin as
7 a medication given.
8 We checked that it wasn't prescribed. We checked
9 that no one else on the unit at the time was on insulin,
10 thinking about: was it done accidentally?
11 But the idea that someone could be doing it
12 deliberately just seemed so fantastical and unlikely
13 that that couldn't possibly be what had happened. With
14 neonatal blood samples, because they're so small and
15 often difficult to obtain, we do get unusual results
16 from time to time, and our normal practice if something
17 is outside of what we would expect is to repeat them.
18 We obviously couldn't repeat the bloods at this point
19 because Child F was well with a normal glucose level, so
20 we wouldn't be able to repeat them.
21 At the time, I just dismissed the idea of someone
22 deliberately administering insulin because it just
23 seemed so impossible, but I deeply regret that that is
24 how I interpreted things both for Child E and F's
25 parents and for all the babies that happened

36

1 subsequently. I wish I'd interpreted these in a very
 2 different light, but at the time it just didn't seem
 3 possible that someone could do that.

4 **Q.** Absolutely recognising that you have just
 5 accepted very candidly that you misinterpreted those
 6 results --

7 **A.** Yes.

8 **Q.** -- and did not take steps that you should have
 9 taken --

10 **A.** (Nods).

11 **Q.** -- just trying to understand a little bit more
 12 about why. You've used that phrase "impossible" more
 13 than once --

14 **A.** Yes.

15 **Q.** -- what about the case of Beverley Allitt,
 16 didn't that potentially come to your mind in any way
 17 that that is a --

18 **A.** It didn't --

19 **Q.** -- real life example?

20 **A.** I don't know why not. That's -- I've sort of
 21 grown up with the knowledge of Beverley Allitt and what
 22 she did in sort of common knowledge, and then later
 23 Harold Shipman, but it just never -- never occurred to
 24 me that that would be something that happened on my ward
 25 to the patients I was looking after.

37

1 result that happening?

2 **A.** Yes, but this wasn't a sort of result that we
 3 had that often. They went -- they got sent off to the
 4 lab in Liverpool, and by far and away the most common
 5 result we got back was that the sample was insufficient
 6 for them to process, so we were more used to not getting
 7 a result because of the technical difficulties.

8 **Q.** That was going to be my follow-up question
 9 because, again, that isn't this scenario, is it --

10 **A.** No.

11 **Q.** -- because you did get some results --

12 **A.** Yes.

13 **Q.** -- with no suggestion from Liverpool that
 14 there was any reason to doubt them.

15 **A.** No.

16 **Q.** Now, just to be clear about two things.
 17 Firstly, and we can look at it if you want to, but
 18 looking at your police same you said:
 19 "I did not have anything unnatural in my mind at
 20 the time."
 21 You've told us about a process where you discussed
 22 it with Dr Lidden, you went so far as to check whether
 23 or not any other baby was due to receive insulin on that
 24 day, and you've described a thought process where --
 25 which, as you've described it, sounds like you thought

39

1 **Q.** And you've raised the fact that you've had
 2 experience of results being surprising and not according
 3 with what you think the picture should be --

4 **A.** Yes.

5 **Q.** -- I hope I've characterised that correctly,
 6 presumably that's a relatively rare occurrence?

7 **A.** It has -- it's in not that rare in neonates.
 8 Because they are physically so small and their veins are
 9 so small the taking of blood is more difficult. The
 10 giving the lab big enough samples that they can analyse
 11 is quite difficult. So the two things that happen are
 12 either that the samples can clot because the blood comes
 13 out quite slowly or that it can haemolyse, which means
 14 the cells break down because of the small veins and the
 15 small needles, and the need for sort of pressure to get
 16 the blood out. So it would be relatively rare in older
 17 children and in adults but it's something we saw not
 18 infrequently in neonates that would have slightly
 19 unexpected readings, and we would repeat them and they'd
 20 be okay.

21 **Q.** And had you ever seen that in relation to
 22 an insulin C-peptide --

23 **A.** Never in relation to an insulin C-peptide.

24 **Q.** And so although it existed as a possibility
 25 for some results, you hadn't seen for this sort of

38

1 about whether there was something unnatural and
 2 dismissed that --

3 **A.** Yes.

4 **Q.** -- as impossible.

5 **A.** Yes.

6 **Q.** So just help us to understand, what was your
 7 true state of mind, did it cross your mind and you
 8 rejected it?

9 **A.** It crossed my mind and I rejected it.

10 **Q.** And, secondly, just in terms of whether you
 11 should have done more, in your witness statement you say
 12 "with hindsight". I'm not suggesting that that's wrong,
 13 but do you think that you need hindsight to know that
 14 you should have done --

15 **A.** No --

16 **Q.** -- something different?

17 **A.** -- I made the wrong decision.

18 **Q.** Should it have prompted a Datix form?

19 **A.** It should have yes.

20 **Q.** Was it potentially serious enough that you
 21 should have contacted Dr Brearey or Dr Jayaram?

22 **A.** Yes, I probably should have done.

23 **Q.** Was it an issue for the nursing ward manager?

24 **A.** Again, if I had not dismissed the thought of
 25 it being deliberate, then if I thought it was

40

1 deliberate, then absolutely it should have done.
 2 **Q.** Now, you say that you weren't involved in any
 3 debrief for Child F. Do you know if one took place?
 4 **A.** I don't think so.
 5 **Q.** Given Child F's course, would you have
 6 expected there to be a debrief for Child F?
 7 **A.** No, because he'd recovered from that episode
 8 of hypoglycemia and was well enough to transfer back to
 9 his home unit (*redacted*).
 10 **Q.** If there had been some sort of debrief, do you
 11 think that, as they were conducted at the time, those
 12 results might have come to the surface and there had
 13 been a discussion about them?
 14 **A.** Yes, I think it would have done.
 15 **Q.** Just help us to understand the practicalities.
 16 Would having a debrief in a case such as Child F
 17 completely overwhelm the department if you applied that
 18 across the board or was it in fact practical to do that?
 19 **A.** I think sort of referring back to what I'd
 20 said earlier about that sort of gradual increase in
 21 acuity and strange things happening, I think at the peak
 22 of that timeline it probably would have overwhelmed the
 23 department, but in the department as we are now and as
 24 we were before this period it wouldn't have done. So it
 25 would have been a sensible thing to have done.

41

1 personal stress.
 2 **LADY JUSTICE THIRLWALL:** You don't need to tell us
 3 about that.
 4 **A.** And I think that probably affected some of
 5 what I was remembering of the previous time.
 6 **MR DE LA POER:** Absolutely, and it's entirely my
 7 fault, Child I died in October 2015 so before you --
 8 **A.** Okay.
 9 **Q.** -- went away. So I don't -- and I'm not
 10 looking it pry at all --
 11 **A.** Yes.
 12 **Q.** -- whether you going off in December affected
 13 the period before or not --
 14 **A.** Yes, I think I have just got confused at the
 15 timeline, but yeah --
 16 **Q.** No, that's my fault.
 17 **A.** -- I don't recall linking them at the time,
 18 other than the feeling that we all had that things had
 19 changed and things --
 20 **Q.** Now --
 21 **A.** -- were not as they had been previously.
 22 **Q.** -- Dr Newby, Dr Gibbs have both told us about
 23 the period after Child I's death when they were involved
 24 in a conversation with Dr Jayaram and Dr Brearey in
 25 which serious concerns were raised.

43

1 **Q.** And so does that go back in part to what you
 2 were saying about how much pressure the paediatric
 3 department was under at that time as well as the
 4 additional stress caused by the increase in the number
 5 of deaths and collapses?
 6 **A.** Yes.
 7 **Q.** Now, you were away from the Countess of
 8 Chester between December 2015 and March 2016; is that
 9 right?
 10 **A.** Yes, that's correct.
 11 **Q.** It will follow from that that you were still
 12 working in 2015 at the time of the collapses of Child G,
 13 H and J. Were you aware of any of those collapses at
 14 the time that they occurred?
 15 **A.** I can't recall.
 16 **Q.** You were also working at the Countess when
 17 Child I repeatedly collapsed over a number of days and
 18 then died.
 19 **A.** Yes.
 20 **Q.** Were you aware of Child I's death?
 21 **A.** Yes.
 22 **Q.** And did Child I's death bring to your mind
 23 your involvement in Child E or Child F?
 24 **A.** I don't think it did. The period where I was
 25 off between December and March was a very significant

42

1 Now, memories perhaps differ about the detail --
 2 **A.** Yes.
 3 **Q.** -- and who was at which discussion, so I don't
 4 want to misstate the position, but were you involved in
 5 any discussions with any of those four people following
 6 the death of Child I, so the period November into
 7 December?
 8 **A.** I think I was. I was aware that there was
 9 a definite sense of unease about what had happened with
 10 several of my colleagues who'd been involved with more
 11 of the babies. I can't recall the exact details of that
 12 but there was a sort of growing sense of unease and
 13 unhappiness at what had happened.
 14 **Q.** In the course of any of the conversations that
 15 you were present at, did anybody suggest to you that
 16 they were concerned that deliberate harm may be being
 17 caused to babies on the neonatal unit?
 18 **A.** I can't recall exactly when that was first
 19 mentioned, whether it was at that point or in early
 20 2016. I do recall someone mentioning the association of
 21 Lucy Letby with the number of deaths and collapses but
 22 that being explained by the fact that she did more
 23 shifts and she was one of the few nurses with the
 24 intensive care qualification who wasn't a shift leader,
 25 so was more likely to be looking after the sick babies.

44

1 Q. Do you recall who it was who drew your
2 attention to her being in common with these deaths?

3 A. I think it might have been Steve Brearey but
4 I'm not 100% sure.

5 Q. And do you recall whether that was before or
6 after you had your period away from the hospital?

7 A. I'm not 100% sure.

8 Q. Just to complete the picture in relation to
9 Child F, we'll just bring up an email here please
10 INQ0005890. We're going to jump right to the end of the
11 period that we are looking at.

12 A. Yes.

13 Q. This is 6 June 2017, so by now the police have
14 been contacted.

15 A. Yes.

16 Q. So we're right at the end, as I say, of the
17 period that we were focusing on.

18 This is an email from you to Dr Brearey in which
19 you are recalling a baby with high glucose requirements
20 seemed to fluctuate. You say:

21 "Astha and I did a lot of hypoglycemic bloods and
22 insulin level was high and C-peptides suggested it could
23 be exogenous insulin."

24 Firstly, can you help us with who Astha is?

25 A. Astha that was one of our junior doctors, but

45

1 A. Yes.

2 Q. -- you tell us in your witness statement you
3 attended a workshop when the CQC visited.

4 A. Yes.

5 Q. And was that a workshop for Consultants?

6 A. Yes, it was.

7 Q. And you tell us that you sought to raise
8 patient safety issues with the person running it and
9 that they suggested you speak to them at the end --

10 A. Yes.

11 Q. -- and by the time the end came, they left
12 immediately and you didn't get to say anything more.

13 A. Yes.

14 Q. What year did that take place?

15 A. I think it took place in 2018. I know that
16 some of my colleagues -- Dr Brearey in his witness
17 statement thinks that I raised something with the CQC in
18 February 2016. I don't have any recollection of doing
19 that. I also was on a period of extended leave at that
20 point and I don't think I would have come into the
21 hospital for a CQC meeting.

22 Q. Just being realistic about it, do you think
23 you would have remembered during that period if you'd
24 come in for such a meeting?

25 A. Yes, I think anything that I came in for

47

1 I think I must have misremembered who it was because she
2 wasn't involved in this particular case.

3 At the time of this email, I was on *(redacted)*
4 leave and I just had something in the back of my mind
5 nagging about Child F's results and the fact that at the
6 time I'd dismissed the possibility of deliberate harm,
7 but now, based on what we were thinking, that didn't
8 seem so impossible any more. But I couldn't remember
9 Child F's details and I wasn't in the hospital to be
10 able to look, so I wanted to flag that to Steve.

11 Q. Thank you, we take that down. So there's no
12 doubt about it, this is Child F that you are --

13 A. Yes.

14 Q. -- seeking to recall?

15 A. Yes.

16 Q. Thank you.

17 Finally for 2015, we've heard evidence from
18 Dr Lambie, who left in September 2015, that she came
19 upon a huddle of nurses who were looking at the rota
20 together to see who had been on when events had
21 occurred. Were you aware of such a huddle taking place
22 or any discussion between the nursing about that?

23 A. I wasn't aware of that, no.

24 Q. Moving forward into 2016, although it may not
25 be 2016, you'll tell us --

46

1 during that period would have to be very significant, so
2 there's a -- I think I probably would remember it.

3 Q. And also, would you have been quite an odd
4 choice to be a spokesperson for the Consultant body and
5 the paediatric department, given that you were -- had
6 been out of the loop for a period of time by the time
7 that meeting happened?

8 A. Yes. I think the meetings are more sort of
9 drop in than sort of nominated representatives. But
10 I don't think I would have gone to represent my
11 colleagues in that period of time. That wasn't where my
12 priorities were.

13 Q. Thank you. Child L who we can deal with
14 briefly. 9 April 2016, Dr Gibbs has described, as I'm
15 sure you know:

16 "It is a collective failure by the Consultant body
17 to interpret and act upon Child L's insulin and
18 C-peptide ratio."

19 Do you agree with that?

20 A. Yes.

21 Q. Now, you returned to the Countess of Chester
22 in March of 2016 --

23 A. Yes.

24 Q. -- from your period of extended leave.

25 A. I had a phased return, so I, over the next few

48

1 months, gradually increased my clinical duties, so
 2 I wasn't sort of fully back at work from March.
 3 **Q.** But were you made aware of the outcome of the
 4 thematic review into neonatal mortality?
 5 **A.** Yes, I was.
 6 **Q.** And I think you were allocated a job under
 7 that action plan to ensure junior doctors knew about
 8 sepsis.
 9 **A.** Yes.
 10 **Q.** In that phased return to work period, at the
 11 latest, was that when you heard Letby's name mentioned
 12 as being a common factor?
 13 **A.** Yes, that was definitely more of a concern
 14 when I came back.
 15 **Q.** So you've told us it may have been before you
 16 went off --
 17 **A.** Yes.
 18 **Q.** -- but if we bookmark it as the latest, it's
 19 that period there?
 20 **A.** Yes.
 21 **Q.** And was it also at the latest during that
 22 period that you became aware of concerns by your
 23 colleagues that deliberate harm may be caused?
 24 **A.** Yes.
 25 **Q.** And was that a view which you agreed with,

49

1 that there was urgent action?
 2 **A.** I should have done.
 3 **Q.** And why is it that you think that you didn't?
 4 **A.** I think partly because the concerns were
 5 coming from my colleagues who were already trying to do
 6 things, partly because there was no definite proof, it
 7 was just a sort of growing concern and
 8 uncomfortableness, and the fact that that would be
 9 a devastating accusation to make.
 10 **Q.** In the context of safeguarding in the
 11 community, do you need to wait for definite evidence --
 12 **A.** No, you don't.
 13 **Q.** -- in order to act.
 14 And so, in reality, was this any different to that?
 15 **A.** No, it wasn't.
 16 **Q.** Did you have any discussion with Dr Brearey
 17 about his meeting on 11 May with the Executive Directors
 18 Ian Harvey and Alison Kelly?
 19 **A.** I can't recall.
 20 **Q.** Do you recall receiving his email on 16 May in
 21 which he asked for any sudden unexpected collapses to be
 22 drawn to his attention?
 23 **A.** Yes, I do recall that email.
 24 **Q.** And what was your understanding at that time
 25 about what steps the senior management were taking?

51

1 disagreed with or thought might be a possibility?
 2 **A.** It's one that I thought might be
 3 a possibility. It was a general feeling of collective
 4 unease at the sudden, unexpected and unexplained nature
 5 of events and the correlation with Lucy being present,
 6 but nobody sort of knew exactly what she was doing to
 7 have a sort of positive explanation for it. It was that
 8 sort of uncomfortable association at that point and the
 9 lack of another plausible explanation.
 10 **Q.** So you told us in relation to Child F that you
 11 considered the possibility of deliberate harm and
 12 rejected it out right.
 13 **A.** Yes.
 14 **Q.** This is different, if I've understood your
 15 answer correctly.
 16 **A.** Yes.
 17 **Q.** So is it fair to characterise it as during
 18 that period you thought that Letby may be harming
 19 babies?
 20 **A.** Yes, but I didn't have any positive evidence
 21 of that. It was more the growing association and the
 22 lack of other explanations.
 23 **Q.** Given that that was your state of mind, that
 24 a member of staff may be harming, may be killing babies,
 25 should you have done something at that stage to ensure

50

1 **A.** I understood at that point that they were
 2 aware of our concerns, that they didn't feel there was
 3 a threshold to do anything at that point but wanted to
 4 be kept apprised of the situation if there were any
 5 more episodes.
 6 **Q.** And were you yourself satisfied at that stage
 7 with that reaction from senior management?
 8 **A.** I think I probably was being a bit more
 9 distant to what was happening than some of my
 10 colleagues.
 11 **Q.** So we come to the deaths of Child O and
 12 Child P.
 13 **A.** Yes.
 14 **Q.** Now, you weren't involved in their care at the
 15 time of their deaths; is that right?
 16 **A.** That's correct.
 17 **Q.** But is it right that you came -- became aware
 18 of their deaths shortly afterwards?
 19 **A.** Yes, I did.
 20 **Q.** And was that before or after the senior
 21 paediatrician meeting on Monday, 27 June, do you know?
 22 **A.** I don't know off the top of my head, no.
 23 **Q.** Was that a meeting that you attended? So the
 24 Child O and Child P died the previous week, 23rd, 24th.
 25 **A.** Can I just check my statement?

52

1 Q. I don't think it's dealt with in your
2 statement.
3 A. Okay. I know that I did have a period of
4 annual leave around the time of those deaths, which is
5 why I wasn't involved in their care. I can't recall
6 exactly which date I returned to work.
7 Q. Do you recall any meeting at which, as we've
8 heard from other witnesses, a group of paediatricians --
9 senior paediatricians together with Eirian Powell met
10 and were saying out loud that they were concerned that
11 Letby may be harming babies?
12 A. Yes.
13 Q. So you remember --
14 A. Yes.
15 Q. -- being present at such a meeting --
16 A. Yes.
17 Q. -- whenever it took place?
18 A. Yes.
19 Q. You know that Dr Saladi sent an email on
20 29 June suggesting that the police should be involved.
21 A. Yes.
22 Q. Was that a view that you agreed with or
23 disagreed with?
24 A. Yes, I thought the police should have been
25 involved as well.

53

1 the fact that we couldn't medically explain these
2 deaths, that there was a -- the continued association of
3 Lucy with sudden unexpected, unexplained deaths and
4 collapses and that that association had gone far beyond
5 coincidence and her working pattern, and, therefore, we
6 thought that she must be involved in some way, either by
7 unconscious incompetence or by a deliberate act.
8 Q. And so for all of those who were at the
9 meeting, would they have been clear that there was a --
10 A. Very, very clear. We were far clearer in the
11 discussion than is in -- on the minutes of that meeting.
12 Q. So not talking in code but speaking your
13 minds.
14 A. Yes.
15 Q. The meeting on 13 July, as we know, involved
16 a presentation of information to the Consultant body
17 about the so-called deep dive --
18 A. Yes.
19 Q. -- that had been done. I'm just going to put
20 up on screen INQ0006458. This is really just so that
21 you know what we are talking about.
22 A. (Nods).
23 Q. I know you've been through it.
24 So this appears to be a PowerPoint presentation or
25 slideshow that has been provided to the Inquiry. Was

55

1 Q. Further up that chain, Ian Harvey gave
2 a direction that emails should cease. Do you recall
3 receiving that?
4 A. Yes.
5 Q. And what was your reaction to that?
6 A. That it seemed like this was something very
7 important and it shouldn't be something that we should
8 be told to stop discussing.
9 Q. Now, on 5 July, you were involved in carrying
10 out a review of Child O and Child P's death.
11 A. Yes.
12 Q. And also participating was Dr U.
13 A. Yes.
14 Q. What you say in your statement is that:
15 "I believe that we referenced the increase in
16 mortality and Letby's presence."
17 And you also say:
18 "Staffing factors and the possibility of Letby
19 having something to do with the deaths either by
20 incompetence or deliberate harm was discussed."
21 A. Yes.
22 Q. I'd just like you to -- in your own words,
23 what was actually said by people at the meeting about
24 Letby and whether deliberate harm may have been caused?
25 A. I think both myself and Dr Brearey stressed

54

1 this the presentation that was made to you?
2 A. No.
3 Q. And you've been through it and satisfied
4 yourself of that?
5 A. Yes.
6 Q. And is there any --
7 A. Some bits of it may be the same but it wasn't
8 the PowerPoint.
9 Q. Thank you, we can take that down. Is there
10 any particular information that was put on screen that
11 isn't in that display that stood out for you at the
12 time?
13 A. Yes. There was a very clear slide projected
14 that had a lot of patient identifiable data of mums and
15 babies, and it sticks very clearly in my mind
16 (redacted).
17 Q. Did you say anything at the time?
18 A. Yes, I did.
19 Q. What did you say?
20 A. I asked Ian Harvey if he could remove the
21 slide (redacted), which he did. (redacted). Dr Harvey
22 carried on with the presentation and didn't reference it
23 again.
24 Q. Did he apologise?
25 A. No.

56

1 Q. Now, as the Inquiry understands it, what was
2 being said at the meeting to the Consultant body was
3 that the increase in deaths may be in part explained by
4 an increase in activity and acuity?

5 A. Yes.

6 Q. Was that a conclusion, having been
7 a Consultant on the ward, that you agreed with or
8 disagreed with?

9 A. I disagreed with it.

10 Q. What was the central point that you
11 Consultants made at the meeting about the data?

12 A. There was some data about staffing levels and
13 the deaths, but it seemed that many of the deaths had
14 happened on the days with better staffing levels as
15 opposed to fewer staff. And although we had -- we had
16 agreed that we had been busier, the nature of the deaths
17 weren't explained by the increased acuity.

18 Q. Did the data take into account whether the
19 deaths were expected or unexpected, explained or
20 unexplained?

21 A. No, and didn't take the gestation of the
22 babies into consideration either when a lot of the
23 babies who'd died were still premature babies but the
24 less extreme prematurities where it's more unusual for
25 children to die.

57

1 there to be -- if she was supervised practice it would
2 need to be constant supervision by someone who knew the
3 reason why they were supervising her because they
4 wouldn't be able to sort of nip out to go to the toilet
5 or get a drink, it would have to be sort of constant
6 supervision because the nature of what we were concerned
7 about.

8 Q. You participated in the interview on
9 1 September with the RCPCH.

10 A. Yes.

11 Q. What was said to the reviewers about Letby, if
12 anything?

13 A. We were very open from the beginning of our
14 meeting that our concern was that Lucy Letby was doing
15 something deliberate to harm babies.

16 Q. Later that month, there was a meeting with
17 Tony Chambers on 19 September, which you deal with in
18 your witness statement, but it wasn't one that you went
19 to but you do comment upon it. Within the minute
20 meeting -- minutes of the meeting, forgive me, it's
21 indicated that the Consultant body did not feel listened
22 to?

23 A. Yes.

24 Q. What was your feel about the approach of the
25 senior managers at that period towards the back end of

59

1 Q. And was that a point made at the meeting?

2 A. Yes.

3 Q. We know that the Trust arranged for the RCPCH
4 to carry out an inspection. What was your view about
5 that as being an appropriate or inappropriate
6 investigative step?

7 A. I felt that it was an appropriate step. We
8 had definite concerns about Lucy Letby. We didn't have
9 any sort of definite proof or anything concrete, and the
10 idea of experienced, knowledgeable people coming and
11 having a look at the situation with outside viewpoints
12 to know whether our concerns were reasonable or not
13 seemed an appropriate step.

14 I think it's important to acknowledge that, at this
15 point, Lucy Letby was on annual leave and wasn't
16 working, so in some ways we felt that had taken some of
17 the urgency out of the situation because she wasn't on
18 the unit at that point.

19 Q. We understand that certain comments were made
20 about the acceptable circumstances for her return CCTV,
21 and direct supervision --

22 A. Yes.

23 Q. -- but we know, is this right, that she
24 returned to a non-patient facing role?

25 A. Yes. We discussed the facts -- the need for

58

1 2016?

2 A. It seemed initially like they didn't want to
3 listen to our concerns, and then over time, as we became
4 more persistent, it seemed that they wanted us to be
5 quiet and shut up about it.

6 Q. And are you able to identify a moment or
7 a period in time when it changed from not listening to
8 "Be quiet"?

9 A. I think the most definite be quiet moment for
10 me was the meeting -- I think it was the 27 January,
11 which is in my statement. Can I just check that that's
12 the correct --

13 Q. It's paragraph 85 I think is the one you have
14 in mind, the 26th?

15 A. Yes, 26 January. I remember this meeting very
16 clearly. We didn't receive the minutes until some time
17 later, and I'm not listed on there but I definitely
18 attended this meeting. There was a very adversarial
19 atmosphere from the moment we first entered the room.

20 Q. Can I just ask you a few questions about --

21 A. Yes.

22 Q. -- about just focusing on a number of aspects?

23 Firstly, how would you describe the tone of the
24 senior managers, was it the same -- were they speaking
25 with the same tone or was it different?

60

1 A. I felt very much -- all of them seemed to be
2 speaking with the same tone and it very much seemed like
3 we'd been called into the headmaster's office like
4 naughty school children.

5 Q. You had a summary provided to you of what the
6 RCPCH and Dr Hawdon had said.

7 A. Yes.

8 Q. As a Consultant paediatrician, are those
9 reports that you would have expected to read before you
10 went into the meeting or would it be usual for it to be
11 presented to you?

12 A. No, I would have expected to see those reports
13 in advance, have time to read and digest, presumably --
14 I would expect there to be complex information in there
15 that I would need time to consider, and as being open to
16 learning and improvement you would want to see the
17 detail of those reports to know exactly what was said
18 and how we as a department could improve things.

19 Q. Is there any particular phrase that you recall
20 being said in the meeting that stands out for you?

21 A. Yes. Tony Chambers said that he was "drawing
22 a line" and we "weren't to cross it".

23 Q. And --

24 A. Which was said in quite a threatening tone.

25 Q. And what did you think that might mean for

61

1 Q. And you said that in those terms to the two
2 Executive Directors?

3 A. Yes.

4 Q. We can -- we've heard a lot of evidence about
5 the exchange of letters that then follows --

6 A. Yes.

7 Q. -- so we can deal with it relatively briefly.
8 But having seen Dr Hawdon and the RCPCH report, did you
9 think the deaths and collapses had been adequately
10 investigated?

11 A. No, I did not.

12 Q. We're just going to have a snapshot of how you
13 were feeling at the time as expressed in an email
14 INQ0006078. It's the email in the middle dated
15 17 February. You say:

16 "I am possibly just too jaded and distrustful now
17 but I worry what the Coroner has been told if he has
18 been given our letter from the 10th and this quite
19 clearly points out our concerns and we have to wait for
20 his response."

21 Why were you describing yourself as "jaded and
22 distrustful"?

23 A. I think it follows on from the College review
24 where it was apparent when we met with the reviewers
25 that they'd already been told of our concerns before but

63

1 your job?

2 A. I very much took it to mention that if we
3 continued to carry on raising our concerns, then my job
4 would be at risk. I went home that night and with my
5 husband worked out how long we could pay our mortgage
6 and bills for if I were to lose my job, so it certainly
7 felt real and that that was a genuine possibility.

8 Q. You mention in your witness statement being
9 taken aside by -- and I'm quoting here "two of the
10 women".

11 A. Yes.

12 Q. Do you know who they were?

13 A. I don't definitely enough to say in this
14 forum.

15 Q. Are you able to say whether they were
16 Executive Directors?

17 A. Yes, they were.

18 Q. And what did those two women say to you when
19 they took you to one side?

20 A. (*redacted*) they intimated that it was
21 Dr Jayaram and Dr Brearey putting pressure on me to go
22 along with what they were saying, which I said that very
23 much wasn't the case, that I had formed my own opinions,
24 and what I found stressful was the fact that no one was
25 taking my considered medical opinion seriously.

62

1 had been told that they were irrational and were quite
2 dismissive of what we were saying. I just worried that
3 the Coroner may be presented with our concerns in
4 a similar fashion, but I felt that our letter was quite
5 straightforward and frank, and if the Coroner had that
6 information, then that would hopefully be sufficient.

7 Q. Thank you, we can take that down.

8 I'd just like to take you to your concluding
9 remarks at paragraphs 110 and 111 of your witness
10 statement. I should acknowledge on the way, you didn't
11 attend the meeting with Simon Medland QC, did you?

12 A. No, (*redacted*).

13 Q. So I don't need to ask you about that.

14 So could you just turn up, please, paragraphs 110
15 and 111 on page 22. Just refresh your memory from that
16 and then just give us, please, Dr ZA, your summary of
17 your experience over this period as captured there.

18 A. So I've said that when raising concerns we
19 were initially ignored and then later actively bullied
20 and victimised. I genuinely believed that my job would
21 be at risk if I continued to raise concerns. I think
22 there was a false narrative developing that Dr Jayaram
23 and Dr Brearey were ring leaders rather than that we
24 were all professionals who'd come to the same
25 conclusion.

64

1 We decided that we needed to continue to raise our
2 concerns collectively as a group of seven and preferably
3 in writing, because then there can be less room for
4 misrepresentation or misinterpretation.

5 And I also had some soul searching about what
6 I would -- at what point would I be happy to stop
7 raising concerns and stop pushing, and I decided that
8 the only point I would feel that I could sleep at night
9 and live with myself was that if Lucy Letby wasn't
10 working as a nurse or as a similar position, and that
11 someone had a forensic look at what had happened to
12 these babies, and I felt that even if I lost my job
13 I should persist until we reached this outcome.

14 **MR DE LA POER:** Dr ZA, thank you. That concludes
15 the questions I have for you. As you know, there will
16 be some further questions but, my Lady, I wonder if that
17 would be a convenient moment?

18 **LADY JUSTICE THIRLWALL:** Yes, certainly.

19 So, doctor, we are going to take a 15-minute break
20 and we will start again just after 20 to.

21 (11.26 am)

22 (A short break)

23 (11.45 am)

24 **LADY JUSTICE THIRLWALL:** I'm sorry to have kept you
25 all waiting. Would you like to come back to the witness

65

1 **Q.** -- necrotising enterocolitis, and you said to
2 them that a postmortem could be done and that Mother E
3 then asked you, "Well, what will this tell us? What
4 more information will this give us?" And you said that
5 you were confident that it was NEC and that it wouldn't
6 tell them any more.

7 Is that a fair summary of what the exchange would
8 have been like?

9 **A.** Probably. I don't recall it in as much detail
10 but then it was obviously --

11 **Q.** It was obviously more of a significant
12 conversation for them --

13 **A.** Yes.

14 **Q.** Yes. I mean, the reality would probably
15 mirror that discussion anyway, isn't it, because if
16 you're uncertain as to the cause of death as a doctor
17 there has to be a postmortem?

18 **A.** Yes, there has to be.

19 **Q.** And so it would follow that unless you said to
20 them that, "I think this is NEC and I'm confident it is
21 NEC", there would have been a postmortem?

22 **A.** Yes.

23 **Q.** As to the evidence of NEC, you recall in your
24 witness statement at paragraph 34 Dr Harkness telling
25 you about a purplish discolouration.

67

1 box, please.

2 **Questions by MR BAKER**

3 **MR BAKER:** Thank you, Dr ZA, my name is
4 Richard Baker, I ask questions on behalf of some of the
5 families, including The Families of Child E and F.

6 **A.** Yes.

7 **Q.** You gave evidence about a decision that was
8 made regarding the postmortem for Child E.

9 **A.** Yes.

10 **Q.** And I understood your evidence to be that the
11 decision not to have a postmortem was driven by the
12 wishes of the family.

13 **A.** I think it was -- I was keen to respect the
14 wishes of the family, but I should have pushed for
15 a postmortem.

16 **Q.** Can I tell you what Mother and Father E
17 recall --

18 **A.** Yes.

19 **Q.** -- of the conversation? They said that when
20 you spoke to them, obviously this is fairly soon after
21 Child E's death --

22 **A.** Yes.

23 **Q.** -- that you said his death was probably due to
24 NEC --

25 **A.** Yes.

66

1 **A.** Yes.

2 **Q.** In your interview to the police you said you
3 didn't see that yourself.

4 **A.** Yes.

5 **Q.** Is that still your evidence?

6 **A.** Yes, that is.

7 **Q.** So it was a transient discolouration, it had
8 gone by the time you got there.

9 **A.** Yes.

10 **Q.** Now, NEC causing discolouration of the abdomen
11 that's caused by an internal septic process, isn't it?

12 **A.** Yes, and that would be permanent and not
13 transient.

14 **Q.** Yes. So it isn't transient for NEC. So
15 that's not evidence of NEC?

16 **A.** Yes.

17 **Q.** Bleeding from the mouth, which had been noted,
18 gastric bleeding, so upper gastrointestinal tract
19 bleeding out of the mouth that wouldn't happen with NEC
20 either, would it, because it's a problem with the
21 intestines, so the baby bleeds from its bottom?

22 **A.** Yes.

23 **Q.** Would the baby with NEC usually have a soft
24 and non-tender abdomen?

25 **A.** No.

68

1 Q. Could we look at the Datix, please. It is
 2 INQ0000194 at page 4, please. If we could scroll down
 3 to page 4, please. I'm taking you here because the
 4 medical records are more difficult to navigate around --
 5 A. Yes.
 6 Q. -- but this is a fair -- if we go on to the
 7 next page, please, sorry -- this is a fair account of
 8 what's written in the medical records.
 9 We can see here an entry for 2 August, so the day
 10 before the collapse.
 11 A. Yes.
 12 Q. "Abdomen soft with no distension."
 13 Can you see that?
 14 A. Yes.
 15 Q. And then on 3 August, there's a reference here
 16 to the pharmacist and then there's a sentence that
 17 begins or a line that begins:
 18 "The baby was tolerating 1ml of expressed breast
 19 milk."
 20 A. Yes.
 21 Q. And it says that:
 22 "Feeds could be increased if the abdomen remained
 23 soft and no increase in nasogastric aspirates."
 24 And then there's a reference to a baby being
 25 examined at 1410 hours:

69

1 abdomen had looked purple and I hadn't noticed the
 2 significance of that not being there when I examined
 3 Child E.
 4 Q. Yes. I mean, a decision about a postmortem,
 5 I don't want to labour the point --
 6 A. Yes.
 7 Q. -- because I appreciate what you've said --
 8 A. Yes.
 9 Q. -- but a decision about the postmortem is
 10 quite important, isn't it?
 11 A. It is.
 12 Q. And making a decision that something is NEC
 13 without a reasonable basis for that avoids a postmortem
 14 in this case and the postmortem is the opportunity to
 15 find out that there isn't NEC, isn't there?
 16 A. Units.
 17 Q. And it's also an opportunity to find evidence
 18 of other things that might have been there.
 19 A. Yes.
 20 Q. I think you do accept that a postmortem should
 21 have been done.
 22 A. Yes, I completely accept that.
 23 Q. Looking then at Child F. The insulin results
 24 received and referred to in Dr Lidden's note of the ward
 25 round at 10.30 of the morning of 13 August?

71

1 "... having good tone and movement. Handling
 2 appropriately. Had a soft abdomen which was not
 3 distended. Bowels not open but bowel sounds present and
 4 no suspicion aspirates."
 5 So again audible bowel sounds, no unusual
 6 aspirates, that would all speak against NEC, wouldn't
 7 it?
 8 A. It would.
 9 Q. And then we come into the time of the
 10 collapse, so 2210 hours, which is a few lines below:
 11 "ST4, who is [Dr Harkness] to review the baby as he
 12 had had a gastric bleed at approximately 2140. He was
 13 alert pink and well profused. The baby's abdomen was
 14 soft not distended. Some bowel sounds were heard."
 15 Now, you agreed that a bleed from the mouth would
 16 not be evidence of NEC and there is no evidence of
 17 distension of the abdomen, there's audible bowel sounds,
 18 the abdomen is soft, and, again, that is all speaking
 19 strongly against NEC, isn't it?
 20 A. It is.
 21 Q. So in your evidence that really what changed
 22 your mind was what you saw on the X-ray, which was also
 23 inconsistent with NEC. I mean, there are no real
 24 symptoms of NEC, are there, prior to the collapse?
 25 A. No, I think my view was by the fact the

70

1 A. Yes.
 2 Q. Now, the family of Child F are still in the
 3 neonatal unit at this point --
 4 A. Yes.
 5 Q. -- because we have a document that shows that
 6 they were transferred -- or that Baby F was transferred
 7 at 12.30. So during the morning ward round Mother E and
 8 F -- mother and father EF are still there.
 9 Did you have a conversation with them about the
 10 hypoglycemia and the abnormal results?
 11 A. I didn't. I know that Dr Lidden's entry is
 12 dated and timed at 10.30 but we had -- I recall having
 13 a conversation about the blood results in my office,
 14 which I think was later in the day and after they'd
 15 left. But I accept that I should have discussed that
 16 with his parents.
 17 Q. So that would be very unusual, wouldn't it?
 18 I mean a note might be timed retrospectively --
 19 A. Yes.
 20 Q. -- but they're not ever timed prospectively,
 21 are they, so it's not -- it's not timed at 10.30
 22 recording a conversation that occurs in the afternoon?
 23 A. Yes. But regardless of whether they were
 24 there or not, I should have discussed that result with
 25 them.

72

1 Q. The insulin results, as the Inquiry will hear,
2 had been telephoned through by Emma Lewis, a Consultant
3 clinical scientist, who made a call to the unit within
4 nine minutes of the laboratory receiving that result --

5 A. (Nods).

6 Q. -- is the evidence the Inquiry will hear. How
7 many times have you been called by a Consultant clinical
8 scientist about an abnormal insulin C-peptide result in
9 your career?

10 A. Never. I don't recall knowing that they'd
11 been called through by Dr Lewis.

12 Q. Right. So, I mean, you -- did you not know
13 that Dr Lidden or somebody within the team had spoken to
14 Dr Lewis --

15 A. I can't recall, I'm afraid.

16 Q. Do you think it's important that whoever
17 received the call should have communicated that to you?

18 A. Yes, but it was my failure to recognise the
19 significance of those results.

20 Q. And your -- your conclusion -- well, let's
21 look at it this way, there are two possibilities, aren't
22 there, the test is either right or it's wrong?

23 A. Yes.

24 Q. Did you take any steps to explore whether the
25 test might be wrong?

73

1 reliable or not, couldn't you?

2 A. I could have done.

3 Q. But it doesn't need for you to think that this
4 is attempted murder, does it, because exogenous insulin
5 in a baby is a serious safety issue however it gets
6 there?

7 A. Yes, and I should have flagged it.

8 Q. Finally, and very briefly, you were involved
9 in the care of Child G as well. Do you recall Child G?

10 A. I would need reminding.

11 Q. Well, let me ask you a general question --

12 A. Yes.

13 Q. -- and just see if you can assist me with
14 this.

15 Child G was found to have collapsed, she was a very
16 premature baby who had reached 37 plus six weeks of
17 corrected gestational age --

18 A. Yes.

19 Q. -- by the time she suffered a collapse with
20 a serious vomit, and that was put down to infection at
21 the time. You assessed Baby G on 7 September, which is
22 a day when she collapsed, and noted that she had a CRP,
23 so c-reactive protein, of less than 1.

24 A. (Nods).

25 Q. Is that consistent with sepsis?

75

1 A. No, I didn't.

2 Q. And so if a test is right, there are two
3 possibilities, either somebody has given Baby F insulin
4 deliberately to harm him --

5 A. Yes.

6 Q. -- or it's a major safety failure.

7 A. Yes.

8 Q. And so we don't have to go straight to
9 attempted murder to realise there's a major safety issue
10 in a baby receiving exogenous insulin.

11 A. Yes.

12 Q. Can you assist then with why, given those
13 three possibilities, you didn't take any steps at all?

14 A. No, I don't know why. It didn't seem like
15 a realistic possibility at the time, but that was
16 completely the wrong decision.

17 Q. What didn't seem like a realistic possibility?

18 A. That it had been done as a deliberate act or
19 an accidental act.

20 Q. But that would be the answer if the test
21 wasn't faulty, wouldn't it?

22 A. Yes.

23 Q. And the possibility, given that it had been
24 produced by a laboratory, you could have contacted the
25 laboratory to find out whether the test was one that was

74

1 A. It wasn't. I do recall now having -- seeing
2 that baby and having that result. Sometimes when the
3 bloods are taken early on in an infection the CRP hasn't
4 risen yet, and that's what I thought at that time
5 because I think I reviewed her not long after that
6 collapse.

7 Q. Well, let me just assist you. You reviewed
8 her -- or your note is at 22.20 at night and she had
9 collapsed at or about 2 o'clock in the morning.

10 A. Okay.

11 Q. The blood test and your note is timed at
12 1500 --

13 A. Okay.

14 Q. -- so about 12 hours after the collapse --

15 A. Yes.

16 Q. -- and CRP of less than 1. That's not
17 consistent with sepsis causing a collapse, is it?

18 A. No, it would depend on the time of when the
19 blood test was taken rather than the time of my note.

20 Q. Yes. I just say your note has 1500 next to
21 the CRP and your note is timed at 2220?

22 A. Okay.

23 Q. So a blood test 12 hours later showing a CRP
24 of less than 1 would not be consistent with infection?

25 A. Yes.

76

1 **MR BAKER:** Okay, thank you, my Lady, I have no more
2 questions?
3 **LADY JUSTICE THIRLWALL:** Thank you very much indeed
4 Mr Baker.
5 Mr Skelton.

6 **Questions by MR SKELTON**

7 **MR SKELTON:** Dr ZA, I ask questions on behalf of
8 the other family group.
9 **A.** Yes.
10 **Q.** I just have two topics, one is just going back
11 to your suspicions about Letby.
12 **A.** Yes.
13 **Q.** You said earlier that when you came back from
14 leave in 2016 --
15 **A.** Yes.
16 **Q.** -- that there was concern amongst the
17 Consultant group --
18 **A.** Yes.
19 **Q.** -- about Letby that she may have been harming
20 children.
21 **A.** Yes.
22 **Q.** And I think in answer to Counsel to the
23 Inquiry, you said that you didn't have definite proof --
24 **A.** Yes.
25 **Q.** -- but there was a growing sense of

77

1 **A.** Yes.
2 **Q.** You've explored the reasons why that might
3 have happened --
4 **A.** Yes.
5 **Q.** -- but do you have any reflections on what
6 could happen in the future to enable those like you,
7 who, for members of public, are senior doctors taking
8 responsibility at the highest level for their children's
9 lives, how you could be enabled to make that call if
10 this ever happens again?
11 **A.** I don't know because, looking back on it, it
12 seems incredible that we didn't, but it just didn't feel
13 like something we could do at the time and I don't know
14 how to change that for the future.
15 **Q.** Well, one answer might be to make it
16 compulsory.
17 **A.** Yes.
18 **Q.** So if you, doctor, suspect anyone, colleague,
19 friend, family member, anyone else is harming a child,
20 you must contact the police. Would that, do you think,
21 have made it almost easier for you as a Consultant to
22 have broken that barrier?
23 **A.** Potentially if that was a sort of obligated
24 process because that would have given us some protection
25 against the internal push-back from the Trust management

79

1 discomfort --
2 **A.** Yes.
3 **Q.** -- among the group. And you agreed with him
4 that safeguarding was, in those circumstances, the
5 appropriate response.
6 **A.** Yes.
7 **Q.** Can you just explain exactly whether that
8 would have entailed had it been triggered?
9 **A.** So I don't have any experience of triggering
10 that in a professional situation. Normally if it was
11 raising safeguarding concerns against parents or careers
12 it would involve the police, medical opinions and social
13 care. I don't know whether social care would be
14 relevant in the context of raising concerns against
15 a professional, but it would likely to be a multi-agency
16 response with at least the police and the hospital.
17 **Q.** So your internal safeguarding team would have
18 been informed?
19 **A.** Yes.
20 **Q.** And the police as an external body --
21 **A.** Yes.
22 **Q.** -- would have been informed from that point?
23 **A.** Yes.
24 **Q.** I think it's right that none of the
25 Consultants ever called the police.

78

1 if it was an obligated duty rather than a decision.
2 **Q.** And looking back, do you recognise that the
3 police were the appropriate --
4 **A.** Yes, completely.
5 **Q.** And they should have been called from the
6 moment suspicions arose?
7 **A.** Yes.
8 **MR BAKER:** Thank you. Thank you, my Lady.
9 **LADY JUSTICE THIRLWALL:** Thank you very much
10 Mr Skelton. Mr De La Poer.
11 **MR DE LA POER:** My Lady I have no further questions
12 for Dr ZA.
13 **LADY JUSTICE THIRLWALL:** Dr ZA, that brings us to
14 the end of your evidence, thank you very much indeed for
15 coming today and giving your evidence so frankly. Thank
16 you very much indeed.
17 You are free to go.
18 **MR DE LA POER:** My Lady our second witness is also
19 subject to a protection from the Crown Court in terms of
20 identification. That witness is Dr V.
21 **LADY JUSTICE THIRLWALL:** Thank you very much.
22 Dr V, would you come and take the oath or
23 affirmation.
24
25

80

1 DR V (affirmed)

2 Questions by MR DE LA POER

3 LADY JUSTICE THIRLWALL: Do sit down, Dr V.

4 A. Thank you.

5 MR DE LA POER: Dr V, can you confirm, please, for
6 us that you provided the Inquiry with a witness
7 statement dated 5 June 2024.

8 A. That's correct.

9 Q. And is the contents of that statement true to
10 the best of your knowledge and belief?

11 A. Yes.

12 Q. We will deal very briefly with your
13 background. You are a qualified medical doctor; is that
14 right?

15 A. That's correct.

16 Q. I'm so sorry, Dr V --

17 A. Sorry.

18 Q. -- it will be me, can I just ask you to keep
19 your voice up a little bit?

20 A. Okay. That's correct, sorry.

21 Q. Thank you very much indeed. That you are both
22 a member and a fellow of the Royal College of
23 Paediatrics and Child Health?

24 A. Yes.

25 Q. And you had been a Consultant paediatrician

81

1 good because everybody did what they said and nobody
2 challenged them."

3 I think the word she used was the Consultants would
4 think it was "cohesive". What comment, if any, do you
5 have on that perspective?

6 A. I don't think I agree with that comment.

7 I don't know what period Eirian was referring to but
8 certainly during my time leading up to that time
9 I remember being challenged about my decisions on many
10 occasions, and I think that was a thing that was almost
11 taken as granted, that the nurses were there, they
12 looked after the babies and were around a lot more than
13 the doctors were, and we always paid a lot of attention
14 to their opinion on what should and shouldn't be done.

15 So, no, I don't agree with that.

16 Q. Now, we heard from your colleague, Dr Holt,
17 something about the arrangement of the offices and the
18 corridor that offices were on. Did you use an office
19 down the corridor?

20 A. No, my office was further -- so initially
21 when -- I think this must have been before Dr Holt
22 started there was just that corridor and there was just
23 the seven of us and we shared offices initially. Then
24 when the number of Consultants expanded and more areas
25 was -- were needed there were three offices created

83

1 for a number of years prior to 2015; is that right?

2 A. That's correct, yes.

3 Q. I'm going to look at the relationships as you
4 experienced them back in 2015. Was the paediatric
5 department a happy place to work?

6 A. Yes, it was.

7 Q. Were there any difficulties that you were
8 aware of as between any of the professional
9 relationships?

10 A. Not that I was aware of, no.

11 Q. You say in your statement that from June 2016
12 things became strained.

13 A. (Nods).

14 Q. Was that as a result of the moving of Letby to
15 a different role in the investigation that the Trust was
16 doing?

17 A. That's correct. It was primarily to do with
18 us raising concerns about Letby that the nurse ward
19 manager and consequently probably a group of nurses felt
20 an insult to their profession and consequently were
21 quite difficult.

22 Q. Now, before that date, so before things became
23 difficult, I would just like you to consider what
24 Eirian Powell has told us. She has suggested that:

25 "The Consultants would think the relationship was

82

1 beyond the -- so there's long consider door then there
2 is a big open area where the paediatric secretaries sit
3 and, at the end of that, there's three rooms and mine
4 was to the right, then there was a middle one and of the
5 left one, and I have been -- I couldn't tell you the
6 exact year but I -- that we moved into that office, I'll
7 have to go back and check (*redacted*).

8 Q. We heard from Dr Holt something about where
9 Dr Howie Isaacs had her office. Was that in the general
10 area?

11 A. Yes, so that was in the general area where
12 the -- so the -- in the -- because the corridor offices
13 are bigger, two Consultants share those offices. The
14 three that I'm referring to, one of which I am, are much
15 smaller, so there's only one Consultant, so there's
16 always an office shared by two Consultants or
17 a Consultant and another, there's a research nurse that
18 shares one with another Consultant. So those offices,
19 because they're bigger -- and that's why Dr Issac shared
20 a room with Dr Holt for a period of time, I think.

21 Q. Dr Issac was community paediatrician but part
22 of the safeguarding team.

23 A. That's right.

24 Q. And does that mean that throughout the period
25 that we're going to consider, you could have found

84

1 Dr Issac fairly easily if Dr Issac was in work or did
 2 Dr Issac not use the office very often?
 3 **A.** As far as I remember, when she was sharing an
 4 office Dr Isaac was there frequently enough. And
 5 whether we could have, yes, we could have.

6 I think the main issue was how we saw that issue as
 7 safeguarding. I do know Dr Isaac was consulted later on
 8 when we were having huge difficulties with the
 9 management. But I think, in good faith, we started the
 10 process by going to the managers because that seemed
 11 like the appropriate channel at the time.

12 **Q.** Just as you look back on it now, bearing in
 13 mind that Dr Issac was around, was a paediatrician, was
 14 involved in safeguarding, do you think Dr Issac should
 15 have been involved sooner than she was?

16 **A.** Yes, I think it would have been definitely
 17 worth having a discussion around it with her and then
 18 she could have advised us what could be done or another
 19 alternative route we could take, or a route that we
 20 could take from the start.

21 **Q.** Now, we're jumping ahead a little bit here but
 22 just focusing on the issue of Dr Issac, were you aware
 23 of a period before June of 2016 where there were
 24 informal discussions between the Consultant
 25 paediatricians about their concern about the neonatal

85

1 exactly what page it is, it does refer to that the SUDIc
 2 process doesn't necessarily apply to neonatal deaths,
 3 they can be dealt with within the neonatal department,
 4 and I think that was what we were doing.

5 So it wasn't that the neonatal deaths weren't being
 6 analysed or discussed. It was not through a SUDIc
 7 process because the SUDIc process essentially is for
 8 children who have collapsed at home or have been brought
 9 very sick to the hospital or to A&E, and then you start
 10 the process by -- with the police and the social care
 11 visiting the home, which is the crime scene, which
 12 again -- I'm not taking this into account, and we can
 13 come back to that -- doesn't seem appropriate to a baby
 14 dying on the unit because if you have had a baby die on
 15 the unit, to call the police in and social care in and
 16 make that a crime scene, it sounds for mostly deaths
 17 that I'd had before Child O and P had been deaths that
 18 we had sadly to some degree anticipated and the
 19 discussion with the Coroner or Coroner's officer would
 20 inform what I thought of that death, whether that was to
 21 some degree expected and explained or not and decide on
 22 a postmortem on the basis of that.

23 So I thought we had a reasonable process to account
 24 for expected, but I think we didn't -- the problem is
 25 it's unexplained and unexpected in neonates, it's how

87

1 unit?

2 **A.** No.

3 **Q.** You weren't part of those discussions?

4 **A.** No.

5 **Q.** We'll come to exactly when you came to have
 6 concerns of your own and when you became aware of others
 7 in due course. So far as safeguarding is concerned, had
 8 you ever received any training on what to do in the
 9 event you were concerned a member of staff posed a risk
 10 to babies?

11 **A.** No. No. We had -- we -- there's mandatory
 12 safeguarding training that we as paediatricians need to
 13 complete, but that's to do with children who have been
 14 harmed or there's a potential to harm them, how to deal
 15 with the families, the children and the processes that
 16 involve social care. But not what to do if it's
 17 a member of staff or a colleague.

18 **Q.** Do you think that's a gap in your training?

19 **A.** Yes.

20 **Q.** As far as the SUDIc process was concerned,
 21 what was your understanding at the time about whether or
 22 not it applied to deaths which occurred on the neonatal
 23 unit?

24 **A.** So I was reading the documents that were sent
 25 through, and when you read on I couldn't tell you

86

1 you define, isn't it? Unexpected is you didn't expect
 2 the child to die in the previous 24 hours by definition,
 3 which will probably apply to a lot of neonates as well,
 4 but what we expect in neonates is they become poorly and
 5 then they gradually decline and get worse over a period
 6 of time and then they sadly die.

7 So to some extent there are certain complications
 8 that explain that.

9 **Q.** If I --

10 **A.** I don't know if I'm --

11 **Q.** If I can just stop you there if you don't
 12 mind --

13 **A.** Yes.

14 **Q.** -- I think what I've gathered from your answer
 15 is -- and I'll just reflect it back to you -- that your
 16 understanding at the time was the SUDIc process did not
 17 apply to hospitals --

18 **A.** Yes.

19 **Q.** -- is that correct?

20 **A.** Yes.

21 **Q.** I'd like to ask you, please, about your
 22 understanding of Datix forms. Please, in summary, can
 23 you tell us what circumstances you thought a Datix form
 24 was required.

25 **A.** So my understanding was Datix was for purposes

88

1 of, for example, drug errors, any clinical event,
 2 administrative event that you wanted to flag up and
 3 whether it would pick up if certain incidents were being
 4 reported again and again, whether there was a theme to
 5 them that you could then pick up and address and share
 6 learning on the basis of that. And then, like Dr ZA
 7 said, deaths were reported just as not because they were
 8 incidents but just so they would be recognised that they
 9 had occurred.

10 **Q.** Does it follow from your answer that, like
 11 Dr ZA, in the event that there was a sudden unexpected
 12 and serious deterioration potentially leading to
 13 resuscitation you did not think that that needed to be
 14 recorded?

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

16 **Q.** I'm going to come to our timeline now, please,
 17 and start in June. You tell us in your witness
 18 statement that you were involved in the care of Child B
 19 on 9 June of 2015; is that correct?

20 **A.** That's correct.

21 **Q.** And that you considered Child B's
 22 deterioration to be unexpected --

23 **A.** Yes.

24 **Q.** -- is that right?

25 And that you were called in and arrived after

89

1 details because that might identify this mother had
 2 a disorder, and we had been looking into how that might
 3 affect the baby, and I think earlier in the day there
 4 had been some discussions with the specialist, so there
 5 was that in the background on my mind.

6 Infection obviously with any neonate who
 7 deteriorates suddenly we would -- because that's
 8 probably the easiest and the quickest thing to do and
 9 very common in babies, and then obviously things
 10 consequent to infection which can be -- which can lead
 11 to problems with coagulation or clotting or platelet
 12 disorder, so those were the kind of things going in my
 13 mind.

14 But I think the reassuring thing at the time that
 15 I thought, whatever that event had been that baby had
 16 improved.

17 **Q.** Did you take any steps to investigate why
 18 Child B suddenly and unexpectedly deteriorated?

19 **A.** No, I did not at the time.

20 **Q.** And should you have?

21 **A.** I think with hindsight if I had known about
 22 Baby A and what had happened and the similarities in the
 23 rash between the two babies, I -- I'm not aware if there
 24 were concerns by this time that were being discussed
 25 about rashes. But I think if I had been aware,

91

1 Child B was receiving emergency treatment.

2 **A.** Yes.

3 **Q.** Did you see any blotchiness or rash on
 4 Child B?

5 **A.** I did. I think in my statement I have
 6 referred to -- I've said that the Registrar has
 7 documented that the rash was much more florid and
 8 widespread, and by the time I arrived the Registrar had
 9 intubated, they'd given a fluid bolus, done bloods and
 10 the rash was blotchy on the right side of abdomen and
 11 arm.

12 **Q.** I believe -- if you're looking for a reference
 13 it's paragraph 34. I don't think you need to turn it up
 14 because that is what your statement says.

15 **A.** Okay.

16 **Q.** What you also say is that Child B was, when
 17 you were there, improving and so you were not
 18 particularly concerned.

19 **A.** Particularly concerned from the point of view
 20 of I think in my statement and my handwritten notes I've
 21 put "sudden deterioration", this rash, and the treatment
 22 and then "much better", and I've put three question
 23 marks or two question marks "cause". And then I have
 24 considered the differential diagnosis that it could be.

25 From what I can remember, I wouldn't go into the

90

1 I probably would have taken it back to my colleagues and
 2 discussed with them what their thoughts were.

3 **Q.** So is it the position that you knew nothing
 4 about the death of Child A?

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

6 **Q.** And does that surprise you now that the
 7 following day you are here treating Child B?

8 **A.** Yes. See, the thing is, as we mentioned
 9 previously how busy we were, so you had one
 10 paediatrician of the week who would know about the
 11 babies on the neonatal unit and the ward, and then there
 12 was an on-call system, so when you're on-call you don't
 13 physically know about every baby and every child. You
 14 would do a sort of ward round, you would be aware the
 15 sick babies and the sick children, and then you're
 16 on-call.

17 Now, previously, previous to this cohort that
 18 started in 2015, the deaths would be discussed at the
 19 mortality and morbidity meetings, and I think they were
 20 so few and far between you would probably find out about
 21 them by speaking to colleagues. And whether it was just
 22 because it had occurred the day before that I hadn't
 23 become aware of it -- and I don't remember, I think the
 24 first I learned the similarity of the rash between A&B
 25 was when I got these statements.

92

1 Q. These statements.
 2 A. Yes.
 3 Q. Well, we'll come to that in a moment, my
 4 question was really whether looking back on it, you're
 5 surprised. I'll just try and unpack that a little bit
 6 for you. We know that deaths on the neonatal unit
 7 before 2015 were not common occurrences.
 8 A. Yes.
 9 Q. This is a death that had taken place just the
 10 day before.
 11 A. Yes.
 12 Q. And just --
 13 A. Yes, I mean --
 14 Q. Is it in fact surprising that nobody --
 15 A. Yes, I think it is --
 16 Q. -- told you --
 17 A. -- especially with what follows after -- and
 18 I don't know whether you're going to ask me that
 19 Dr Lambie questions that I didn't know about this and
 20 things that I did. Dr Lambie was on that night, and
 21 I don't recall her mentioning that she was -- I know she
 22 went and found other colleagues and discussed with them
 23 and that generated a discussion, following which there
 24 was an assumption I was part of that discussion. But at
 25 the time, neither the nurses nor the doctor on duty said

93

1 INQ0025743, and we looked at this with Dr ZA this
 2 morning. This is an email, 23 June, if we go to the
 3 page 2, please.
 4 A. Okay.
 5 Q. We can see at the top that you are one of the
 6 people that Dr Gibbs sent that email to.
 7 A. Okay.
 8 Q. And he specifically draws attention not only
 9 to Dr Lambie who he's spoken to but to the commonality
 10 of the "strange purpuric-looking rash". And, Dr V, my
 11 question is this, that if having seen that email, which
 12 I'm sure you can agree now --
 13 A. Yes.
 14 Q. -- draws an association between Child A who
 15 you didn't treat and Child B who you did --
 16 A. Yes.
 17 Q. -- was that not a prompt for you to go and
 18 speak to your colleagues to discuss it further?
 19 A. I honestly don't remember this email.
 20 I don't.
 21 Q. Well, do you have --
 22 A. In the bundle that I have I'm not copied into
 23 that email.
 24 Q. Well, if you could just accept from me for
 25 a moment --

95

1 this is really unusual, this is what happened two days
 2 before, and that might have prompted me to discuss with
 3 colleagues.
 4 Q. You've told us that in fact you didn't find
 5 out about the similarity between Child A and Child B's
 6 presentation until when you did your police witness
 7 statement or when you did the Inquiry statements, when
 8 was it --
 9 A. I think with the Inquiry statement because --
 10 I'm not quite sure at what point, because when I was
 11 doing the police statements I was only doing my
 12 statement. I wouldn't have known because I had never
 13 been involved with Child A, so I wouldn't have known.
 14 And from -- I mean, I can't remember from
 15 eight/nine years ago whether I knew that night when
 16 I came in, and I have documented that I have updated the
 17 parents whether I knew that they'd lost the twin. I'm
 18 really sorry but I don't remember.
 19 Q. Dr V, I understand that your evidence, though,
 20 is that if you had known about the connection --
 21 A. Yes.
 22 Q. -- you would have gone to speak to your
 23 colleagues about it.
 24 A. Probably, yes.
 25 Q. Well, can I just seek to refresh your memory.

94

1 A. Yeah, fine, yeah.
 2 Q. -- that this is the copy --
 3 A. Yeah, yeah.
 4 Q. -- that the Inquiry has --
 5 A. Yeah.
 6 Q. -- and, I mean, on the face of it you are
 7 copied in --
 8 A. Yeah.
 9 Q. -- so if it is right that you were sent that
 10 email, should you have gone to speak to your colleagues
 11 having received that email to try and understand --
 12 A. Yes.
 13 Q. -- more about the rash?
 14 A. Yes.
 15 Q. Now, as you say, there was a neonatal -- thank
 16 you very much indeed, we can take that down -- there was
 17 a Neonatal Mortality Meeting on 29 July, and you deal
 18 with this in your witness statement saying:
 19 "I don't recall discussions with anyone who had
 20 attended the Neonatal Mortality Meeting on 29 July."
 21 Obviously Child B who you dealt with wasn't the
 22 immediate subject matter of that meeting. But, again,
 23 should there have been discussions between the
 24 Consultant paediatricians to pool your knowledge, given
 25 that the connection or potential connection between

96

1 those four babies A, B, C, and D had been identified on
 2 23 June?
 3 **A.** Yes.
 4 **Q.** And doing the best you can, what do you think
 5 the reason is for that apparent lack of communication at
 6 the time?
 7 **A.** I've -- I've thought long and hard about this.
 8 I think people were concerned individually and talking
 9 to each other in smaller groups. I don't know whether
 10 it was the workload, lack of time, that there wasn't
 11 this around the table thrashing out what was actually
 12 going on.
 13 I think the perinatal morbidity and mortality
 14 meetings tend to be more they were joint obstetric and
 15 neonatal meetings. They were more a learning and --
 16 and, from that point of view, chronology of events. To
 17 pick up trends, yes, but to bring up issues like if
 18 there was potential harm being done, I'm not sure if
 19 they were the right forum for that.
 20 Now, whether that needed to be taken out of that
 21 mortality and morbidity meeting and something that the
 22 Consultants should have come together separately for --
 23 **Q.** Well, this was -- and I'm here just talking
 24 about the period of June 2015 -- this was an
 25 extraordinary time for the neonatal ward or unit, wasn't

97

1 **Q.** -- and you had a valuable contribution to
 2 make, didn't you?
 3 **A.** I did, yes.
 4 **Q.** Child F, you heard me ask questions of Dr ZA
 5 about Child F and the insulin result. Dr Gibbs has
 6 described it as a collective failure by the Consultants
 7 in relation to the insulin and C-peptide result --
 8 **A.** (Nods).
 9 **Q.** -- and the fact that that wasn't acted upon.
 10 Do you agree with that?
 11 **A.** Yes.
 12 **Q.** Now, there was a Neonatal Mortality Meeting
 13 for Child D on 10 September 2015. Do you, sitting there
 14 now, have any recollection of what was discussed at that
 15 meeting?
 16 **A.** No, I'm sorry.
 17 **Q.** Let's just bring up the INQ, INQ0005445.
 18 So we can see that there was another non-indictment
 19 baby discussed in the first row. You are one of those
 20 in the top right-hand corner identified as attending
 21 this meeting. Do you see that?
 22 **A.** Yes.
 23 **Q.** And then we can see Child D is mentioned
 24 towards the bottom.
 25 **A.** Yes.

99

1 it?
 2 **A.** Yes.
 3 **Q.** And so do you think that that required
 4 something that was tailored for this particular
 5 situation to have a formal look at that cluster?
 6 **A.** Yeah, I think that was done. From what
 7 I gather, these -- at least three deaths were reported
 8 as a serious incident, but -- and -- and looked into but
 9 I wasn't aware that that had happened. So I think that
 10 was done, so the neonatal lead did pick up that these
 11 three deaths had happened in quick succession and there
 12 was -- I think it was reported as a serious incident and
 13 that was -- then those deaths were analysed.
 14 **Q.** I mean, if I can just stop you there, you're
 15 quite right that there was a serious untoward meeting --
 16 incident meeting, but really the reason I'm asking you
 17 these questions is because your involvement was with
 18 a baby that --
 19 **A.** Didn't --
 20 **Q.** -- didn't fit the criteria for that meeting on
 21 the face of it --
 22 **A.** Yes.
 23 **Q.** -- and it's -- we can see that on 23 June the
 24 association between all four was being discussed --
 25 **A.** Yes.

98

1 **Q.** And if we turn over the page, we can see in
 2 the left-hand column with text, about halfway down:
 3 "Episode? Purpura in evening that resolved."
 4 **A.** Yeah.
 5 **Q.** And obviously we'd seen that email from the
 6 end of June where this -- that exact word was used to
 7 describe A, B and D, and here you are at a meeting in
 8 September discussing D.
 9 I appreciate you say that you don't have any
 10 recollection of the meeting, but just think back. You'd
 11 seen on Child B purpura, was that something that it
 12 would have been relevant for you to raise at that
 13 meeting, or is it just focused on Child D and,
 14 therefore, it wouldn't be appropriate to say, "Well,
 15 that's something that I think I may have seen around the
 16 same time"?
 17 **A.** I don't know. If I can -- I mean, yes, with
 18 hindsight, whilst we are putting the chronology of
 19 events as we know now, it seems very relevant. But it
 20 doesn't look like it jiggled my memory that way at the
 21 time is all I can say.
 22 **Q.** Just to examine that for a moment. To try and
 23 understand the approach that was being taken by you at
 24 the time, obviously when there is a death that is
 25 a terrible incident that requires further investigations

100

1 and it has its own process, but you have told us that
 2 when there is a collapse from which a baby recovers
 3 there isn't such formality around it?
 4 **A.** (Nods).
 5 **Q.** And that was your situation for Child B,
 6 wasn't it?
 7 **A.** Yes.
 8 **Q.** Was it the position that at the time the
 9 Consultants in relation to anything that didn't result
 10 in a death simply just moved on rather than keeping
 11 a mental record of it and thinking back to it?
 12 **A.** I think that is probably up until Child O and
 13 P the only collapse that I went to. So it was the first
 14 and the last because the later involvement that we will
 15 discuss -- and for me, yes, it was an unexpected event.
 16 I didn't quite understand what had happened.
 17 But at the back of my mind I wasn't aware that this
 18 was happening with other babies and with other people
 19 and I think that probably -- that information would have
 20 been helpful that if this was known that these unusual
 21 events were occurring to all of us -- or with all of us
 22 whilst we were on-call that might have rang alarm bells.
 23 **Q.** And whose responsibility, if anybody's, was it
 24 to make sure that when there were things that you could
 25 all discuss to derive learning from that that discussion

101

1 "Child I had recurrent episodes of abdominal
 2 distension of feed intolerance. She had raised
 3 infection markers and had been on antibiotics. The plan
 4 was to complete 7 days of antibiotics. On 12 October
 5 she was found blue and apnoeic in her COT received
 6 resuscitation."
 7 And, yeah -- so that was the collapse, so that was
 8 the night of the 12th, and I saw her on the ward round
 9 on the 13th.
 10 **Q.** Yes.
 11 **A.** Sorry, yes.
 12 **Q.** Yes.
 13 **A.** Yes.
 14 **Q.** So I think it was at the early hours of the
 15 13th --
 16 **A.** Yes.
 17 **Q.** -- that the collapse happened --
 18 **A.** Yes, yes.
 19 **Q.** -- and you were aware when you came on duty --
 20 **A.** Yes.
 21 **Q.** -- of that collapse, and indeed what you tell
 22 us is that there was further deterioration later that
 23 morning.
 24 **A.** Yes.
 25 **Q.** And so, again, just reflecting, Dr V, on what

103

1 should be organised?
 2 **A.** I think the responsibility was from all of us,
 3 on all of us, yes. So I'm as much to -- I didn't raise
 4 it on any forum either at the time.
 5 **Q.** Move forward, please, to October 2015 and
 6 Child I. Child I, insofar as you were aware, suddenly
 7 and unexpectedly deteriorated in the early hours of
 8 13 October; is that right?
 9 **A.** That's right. I think if I can go back to my
 10 statement there was a background to her.
 11 **Q.** By all means, it's from paragraph 52, page 7.
 12 **A.** Sorry. Sorry, which bit is my statement in?
 13 **Q.** It should be the very first tab that you have?
 14 **LADY JUSTICE THIRLWALL:** It may be tab 2.
 15 **A.** Yes, sorry, which page did you say?
 16 **MR DE LA POER:** Page 7. Paragraph 52 is the start
 17 of where you deal with Child I, and I've just asked you
 18 a question focused on whether you say at paragraph 53.
 19 **A.** Yes. I've got the wrong -- I don't know where
 20 my statement is. Is it --
 21 **Q.** I don't know whether Mr Suter is able --
 22 my Lady, if you think it appropriate, to see if we can
 23 assist the witness.
 24 **A.** Yeah, I think I've found it. Yeah, so I've
 25 put:

102

1 you've told us, you said that Child B was the only
 2 collapse you were involved with. I appreciate that you
 3 weren't physically present for Child I's first collapse,
 4 but in fact were you aware at the time that Child I also
 5 was suddenly and unexpectedly deteriorating?
 6 **A.** Yes. So I've looked into this and read back
 7 on my handwritten notes as well and, rightly or wrongly,
 8 at the time I thought there was a reason because she had
 9 abdominal distension, and I've written my examination
 10 findings that her abdomen was tender. If --
 11 **Q.** No --
 12 **A.** Given the -- with abdominal distension the
 13 most likely reason was the abdomen, and my assessment
 14 that I've referred to my statement was that that was
 15 what was causing the problems which led me to discuss
 16 her with the surgeons at Alder Hey.
 17 So I think, yes, I recognised that the collapses
 18 were happening but I was putting them down to a medical
 19 reason, which, again with hindsight, was not the correct
 20 judgment. But I didn't think they were unexpected
 21 collapses. I think they were consequent to her
 22 infection. And then she was -- and I think what
 23 I didn't connect was that that happened multiple times,
 24 she would improve in the daytime, collapse again at
 25 night, she would go away, get better come back, and that

104

1 it would happen again until the time that --

2 **Q.** So you noted, did you, that a significant
3 number of these collapses were happening at night?

4 **A.** Only now with hindsight looking at -- at the
5 time, no.

6 **Q.** Now what you tell us having charted Child I's
7 progress over a number of days and there were a number
8 of collapses deteriorations, you say this:

9 "It never crossed my mind there was even a remote
10 possibility of deliberate harm being inflicted on
11 Child I."

12 **A.** Yes.

13 **Q.** And just bearing in mind that there had been
14 the deaths in June, and we know that Child E died in
15 August, why do you think it was that that thought didn't
16 even cross your mind?

17 **A.** I just couldn't think that that was
18 a possibility. That's all I can say.

19 **Q.** Did you have any discussion with your
20 colleagues following the death of Child I about concerns
21 that you or they had about what was happening on the
22 neonatal unit?

23 **A.** No.

24 **Q.** And you heard me say to Dr ZA earlier that the
25 Inquiry has received evidence that Dr Newby, Dr Gibbs,

105

1 lead for paediatrics, what I tend to do is I can move
2 the cases around. If someone says "I want to present X
3 but I'm not there", either they will supervise a trainee
4 with the case presentation and learning or they will
5 move it to a time that they are available.

6 I don't know what the arrangements with perinatal
7 mortality and morbidity meetings were but I think making
8 an effort that the person who was involved then you come
9 to -- I think Dr Gibbs was at the death -- was he, at
10 the meeting?

11 **Q.** Yes, Dr Gibbs was at the meeting.

12 **A.** Yes. So, yeah -- and for the collapses that
13 were -- so I didn't witness a collapse as such. They
14 were happening on nights. So if they had -- she had
15 four collapses, then that would have been probably four
16 different Consultants. So I'm assuming that at least
17 some of the Consultants who witnessed collapses were
18 there in addition to Dr Gibbs and whether all of us
19 should have been there, yes, in an ideal world but
20 realistically it's probably, given -- I mean, there have
21 been times when I have been in the hospital but
22 I haven't been able to go to the meeting because I've
23 got something more urgent to do. So --

24 **Q.** I think you mentioned it as a perinatal review
25 meeting which takes place with your obstetric

107

1 Dr Jayaram and Dr Brearey appear to have been talking
2 around that time. You weren't involved in those
3 discussions?

4 **A.** No.

5 **Q.** And if it be right that they were concerned
6 about what was happening on the neonatal unit, whatever
7 their level of suspicion, should you have been spoken to
8 as one of the Consultant paediatricians?

9 **A.** Yes.

10 **Q.** Now, there was a Neonatal Mortality Meeting on
11 26 November which you didn't attend. That was in
12 relation to Child I. Now, bearing in mind that you were
13 substantially involved in Child I's care, and a number
14 of very serious episodes, should arrangements have been
15 made to make sure that you were able to attend?

16 **A.** So just to give you a background of how these
17 perinatal morbidity and mortality meetings are arranged,
18 I think I've explained somewhere in my statement, these
19 are preset rolling half days and the idea is that both
20 obstetric and paediatric teams attend, so these are
21 preset for the whole year, like we have for (redacted)
22 preset days when they'll be perinatal and paediatric
23 mortality and morbidity meetings. And, as it happens,
24 not everyone can be present at every meeting.

25 What we tend to do -- because being the governance

106

1 colleagues. In fact this was just a Neonatal Mortality
2 Meeting.

3 **A.** Okay. Right. Okay.

4 **Q.** So you can take it from me or I can bring it
5 on the screen --

6 **A.** No, that's fine, that's fine, I --

7 **Q.** So was there greater flexibility around the
8 timing of the Neonatal Mortality Meeting?

9 **A.** I don't know because my understanding was
10 unless this -- this was arranged like this, but they're
11 usually called PNMMS and they are pre-decided however
12 times a year. I know that because they get the first
13 pick and I get the second one when we do the -- because
14 they have to liaise with obstetrics, so they take
15 priority because it's two different departments.

16 **Q.** Well, we can perhaps investigate that further
17 with another witness.

18 I just want to deal, please, with one more topic
19 under the heading of Child I. The Inquiry is
20 investigating whether it was the case that Letby was on
21 one shift moved away from being responsible from
22 child -- for Child I.

23 Is that something that you were aware of?

24 **A.** No.

25 **Q.** If that happened, as somebody who was involved

108

1 in the care of Child I, should you have been told about
2 it?

3 **A.** Absolutely, yes. I think it would depend on
4 why she was removed from the care, what the reason had
5 been because that decision would have been made by the
6 nursing staff because there is a shift leader who
7 decides which nurse will look after which baby, and if
8 they have made that decision I think you would probably
9 need to know what the reason for that decision was and,
10 if the reason for the decision was to give Letby some
11 respite from looking after an intensive care baby that's
12 a different matter that probably the doctors didn't need
13 to know about.

14 If it was to do with the shift leader's concern
15 about harm, then I think that should have been escalated
16 immediately to everyone.

17 **Q.** And in fact presumably not just stopping at
18 the Consultant paediatricians but going higher would you
19 say?

20 **A.** Yes, yes absolutely. Yes.

21 **Q.** So Dr V, we're going to move forward to 2016
22 and the thematic review of neonatal mortality.

23 The meeting took place on 8 February 2016 and you
24 were one of the attendees; is that right?

25 **A.** That's right.

109

1 or special skills --

2 **A.** Yes.

3 **Q.** -- or special pre-awareness of the issues?

4 **A.** No.

5 **Q.** Before you went to the meeting, did your
6 Consultant colleagues know that you were there
7 effectively as -- to represent their interests on that
8 meeting?

9 **A.** I think that's an assumption because the email
10 goes out to all of us, and if somebody offers, "Yes,
11 I will go", then it's an assumption that that's
12 a representation from all of us. And Dr Brearey was
13 going to be there as the neonatal lead so ...

14 **Q.** And did any of your colleagues approach you
15 before the meeting took place to say, "Look, I have this
16 particular concern about this particular baby, could you
17 see whether that is one of the themes that you identify
18 as part of your thematic review?"

19 **A.** No.

20 **Q.** Again, looking back on it now, bearing in mind
21 that this is a thematic review and different Consultants
22 had been involved at different stages of the care, does
23 it surprise you that there was no prior discussion with
24 your colleagues who couldn't be there about any
25 particular concerns that they may have had?

111

1 **Q.** Just help us to understand why it was that it
2 was -- you and Dr Brearey from the Consultant body,
3 why -- why did you attend that --

4 **A.** Yes.

5 **Q.** -- given that you hadn't in fact, I don't
6 think, been present at any of the deaths certainly of
7 the indictment babies?

8 **A.** Yes. So I remember -- well, there was
9 an email that went round saying that an external
10 reviewer is coming to look at some data that we need to
11 present to them and I need another paediatrician for the
12 meeting to be quorate, and that happened with a lot of
13 other commitments where more than one Consultant was
14 needed or there was a certain number needed to complete
15 a review, and we offered depending on our availability,
16 and it was consequent to that because I was available at
17 that time I said I could go, and it was mainly that more
18 than anything else.

19 **Q.** So it was, and I'm not underestimating the
20 complexity of people's diaries, but entirely down to
21 availability --

22 **A.** Yes.

23 **Q.** -- that you went as opposed to anyone else --

24 **A.** Yes.

25 **Q.** -- not because you had any special knowledge

110

1 **A.** Yes.

2 **Q.** I mean, for that meeting to be truly
3 effective, didn't there need to be that feeding in from
4 the Consultant body so that all of their perspectives
5 were represented at the meeting?

6 **A.** Yes.

7 **Q.** We will ask Dr Brearey about it, but certainly
8 speaking for yourself, you weren't aware of any such --

9 **A.** No.

10 **Q.** And going into that meeting, did you have any
11 awareness that any of your colleagues, whether
12 Dr Brearey, other Consultants or anybody else, had any
13 concern at all that these deaths may be unnatural?

14 **A.** No.

15 **Q.** Did you have any such concern yourself going
16 into that meeting?

17 **A.** No.

18 **Q.** Now, in the form the Inquiry has received it,
19 the record of that meeting on 8 February has an appendix
20 attached to it with staff names.

21 **A.** (Nods).

22 **Q.** I would just like to bring up, please
23 INQ0003190.

24 So this, Dr V, is a version of that appendix but it
25 has one very significant difference to the version that

112

1 was appended to the meeting, which is that, as we can
2 scroll through the pages, Letby's name is identified in
3 red whenever it appears.

4 **A.** Yes.

5 **Q.** Now, this document is dated 19 January, so
6 it's about two weeks or so before -- perhaps three weeks
7 before the thematic review meeting on 8 February, and it
8 was prepared, as we understand it, by Eirian Powell.

9 Did you ever see this version, ie the version with
10 Letby's name in red highlighted?

11 **A.** No. No, I've seen it at some point recently.

12 I don't know whether that's part of whether it's been
13 sent in the Inquiry thing. But certainly at the
14 thematic review and afterwards, I wasn't -- I didn't
15 clock on from that thematic review that Letby was
16 looking after or on shift for all of these babies.

17 **Q.** Thank you, we can take that document down.

18 So we'll come to the record, and there are
19 effectively two versions of the thematic review, one
20 which is dated 8 February and one which is 2 March when
21 additional changes are made. But let's look at the
22 version from the meeting that you attended. INQ0003217.

23 So we can see there that you are identified as one
24 of the attendees, the second on the list, and we don't
25 need to review every line of this, I'm sure you are well

113

1 provided care to?

2 **A.** No.

3 **Q.** And -- but bearing in mind you've told us that
4 those sudden unexpected collapses, that was the only
5 one, although Child I perhaps, why do you think that
6 seeing that there was a reference to a twin who arrested
7 24 hours later that didn't prompt a recollection in you
8 about Child B, the rash and all the discussion that had
9 taken place over email as we have seen it back in June?

10 **A.** All I can say to you is I, like I said to you,
11 I do not remember that email and the email version that
12 I have of the rash I am not copied into it in my bundle.

13 Coming to this, should it have prompted me to think
14 about it? Yes. It should have and no, it didn't. I'm
15 sorry.

16 **Q.** And we will just move through the document.
17 We can go to page 3. We can see for Child C, for
18 example, that the discussion included that there was
19 a PM report but no cause for deterioration identified.

20 **A.** Mmm.

21 **Q.** Do you have any recollection, sitting there
22 now, of the discussion about Child C and the fact that
23 there was no cause for the deterioration that even after
24 a postmortem that was identified?

25 **A.** No.

115

1 familiar Dr V --

2 **A.** Yes.

3 **Q.** -- with the content of this document?

4 **A.** Yes.

5 **Q.** But if we go over the page, we'll get

6 a flavour of what was going on, that under the heading
7 "Summary of Mortality Cases Discussed" we see a table
8 where there is a diagnosis and summary of discussion and
9 any action points arising.

10 Now, the second entry on that is Child A, and we
11 can see most of the way, it's about five lines up from
12 the bottom, that one of the entries about Child A's
13 presentation is:

14 "Sudden unexpected arrest." With.

15 The age that was visible then.

16 **A.** Yes.

17 **Q.** "Twin also arrested 24 hours later."

18 Now, that "Twin also arrested 24 hours later" is
19 a reference to Child B --

20 **A.** Yes.

21 **Q.** -- who you've told us you were involved with.

22 **A.** Yes.

23 **Q.** At that meeting, did you register the fact,
24 and we are here about eight months later, the fact that
25 you were talking about the twin of a child that you had

114

1 **Q.** I mean, does that, sitting there now, strike
2 you as unusual that you would have a death on the
3 neonatal unit and a postmortem report, but no cause for
4 the deterioration being known?

5 **A.** No. I am just thinking through because pm
6 says "widespread hypoxic ischemic damage to the heart"
7 and because I have followed the transcript, I know there
8 was a prolonged discussion whether that hypoxic ischemic
9 damage was before or after the collapse and I think
10 there were varying opinions on cause and effect, and the
11 baby was IUGR, absent end diastolic flow.

12 So there were factors there to compromise the baby
13 significantly.

14 **Q.** But be those factors as they may, the record
15 of the discussion is --

16 **A.** Yes.

17 **Q.** -- no cause for deterioration identified.

18 My question really is, is that an unusual state of
19 affairs?

20 **A.** Yes.

21 **Q.** Did it stand out to you at the time?

22 **A.** No.

23 **Q.** If we move forward, please, to page 5, we
24 don't need to look. We can see that there was
25 a discussion about Child I.

116

1 A. Mmm.
2 Q. Obviously you had been involved in Child I's
3 care?

4 A. Mmm.
5 Q. Do you have any recollection of bringing your
6 experience of the treatment of Child I to the discussion
7 that took place or was the focus upon Child I's death
8 only?

9 A. I don't think there was a discussion around
10 opinions. They were presented as chronology of events
11 as they are. I don't recall actively contributing,
12 giving my opinion.

13 Q. If we go over the page, to page 6. We can --
14 forgive me, it's my mistake, a reference there -- at
15 page 7. We can see the themes that were identified.

16 A. Mmm.

17 Q. And one of the themes is the timing of
18 arrests?

19 A. Yes.

20 Q. Now, one of the babies under discussion was
21 Child I and you had seen Child I on a number of
22 consecutive mornings and known about the collapses.

23 A. (Nods).

24 Q. Did -- seeing that that was a theme that was
25 identified, did you contribute that you can recall to

117

1 Q. But it is related. If we just go over the
2 page just so that we can understand how the system
3 works.

4 If we then start at page 9, please, we will see
5 that appendix 1. My question about that was that
6 appears attached to the meeting notes. Was that a chart
7 that you all had in front of you which you talked about
8 in the meeting or did you not see that chart as part of
9 the meeting?

10 A. I don't remember seeing this Level 2 report
11 and all this. It might have been there, but I -- all
12 I remember is the slides that we have discussed and
13 I think there might have been some staffing analysis
14 slides as well, but just staffing analysis as in doctors
15 and nurses who was on, as far as I can remember. But
16 I --

17 Q. So that brings me back. Thank you, we can
18 take this document down. That brings me back to the
19 evidence that you have just given.

20 When you were at the meeting, was there any
21 discussion about the fact that there appeared to be
22 a very strong association between Letby and all of the
23 cases that were under discussion?

24 A. No.

25 Q. Was there any suggestion at all that there was

119

1 the discussion saying: well, I had experience of
2 Child I and now I think about it and look back over the
3 notes, actually that was true for Child I?

4 A. Yes. I think that had been an observation
5 from the thematic review following which some
6 recommendations were put forward about what more we
7 could look at, whether there had been any deterioration
8 in their observations prior to the time of collapse that
9 we could look -- and so I think Eirian went away to do
10 some more work after that.

11 So there was some discussion on why this would be,
12 whether there are any factors that we can identify
13 what's happening and at the time what wasn't pointed out
14 was the staff member thing because I think that had been
15 a big thing, which wasn't openly discussed, at least
16 during the time that I was there, and I think she went
17 away and did some work on that and if I am correct
18 I think maybe, apart from one baby, didn't identify any
19 untoward signs of deterioration before collapses.

20 Q. So we will come back. I do -- you have just
21 given some important evidence if I may say about what
22 was and wasn't discussed in your presence.

23 I would just like to finish looking at this
24 document and then we will come back to that.

25 A. Okay. Sorry, yes.

118

1 any concern about any particular staff member, even if
2 Letby wasn't named?

3 A. No. I think the general comments were that no
4 particular association between any medical and nursing
5 staff or something along those lines had been
6 identified.

7 So there were no themes as such to go by that we
8 could say, "Well, we can change this and make things
9 better", was the understanding that I left the meeting
10 with.

11 Q. And you left the meeting. Just describe for
12 us as best you can the circumstances of you leaving the
13 meeting. Was it when it was finished and everybody got
14 up and left?

15 A. Yes. Yes, so basically my understanding was
16 the meeting has come to an end, it probably would have
17 been from this time to time and it may -- I mean,
18 I don't remember going back so many years, but I might
19 have had something. You know, the meeting is from
20 1 to 2 and at 2 o'clock I have to go and do this.

21 So even if not everybody has gotten up and left the
22 room I -- my understanding is that the meeting purpose
23 has come to an end, so I can leave now. So I didn't
24 leave as in the middle of the meeting.

25 My understanding from what I can recall is, yes,

120

1 people may have still been sitting there but the meeting
2 presentation bit was over. I probably had another
3 commitment I had to go to, so I left.

4 **Q.** Just to conclude this topic, Dr V. You tell
5 us in your witness statement that at some point after
6 the meeting you have had a discussion with Dr Brearey
7 about what was and wasn't mentioned at the meeting.

8 **A.** (Nods).

9 **Q.** Can you just first help us with when that
10 discussion took place. Was it before the deaths of
11 Child O and P or was it after?

12 **A.** No, that was last year.

13 **Q.** Last year, as recently as last year?

14 **A.** Either this year or last year because I think
15 that had been something on my mind for a long time. It
16 was something that had bothered me a lot to the point
17 that I asked him.

18 **Q.** So you sought Dr Brearey out?

19 **A.** Yes.

20 **Q.** And what is it that you said to him?

21 **A.** He was -- basically said, "Oh, we talked about
22 it afterwards."

23 **Q.** Can I just stop you there. It will be
24 important to hear what he said, but could you tell us
25 what you said to him first?

121

1 **MR DE LA POER:** My Lady, thank you.

2 Dr V, we had reached the thematic review in
3 February. The final version of that document is dated
4 2 March of 2016 and there's an additional section
5 included in it about sudden and unexpected
6 deteriorations. Do you know the section I'm speaking
7 about?

8 **A.** Was it part of my bundle? If it was, then
9 I would have looked at it, yeah.

10 **Q.** It was let's just bring it up INQ0003251. We
11 are going to go to page 7.

12 So although the date at the bottom there is still
13 8 February, in fact we know from the very end that it
14 was updated and there is an additional section, you see
15 number 1 there:

16 "Sudden deterioration. Some of the babies suddenly
17 and unexpectedly deteriorated and there was no clear
18 cause for the deterioration death identified at
19 postmortem."

20 Now, that wasn't in the first version.

21 Firstly, was that discussed at the meeting that you
22 attended on 8 February?

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

24 **Q.** Secondly, were you consulted about this change
25 when -- before it was made?

123

1 **A.** Oh, yes, okay. Sorry. So I said to him that,
2 you know, at the thematic review what is coming out is
3 that one of the things that was identified was that
4 Letby was present at all the -- all -- in all -- on all
5 of the shifts when these babies collapsed. But that
6 wasn't what I took away from that meeting.

7 And he said, "We discussed it after, after the
8 presentation." I said, "Well, I don't remember that",
9 and he said, "Well, it must have been after you left
10 then."

11 That was that.

12 **MR DE LA POER:** Dr V, thank you very much for the
13 time being.

14 My Lady, I have run slightly past 1 o'clock. Can
15 I apologise for that. Given the witnesses that we have
16 today, can I invite my Lady to rise for just 45 minutes
17 over lunch to ensure that we finish at a sensible time
18 today?

19 **LADY JUSTICE THIRLWALL:** Very well. So we will
20 rise now and we will start again at ten to 2 please. If
21 you could be back at ten to.

22 (1.04 pm)

(The luncheon adjournment)

24 (1.50 pm)

25 **LADY JUSTICE THIRLWALL:** Mr De La Poer.

122

1 **A.** No, not that I can recall.

2 **Q.** And, thirdly, did you notice this change when
3 this document was sent to you by email on 2 March?

4 **A.** I don't think so.

5 **Q.** Child L, April 2016, Dr Gibbs has described
6 this as a collective failure of the Consultants in terms
7 of the insulin C-peptide. Do you agree with that?

8 **A.** Yes.

9 **Q.** Were you aware, Dr V, that in May Ian Harvey
10 and Alison Kelly met with Dr Brearey?

11 **A.** Yes.

12 **Q.** You were aware at the time?

13 **A.** I only am aware through the email that he sent
14 later.

15 **Q.** On the 16th?

16 **A.** Yes, that was in May.

17 **Q.** Yes.

18 **A.** Yes.

19 **Q.** What did you understand the purpose of that
20 meeting to be at the time?

21 **A.** I didn't -- if I am honest, I didn't about the
22 meeting. It's the content of that email that Dr Brearey
23 had sent that he had a meeting with Ian Harvey and
24 Alison Kelly following which it was discussed that he
25 and I think Eirian Powell should be informed of any

124

1 collapses.

2 **Q.** Did you discuss with -- if you didn't know
3 about the meeting at the time that it was happening --

4 **A.** Yes.

5 **Q.** -- when you received that email, did you speak
6 to Dr Brearey about, "Why were you meeting Ian Harvey or
7 Alison Kelly?"

8 **A.** No.

9 **Q.** Were you curious when you received that email
10 why it was that Dr Brearey had met them and why he was
11 asking to be notified about collapses?

12 **A.** Yes, I think with hindsight I probably should
13 have been more curious than I was. At the time, the
14 information that I processed in my mind was following
15 that thematic review, because there hadn't been any
16 pattern noted, maybe going forward this was a plan that
17 had been agreed. And, again -- for something that will
18 follow I can say then or I can say it now -- and maybe
19 asked, "Well, what happens when there is a collapse?"
20 Because when there were we didn't have a plan, "What
21 were we going to do?" But I don't think that really
22 sunk in what it meant at the time until much later.

23 **Q.** So we come to the deaths of Child O and
24 Child P. Up until that point in our chronology, so
25 23 June, did you yourself have any concerns whatsoever

125

1 that you went into the thematic review meeting on
2 8 February with Letby's name in your mind?

3 **A.** No, I didn't, because I didn't think those
4 comments were made to the extent to implicate that -- so
5 somebody being there doesn't mean that they're doing
6 something.

7 **Q.** But the point of the thematic review was to
8 look at what might be causing not necessarily to the
9 point of deliberate harm, but what you are telling us is
10 that you heard Dr Newby draw attention to the fact that
11 Letby appeared to be a common factor.

12 **A.** No, no, no. So Dr Newby -- sorry, maybe
13 I didn't say it right -- Dr Newby mentioned after having
14 been on-call that, "She has been there a few times when
15 I have gone in with sick babies." So that was the
16 association she had made, and that was the same
17 association -- not implying that she was connected to
18 the deteriorations. So that at least wasn't my
19 understanding.

20 **Q.** What about Dr Jayaram, when did you hear
21 Dr Jayaram speaking about Letby being associated --

22 **A.** I think again that was in passing, nothing in
23 particular. Just saying that, you know, she's on or
24 she's around.

25 **Q.** I mean, this is a very serious matter, isn't

127

1 about what might be happening on the neonatal unit and
2 whether any of these deaths or collapses were unnatural?

3 **A.** No. So what I did know, and I've mentioned it
4 in my statement, was I'd overheard remarks being made
5 about how when Lucy was around -- around things were
6 happening, and it was more so not being able to
7 quantify, well, is it because she's unlucky that she has
8 shifts which has really sick babies and things happen?
9 And I know from personal experience that you can go
10 through phases where you'll have really bad weeks or
11 really bad on-calls to the point that people say, "Oh,
12 it's you", kind of a thing.

13 And I put it down more to that than even thinking
14 about harm in that context.

15 **Q.** Who was it that you overheard speaking?

16 **A.** I think it probably would have been a few
17 comments from Dr Jayaram, probably Dr Newby, once or
18 twice and saying, "Oh she's on today."

19 **Q.** If I just stop you there. Dr Newby left in
20 February of 2016, so does it follow that you heard
21 Dr Newby say that before February 2016?

22 **A.** Yeah, yeah. So, yeah, yeah, it would have
23 been because I haven't seen her afterwards.

24 **Q.** And having heard your colleagues draw
25 attention to Letby before February 2016, does it follow

126

1 it --

2 **A.** Yes.

3 **Q.** -- because we're talking about babies who have
4 died?

5 **A.** Yeah, yeah. But I don't remember any
6 discussion which implicated that she was actually
7 causing harm.

8 **Q.** When Dr Jayaram said -- drew attention to
9 Letby and her association, did you say to him,
10 "Dr Jayaram, what are you saying? Why are you -- why
11 are you drawing attention to that?"

12 **A.** I think -- because I think we would
13 normally -- that does happen to member of staffs, for
14 example, you know, if I had had a really bad week or
15 I had had a run of bad weeks people would associate that
16 with that this particular individual is heavy footed or
17 attracts emergencies or sick people, which doesn't
18 necessarily mean that they are the ones causing any
19 problems.

20 So I just -- whatever the comments were, they
21 weren't that she is doing something. It was that, you
22 know, she's -- she's on, she's there today, or -- but
23 just -- yeah, I didn't ask in more detail is all I can
24 say because I didn't connect that it could mean
25 deliberate harm.

128

1 Q. Or even accidental harm?
 2 A. Or even accidental harm, yes, yes.
 3 Q. Do you think you should have asked more
 4 questions about why your colleagues were choosing to
 5 speak about that in this very, very serious context?
 6 A. With hindsight, yes. Yeah.
 7 Q. Do you need hindsight to see that that is
 8 a relevant inquiry that you should be making as
 9 a Consultant paediatrician when your colleagues are
 10 talking about it?
 11 A. I think with the way those comments was --
 12 were made at the time I couldn't tell you exactly what
 13 was said. But I don't remember the way these -- so
 14 these were casual conversations, they weren't serious
 15 conversations in passing. They certainly weren't
 16 discussions that we have talked about the rashes and the
 17 connection and discussing with the juniors. None of the
 18 juniors ever spoke with me about concerns.
 19 So with the way those comments were made, I think
 20 now that I know what I know now I would ask more
 21 questions, but at the time it didn't seem concerning.
 22 Q. You were involved in the care of Child O when
 23 Child O died; is that right?
 24 A. Yes.
 25 Q. You had received an email on 16 May from

129

1 The next morning -- so the handovers are generally
 2 a tool that are used for sharing information about
 3 children and babies who are on the ward and how to
 4 manage those problems. It is not normal practice to
 5 discuss what has happened.
 6 What we do do is we will speak to the doctors
 7 separately or ask them to come and see us and offer
 8 support in what way we feel they might need it or
 9 signpost them.
 10 Q. So one reason you might have discussed the
 11 death of Child O is, of course, there were still Child P
 12 and Child R in your care, and you've told us about your
 13 experience of Child B and apparently not being told
 14 about the death of Child B's twin, wouldn't it have been
 15 appropriate if for no other reason so that people knew
 16 it when they spoke to the parents of Child P and R to be
 17 mentioning the fact that Child O had died?
 18 A. I think I don't recall specifically making
 19 that conversation, but I -- given that the statement
 20 about Child P, the night Registrar was aware of Child O.
 21 The Consultant -- I mean, Friday night I would have --
 22 Thursday night Consultant would have been aware because
 23 they were there at the resuscitation.
 24 Friday, I was on-call myself, so I knew. So the
 25 Consultant team and the doctors team knew what had

131

1 Dr Brearey talking about -- drawing to his and
 2 Eirian Powell's attention any sudden unexpected
 3 deteriorations.
 4 A. (Nods).
 5 Q. Was Child O's deterioration and death sudden
 6 and unexpected, so far as you were concerned?
 7 A. Yes.
 8 Q. And so did you contact Dr Brearey or
 9 Eirian Powell to say that you had had such a death that
 10 you had --
 11 A. Dr Brearey was there.
 12 Q. Was there? Did you say to Dr Brearey --
 13 A. No, I didn't practically say to him because he
 14 witnessed the whole situation.
 15 Q. You tell us in your witness statement that
 16 Child O's death wasn't discussed at the evening handover
 17 on the night of the 23rd or the morning handover on the
 18 24th, should Child O's death have been discussed at
 19 either of those handovers?
 20 A. I think I've tried to explain the purpose of
 21 handovers. The night handovers -- so the night
 22 handovers the Consultant isn't at for the night team,
 23 the half past 8 one. The 4 o'clock one handover that
 24 very day I didn't go to it because I was busy on the
 25 unit.

130

1 happened with the other twin. So there was that
 2 information from that point of view I think was shared,
 3 even though I don't remember bringing it up, probably
 4 because Dr Gibbs was at -- on Thursday night, and he was
 5 on, and Friday I was on-call, and the night juniors,
 6 given what Dr Mayberry had done and said, would have
 7 probably meant that he knew about Child O.
 8 Q. You say that Child P's deterioration was very
 9 unexpected; is that right?
 10 A. Yes.
 11 Q. And you'd seen Child P shortly before that
 12 collapse and he was stable and looked reasonably well.
 13 A. Yes.
 14 Q. Now, you describe in paragraph 106 of your
 15 witness statement -- and I am drawing your attention to
 16 it because you quote something that Letby said and so
 17 it's important that we're accurate about this, it's
 18 page 13.
 19 A. Yes.
 20 Q. Your paragraph 106.
 21 A. Yes.
 22 Q. Just refresh your memory from that, please,
 23 and tell us what it was that you heard Letby say.
 24 A. What I have said in that paragraph, so this
 25 baby collapsed unexpectedly and we resuscitated him, and

132

1 then I think he collapsed again a little while later
 2 when we left the room for a short period of time. After
 3 that we resuscitated him again, so nurseries are 1, 2, 3
 4 numbered. Baby P was in nursery 2 and, after we had
 5 done a gas I'd spoken to the transport team and they
 6 were on their way. I sort of walked across to Nursery 1
 7 and I remember just standing there looking at the clock
 8 counting minutes saying -- What have I said? Yeah --
 9 and we'd just done a gas, which was reasonable, and
 10 I said something along the lines of, "The transport team
 11 are on their way, they should be here soon." So Letby
 12 was there and a few other member -- members of the
 13 nursing staff were there, and she basically just said,
 14 "He's not leaving here alive, is he?" Which I found
 15 I think it was more disbelief that she had actually
 16 uttered such a sentence, and I said something along the
 17 lines of, "Don't say that, he's had a good gas and is
 18 stable."

19 And at the time I don't think it sank in or
 20 I actually pondered on -- for what for the next few
 21 hours on this information for some time until I had time
 22 to reflect on what happened after that.

23 **Q.** Dr V, in all your experience of being
 24 a doctor, had you ever heard any professional person
 25 make a comment such as that --

133

1 make a memory box for P the same way I did yesterday?"
 2 And it was -- it was just the way she was -- the parents
 3 were sitting there and I can't remember which one would
 4 have said, "Yes, please", so it was like, you know, they
 5 were grateful for her making the memory box, but it was
 6 just the whole manner in -- in which she was saying it.
 7 I just found it very inappropriate.

8 **Q.** You describe in your witness statement her as
 9 appearing "very excited and animated", is that a fair
 10 way of capturing your experience of how she was
 11 behaving?

12 **A.** Yes.

13 **Q.** Child R was transferred to a Level 3 unit.
 14 Whose decision was that?

15 **A.** So at the time -- I think again this is
 16 mentioned, either somewhere in the statement or notes,
 17 that when I'd spoken to Dr Rackham about Child P going
 18 across he had mentioned something along the lines of,
 19 "We will bring R as well." So the initial plan had been
 20 that the two of them will go together.

21 But obviously when he arrived, Baby P sadly
 22 arrested again and then died. After that period,
 23 I remember we were in the room and when the final
 24 resuscitation was being carried out somebody wheeled
 25 baby R next to Baby P, and I think Dad and Mum were

135

1 **A.** No.

2 **Q.** -- at such a difficult time?

3 **A.** No.

4 **Q.** At your paragraph 110 you speak about Letby's
 5 presentation when you went to speak to the parents of
 6 Child P --

7 **A.** Yes.

8 **Q.** -- after Child P had died, and just tell us,
 9 please, in your own words, having refreshed your memory,
 10 how did Letby appear to you then?

11 **A.** Yes. So this is after both of them had
 12 passed. There is a corridor that leads from the
 13 neonatal unit through double doors into the end of what
 14 is called the Lavender Suite, that's like a quiet zone
 15 where parents with a loss or any problems it's
 16 a contained area which is laid out in a way to make it
 17 a bit more peaceful.

18 So Letby and I went to speak to the parents there.
 19 I remember thinking I don't know what I am going to say
 20 to them because I just didn't know what to say, and her
 21 conversation was very much -- the parents were sitting
 22 on the sofas that were there. I think we were both
 23 standing. I can't remember if I sat down later on
 24 and -- so she was sort of going on about making memory
 25 boxes for them and said, "Do you want me to make you --

134

1 there as well -- I'm sorry, just one second.

2 After we declared Baby P, Dad was crying and he
 3 said to Dr Rackham, "Can you please take him?" And
 4 I just remember begging in my head and I just said,
 5 "Yes, can you please take him along as well."

6 So that was -- and Dr Rackham agreed.

7 **Q.** Perhaps this is the best way of dealing with
 8 this, I'll just remind you of what you said in your
 9 witness statement. You said:

10 "I just fear he [that is Child R] was going to be
 11 the next one and there was nothing that was going to be
 12 able to stop it."

13 Was that how you were feeling when you were saying
 14 to --

15 **A.** Yeah.

16 **Q.** -- Dr Rackham --

17 **A.** Yeah.

18 **Q.** -- "Please take Child R."

19 **A.** Yeah.

20 **Q.** Now, I'm going to move forward in time to
 21 27 June. Are you okay to carry on?

22 **A.** Yeah.

23 **Q.** And a conversation that you had with
 24 Christine Hurst, the Coroner's officer. We can see in
 25 the notes that the conversation was timed at 10.45, and

136

1 I hope you've had an opportunity to see what Ms Hurst
2 says about that conversation. Have you had a chance to
3 see that?

4 **A.** I have.

5 **Q.** I will just remind you of it. She describes
6 you as being naturally very upset. Does that accord
7 with your recollection?

8 **A.** Yeah. That wasn't the first time I spoke to
9 Christina Hurst, though, because my note entry -- and
10 I've included it in my statement -- I'll let you finish.

11 **Q.** Absolutely, we're aware that you spoke to the
12 Coroner's officer before that, I'm just asking about
13 this very specific conversation on the 27th.

14 **A.** Yeah, but I had already spoken to her --

15 **Q.** Yes.

16 **A.** -- on the 24th. This wasn't my first
17 conversation with her.

18 **Q.** No. And she says that she asked you about who
19 was on duty at the time of the collapses. Do you
20 remember her asking you that?

21 **A.** No.

22 **Q.** And she says that your tone changed
23 immediately, that you became a little short with her,
24 and said words to the effect:

25 "What do you mean? Don't you think my colleagues
137

1 confirming the arrangements about what we had spoken
2 about on the 24th.

3 I think if I'd had that kind of a conversation with
4 Mrs Hurst, about her asking me if -- who was on duty --
5 and again something that's in there, the Coroner's notes
6 as well, nothing suspicious -- it would have stuck in my
7 mind, because I think those -- many events from those --
8 that day are imprinted in my mind and I can't get rid of
9 them. And even if I hadn't documented them, the fact
10 that she'd asked me such big questions I probably would
11 have taken it to that meeting that I went to two hours
12 later and said, "Well, this is" -- because I spoke about
13 everything that had happened and how I was distressed
14 with everything, especially with what followed for
15 months and months after, if I had thought that there was
16 an opportunity to take to someone I'm sure that wasn't
17 information I wanted to keep to myself, I would have --
18 and you're probably going to ask me why I didn't tell
19 her about -- so I will let you ask and then answer that.

20 **Q.** We'll come to that in just a moment. What you
21 tell us in your statement is at the time of this call
22 you had grave concerns about both deaths.

23 **A.** Yes.

24 **Q.** So if you did have grave concerns about both
25 those deaths you tell us, why didn't you relay those to
139

1 and I are distressed enough without you implying that
2 someone may have done something?"

3 Does that accord with your recollection of that
4 conversation with Ms Hurst?

5 **A.** No?

6 **Q.** Was anything like that discussed?

7 **A.** No.

8 **Q.** To complete it, Ms Hurst says that she replied
9 to you that she was not implying anything and it was her
10 job to ask questions. Again, does that accord with your
11 recollection of the conversation --

12 **A.** No?

13 **Q.** -- on the 27th.

14 **A.** No, no, it doesn't and I've sort of gone back
15 and thought about what Mrs Hurst has put there, and can
16 I add a few comments to that?

17 One of the things is that in Mrs Hurst's statement
18 she implies that the first and the only time she spoke
19 to me was on the Monday. From my note entry, and
20 I don't have recollection of this, it looks like I spoke
21 to Chris, I've put "the Coroner's officer", and then
22 Christina Hurst, and then I've made a long note entry
23 about the discussion we had about the arrangements, how
24 various things would happen. And the Monday phone call
25 is almost a follow-up phone call from Friday in just
138

1 Ms Hurst the Coroner's officer on the 27th?

2 **A.** Yes. So at that time, my concerns were my
3 suspicions, I hadn't seen her do anything, neither had
4 anybody else. It was just the way these two babies had
5 died with me spending hours and hours going through my
6 mind thinking: what could have gone wrong? What was it
7 that I wasn't getting? And then just these comments and
8 all.

9 So it -- so if I had mentioned something to her it
10 would just have been, "Well, I can't explain what has
11 happened. I was there for both of them. Dr U was there
12 for both of them. And she was there for both of them."
13 So it wasn't like she was just the common denominator.
14 There were other people there who had been there for two
15 deaths as well. And I felt that the idea of reporting
16 it to the Coroner's officer and then the Coroner is
17 giving them facts, I don't know why they have died, they
18 are unexpected and unexplained.

19 With hindsight, I probably -- if I was suspicious,
20 even though I had no basis for those suspicions,
21 I should have mentioned it. But my only reason for not
22 doing it at that time was I wasn't sure what to do with
23 the doubts in my mind that I had and I wanted to be in
24 a -- in a more safe space with my colleagues and air my
25 concerns and then see what other people thought.
140

1 Q. And so having gone into the -- you then had
2 a meeting two hours later at which it was said out loud
3 that your colleagues were concerned that Letby was
4 deliberately harming babies?

5 A. (Nods).

6 Q. So you had an opportunity at that meeting to
7 share your experience, including Letby's presentation
8 and the remark that she made about Child P. Having had
9 an opportunity to hear what your colleagues had to say,
10 would it have been a good idea for you then to pick up
11 the phone to Ms Hurst after that, who you'd just been
12 speaking to in the morning, and said, "I've had a chance
13 to get my thoughts together, I've spoken to my
14 colleagues, we are worried about this"?

15 A. Yes. But at that meeting a plan was decided
16 about further actions, and the right -- so my colleagues
17 knew that I'd reported to the Coroner, I'd asked for
18 a pm because the deaths were unexplained and unexpected,
19 that bit they knew. I obviously hadn't discussed
20 anything else with the Coroners's officer. From that
21 meeting there was a plan made on how to escalate our
22 concerns, and my understanding, rightly or wrongly at
23 the time, was we're going to go down the way of
24 escalating this. So that is happening now.

25 Q. Dr V, just to understand that. I mean, did
141

1 happened in the following few weeks. If the records
2 show that she didn't come back to clinical work after
3 her annual leave, then it probably was that week.

4 Q. And was it your understanding at that time
5 that she was allowed to continue to work but that she
6 would be under supervision?

7 A. Yes.

8 Q. And who had told you that?

9 A. I don't remember exactly but that probably was
10 the agreement, but I -- when I saw her at first I think
11 I completely forgot that she was to be clinically
12 supervised, and I just remember being terrified that,
13 "Oh, she's here now, what's going to happen?" And just
14 feeling that terrible things were going to start
15 happening again basically. Until then another nurse
16 intervened and said, "What do you need? I'll get that
17 for you." And then I suddenly remembered, "Oh, she's
18 supervised, she can't do any hands-on clinical work."
19 And then we sort of managed.

20 Q. Just a couple more events to deal with with
21 you, please, Dr V. The first is the meeting on
22 26 January 2017. You tell us in your witness statement
23 that you had spoken to Dr David Semple prior to the
24 meeting.

25 A. (Nods).

143

1 you view yourself as having a personal duty, your duty
2 to the Coroner to assist the Coroner with the Coroner's
3 investigation?

4 A. At the time I didn't think the information
5 I had with no evidence and no facts as such would be of
6 any use to the Coroner, if you put it that way. I don't
7 know. That's what I thought then. I would probably do
8 things very differently now.

9 Q. Looking back on it, do you think that that was
10 the wrong way to think about it?

11 A. Yes.

12 Q. I would like to ask you about an incident on
13 what we believe was either 28th, 29th or 30th June which
14 you speak about in your witness statement when you
15 encountered Letby on the ward.

16 A. Yes.

17 Q. So it would be right -- you don't give a date
18 in your statement but we know that Letby went on who
19 will on 1 July and in fact didn't return to the NNU
20 after that, so have we got it right that it was in the
21 week that began with you speaking to the Coroner's
22 officer and having the paediatricians meeting?

23 A. I don't remember that. I just remember that
24 this was another on-call. Now, exactly how long after
25 27 June, I don't remember. I do remember that it
142

1 Q. What, in summary, had Dr David Semple told you
2 about what to expect from the meeting?

3 A. So I remember Mr Semple came down and it was
4 the corridor offices, as we've referred to before, and
5 he was in one of those offices and there was a few of us
6 around there. I couldn't tell you who else was there
7 but there was at least three or four of us. And he
8 looked quite worried, and I don't remember the exact
9 conversation but his advice was mainly to keep quiet and
10 saying that, you know, "The execs don't have very good
11 plans about you, so I would suggest that you just keep
12 quiet in the meeting and sit it out."

13 Q. And in terms of --

14 A. I may be wrong but I just vaguely remember
15 this statement, "Heads would roll", or something like
16 that. I don't know if I'm -- but, yeah, he, he looked
17 very, very worried.

18 Q. And again in summary, as we've heard from
19 a number of people, we want to hear your experience,
20 what was the tone of the meeting that you had on the
21 26th with Tony Chambers and Ian Harvey and others?

22 A. Very aggressive, very angry to the point of
23 being scary, intimidating.

24 Q. Two more matters to deal with. The first is
25 your meeting with Simon Medland Queen's Counsel as he
144

1 was. What you tell us, and I'll just quote from your
2 statement, is that you remember that:
3 "He looked quite shocked at the information that we
4 shared with him."

5 And so just to understand that, we know from the
6 record that he came and introduced himself. Did you and
7 your colleagues then explain at some early point in the
8 meeting that you were concerned?

9 **A.** Yes. So I think we each of us individually
10 recounted our experiences. I certainly remember
11 recounting mine.

12 **Q.** And your perception was that he looked
13 shocked?

14 **A.** Yes. So then we asked him if he had been
15 briefed about our concerns and, from what I can
16 remember, he -- he hadn't been, which wasn't our
17 impression when we went for that meeting.

18 **Q.** The final thing I would like to ask you about
19 is your statements to the Coroner. If we just bring up
20 INQ0008605.

21 This is a statement that you made to the Coroner,
22 and if we move to page 7, this one being about Child O,
23 we can see that it's signed and dated on 3 November 2016
24 and there is similarly a statement you made on the same
25 day for Child P as well; is that right?

145

1 and I know I added later on in my police statements,
2 these two incidents, and I was asked later on in the
3 trial as well why I hadn't included them, all I can say
4 is it wasn't a conscious remission of facts that I was
5 trying to keep from him.

6 My understanding is -- was that a Coroner's
7 statement is a statement of facts, and whilst, yes, we
8 had our suspicions and we were pursuing our concerns, we
9 didn't have as such evidence to support. However,
10 again, with how things have happened and unravelled over
11 a period of time, I think it was probably not the right
12 thing to do. I should have included those statements.
13 And, again, you know, I think we were pursuing
14 a different line of raising our concerns and felt that
15 since we were already doing that, and my understanding
16 at the time -- or maybe I didn't know at the time -- but
17 later on had also been that Coroner was aware of our
18 concerns.

19 So I don't know why I didn't put them down but it
20 wasn't something I was trying to hide.

21 **Q.** Just to pick up on something you just said
22 there. According to the correspondence, it's not until
23 February 2017 that the Coroner was being told about your
24 concerns in terms, that's what was being reported in the
25 correspondence.

147

1 **A.** Yes.

2 **Q.** Thank you we can take that down.

3 Dr V, at that point in the sequence of events, you
4 had sat at meetings with your Consultant colleagues and
5 talked about the possibility of deliberate harm.

6 **A.** (Nods).

7 **Q.** You knew that that concern had been raised
8 with the Executives, so it was being spoken about openly
9 with the higher management in the hospital, and no doubt
10 you were aware that the RCPCH were told something
11 similar as well.

12 **A.** (Nods).

13 **Q.** If we look at those statements to the Coroner,
14 you don't appear to have said anything about any of
15 those concerns. Why were you not telling the Coroner,
16 whether in that statement or in an accompanying letter
17 when you sent it across, that as a Consultant body you
18 were all extremely worried that a member of staff had
19 murdered Child O and Child P? Why didn't you tell the
20 Coroner that?

21 **A.** I don't think it was anything I was
22 particularly trying to keep from the Coroner. I think
23 it probably was just my understanding of a Coroner's
24 statement is a statement of facts that -- how things
25 have happened, and I didn't think -- even at that time,

146

1 Just think back, when you did that statement on
2 3 November of 2016, was it really the case that you
3 thought the Coroner knows all about this?

4 **A.** No -- yeah, no, it wasn't, it wasn't, you're
5 right, yeah.

6 **Q.** And obviously the function of the Coroner is
7 to establish how that baby had come about their death.

8 **A.** Yes.

9 **Q.** Do you accept that that was highly relevant
10 information that you had to give to the Coroner to help
11 the Coroner determine how Child O and Child P had come
12 about their deaths?

13 **A.** Yes.

14 **MR DE LA POER:** Dr V, those are all the questions
15 that I have for you. I think that there are two further
16 sets of questions, and I think, my Lady, Mr Skelton is
17 to go first.

18 **LADY JUSTICE THIRLWALL:** Thank you.
19 Mr Skelton.

Questions by MR SKELTON

21 **MR SKELTON:** Dr V, I'm going to ask you questions
22 about Child A and Child B, and I'd like you to think
23 very carefully about what you can recollect about the
24 two of those children.

25 You'll recall just by way of background that one of

148

1 them was murdered on 8 June 2015, that's Child A, and
 2 two days later his sister, Child B -- twin sister --
 3 collapsed and you were involved in the resuscitation, so
 4 you know who I am talking about.

5 **A.** Yes.

6 **Q.** You, I think after Child A's death, were
 7 involved with Child B's care to the extent that you were
 8 involved in getting or assisting with investigating
 9 whether there may be a haematological cause to the death
 10 which may affect Child B. Do you remember that?

11 **A.** Yes, I remember that from the documentation
 12 which says discussion with the haematologist about
 13 mother's condition.

14 **Q.** And the reason that that was being
 15 investigated was that Child A had died and there was
 16 a concern that there may be something that hadn't been
 17 identified, a condition that the mum had, which might
 18 affect Child B and also cause potential risk to her. Do
 19 you remember that?

20 **A.** I don't remember -- remember exactly but if
 21 that's what it says in the notes, I -- I -- from what
 22 I have read the documentation was discussion with the
 23 haematologist. I don't recall -- but, yeah.

24 **Q.** Well, let's have a look at the medical records
 25 briefly then, INQ00000698, page 25, please. I'm hoping

149

1 **A.** Yeah.

2 **Q.** -- continuing the same analysis --

3 **A.** Yes.

4 **Q.** -- this time a message from the
 5 obstetrician --

6 **A.** Yeah.

7 **Q.** -- that had been treating mother A --

8 **A.** Yeah.

9 **Q.** -- and again discussing haematology and
 10 specialist assistance.

11 **A.** Yes.

12 **Q.** And then if we go down to the bottom, you can
 13 see that you are involved, DW, which is "discussed
 14 with", Dr V, and you give some advice about progressing
 15 things.

16 **A.** Yes.

17 **Q.** So trying to refresh your memory as best you
 18 can, does it look like you must have known about
 19 Child A's death and the mother's potential connection
 20 with investigation of a haematological condition?

21 **A.** From these notes, yes. From memory, I can't
 22 recall, I'm sorry.

23 **Q.** When you -- do you remember giving evidence at
 24 the criminal trial?

25 **A.** Yes.

151

1 that's going to come on screen. Page 25.

2 So this is the 9 June, so this is the day after
 3 Child A has died, and you see initially a note by
 4 Specialist Trainee Beach?

5 **A.** Yes.

6 **Q.** And this is to do with chasing up some
 7 haematology from a different hospital which has
 8 a specialist investigatory unit.

9 And we won't go into the background to the mother's
 10 condition but suffice to say there was some concern that
 11 the mother's --

12 **A.** Yeah.

13 **Q.** -- condition may be involved with the
 14 Child A's death. Do you remember that?

15 **A.** I don't remember it but I can read it. It
 16 says that they have discussed with the haematologist and
 17 they've asked for some samples from Child A.

18 **Q.** Yes.

19 **A.** And --

20 **Q.** So this is Child B's notes --

21 **A.** Yeah.

22 **Q.** -- talking about Child A.

23 **A.** Yeah, yeah.

24 **Q.** And further down we can see another trainee,
 25 Davis --

150

1 **Q.** I'm just going to take you again by way of
 2 reminder to that because the reason I'm asking you these
 3 questions is in answer to Mr De La Poer's questions this
 4 morning you said you couldn't remember Child A's death
 5 at the time of Child B's collapse.

6 **A.** Yes.

7 **Q.** And I want to try and get you back into the
 8 frame of mind where you may revive that answer. But
 9 I don't want to do so without allowing you the
 10 opportunity to see what you've said previously.

11 So may we look at the records from the criminal
 12 trial, please, at INQ0010269.

13 If you could go to electronic page 5 and then focus
 14 on the -- it's quite a small print, so I'm going to try
 15 and focus on page 14, first of all, which is the bottom
 16 left quarter, and if you could expand that quarter,
 17 please. Thank you.

18 So just to put this in context, Dr V, this is quite
 19 a long period of examination when you're asked about
 20 Child B and you're discussing the records, which I'm
 21 going to come on to in a few minutes, about her
 22 collapse, and at the end you start to talk about a bit
 23 of the background.

24 So can you see just at the bottom there you were
 25 asked --

152

1 A. Yes.
 2 Q. -- you were asked about the background:
 3 "So basically the evening before I'd reviewed this
 4 baby I had reviewed Child B and we had a background
 5 history of maternal (and this is irrelevant) and
 6 I had ..."
 7 May we now go to page 15, which is at the top
 8 right, it's a different form of transcription, so it's
 9 the same page, page 5, just the top right quarter, which
 10 is internal page 15.
 11 So just take a moment just to read that through,
 12 Dr V.
 13 A. Yes.
 14 Q. It also says you've been made aware that
 15 Child A, Child B's brother, had passed away.
 16 A. Yes.
 17 Q. "... and obviously there was an increased
 18 alertness and anxiety about what could be done in
 19 anticipation for Child B to give us some help etc, etc."
 20 So it looks like -- this is two years ago, I think
 21 it is 25 October 2022 -- you could remember Child A.
 22 Does that jog your memory?
 23 A. Yeah, so I think I -- probably when I have
 24 prepared this reply I haven't consulted the notes
 25 properly, I apologise.

153

1 patches."
 2 So that was a clinical finding that she made at the
 3 time.
 4 And without going into the notes, what happens is
 5 that they suspect potential sepsis or possible
 6 coagulopathy, in other words a blood disorder, and you
 7 get called, and presumably you are at home in bed, and
 8 are called in and arrive within the hospital within
 9 about 14 minutes, I think. Do you remember that?
 10 A. Yes. I don't remember it but it's from
 11 reading the notes.
 12 Q. If we go to your notes, which are a couple of
 13 pages on, on page 28, please, this is your note, again
 14 written retrospectively, so you're arriving at 12.50 am
 15 but you're writing this a couple of hours later or so,
 16 and one of the first things you note is the purple
 17 blotching of the body all over with the slowing of heart
 18 rate.
 19 A. (Nods).
 20 Q. And, again, you mention the purple blotching
 21 a second time in the first half of your own notes. Do
 22 you see that?
 23 A. Yes, I do. I've just said, "Baby tubed by
 24 Reg", and obviously the description I have written is
 25 what the Reg, had seen then I go down upon my arrival

155

1 Q. And indeed Mother A was around throughout this
 2 period, wasn't she? Do you remember she was extremely
 3 distressed, understandably, by the death of her son?
 4 A. Yes.
 5 Q. And she didn't want to leave her daughter
 6 alone. And in fact it was only at the moment that she
 7 left her daughter that her daughter collapsed. Do you
 8 remember Mother A being around on the unit?
 9 A. I don't, I'm sorry.
 10 Q. May we just look at the notes that you have
 11 made in respect of the collapse of Child B. And, first
 12 of all, I think it is worth starting with Dr Lambie's
 13 notes, and if you give me one second, it's in the --
 14 I'll give you the reference. Dr Lambie's notes start --
 15 it's INQ0000698, at page 26, please. Thank you.
 16 So this is a note that's written in retrospect
 17 after Child B's collapse by Dr Lambie who you will
 18 recall as being a senior Registrar colleague.
 19 A. (Nods).
 20 Q. And she has written -- I'll ask you again just
 21 to familiarise yourself with the note but you can see:
 22 "Had acute apnea with no warning."
 23 So the baby just suddenly stopped breathing,
 24 without warning, and she notes:
 25 "... widespread purple discolour of skin with white

154

1 the blotchiness was on the right mid abdomen and right
 2 hand, "pink and active".
 3 Q. That's right. So it's reported to you, first
 4 of all, presumably by Dr Lambie --
 5 A. Yes.
 6 Q. -- and then you go and have a look and it's
 7 still there and you note where it is.
 8 A. Yeah.
 9 Q. Correct.
 10 And then your note goes on for a couple of pages,
 11 but if we go to the next page you can see you spoke to
 12 the parents. This is at page 29.
 13 A. Yeah.
 14 Q. It's going to come on the screen page 29. Can
 15 you see that there?
 16 A. Yeah.
 17 Q. "Spoke to the parents. Purple discolouration
 18 almost resolved ?? Cause."
 19 And then you talk about how the baby stabilised for
 20 the time being.
 21 So when you spoke to the parents -- and if you
 22 don't remember this, of course say, Dr V -- do you
 23 remember mentioning the rash to them and saying, "We
 24 don't know what's caused it"?
 25 A. I don't remember that, but how I have written

156

1 it there's no reason why I wouldn't have mentioned it
 2 because there's a description of what happened, and then
 3 there was rash there, and if the parents were present
 4 I would have discussed that, yes, the rash was much more
 5 florid. And, again, I'm not speaking from memory, I'm
 6 just thinking what I would have said to them that I'm
 7 not certain what's caused it.

8 **Q.** Mother A has given evidence to the Inquiry
 9 orally that she remembers speaking to the on-call
 10 Consultant who, if she's correct, would have been you
 11 because that was you that night, you were literally
 12 called into the hospital at midnight, and being asked by
 13 that Consultant to take a photograph of the rash. Does
 14 that jog a memory?

15 **A.** I'm really sorry but I can't remember. I have
 16 read Mother's transcript that the on-call Consultant
 17 said that they weren't -- they hadn't seen anything like
 18 that before and asked if they could take a picture, and
 19 then the nurse went off to take a photo -- to get the
 20 camera, and by the time she came back the rash had
 21 disappeared. So we decided not to take a photograph.

22 I'm really sorry but I don't remember that.

23 **Q.** Just focusing on your clinical thinking, your
 24 decision-making and analysis. You have a widespread
 25 purple rash on a baby and Dr Lambie has noted as well

157

1 **A.** Yes.

2 **Q.** Why is that?

3 **A.** I think that is basically a lesson for me to
 4 write more and put a bit more detail in my documentation
 5 when I'm writing down making sure whatever my thought
 6 processes are, are documented properly.

7 **Q.** And, of course, that is a -- it's a basic
 8 tenet of medicine, isn't it, that you note down your
 9 thinking in response to the diagnostic science, and in
 10 fact it's reported repeatedly there's a rash but there's
 11 no analysis at all of what the cause might be.

12 **A.** Yes.

13 **Q.** You didn't I think also connect Child B to
 14 Child A in terms of your notes either at any point; is
 15 that correct?

16 **A.** That's correct.

17 **Q.** And in fact Child A, as it happens, had shown
 18 a similar rash as he collapsed and died. Recognising
 19 now that the significance of your own notes, it would
 20 have been helpful to have connected those two things,
 21 and you accept that's a failing on your part?

22 **A.** Yes.

23 **Q.** And it's also a failing of those who were
 24 involved with Child A's care not to communicate the
 25 diagnostic signs about his collapse that would have

159

1 that it's sort of disappearing as well. It's come and
 2 it's begun, so it's resolved relatively quickly around
 3 the same time that the child has recovered.

4 **Q.** What is your differential diagnosis for the cause
 5 of the rash?

6 **A.** So the differential diagnosis at the time
 7 would have been a problem with infection, so one of the
 8 first things that we think about is: was it some kind of
 9 infection? Is it the background related to maternal
 10 condition? Is it to do with there's another condition
 11 which is called disseminated intravascular coagulation.
 12 However, the rash wouldn't be expected to disappear so
 13 quickly. We had requested some blood products, but
 14 I don't think we needed to give them.

15 **A.** At the time, what I would honestly say is that the
 16 idea of the rash having been caused by some type of
 17 inflicted or deliberate harm didn't cross my mind.

18 **Q.** I understand that, but what we don't see in
 19 the notes is an analysis of what it might have actually
 20 been diagnostically?

21 **A.** Yes.

22 **Q.** So you don't appear to have written down --

23 **A.** No.

24 **Q.** -- what has caused the rash?? X, Y or Z, the
 25 things you've just explained.

158

1 helped you to understand Child B.

2 **A.** Yes.

3 **Q.** Do you understand that?

4 **A.** Yes.

5 **Q.** In other words, you both needed to speak to
 6 each other and then would have understood the rash had
 7 been common -- a common factor.

8 **A.** (Nods).

9 **Q.** If you had gone through a formal process of
 10 thinking about the rash and had managed to exclude the
 11 various diagnoses that you've just explained, so
 12 coagulopathy, sepsis and so on, and still couldn't
 13 explain it, and also knew that Child B who -- Child A
 14 who died had had the same rash, would you have reached
 15 the point where you suspected that there was something
 16 going on that you needed to investigate further?

17 **A.** I think it was definitely probably would have
 18 been something I would have discussed with my colleagues
 19 or maybe with the tertiary specialist to ask if there
 20 was anything I was missing in that. I'm not sure if it
 21 would have directed my mind to deliberate harm.

22 I'm just speaking with the mindset I was in at the
 23 time, I think it was fixed on a pathology and that I was
 24 missing some information about a disorder that I wasn't
 25 aware about, especially given that they were twins, so

160

1 there was a possibility that they might have the same
2 disorder.

3 **Q.** But you accept I think that the link between
4 the two needed to have been identified at the time --

5 **A.** Yes.

6 **Q.** -- and indeed the link between those two and
7 further deaths on the unit and similar rashes in respect
8 of those children should have been identified at the
9 time?

10 **A.** Yes.

11 **MR SKELTON:** Thank you. Thank you, my Lady.

12 **LADY JUSTICE THIRLWALL:** Thank you very much,
13 Mr Skelton.

14 **Questions by MR BAKER**

15 **LADY JUSTICE THIRLWALL:** Mr Baker.

16 **MR BAKER:** Thank you, my Lady.

17 Dr V, I also ask questions on behalf of some of the
18 families. I want to ask you some questions in
19 particular about your interactions with Lucy Letby
20 surrounding Child P.

21 You've given evidence already about the comment
22 that she made during the resuscitation that he's not
23 getting out of here alive.

24 You also described a meeting between you and
25 Lucy Letby and the parents of Child P.

161

1 normal behaviour by Letby?

2 **A.** I don't know what legitimate explanations
3 apart from what the defence lawyers said there could be,
4 which -- I -- I still thought her behaviour was a bit
5 inappropriate. That was my opinion. That might just
6 have been my personal opinion.

7 **Q.** So prior to these two incidents, your evidence
8 is that you had no personal suspicions about Letby?

9 **A.** (Nods).

10 **Q.** You attended a meeting -- so Child P died on
11 23 June, and you describe at paragraph 114 of your
12 witness statement attending a meeting where, amongst
13 other people, Eirian Powell was present?

14 **A.** Mmm.

15 **Q.** Can you see that section there?

16 **A.** Yes.

17 **Q.** And you say here that you became very upset
18 and emotional at the meeting. In your own words, why
19 did you become upset and emotional when meeting with
20 Eirian Powell on 27 June?

21 **A.** On their deaths, that they had died and
22 I didn't know why and how.

23 **Q.** Did you say anything to Eirian Powell about
24 what Letby had said to you or in your presence?

25 **A.** So I said to Eirian two things, I think I said

163

1 **A.** (Nods).

2 **Q.** You've presumably attended other meetings
3 before where it was necessary to talk about unhappy
4 things?

5 **A.** Sorry, say the last bit again.

6 **Q.** You've presumably attended meetings before
7 where it's been necessary to talk to parents about
8 unhappy news?

9 **A.** (Nods).

10 **Q.** What was it about Letby's behaviour on this
11 occasion that struck you as unusual, because it clearly
12 was something you've since reflected upon?

13 **A.** As I have tried to explain before, it was the
14 inappropriate jolliness, brightness to it, which, as
15 when I was being questioned at the criminal trial, was
16 put to me as could it have been somebody trying to make
17 the best of a worst situation, and that's not how
18 I perceived it, probably because that's not how I would
19 interact with bereaved parents. And my experience of
20 previously doing this with other nurses it can be done
21 in a calm, peaceful, reassuring manner, but not in the
22 manner that she did.

23 **Q.** You presumably reflected on this meeting after
24 the event. Did you try to look for legitimate
25 explanations to try and convince yourself that this was

162

1 to her about the not leaving here alive. I recounted
2 that incident to her. And I said it wasn't just me,
3 there were other nurses there as well, and I also
4 probably recounted the Lavender Suite incidents as well.

5 **Q.** So is it correct to say then that the death of
6 occurred on 23 June, prior to that point you had no
7 suspicions personally about Letby?

8 **A.** No.

9 **Q.** But by 27 June, so the Monday after the
10 Thursday when Child P died, you were emotionally
11 recounting to Eirian Powell your concerns about
12 Lucy Letby?

13 **A.** Yes.

14 **MR BAKER:** Thank you, my Lady, I have no more
15 questions.

16 **LADY JUSTICE THIRLWALL:** Thank you.

17 **MR DE LA POER:** My Lady, just one short matter not
18 by way of question, however, and that is just, Dr V,
19 just to let you know that we've checked with the
20 Countess of Chester and the email that you had dated
21 23 June 2015 that they hold does have your name on it
22 and I just wanted to alert you to that fact because it
23 may be the Inquiry will ask you to provide a further
24 statement to clarify that fact.

25 **A.** Okay.

164

1 **Questions by LADY JUSTICE THIRLWALL**

2 **LADY JUSTICE THIRLWALL:** Thank you very much
3 indeed, Mr De La Poer.

4 Can I just clarify one thing, from my perspective,
5 and it may be obvious from some of your answers earlier
6 to Mr Skelton, and it may be that I misheard you, but
7 when you were giving your evidence earlier and you were
8 saying that you were unaware -- I'm talking now about
9 Baby B -- you were unaware the death of A, and I think
10 you said you were also unaware that they were twins, or
11 is that -- have I misunderstood?

12 **A.** No, I think from the discussion that we've had
13 now, I said earlier that I wasn't aware that Baby A, the
14 other twin, had passed and that probably has been from
15 when I've prepared my statement from the information
16 that I have been given I haven't gone back to the
17 original notes far enough, which we did just now, to see
18 that I actually was aware. So --

19 **LADY JUSTICE THIRLWALL:** It seems likely, doesn't
20 it, that if --

21 **A.** Yes.

22 **LADY JUSTICE THIRLWALL:** -- that you would be aware
23 because you had the other doctors and nurses there?

24 **A.** Yeah, yeah.

25 **LADY JUSTICE THIRLWALL:** And the parents were
165

1 session all the way through. I don't know whether that
2 was what my Lady had in mind, and that leaves us with
3 a single block, or whether my Lady wishes it save that
4 break until later in the --

5 **LADY JUSTICE THIRLWALL:** That's a very generous
6 interpretation, Mr De La Poer. Let's take the break now
7 and we'll start again at 10 past if we are ready.

8 (2.53 pm)

9 (A short break)

10 (3.10 pm)

11 **MS LANGDALE:** My Lady, may I call Dr U and may the
12 witness be sworn, thank you.

13 **DR U (affirmed)**

14 **Questions by MS LANGDALE**

15 **LADY JUSTICE THIRLWALL:** If we just wait a moment
16 because there is a bit of noise at the back.

17 Ms Langdale.

18 **MS LANGDALE:** Thank you. Dr U, you have prepared
19 two statements for the Inquiry, the first dated
20 3 September and the second dated 9 August 2024.

21 Can you confirm that the contents are true and
22 accurate as far as you're concerned?

23 **A.** Yes.

24 **Q.** Dr U, you worked, we know, at the Countess of
25 Chester between September 2015 and September 2016 as
167

1 there?

2 **A.** Yes.

3 **LADY JUSTICE THIRLWALL:** And so I suppose that's
4 why I wondered why you didn't make a link between what
5 had been seen -- what you had seen on B and what was
6 known about A?

7 **A.** Yes, I'm not sure I knew about the rash on A.

8 **LADY JUSTICE THIRLWALL:** Did you ask anything about
9 the circumstances of A's death?

10 **A.** I couldn't remember right now, but I --
11 I can't recall.

12 **LADY JUSTICE THIRLWALL:** All right. Thank you very
13 much indeed.

14 Now, those are all the questions that we have for
15 you. You are free to go.

16 **A.** Okay, thank you.

17 **LADY JUSTICE THIRLWALL:** I think we are going to
18 slightly reconfigure the room, so if everyone would
19 leave. I've been asked to stay because it causes less
20 disruption, so I'll just stay here but if everyone would
21 move out and then we'll come back in again. Have I got
22 that wrong Mr De La Poer?

23 **MR DE LA POER:** My Lady absolutely hasn't, but it
24 just occurred to me that it might be a convenient moment
25 for us to take our break so that we have a single
166

1 a paediatric Registrar.

2 **A.** That's right.

3 **Q.** And you worked between September 2016 and
4 July 2018 as a locum Consultant in diabetes and general
5 paediatrics at Alder Hayes hospital?

6 **A.** That's right.

7 **Q.** You've set out in your statement the culture
8 and atmosphere of the neonatal unit, as far as you're
9 concerned, in 2015 to 2016.

10 Can I ask you to go to paragraph 10 of your
11 statement, please, You were the most senior Registrar,
12 I think, at that time, weren't you? You were the most
13 senior Registrar?

14 **A.** I think so.

15 **Q.** Do you see at paragraph 10 --

16 **A.** Yes.

17 **Q.** -- you set out:

18 "There were seven Consultants who clinically
19 managed the junior doctors, including myself."

20 What was your relationship with the Consultants
21 like?

22 **A.** I would say it was generally friendly. It was
23 a collaborative relationship, they supported me, and
24 because of my length of training and my -- my previous
25 experience I was maybe able to relieve them of some of
168

1 the workload that the more junior Registrars couldn't.
 2 **Q.** And you say junior doctors would report to the
 3 Consultant who was on the hot week, was that a different
 4 person each week?
 5 **A.** Yes.
 6 **Q.** So how would you describe your relationship
 7 with Drs Brearey, Gibbs, Jayaram and the like?
 8 **A.** Generally friendly, yes.
 9 **Q.** You say at paragraph 11, as far as you were:
 10 "... aware the nurses and midwives had good working
 11 relationships, occasionally antagonism at times mainly
 12 due to communication and workload."
 13 Was that your sense of relationships between those
 14 two groups insofar as you got on?
 15 **A.** That's how I recall it. The workload was
 16 unpredictable, but sometimes there was a lot of work
 17 that needed doing in a short space of time and that did
 18 cause some friction.
 19 **Q.** Junior doctors and the nurses you say good
 20 working relationships on the children's ward and between
 21 the junior doctors and nurses on the NNU. Was that your
 22 understanding or experience?
 23 **A.** Yes.
 24 **Q.** I think Eirian Powell has suggested that the
 25 Consultants -- what they said had to go or something to
 169

1 happy and felt positive and no obvious problems in team
 2 working.
 3 **A.** No.
 4 **Q.** No, as in you agree that's what you think?
 5 **A.** That's correct.
 6 **LADY JUSTICE THIRLWALL:** I wonder, doctor, if you
 7 just keep your voice up a little bit. We've got very
 8 good microphones but I think in the far distant corners
 9 it's not so easy to hear you.
 10 **A.** Certainly.
 11 **MS LANGDALE:** You say you can't recall precise
 12 timings, but in around July 2016 when Letby was
 13 restricted to an administrative role you were aware that
 14 more questions were being asked in relation to patient
 15 management on the NNU and that some of the nurses felt
 16 uneasy about being watched.
 17 Can you expand upon that, what do you mean?
 18 **A.** By July 2016, there had been the deaths that
 19 have been tried at the criminal trial and there was
 20 a lot more focus on the neonatal unit, and certainly
 21 more of the senior neonatal unit nurses were uneasy
 22 about the level of attention that was being cast.
 23 Whether that was because they felt that they were being
 24 watched to see if they made mistakes or whether it was
 25 just collectively as a group of nurses they felt
 171

1 that effect, was that your experience, or do you think
 2 it was a very collaborative relationship between doctors
 3 and nurses generally?
 4 **A.** Generally, yes.
 5 **Q.** Generally yes, collaborative. You say
 6 relationships between the labour ward midwives and other
 7 clinicians were a bit more strained as they wanted to be
 8 autonomous practitioners.
 9 What do you mean by that?
 10 **A.** Labour ward midwives didn't -- they work
 11 autonomously and that sometimes meant that
 12 collaboration, communication with the neonatal unit was
 13 maybe not as it would like or should have been, such as
 14 babies about to deliver and it resulted in a crash call
 15 and a run to the labour ward rather than knowing about
 16 it upfront.
 17 **Q.** Rather than -- sorry, I missed that?
 18 **A.** Rather than knowing that that baby was about
 19 to deliver in advance.
 20 **Q.** Right, right. So the communication put
 21 pressure -- the lack of communication --
 22 **A.** Sometimes.
 23 **Q.** Sometimes. But overall?
 24 **A.** Overall it worked.
 25 **Q.** You say NNU felt the atmosphere was generally
 170

1 defensive, I wouldn't -- I don't know.
 2 **Q.** You say there was a general feeling of
 3 unhappiness when Letby was suspended. What do you mean
 4 suspended, do you mean moved duties in the --
 5 **A.** Moved to the administrative role.
 6 **Q.** -- non-clinical -- yeah. So when she moved to
 7 that clinical -- non-clinical role, you say -- well,
 8 what do you say was the impact on some nurses?
 9 **A.** They were unhappy that Letby had been singled
 10 out and moved. Whether that was due to the lack of
 11 communication or whether that was just because they felt
 12 that somebody had been identified and moved, I don't
 13 know.
 14 **Q.** Which nurses were unhappy about that?
 15 **A.** So I don't know their full names. One was
 16 Mina and the other, Nurse T, both of whom I --
 17 **Q.** So a couple when she was moved to non-clinical
 18 roles?
 19 **A.** Yeah. I think there were more but those are
 20 the two that I -- that stick out at the moment.
 21 **Q.** Sorry, I am really struggling to hear you.
 22 **A.** I think there were more that were unhappy but
 23 those are the two that I remember being --
 24 **Q.** Why do you think there were more? Did Letby
 25 suggest that to you or do you know that for yourself?
 172

1 A. No, I think she may have suggested that to me
2 but I don't recall.

3 Q. As far as you are aware, for your knowledge,
4 you've got a couple of names that when she moved to
5 non-clinical duties you think -- felt what about that?

6 A. Sorry, I didn't hear.

7 Q. What did you think the couple that you've
8 mentioned felt about her being moved to a non-clinical
9 role?

10 A. I don't know exactly what they were thinking
11 but they certainly seemed sorry for her, unhappy that
12 she'd been moved.

13 Q. Again, I must ask you, is that something that
14 you got from them or something that Letby told you about
15 them?

16 A. Both, I think.

17 Q. I'm going to ask you about your involvement
18 with some of the babies named on the indictment. You
19 gave a number of statements to the police, didn't you,
20 and I think you gave evidence -- yes, you've given
21 a number of statements.

22 A. That's right.

23 Q. In terms of Child I, if you go to paragraph 20
24 of your statement, you attended a resuscitation call,
25 didn't you --

173

1 Q. Did you have an office or a base -- we know
2 there was a corridor with Consultants and who they
3 shared rooms with, did you share a room with anyone?

4 A. No.

5 Q. No. So how did the Registrars work you don't
6 have an office space you just go to work?

7 A. Yes.

8 Q. So are there any parts of the hospital you
9 would gather or talk together or have a little bit more
10 of an informal chat?

11 A. There is an office for the junior doctors on
12 the children's ward. There is a mess for the junior
13 doctors to eat their food.

14 Q. And who were the fellow Registrars when you
15 were there?

16 A. There was Doctor S, Dr Upadastra, Dr Mayberry,
17 Dr Ukoh.

18 Q. My Lady, at least one of those names can't be
19 reported. And I remind people to look at the list who
20 are reporting.

21 **LADY JUSTICE THIRLWALL:** Thank you.

22 **MS LANGDALE:** So you could sit together and have
23 conversations if you wanted to at different times of the
24 day and -- just to catch up with each other?

25 A. Yes.

175

1 A. Yes.

2 Q. -- and you had to respond to an acute
3 inventory as Child I had deteriorated; yes?

4 A. Yes.

5 Q. You tell us you don't recall if you
6 specifically discussed this deterioration with anyone
7 else, and although there was a debrief much later on,
8 you didn't go to that debrief. Why wouldn't -- why
9 didn't you go to the debrief?

10 A. I don't know why specifically. It may have
11 been that I was on nights at the time or just not
12 working at the time that the debrief took place.

13 Q. You do tell us at paragraph 23 that
14 discussions did happen all of the time, in other words
15 even if there's a not a debrief you can have discussions
16 amongst you as clinicians, doctors, nurses about events
17 on the unit presumably. You can have discussions, is
18 that right, you would have informal discussions even if
19 you didn't go to a debrief?

20 A. Yes, so the people that attend the debrief may
21 then tell others that weren't available to go or were
22 busy at the time, they may pass on those details, yes.

23 Q. Did anyone pass on to you about that debrief
24 or discussions about Baby I?

25 A. I'm sorry, I don't remember. I don't know.

174

1 Q. You had started work in September, hadn't you,
2 and so this death of Child I occurred within the first
3 month that you were there?

4 A. Yes.

5 Q. Yes. And we know it was a sudden and
6 unexpected death. The Inquiry is very aware of that
7 detail.

8 Did any of those Registrars or any of the other
9 Consultants or nurses discuss with you, as someone who
10 had been at least in one event with Baby I, that sudden
11 and unexpected death and what it might mean and what
12 needed to be done?

13 A. I don't think there was an informal discussion
14 but it would have been discussed at the handover meeting
15 between the daytime team and the night team. All of the
16 babies on either the children or -- in fact all patients
17 on either the children's ward or the neonatal unit would
18 be covered as part of this handover process.

19 Q. Did you understand that Baby I had died? Did
20 you know about her death?

21 A. I'm not --

22 Q. I'm not talking about the night you were
23 working, I mean generally, did you know about her death?

24 A. I'm not sure. I don't know.

25 Q. Do you know if anyone discussed with you about

176

1 her death and what it represented?

2 **A.** They may have done, but I don't remember those
3 conversations from -- from 2015.

4 **Q.** Would you agree with me that unexpected and
5 unexplained deaths in neonates are rare?

6 **A.** They are.

7 **Q.** So as a rare event, if it had been discussed
8 with you, do you think you would have remembered?

9 **A.** I may have remembered closer to the time, but
10 I -- I don't have a memory of that discussion now.

11 **Q.** Child L, paragraph 25. You set out at
12 paragraph 27 that you cared during the night shift on

13 9 to 10 April for Child L and when you attended to
14 Child L, they had a low blood sugar reading and you

15 worked to stabilise the blood glucose in order to
16 prevent harm from being caused. You set that out.

17 You also tell us you were unaware of the
18 hypoglycaemia screen test results that had been ordered
19 by Dr Ukoh beforehand?

20 **A.** (Nods).

21 **Q.** When we look at the notes, Dr U -- and I can
22 take you to them but you may just accept this -- it's
23 a page before where we see an entry to the effect:

24 "Bloods for hypoglycaemia investigations have been
25 requested."

177

1 different locations. I believe that the insulin level
2 is a send away sample that gets sent to the Royal in
3 Liverpool and takes some time for the result to go back
4 to Chester.

5 It would be my normal practice to look and see what
6 results were available. I don't recall the results and
7 if I haven't written them down in the notes there was
8 maybe nothing there to comment on.

9 **Q.** The results, we know, were provided later and
10 Dr Gibbs has accepted collective failure for the
11 Consultants for not viewing those results, you're aware
12 of that, aren't you, in respect of Baby L?

13 **A.** I wasn't aware of that, no.

14 **Q.** You weren't aware that the results that were
15 sent back to the hospital test results about the fact
16 that manufactured synthetic insulin could be in his
17 blood? You weren't aware of that?

18 **A.** No, I knew that from the criminal trial.
19 I wasn't aware of Dr Gibbs' comments.

20 **Q.** Right. So now you are, do you take some
21 responsibility too for not checking those records having
22 treated Baby L and managed his low glucose readings, not
23 looking later to see what those test results were when
24 they had been requested?

25 **A.** I wouldn't have expected those results to be
179

1 My question is when you were looking after Baby L,
2 do you look back in the notes to see what somebody has
3 done before you if there's something that you don't know
4 why it's happening or what it means is going on?

5 **A.** Yes. Yes, I will have looked back through the
6 notes, maybe only for the previous 24 hours, to see if
7 that explains the current situation.

8 **Q.** Well, the note -- the entry I think was at
9 19.20 on the 9th, so if you had looked back you might
10 have been expecting to see then that those screen tests
11 results had been ordered, at least requested?

12 **A.** Yes.

13 **Q.** Yes. If you had seen they had been requested,
14 would you wonder why the person before you had requested
15 them?

16 **A.** So if the hypoglycaemia screen had been
17 requested it was because the baby had undergone low
18 blood glucose.

19 **Q.** So you understood then those tests had been
20 ordered?

21 **A.** Yes.

22 **Q.** But you didn't obviously have the results,
23 they came in later?

24 **A.** So the hypoglycaemia screen results come back
25 at different times because the tests are performed at

178

1 back within that night shift.

2 **Q.** No, sure, I meant later, a few days later.
3 I'm not suggesting they were available to you on the
4 day. By 14/15 April you're still working at the
5 hospital, having a look and thinking, "Oh, I looked
6 after this baby let me see what's come back"?

7 **A.** No, that -- normally I would only be looking
8 for the results of the child that I was dealing with at
9 the time. I wouldn't go looking back retrospectively.
10 I would have presumed that the doctor looking after that
11 baby on that day would be aware and checking for current
12 results. Otherwise, you would end up looking at the
13 results of every child on the unit every day to see what
14 had returned.

15 **Q.** So you would only have done it if you were
16 looking after the child on the day that the results came
17 back?

18 **A.** Yes, you would be looking for new results.
19 Generally, if there is a result that is unusual, then it
20 gets telephoned through to the neonatal unit or to the
21 children's ward.

22 **Q.** That was an opportunity missed, wasn't it, to
23 detect deliberate administration of insulin to a baby,
24 not seeing those test results at the time for Baby L?

25 **A.** So -- yes.

180

1 Q. So with your knowledge of how the medical
2 records were put together, how do you think that might
3 be avoided in the future? What could either the doctor
4 in your position or anyone else have done to prevent
5 that?

6 A. I'm not sure what changes would work best
7 there. It was normal practice in many of the district
8 general hospitals that the results went back to the
9 Consultant named on the top of the request form, and
10 then that way a paper trail led back to the responsible
11 clinician, not the junior doctors that were rotating
12 through shifts or sequences of shifts.

13 Q. Baby M, you were also involved in Child M's
14 initial deterioration, you see at paragraph 33? You
15 say:

16 "I have no recollection of whether there was any
17 discussion about the cause of Child M's initial decline
18 that required mechanical ventilation to be commenced
19 and/or any discussion about an unexpected event when
20 I started my shift on the evening of 9 April."

21 Do you remember that? You stated that, and you
22 don't remember anybody discussing it with you?

23 A. It will have been covered in the handover from
24 the day shift to the night shift. I don't remember the
25 details of that handover.

181

1 certainly prior to the start of the next day shift,
2 I think she asked me how he was and I had explained that
3 he'd been unwell over the course of the night and we'd
4 sent some investigations off to see if I could identify
5 the cause of that. And then the following morning, he
6 deteriorated further. And the last intervention that
7 I had to do with him was trying to intubate him and put
8 him on to a mechanical ventilator but I was unable to do
9 that.

10 Q. And others were able to achieve that later?

11 A. Yes.

12 Q. Shall we go to the messages if we can? It's
13 INQ0000569, page 2. It starts at message 17 on that
14 page.

15 So these are extracts of Facebook messaging between
16 yourself and Letby. Just before I start with that,
17 Dr U, you had, I think, begun in June 2016 Facebook
18 messaging Letby, is that right, around June 2016?

19 A. Yes, I believe so.

20 Q. And we have a great deal of messages, if I can
21 just say between, June 2016 and September 2016 about
22 1,355 messages. There's a large volume of messaging,
23 isn't there?

24 A. Yes.

25 Q. Would you like to explain that?

183

1 Q. You don't recall any discussion about anything
2 unusual about the appearance of Child M, and you didn't
3 attend any debrief. Again, is that because you didn't
4 have significant involvement with Child M?

5 A. Most likely, yes.

6 Q. Do you think it would be useful in any event
7 and for learning to have had involvement in any debrief
8 or discussion?

9 A. Yes, I do.

10 Q. Child N. Child N you were involved in
11 discussions or messaging, weren't you, with Letby about
12 Child N?

13 A. Yes.

14 Q. Can you tell us, first of all, your own
15 involvement or direct involvement with Child N?

16 A. On this night in particular? Or --

17 Q. Yes.

18 A. Okay. So on this night in particular, I was
19 the night shift Registrar and Letby had been looking
20 after him on the day shift. The time differences
21 between the two changeovers meant that nurses and
22 doctors changed over at different times so that there
23 was always cover on the unit.

24 We had passed several messages. I think later in
25 the night, the earlier hours of the morning and

182

1 A. Letby was struggling with her mental health
2 and I think I picked up on that and I'd offered some
3 support, and that support, it grew, and I understand
4 that she slept very poorly because of worry and anxiety,
5 and there were often messages that were passed
6 throughout the day and sometimes late at night, earlier
7 in the morning.

8 Q. If we start around Child N or Baby N., we see
9 in fact at message 17 you say:

10 "Is he okay?"

11 She gives you an answer:

12 "Looks like pulmonary bleed on X-ray."

13 Then:

14 "Sorry if I was off during intubation. Bernie ...

15 faffing, et cetera, like things to be tidy and calm.

16 Well, as much as possible."

17 It continues down the page.

18 If we go to message 22 -- sorry, 23, message from
19 her telling you how Baby N is. Then saying:

20 "Sat having a quiet moment. Want to cry. Just mad
21 with so many people."

22 You say, message 25:

23 "Oh, Lucy poor little thing and you."

24 And you continue to discuss Baby N, don't you? If

25 you go down to 27. You say:

184

1 "I've never heard of epiglottitis in a baby. Odd
2 then his CRP was less than 1. Blood obscuring my view
3 of the chords and inflammatory being going on. Poor
4 you. Are you going to be okay? I'm sure he's had the
5 best care possible and you'll have done everything you
6 can for him."

7 If you go over the page, it's page 4 of the
8 messages, number 40. You asking her:

9 "Are you okay?"

10 "Yes, thank you just glad he's okay. Quite
11 impressed they got everyone together so quickly. What
12 do you think has caused his bleed?"

13 And you say:

14 "I think there will be haemangioma or collection."

15 And you continue.

16 If we go further down the page, message 57. Here
17 you say.

18 "I called PICU. Stable overnight."

19 Who have you called? What's happened there?

20 **A.** So it's common practice to phone the
21 destination location for babies that are transferred
22 partly to go on the bottom of the handover sheets so the
23 rest of the team are aware of the status of the baby,
24 which helps them prepare for transfer back to the unit
25 if that's going to be required. I will have made that

185

1 getting their information from because I presumed that
2 they were at Alder Hey in the intensive care unit with
3 the baby.

4 **Q.** But there was at least a chance that you were
5 giving information that they may not even have known
6 about their own baby at that time. You wouldn't have
7 known that, would you, one way or the other?

8 **A.** No, I -- I didn't. I presumed that they'd
9 travelled with the child.

10 **Q.** And within those messages, it fleets from
11 information about the child to quite frivolous, casual
12 conversation in the way that friends do, doesn't it?

13 **A.** It does.

14 **Q.** Entirely inappropriate to have somebody's baby
15 in the centre of that communication after such a serious
16 deterioration and now we know an attack --

17 **A.** Yes.

18 **Q.** -- an attempt murder.

19 Can we go, please, to your statement on Child O and
20 Child P starting at paragraph 37. You tell us you have:

21 "... quite a good recollection of the events as it
22 was a very traumatic experience for all of us on the
23 NNU."

24 The Inquiry has received written and oral evidence
25 from a number of people about Baby O and Baby P and it

187

1 phone call when it was quieter with reduced workload
2 overnight, just asked for an update, how's he getting
3 on, and then I will have shared that with the shift
4 leader of the night shift or whichever shift it was, and
5 in this instance I've shared it with Letby because she
6 will have asked me if I knew anything more about how he
7 was.

8 **Q.** Do you think it was appropriate to be
9 messaging about Baby N with her at this time?

10 **A.** In hindsight, no.

11 **Q.** Why not?

12 **A.** Looking at the content of the messages here,
13 I've shared too much, and from my reflections since this
14 has happened, it's common to give updates on how
15 patients are without naming them, without giving lots of
16 clinical detail to help the recipient understand where
17 that patient is up to. I gave, at the time, details
18 that I thought were helpful but I see now that that
19 probably wasn't the case.

20 **Q.** And how do you think Baby N's parents would
21 feel about that?

22 **A.** I'm sure that's very upsetting.

23 **Q.** Would you have even known if they were being
24 kept up to date at that time about their baby?

25 **A.** I didn't know -- I didn't know where they were

186

1 was traumatic, wasn't it?

2 **A.** Yes.

3 **Q.** Unexpected, unexplained, devastating. Do you
4 agree?

5 **A.** Yes.

6 **Q.** You also say at paragraph 40.

7 "I agree with Dr Brearey's statement that Child O
8 as well as Child P were born in excellent condition of
9 good weight and there were no obvious concerns for
10 either of them."

11 Do you agree?

12 **A.** Yes.

13 **Q.** These were well stable triplets, weren't they?

14 **A.** They were.

15 **Q.** You were part of the delivery team.

16 **A.** Yes.

17 **Q.** One Registrar per baby, all set up to welcome
18 them into the world.

19 **A.** Yes.

20 **Q.** You say at paragraph 48:

21 "We were all very traumatised by Child O's
22 unexpected and unexplained death."

23 You then say:

24 "We could not attribute it to a non-medical cause
25 and had not observed anything suspicious."

188

1 You couldn't give it a medical cause either, could
2 you, it was unexplained, unexpected and you didn't know
3 what had happened?

4 **A.** That's correct.

5 **Q.** Surely anything unexplained, unexpected and
6 you didn't know what had happened falls in the category
7 of suspicious "We don't know. This shouldn't have
8 happened. Until we know more this is suspicious."

9 **A.** Yes, I agree. The problem with trying to
10 attribute a cause at the time of the death is
11 problematic because not all of the investigations have
12 been returned. If this was an overwhelming infection
13 that result isn't going to be available for another 36
14 to 48 hours.

15 **Q.** It may take longer, not 46 to 48 hours for
16 a real forensic scrutiny?

17 **A.** Yes.

18 **Q.** And that's what's required, isn't it,
19 unexpected, unexplained detailed forensic scrutiny is
20 required to see what's happened. Do you agree?

21 **A.** Yes.

22 **Q.** Did you know the process to be followed or
23 what should happen after an unexpected and unexplained
24 death?

25 **A.** Yes, I'm -- I'm aware of the sudden death

189

1 **A.** Yes, it would have been referred to the
2 Coroner.

3 **Q.** You say at paragraph 49:

4 "There was a lot of discussion amongst the doctors
5 at handover following Child O's death as there were
6 still two siblings who were alive and we wanted to
7 ensure that we considered how best to manage them. This
8 was a medically unexplained event but there were no
9 concerns about mismanagement or suspicions that someone
10 was to blame as far as I was aware."

11 How can you say there were no concerns about
12 mismanagement or suspicions when no one knew how the
13 death had arisen? Until that has been investigated, you
14 can't assert there were no concerns, can you?

15 **A.** I think what I'm meaning in that paragraph is
16 that there was no event attributable to that -- that
17 decline. It wasn't that a tube had been displaced or
18 pushed too far, it wasn't that an incorrect medication
19 had been administered as far as recorded on the
20 prescription chart or recorded in the notes. I'm not
21 sure that any of us would have considered a deliberate
22 act.

23 **Q.** Why not?

24 **A.** Because I don't think any -- any of the
25 doctors or nurses on that neonatal unit had thought that

191

1 protocols. The -- and I'm unsure as to how much of that
2 was carried out at this time.

3 **Q.** Were you aware then what the protocols were,
4 back in -- taking yourself back some time ago now to
5 2016?

6 **A.** I'm not sure. I'm sure that they were part of
7 the induction or had been -- that I had looked at them
8 previously. I don't recall whether I was able to recite
9 them or able to pull them to mind at the time.

10 **Q.** Did you and your colleagues, your medical
11 colleagues, have discussions about what should be done?
12 It is clear everyone was devastated, but practically,
13 what should be done?

14 **A.** Baby O died late in the afternoon, just into
15 the early evening and I think a large number of the
16 people that had stayed to help with the resuscitation
17 had stayed beyond the end of their shifts, and the
18 process of taking samples, making the extended case
19 notes were done by those that were remaining for the
20 rest of the day.

21 **Q.** But I'm thinking more about the process of
22 where the deaths should be referred to. Who should be
23 examining the death? What needs to be considered?

24 **A.** Well --

25 **Q.** Do you know?

190

1 there may be somebody causing harm to babies. The --
2 the professionalism and the good practice demonstrated
3 by all members of the team on that unit didn't raise any
4 suspicions. Certainly, as far as I was concerned,
5 I hadn't seen anything that had worried me. I hadn't
6 seen anything that I had gone back and had a second look
7 and thought "Oh, what was that?" I hadn't observed
8 anything.

9 **Q.** Dr Lambie told us last week that by
10 September 2015 she had observed a group of nurses in
11 a huddle conducting an exercise where they were looking
12 for a name or information that might link someone to
13 events on the unit that had been unexpected, caused
14 concern and suspicion, otherwise they wouldn't have been
15 doing that exercise. That was in September 2015.

16 Did you ever understand that people were putting
17 together information to see who might be present at
18 these unexpected and unexplained events, not just
19 deaths, unexpected and unexplained events be they death
20 or deteriorations, when did you understand that kind of
21 information was being collated?

22 **A.** I think that was later in 2016. I don't
23 recall the exact month but it was in the middle to
24 latter half of 2016.

25 **Q.** After Baby O's death or before?

192

1 A. I'm not sure.
 2 Q. We know that Dr Brearey had sent an email to
 3 fellow Consultants saying that he would like to know or
 4 be informed about any deteriorations that had happened,
 5 and Baby N fell into -- taking into account after that
 6 email had been sent. Did you know about that email from
 7 Dr Brearey wanting to know about deteriorations or
 8 unexpected events?
 9 A. To the other Consultants?
 10 Q. Yes.
 11 A. No, I don't think I was aware of that email.
 12 Q. But you did talk to the other Consultants,
 13 you're a collaborative group, were you not aware
 14 informally that Dr Brearey was keen to know about
 15 unexpected deteriorations or anything suspicious?
 16 A. Not as a result of that email.
 17 Q. What was it as a result of then?
 18 A. I beg your pardon?
 19 Q. What was it -- you say not as a result of
 20 an email, what did you hear that from?
 21 A. There was a discussion with the junior doctors
 22 in the office on the paediatric ward, the middle to
 23 latter half of 2016, where I believe it was Dr Jayaram
 24 and Dr Brearey mentioned to us -- I think it was at the
 25 end of an afternoon handover -- that the deteriorations,

193

1 neonatal unit that day because of the events of the
 2 previous afternoon.
 3 Q. Pausing there. Why, because you'd endured the
 4 death the previous day and shouldn't go back again or
 5 what -- why?
 6 A. Yes.
 7 Q. So that was a protective way of managing
 8 doctors or nurses, was it, if they'd been exposed to
 9 something traumatic before?
 10 A. Yes.
 11 Q. So who gave you that instruction or suggested
 12 that you shouldn't go back?
 13 A. That will have been done at the morning
 14 handover because both wards were handed over at the same
 15 time. It was most likely the Consultant of the week.
 16 I think that was Doctor V that week.
 17 Q. Again, my Lady.
 18 **LADY JUSTICE THIRLWALL:** So that name is not to be
 19 reported.
 20 **MS LANGDALE:** So on that next day, you were told
 21 not to go there but did you end up going there?
 22 A. I did.
 23 Q. Right. How did that come about?
 24 A. I was contacted using the bleep system to --
 25 I was bleeped and a message was passed that I should go

195

1 the -- the neonatal unit was -- I'm sorry, I'm
 2 struggling to find the right words -- he had suggested
 3 that the neonatal unit was having a bad run, that there
 4 were more events occurring on the neonatal unit than had
 5 been in previous years and we were I think during that
 6 handover asked just to keep our eyes open.
 7 Q. Keep your eyes open, what for?
 8 A. Well, I suspect for things -- for things that
 9 may be the cause of the deteriorations.
 10 Q. We know the email Dr Brearey sent was
 11 May 2016. Is this conversation around that time -- you
 12 sent it to Consultants, but is this a conversation with
 13 you around that time?
 14 A. It was around that time, May or June
 15 I suspect.
 16 Q. So by the time of Baby O's death, you are
 17 aware of that conversation.
 18 A. Yes.
 19 Q. And Baby O's death comes out of the blue.
 20 A. Yes.
 21 Q. Baby P. What was your involvement with
 22 Baby P?
 23 A. On the Friday morning that Baby P
 24 deteriorated, I was conducting the ward round on the
 25 children's ward. I had been told not to go to the

194

1 to the neonatal unit.
 2 Q. And what was the scene on your arrival?
 3 A. So Baby P was in the far right-hand side of
 4 Nursery 2 and there were a lot of people in that room,
 5 doctors and nurses, and Baby P was clearly unwell from
 6 the monitoring system and just how he looked. I had
 7 a very, very quick handover about what had happened but
 8 it was clear that he was at the point of needing to be
 9 resuscitated.
 10 Q. Did you think at the time, "How is this
 11 happening again?" You'd said earlier you were all
 12 conscious, two siblings, and here you are walking into
 13 that scene?
 14 A. At that time my priority was to resuscitate
 15 the baby. I -- and I got on with the tasks needed to
 16 get him mechanically ventilated and then starting to put
 17 more venous lines in so that more drugs could be
 18 administered.
 19 Q. And after the intensity of the scene, did you
 20 then think, "How can we be here again?"
 21 A. So the rest of that day, the intensity only
 22 dropped slightly. He got a little bit better and then
 23 declined again, then got a little bit better and
 24 declined. I stayed predominantly at the side the cot
 25 dealing with breathing, circulation, volume replacement,

196

1 and I -- I didn't have the big picture. I had a summary
 2 of what had happened prior to me arriving there.
 3 I didn't know what had happened, I don't think,
 4 overnight. And I -- I spent I think the rest of the day
 5 in that room. There were some discussions because many
 6 of the Consultants came through and joined during the
 7 day and I -- I understood that they were discussing with
 8 the transport team and what should be done next.
 9 **Q.** Baby O, P, and R's parents knew that they
 10 needed to get Baby R out of the Countess of Chester to
 11 keep him safe. They didn't know medically what had
 12 happened or how, but they knew Baby R was not safe
 13 there. Did you as a doctor think something's happening,
 14 he's not safe here after what had happened to O and then
 15 P?
 16 **A.** I was glad that Baby R was transferred.
 17 I don't think I had put together the string of events of
 18 O and P. I was still looking for a medical cause for
 19 their deterioration. But I was glad that Baby R moved.
 20 **Q.** We know, going back to messages from Letby to
 21 you -- if we go back to 0000569, page 5, a message -- 94
 22 and 95, you message her at 94:
 23 "Chaos this morning and triplets this afternoon.
 24 What a day."
 25 And she says at 95:

197

1 how many have you been involved in the delivery of?
 2 **A.** Three, I think.
 3 **Q.** So if we go to the message over the page at
 4 216, so page 9, 216. It looks as though -- and this is
 5 the 23 June, so page 9 of the sheet, message 216, you
 6 say here:
 7 "I'm glad you could talk to me and hope I helped."
 8 She says:
 9 "That's okay. Didn't want you collapsing mid
 10 resus. Good to talk it through."
 11 "I think the debrief was good [this is you]. We
 12 didn't come up with anything missed or delayed. Maybe
 13 it is better to do it straight away rather than wait."
 14 What are you discussing, what debrief here?
 15 **A.** So I -- I think there that there will have
 16 been a discussion at the end of the resuscitation so
 17 that everybody had the opportunity to say what they'd
 18 seen, what maybe hadn't been noticed by others at the
 19 time and to then pick up any of the points of
 20 information that may be helpful.
 21 **Q.** So you're discussing at this point a sudden
 22 and unexpected death of Baby O between you in the
 23 messaging?
 24 **A.** We did, yes.
 25 **Q.** If we go over the page, so page 11, message

199

1 "The triplets delivered. Wow. How did you manage
 2 to finish early and actually leave the building?"
 3 So she's asking you, isn't she, about triplets
 4 there.
 5 And if we go over the page, page 7 of the message,
 6 message number 125:
 7 "What gestation are the trips? Are you on NNU
 8 tomorrow?"
 9 And you respond at 126:
 10 "33 plus 5."
 11 Again, somebody asking you about the babies at that
 12 point in her messaging. Did you understand why she
 13 would be asking that or think that was an unusual thing
 14 to be asking you about?
 15 **A.** That message I presumed was getting ready for
 16 returning to work.
 17 **Q.** Sorry, say that again?
 18 **A.** I -- I thought that that message was getting
 19 ready for returning to work. I believe she'd been on
 20 holiday prior to that.
 21 **Q.** Right. And presumably the fact that triplets
 22 were going to be born at the hospital was a big source
 23 of excitement. It's very rare, isn't it?
 24 **A.** It's unusual.
 25 **Q.** How many sets of triplets have you known --

198

1 323, this is the start of the next day, you -- you say
 2 there was thought about you not going back to be
 3 allocated to the sibling. It appears that Letby was.
 4 She was back on, wasn't she, with P?
 5 **A.** Yes.
 6 **Q.** She says:
 7 "I've got my student again but might see if she can
 8 work with someone else as I don't feel I'm in the frame
 9 of mind to support her. Loads of paperwork to finish
 10 off."
 11 And she has made reference to Baby P as:
 12 "Stop feeds, is large asps."
 13 Meaning aspirations presumably?
 14 **A.** Yes.
 15 **Q.** And you say:
 16 "Large asps. I wonder if they have all been
 17 exposed to a bug that B Pen and Gen didn't account for.
 18 Are you okay?"
 19 She says:
 20 "I will be watching them both like a hawk."
 21 If we go further down at 324, message 324, she is
 22 messaging about Child P:
 23 "Just going to dress him take footprints. Hope
 24 you're okay."
 25 Further down, at 330/331 she says:

200

1 "I made a fool of myself whilst there. I asked
2 them to be quick for you."
3 And so it continues.
4 If we go over the page, at 457, this by then is
5 25 June, we see at 22.46 Letby saying to you:
6 "Do I need to be worried about what Dr Gibbs was
7 asking?"
8 You say:
9 "No, he was asking to make sure normal procedures
10 were being carried out."
11 What was going on there? We can see -- we can by
12 all means have a look at that exchange, what's she
13 worrying about?
14 **A.** I don't know exactly what she was worrying
15 about. But the -- I think, having looked after the two
16 babies on consecutive days, she was concerned that she
17 would be thought to be responsible for the deaths and,
18 as I didn't know of the number of preceding deaths,
19 I didn't -- it was a reassuring, no, I don't -- I hadn't
20 observed anything that had gone wrong in the
21 resuscitation of O or P.
22 **Q.** You were a Registrar, albeit one of the most
23 experienced ones, at the resuscitation. How could you
24 possibly say, no, nothing to worry about? You didn't
25 know what this death represented. You couldn't know.

201

1 to day shifts -- comes back from holiday -- and that's
2 where you knew she had come back from holiday, and
3 that's when Baby O died, the day she came back.
4 **A.** I don't -- I don't think I was aware that it
5 was day shifts only.
6 **Q.** You didn't know she'd moved to day shifts?
7 **A.** I'm not -- no, I don't think so. It may have
8 been mentioned in passing but it wasn't something
9 that -- that I remembered.
10 **Q.** She did talk to you about moving to day
11 shifts, didn't she? If we go to page 19, message 681,
12 you see there:
13 "Eirian has just phoned telling me not to come in
14 tonight and do days instead. Asked if there was
15 a problem. She said no just trying to protect me a bit.
16 We can have a chat about it tomorrow but now I'm
17 worried."
18 You say:
19 "Please don't worry."
20 She says:
21 "I can't do this job if it's going to be like this.
22 My head is a mess. Why is she ringing at this time?
23 There must be a problem."
24 And you continue to say:
25 "You did nothing wrong at all. We all work

203

1 **A.** No, it was -- it was a reassuring no because
2 I -- again, I was aware of her mental health problems
3 and the amount of anxiety that she had.
4 **Q.** Well, she was worried, wasn't she, if people
5 are asking questions about it?
6 **A.** In hindsight, yes, obviously.
7 **Q.** And at the time you mistook that for, what?
8 **A.** Anxiety.
9 **Q.** If you look at page 14, at message 471, you
10 are reassuring her:
11 "If anyone knows how hard you have worked over the
12 last three days it's me. If anybody says anything to
13 you about not being good enough or performing adequately
14 give my details. I can provide a statement."
15 She says:
16 "Sincerely I hope I won't ever be needing
17 a statement, but thank you."
18 And you then say, message 473:
19 "You will know that the coch nice mortality rate is
20 a bit higher than the network average. Makes people,
21 consultants look at trends and patterns. That may have
22 been why Dr G came to ask."
23 It wasn't about mortality rates, was it, it was
24 about unexpected deaths?
25 And were you aware that Letby had only been moved

202

1 tirelessly."
2 Message 691:
3 "We did everything possible. I don't see how
4 anyone can question that E has always been very
5 supportive."
6 And from this point onwards, of course, she was
7 going -- just to finish with messages -- she had to
8 undertake or was undertaking a number of processes,
9 wasn't she, she went on to have a grievance process, and
10 you continued to message her during that time?
11 **A.** Yes.
12 **Q.** If we go to message on page 27, 1028, 6 July,
13 you say:
14 "You need to keep this to yourself. The meeting
15 this afternoon looked at everything with Child O and P
16 from birth onwards, reviewed everything, the room, beds
17 medical views and actions. We looked at all
18 documentation, medicine. If you have any doubt about
19 how good you are at your job stop now, documentation was
20 perfect. Everyone commented about the appropriateness
21 of your request for review following the vomits."
22 What meeting were you referring to there?
23 **A.** This was a meeting on the neonatal unit
24 looking at these two deaths. And it was a review -- it
25 was a review of the written medical notes and of the

204

1 typed nursing notes and whatever other information was
2 available at the time, and we looked from birth through
3 to death for both babies.

4 **Q.** Was this one where Dr Brearey, Powell,
5 Williams, Griffiths you, Dr ZA and Hayley Cooper were
6 present, a mortality review, or was it something
7 different?

8 **A.** It may have been something different. I --
9 I recall it as a meeting in an office on the neonatal
10 unit.

11 **Q.** You say at 6 July there when you say -- when
12 you send the message, "This meeting this afternoon", was
13 that the day -- well, actually it's -- what time is that
14 message? Five to 1, so to could it have happened on
15 5 July?

16 **A.** Yes.

17 **Q.** Right. If we go -- we can leave the message
18 for a moment -- to that mortality meeting that occurred
19 on 5 July -- mortality review -- it's INQ0005121. So
20 that's page 1, 2. If we go to page 3.

21 We see the people you said you were likely to be
22 with doctors Brearey, Williams, Powell, Griffiths,
23 Dr ZA. Dr ZA -- and there's one for P as well. There
24 are two babies, everything is being looked at, as you
25 have said. Dr ZA gave evidence this morning to say that
205

1 an association with the deaths or deteriorations.

2 **A.** So I -- I think if I'd left earlier in that
3 meeting I may not have been aware of that bit of the
4 discussion about specific concerns.

5 **Q.** If you left that meeting early, it doesn't
6 change the fact that all of your colleagues -- your
7 medical colleagues had those concerns at this point. Do
8 you agree?

9 **A.** Yes.

10 **Q.** So how is it you're the only one who says you
11 had no concerns at this point? Were you not speaking to
12 any of them?

13 **A.** Yes, I mean we -- we spoke all of the time.
14 I'm not sure that we discussed specific members of
15 staff. I'm not sure that we discussed specific babies
16 to that extent.

17 **Q.** Why did you say in that messaging I took you
18 to earlier "You need to keep this to yourself" to Letby.

19 **A.** I wasn't sure whether the nursing team knew
20 that there was review into the deaths, and I didn't --
21 I think the unit was still very upset about the deaths
22 of Baby O and Baby P and I didn't want it to be
23 gossiped about.

24 **Q.** If they had wanted Letby at the meeting or the
25 mortality review she would have been invited, wouldn't
207

1 Letby's presence was referred to in this meeting of
2 5 July and Letby having something to do with the deaths,
3 her continued association, and things had gone beyond
4 a coincidence and she might have been involved in some
5 way either deliberately or through incompetence.

6 Do you remember that Letby was mentioned in this
7 meeting as Dr ZA told us this morning?

8 **A.** I think I was only present for the beginning
9 of that meeting, so for the bits where the cases were
10 discussed, because I was present for both of them. I --
11 I think I left and then the conversation continued
12 afterwards.

13 **Q.** Why do you think it continued after you left?

14 **A.** I -- I presume they wanted to discuss what
15 they were considering.

16 **Q.** Dr ZA said anyone at the meeting was very
17 clear about this association, but your evidence is that
18 conversation or part of the discussion didn't happen
19 when you were there?

20 **A.** I don't think it did. I'm sure that I was
21 just there to give evidence for the -- not evidence,
22 information about the resuscitations.

23 **Q.** At this point, it seems everyone has to accept
24 they were discussing or thinking about it, but you say
25 you still weren't at this point thinking that Letby had
206

1 she?

2 **A.** Yes.

3 **Q.** So why was it for you to pass on information
4 about that meeting to her?

5 **A.** She'd appeared very upset after the deaths of
6 both Baby O and Baby P.

7 **Q.** Everyone was upset.

8 **A.** They were, they were. And as the nurse
9 looking after the two babies she told me that she was --
10 she was upset by it, and I was -- I went -- I gave her
11 information to reassure her that her part in the
12 resuscitation process had been very good. I -- I don't
13 think I actually discussed the resuscitation with her or
14 the discussion about it. I just said that her notes
15 were very clearly written.

16 **Q.** If we go back to the messages, so again
17 INQ0000569, page 28, at 1071, please, you say:

18 "I've since had an email from SB [that's
19 Stephen Brearey] which makes me understand what's going
20 on. I'll forward it to you, you might find it
21 interesting."

22 And you forward an email that you've received to
23 her email address, don't you?

24 And if we go to it we can see that email at
25 INQ0001445, page 1.
208

1 So you're sent this from Dr Brearey:
 2 "I think it's quite likely both will go to an
 3 Inquest and you're likely to be asked to give
 4 a statement. Can I suggest you prepare it now when
 5 everything is fresh in your mind. It can include things
 6 we discussed yesterday that might not be in the notes,
 7 particularly around Child P's initial arrest and who put
 8 IOs in and where and what went through them."
 9 What can you remember was discussed that wasn't in
 10 the notes at the meeting of 5 July?
 11 **A.** My recollection of that meeting on 5 July was
 12 about the resuscitations for the two babies. I'm --
 13 clearly there was other -- other items discussed. I'm
 14 not -- I don't think I was aware of those.
 15 **Q.** Well, were the other items the concern of
 16 Letby's association with the deaths again?
 17 **A.** They may well have been, yes.
 18 **Q.** So does that mean Dr Brearey had raised those
 19 concerns with you?
 20 **A.** I don't recall them being raised as a specific
 21 concern about a specific member of staff at that time.
 22 **Q.** If we were to go back to the notes, we know
 23 that Letby says to you -- I can perhaps read them out
 24 rather than going back on to the screen -- she says on
 25 6 July:

209

1 **A.** Potentially, yes.
 2 **Q.** Why was it for you to tell her that?
 3 **A.** It wasn't. Again, in hindsight that was
 4 an error on my part.
 5 **Q.** And you say to her:
 6 "This email has to stay between us, is that okay?"
 7 So you knew you shouldn't be sending it to her
 8 otherwise why would you say that?
 9 **A.** I shouldn't have sent it.
 10 **Q.** And you knew that at the time, because you
 11 say -- you say that.
 12 **A.** I think at the time I -- I sent it in order to
 13 help reassure her that the process was being followed,
 14 but I didn't send it as a way of bypassing normal
 15 routes. I did it as a reassurance that the process was
 16 being followed.
 17 **Q.** She was also -- she went on to be worried
 18 about her RCPCH interview, didn't she?
 19 **A.** Yes.
 20 **Q.** And if we go to the messages, 0000569,
 21 page 33, message 1234:
 22 "Karen has just come. The panel want to see me
 23 ASAP. Waiting for a time slot. The rep isn't available
 24 so Karen coming with me."
 25 1234, do we have that? Yes.

211

1 "Why is it going to Inquest?"
 2 You say:
 3 "Unexplained cause times 2."
 4 She says:
 5 "It's a bit of a worry if it's going that far."
 6 And then she asks:
 7 "Do you think I will be involved?"
 8 And you say:
 9 "Probably not. Your documentation most likely will
 10 be used in place of a statement. The questions will be
 11 about management and procedures."
 12 She says:
 13 "I don't know what to say. Feels like a bit of
 14 a blow considering everyone's hard work."
 15 Why did you send that email to her?
 16 **A.** Why did I forward that email?
 17 **Q.** Yes.
 18 **A.** It was because of the -- the worry about these
 19 two babies, they were unexpected deaths, and she had
 20 been -- or gave me the impression that she was very
 21 upset by them and was doing a lot of -- there was a lot
 22 of conversation about these two babies and I was
 23 basically trying to give her some insight into what was
 24 going on.
 25 **Q.** That there was going to be an Inquest?

210

1 Letby asks you:
 2 "Do you think there's a problem?"
 3 You say:
 4 "No, I don't think there's a problem."
 5 You say:
 6 "They will probably want to talk about what you
 7 remember. Be calm it is in the a review of you."
 8 She says -- you see what she says there:
 9 "On the verge of a massive meltdown."
 10 You say:
 11 "Remember the debrief with Olivier. I want you to
 12 go through in your mind when you meet the reviewers deal
 13 with it in the same way. There are no trick questions.
 14 You didn't do anything wrong and you are still the best
 15 NNU nurse I have ever worked with."
 16 She says she's:
 17 "A bit concerned about going without a rep but
 18 Karen says has to be today."
 19 And then if we go overleaf, so it's page 34, so it
 20 is page 34. She has the meeting, we see messages going
 21 backwards and forwards.
 22 Message 1274, page 34, she says:
 23 "The two members were nice. They didn't ask much
 24 about the babies it was more about the unit as a whole.
 25 In brief it looks as though there's the potential for

212

1 this to go further over a long period of time. H thinks
2 we need it look at taking out a grievance case."

3 So we know she does take out a grievance, and she
4 messages you about that as well. And you're broadly
5 supportive of her taking a grievance; is that right?

6 **A.** Yes. The --

7 **Q.** Did you ever think these are your Consultant
8 colleagues, doctors Brearey, Dr Jayaram, who are really
9 worried about her role and what she has been doing and
10 you support her to take out a grievance in whatever way
11 you can, texting or messaging, did you never stand back
12 and think, "My doctor colleagues are really worried
13 about this?"

14 **A.** No. What had happened, I'd become part of
15 that support process, largely mental health and anxiety,
16 and a lot of the time the messages were supportive in
17 nature, whilst I was doing other things, and I was
18 providing a conversation on the phone, but I wasn't --

19 **Q.** Can we deal with that -- sorry, Dr U, finish
20 if you like.

21 **A.** Carry on.

22 **Q.** Can we just remove the word "anxiety" and in
23 your reflection would you accept a guilt about being
24 challenged about what she had done having meetings and
25 reviews?

213

1 **A.** Yes.

2 **Q.** And you sent an email, if we go to
3 INQ01078440001. See there at the bottom:

4 "Dear colleagues Mr Lamont has recommended I email
5 you to enquire about the possibility of arranging some
6 theatre observation time for a neonatal intensive care
7 unit practitioner. Lucy Letby is a band 5 staff nurse
8 with an interest in NICU nursing of post-operative
9 babies. In order to facilitate her personal
10 development, she would like to have the opportunity to
11 observe some theatre sessions. Mr Lamont feels that
12 there is no problem from a surgical perspective."

13 We see the clinical lead above in the email
14 responding -- clinical lead for training, I should say:

15 "As long as she has the clearance to work within
16 the trust coming theatre won't be a problem. Will Lucy
17 be visiting on an ad hoc basis or is there a specific
18 date that you would like her to come. I am assuming you
19 are co-ordinating with Mr Lamont."

20 If you go to, please, INQ0107841. So 0107841,
21 there's further discussion here between whether an
22 honorary contract is required or not. I think it should
23 be -- at the bottom the page is the first one, I think.
24 You've asked prior to that:

25 "Does she need to complete an honorary pro forma?"

215

1 **A.** In hindsight, yes.

2 **Q.** There's reference to her saying she was
3 panicking at some points.

4 **A.** Yes.

5 **Q.** Yes? So rather than using the word "how it
6 felt at the time", what do you think now when you look
7 at it?

8 **A.** Now it does look as those these were moments
9 of panic about the events that had taken place and her
10 role in them.

11 **Q.** And getting information about -- from you
12 about babies, how they might have died, how they were?

13 **A.** That -- from -- from what felt like being
14 a supportive gesture, that now feels like a massive
15 mistake. It's something that I've considered on a daily
16 basis for the last six to eight years. The amount of
17 reflection that I've done over this is significant.

18 **Q.** You supported her, didn't you, at the time in
19 December 2016 to get some observational experience at
20 Alder Hey as well?

21 **A.** Yes.

22 **Q.** We've got emails in relation to that. But you
23 had a conversation I think, first of all, with the
24 senior retired now surgeon a Mr Lamont about it; is that
25 right?

214

1 And we see at the bottom the page from recruitment:
2 "Yes, this is correct. I am sending your email to
3 the recruitment team is there now processing the
4 honorary pro formas. Will the person in question be
5 observing only?"

6 Comes back to you:

7 "Yes. A neonatal intensive care unit nurse. She
8 is using the theatre observation to build up part of her
9 PDP. It will just be observation in theatre, most
10 likely two to three days Jan/Feb 2017."

11 "She would not need an honorary contract. We can
12 issue her with a letter of access. I will contact the
13 Countess of Chester."

14 I think you say in your statement it was
15 Karen Reece you thought from the Countess of Chester who
16 approved their end --

17 **A.** Yes.

18 **Q.** -- or gave information about DBS checks; yeah?

19 **A.** Yes.

20 **Q.** We can ask her about that.

21 You then send another email, INQ0107842, page 2 --
22 0002. I don't think that's the right one. That's it:

23 "Lucy is having a little trouble being released
24 from Chester to attend Alder Hey for the observation."

25 This is May 2017:

216

1 "Would you mind extending the letter of authority
2 through to December for me?"

3 That's May 2017.

4 And then if we go to INQ01078321, we see
5 9 December 2016 the letter of authority:

6 "Because it is an observational visit she must be
7 supervised at all times. No direct patient contact is
8 permitted during your visit."

9 You do not say in your --

10 **LADY JUSTICE THIRLWALL:** We just got that one
11 actually.

12 **MS LANGDALE:** Sorry. Thank you, my Lady. Have
13 a look at that. Just that page is fine.

14 So the conditions are set, supervise, "no direct
15 patient contact is permitted" because she's gone through
16 this route.

17 You don't say, do you, in any of your emails, and
18 presumably not to Mr Lamont either, that she is not
19 occupying any patient-facing role at that time at the
20 Countess of Chester, that she can't be with babies on
21 the unit? You don't set that out in this request at
22 all, do you, the situation at the Countess of Chester?

23 **A.** I didn't. And the -- she was still having
24 patient contact at that time. My understanding was that
25 she was conducting the clinical audits in the obstetric

217

1 and she used that document for revalidation or to assist
2 with the revalidation.

3 **Q.** Were you having discussions with Karen Reece
4 or Eirian Powell or anyone from the Countess of Chester
5 at this time about plans for Letby or her aspirations
6 for her career or anything like that?

7 **A.** No, I didn't. The -- the request came for the
8 clinical observation and I was told that it had been
9 approved by whoever was managing Letby at the Countess
10 of Chester at the time. I, again in hindsight, was
11 remiss not to complete the loop and check that that was
12 correct. But my assumption here was that in offering
13 a letter of access, with contact with the Countess of
14 Chester, that had all been signed off as appropriate,
15 and if it wasn't appropriate, the HR or the nursing
16 management team from the Countess would have said "No".

17 **Q.** A matter you raise on a different point, in
18 your second statement, you refer to a comment reported
19 to you by Letby in which she said a Consultant had
20 referred to her as a baby killer, and you wanted to
21 clarify an elaborate on that. Can you tell us about
22 that now?

23 **A.** Yes. So this was recounted to me and this was
24 information second to third hand.

25 **Q.** From Letby?

219

1 or gynaecology outpatient department and had been to
2 somewhere else within the Countess to cover an audit
3 of -- of a service.

4 **Q.** Is that office-based? When you say patient
5 contact, is it contact with patience in an office or --

6 **A.** No, so this was in the clinic rooms --

7 **Q.** Right.

8 **A.** -- and from that, I assumed that the move that
9 she had to the admin role had been for retraining and
10 for then deciding what other interventions were required
11 alongside a masters module that she was reading for.

12 **Q.** When the police went to her home, they
13 found -- if we can go to INQ0100851, page 2-3. So
14 0100851, page 2 to 3.

15 Next page, 2 to 3, please, not that.

16 2 to 3 we see there, signed by you -- if we go for
17 2 first, please. If we can just -- sorry,

18 Ms Killingback, go back to page 2, the first page of
19 this two-page document, we see here a list of what she
20 has done, and I understand it is undated but signed by
21 you, so can you tell us how that was put together
22 presumably for her by you?

23 **A.** This was put together because she required
24 documents to add in for her revalidation and the number
25 of times that she had attended Alder Hey I summarised,

218

1 **A.** She told me --

2 **Q.** Right.

3 **A.** -- what she had been told which had been
4 overheard by somebody else.

5 **Q.** Right.

6 **A.** That --

7 **Q.** Do you know who the somebody else was who was
8 supposed to have told her that?

9 **A.** No, and even if I'd had the name I don't think
10 I would have known who that was.

11 **Q.** Was it a nurse -- another nurse?

12 **A.** I believe it was a doctor.

13 **Q.** No, not -- not a nurse who said it -- sorry,
14 said the comment. Do you think it was a nurse who told
15 Letby somebody had said that about her?

16 **A.** Yes.

17 **Q.** Yes. So what nurse told Letby a doctor had
18 said something like that?

19 **A.** I don't know. I don't think I was ever told
20 that.

21 **Q.** Okay. So she told you someone had referred to
22 her as a baby killer, what did she say?

23 **A.** So I don't think she was referred to as a baby
24 killer. I think the message that was passed to me was
25 there's a baby killer on the unit.

220

1 Q. Right. So Letby said to you that somebody had
2 said there was a baby killer on the unit?

3 A. Yes.

4 Q. Did you know who was supposed to have said
5 that?

6 A. I don't think I did. It -- from further
7 discussions -- and, again, I didn't know the name of the
8 doctor -- I understood it to have been an obstetrician.

9 Q. And you say:

10 "At some later point in time, although I can't
11 recall when, the comment was attributed to Letby.
12 I know this as I was told that the consultant
13 obstetrician had to write an apology letter to Letby."

14 So you knew there was a link with her with that
15 remark?

16 A. Yes. So I think after that initial comment,
17 at some point it was refined to be directed towards
18 Letby, and I don't know who or where that took place,
19 but I do know that an apology letter was written later
20 on. I don't know the contents of that letter.

21 Q. And, again, she was the conduit for the
22 information to you, was she?

23 A. Yes.

24 Q. So finally from me, Dr U, do you have anything
25 to add or say or reflect upon in the light of the

221

1 information. During the period that the babies were
2 harmed at the Countess of Chester you were the senior
3 Registrar.

4 A. That's correct.

5 Q. And from September 2016 you were a locum
6 Consultant with a specialism in part in diabetes and
7 also in general paediatrics?

8 A. That's correct.

9 Q. And you are now a (*redacted*) Consultant
10 (*redacted*)?

11 A. Yes.

12 Q. Can I ask you first about Child L. It may be
13 helpful to look at the medical notes in this regard just
14 to anchor your answers in the contemporaneous records
15 INQ0001169, please. Do you remember Child L?

16 A. I don't recall the position of the child
17 within the nursery and I don't recall the events that
18 took place, but I may have more recollection after
19 looking at the notes.

20 Q. Thank you. Let's look at those, then. May we
21 go to page 13 first. This is just to refresh your
22 memory.

23 A. Yes.

24 Q. This is a note by you on 10 April 2016, half
25 past midnight, and if you take a moment there, you can

223

1 evidence that you have given?

2 A. Yes. I -- I have reflected on this daily
3 since -- well, certainly since my first police
4 interviews in January 2018, and I think I've become more
5 aware that I wasn't aware of the full clinical picture,
6 and I provided support by being misled and maybe
7 manipulated, and for that I'm -- I'm really sorry that
8 things have come to end as they have.

9 I have a lot of regrets about how that period of
10 time took place.

11 MS LANGDALE: My Lady, Mr Skelton has a few
12 questions. I know there's a statement of evidence we
13 are due to prepared in as well. I don't know if a break
14 is necessary for Dr U, I see the time, or whether we
15 should be pressing on for I imagine 15 minutes in total
16 with the statement read as well, but --

17 LADY JUSTICE THIRLWALL: Dr U, you are all right
18 for another 15 minutes or so?

19 A. Of course.

20 LADY JUSTICE THIRLWALL: Thank you, then we can
21 finish off today.

22 Mr Skelton.

23 Questions by MR SKELTON

24 MR SKELTON: Dr U, can I just recap on your
25 background without trespassing into confidential

222

1 see that there's -- one of the first notes that you make
2 is about blood glucose and the need for glucose to be
3 administered.

4 A. That's right, yes.

5 Q. A fairly common problem with neonates.

6 A. It -- it can be, yes.

7 Q. Prior to that, but I won't take you to the
8 notes, there had been a period in which Child L was
9 suffering from hypoglycaemia, for obvious reasons, and
10 you're in fact a continuation of the care that has been
11 given in response to that.

12 A. Yes.

13 Q. Father L and M, because there were two babies
14 from the same family, don't recall being told about the
15 hypoglycaemia and its significance. Can you explain why
16 that might have been the case?

17 A. Yes. So this was half past midnight and on
18 a night shift at the Countess there will have been me
19 and a more junior doctor and it is -- I don't recall who
20 the junior doctor was that night, but it's quite likely
21 that they were a foundation doctor or a GP trainee
22 without a lot of paediatric experience, which meant that
23 I was dealing with the calculations, the practical
24 procedures and all of the management of the glucose on
25 my own.

224

1 The junior doctor will have been dealing with
2 requests for reviews either from the postnatal ward,
3 labour ward, children's ward or A&E, and in that way
4 I was protected to get on with looking after Baby L, and
5 the management of Baby L's glucose worked, and I carried
6 on managing it. I didn't go up to the postnatal able
7 ward and leave the neonatal unit and this baby in
8 particular without me supporting them to wake up
9 Baby L's mother and father if he was there to tell them.

10 **Q.** Just pausing there?

11 **A.** Can I sorry -- can I --

12 **Q.** Please go ahead.

13 **A.** At the time it was common practice for
14 information about babies to be given to the parents on
15 the morning ward round and they were encouraged to come
16 down for the ward round so that they could be updated.
17 That's what I presumed would happen the next morning.

18 **Q.** So at some point they should have been told
19 this?

20 **A.** Yes.

21 **Q.** And if they weren't told that that may have
22 been a mistake?

23 **A.** Yes.

24 **Q.** And in fact I think you had to scrub in to do
25 a long line for this child, didn't you?

225

1 **Q.** Thank you. Can we then turn to what happens
2 in the subsequent period of time.

3 You I think were on duty subsequently. Is that
4 right, you were on -- I've taken you to the 10 April,
5 but you were also on on 14 April, if we go to page 19,
6 in the morning.

7 That's you I think there, isn't it, at the bottom,
8 your notes?

9 **A.** Yes.

10 **Q.** Your handwriting?

11 **A.** Yes, it is.

12 **Q.** So you are there on the 14th, and if we
13 continue on -- I think you're also there on the 15th; is
14 that right?

15 **A.** No, the information at the top there is the
16 remainder of --

17 **Q.** Sorry, I'll take you to the page just for
18 clarification. Page 22, further down. That's you there
19 on a cranial ultrasound.

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

21 **Q.** Just pausing there, can you remember what that
22 was for?

23 **A.** No, but I don't recall the baby's gestation or
24 birth weight because they may have played a role in the
25 need for a cranial ultrasound.

227

1 **A.** That's right.

2 **Q.** Which was -- took you off your otherwise
3 onerous tasks with other children presumably?

4 **A.** Well, they weren't onerous tasks. They took
5 me away from being able to leave immediately to respond
6 to something. So for the period of time that it took to
7 site this long line, I will have been supported by the
8 junior doctor who was working with me, and if anything
9 had been -- if I'd been needed for anything clearly
10 I would have abandoned the long line and gone to help.
11 But, yes, it does take me out of circulation for
12 a period of time, half an hour or so.

13 **Q.** The previous day -- if we go to page 12 just
14 above that, please, just if you could just highlight the
15 bottom half. Is that a note by Dr Jayaram?

16 **A.** Yes.

17 **Q.** And is he in that note ordering blood
18 investigations? Is it bloods for -- is it hypoglycaemia
19 or is that another word there?

20 **A.** I think it says, "Bloods for hypoglycaemia
21 investigations sent."

22 **Q.** So do you think that's the blood result -- the
23 blood testing that's being initiated that comes back
24 five days later?

25 **A.** Yes.

226

1 **Q.** So at this remove you can't remember the
2 specific reason that you might have asked for that but
3 it could be to do with just checking on the health of
4 the baby's skull and brain?

5 **A.** So the cranial ultrasound is to look for
6 evidence of bleeding within the fluid compartments
7 within the brain and it's to look for those and to look
8 for evidence of other bleeds or other lesions within the
9 brain.

10 **Q.** What might have prompted that request? If you
11 look at the page, there doesn't seem to be much of
12 an indication of a reason?

13 **A.** I'm just looking at the top of that page.

14 **Q.** Yes.

15 **A.** And the plan says cranial ultrasound.

16 **Q.** In response to what? Is it suspected
17 infection?

18 **A.** No, I wouldn't have thought infection would be
19 the planned -- would be the plan for a cranial
20 ultrasound, but I'm assuming that the baby has been
21 jaundiced or there is a concern that blood has been lost
22 somewhere, and the ultrasound is to check that there
23 hasn't been a bleed into the fluid compartments of the
24 brain.

25 **Q.** So you were on shift on the 14th in the

228

1 morning, and we've seen a note that I've taken you to at
2 9.20 in the morning, and then the next note in this
3 child's records by you is at 4 pm the next day. Would
4 you have been doing two day shifts in the hospital
5 throughout that period of time?

6 **A.** Yes.

7 **Q.** If we go back to the page 21, which is above
8 your -- which is earlier in the day on the 15th, you
9 will see that a doctor, name unknown, is making a note
10 about Child L's blood results. Can you see that, it's
11 slightly off the usual run of narrative on the
12 right-hand side in the middle?

13 **A.** Yes.

14 **Q.** If you were on duty as the senior Registrar on
15 the 15th would you have looked at Child L's notes for
16 that day? I appreciate you said to Ms Langdale you
17 don't have the time and don't necessarily have the need
18 to look back for days and days of every child you look
19 at, but would you look at the day's medical records to
20 see what's going on?

21 **A.** No, I suspect because I've just written that
22 short note about a cranial ultrasound I've gone in
23 performed the scan as required, reviewed the images and
24 then written the procedure in the notes. I would
25 have -- as this is a morning ward round, any abnormal

229

1 whoever this is a junior doctor, not a Consultant, has
2 written down the blood results but there hasn't been any
3 interpretation of them and their significance at all at
4 the time.

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

6 **Q.** In terms of the responsibility for that
7 absence, Dr Jayaram organised the -- or asked for the
8 blood results. They come in at a time when presumably
9 he is not here, he certainly doesn't reappear in the
10 notes around this time. Whose responsibility is it to
11 receive and think about the results when they come in?

12 **A.** I'm sure every hospital has a slightly
13 different system and, as I explained earlier, it's often
14 the case that the result goes back to the Consultant
15 whose week it was because they were responsible for the
16 care of the babies that week. Unusually, abnormal
17 results are normally phoned through from the lab direct
18 to the neonatal unit so that the team looking after the
19 baby at that time is aware of them. Obviously that may
20 not be the case for an insulin level that's five days
21 old but, again, if it's an unusual result, many
22 laboratories will phone it through.

23 As for what happened to the results subsequent to
24 the hot week of that Consultant, I don't know. I had
25 presumed that because they're all on an electronic

231

1 results would usually then be discussed with the
2 Consultant whose week -- who is the neonatal hot week.
3 I think for that cranial ultrasound there were not many
4 of us that could perform the procedure, so I've gone in
5 and done the scan and written the notes down.

6 **Q.** So trying to understand how these results
7 would have been recorded and interpreted, they've been
8 picked up, have they, on the ward round in the morning
9 first thing at 9.30?

10 **A.** It looks like it as they're entered in the
11 ward round notes, yes.

12 **Q.** Can you at this removed assist in who was the
13 Consultant who might have been on that ward round from
14 what you can see from this page?

15 **A.** No, I don't recall who was the Consultant for
16 the week of the 15th.

17 **Q.** But there always is a Consultant on that ward
18 round?

19 **A.** No, there is always a Consultant responsible
20 for the hot week for that week, and then the ward round
21 is done, and at the time, on a Thursday, there would be
22 a Consultant ward round and also one of the weekend
23 days, so a Saturday or a Sunday, and they would
24 alternate with the Registrar.

25 **Q.** So it looks like what's happened is that

230

1 system I would presume that they go back to the
2 Consultant to have a checklist for, but I don't know how
3 the Consultants organised their results management.

4 **Q.** From your perspective, (*redacted*) these are
5 obviously abnormal reluctance and they appear to
6 indicate exogenous insulin having been administered
7 either deliberately or inadvertently?

8 **A.** Yes. So these are not results that you would
9 see in the patients that I deal with because this is
10 a result of too much insulin rather than not being able
11 to make enough. But, yes, they are abnormal results and
12 I would have expected that they had flagged some sort of
13 warning or alert.

14 **Q.** And in a baby with hypoglycaemia?

15 **A.** Yes, on the -- on the night in question if
16 those results had been available, they would have been
17 very helpful. But, as I said earlier, insulin is
18 a sample that gets I believe sent away to Liverpool and
19 then comes back days later.

20 **Q.** So there will be evidence later in the week
21 from the scientists. I think there was a phone call
22 from the lab to the scientists in your hospital and then
23 an attempt to call the ward --

24 **A.** Sorry, I didn't hear.

25 **Q.** And then an attempt to call the ward but no

232

1 record of a telephone call. But at some point, whoever
2 has made this note has received them probably by
3 electronics means or by paper copy --

4 **A.** Yes.

5 **Q.** -- the day after I think they were in fact
6 received at the hospital, so they were received on the
7 14th and they appear in the notes on the 15th.

8 No one appears to have looked at them. Had you
9 noticed that, bearing in mind that you were aware of the
10 child's hypoglycaemia, would you have recognised this
11 was something that required immediate follow-up?

12 **A.** I'm just trying to look for a blood glucose
13 reading at the time that those results are written down
14 and --

15 **Q.** Well, the child has been treated for
16 hypoglycaemia at the time?

17 **A.** No, I -- absolutely. But, the -- if the --
18 the length of action -- once the source of the insulin
19 is removed the baby's blood glucose will return down to
20 normal as I think happened in this case and the
21 calculations for how much extra glucose is required are
22 then dialled back because the baby doesn't need all the
23 supplemental glucose.

24 I agree that that result is -- that the insulin
25 level is unusually high.

233

1 **Q.** -- clinically?

2 **A.** Yes.

3 **Q.** And of course insulin administration or air
4 administration is precisely that kind of action?

5 **A.** Yes.

6 **Q.** If you had been aware the unusual rash
7 recalled but not recorded by Dr Jayaram, might that have
8 affected your interpretation of the cause of this
9 child's collapse bearing in mind Child B's collapse some
10 time previously with the same -- with a similarly
11 unusual rash?

12 **A.** There was discussion about babies with rashes
13 and we I don't think had been able to come up with
14 a clear reason for why those rashes were occurring and
15 that continued through to the time that I finished at
16 the Countess.

17 **Q.** And it took Dr Jayaram I think to begin to
18 suspect it may have been administration of air and did
19 the research that he will explain no doubt when he comes
20 to give evidence. But none of the rest of you suspected
21 that, is that correct?

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

23 **Q.** At any time?

24 **A.** It's not anything that I have ever, ever
25 considered would be done. Administration of air is not

235

1 **Q.** The clinical condition may have resolved, but
2 the problem that may have contributed to that condition,
3 namely insulin that shouldn't have been administered,
4 needs investigation, doesn't it?

5 **A.** Yes.

6 **Q.** Because there's only really one of two
7 possibilities: deliberate or mistaken?

8 **A.** Yes.

9 **Q.** Either of which is unacceptable?

10 **A.** Yes.

11 **Q.** May I just turn briefly to some of the other
12 children, Child M. You were asked about this child
13 a little by Ms Langdale and I don't want to touch on it
14 in any detail of course bearing in mind the time.

15 In your statement you say that you don't, this is
16 paragraph 34 if you want to refer to it, you didn't
17 observe any clinical signs which made you suspect
18 a non-medical cause for that child's collapse.

19 Could you just explain what you mean by that?

20 **A.** So a non-medical cause would be a deliberate
21 act or an act done in error, that had caused those signs
22 and symptoms and I hadn't witnessed any of those.

23 **Q.** But you are alert to the possibility that
24 there may be no evidence of such an act --

25 **A.** Yes.

234

1 something -- you work to prevent that at all costs.

2 **Q.** Briefly on Child Q and I only ask this because
3 this isn't something dealt with in any detail in your
4 statement or at all in any depth. You were involved
5 with Child Q's care.

6 **A.** Yes.

7 **Q.** And there are a number of notes, I won't take
8 you through them, but is there anything that you can
9 assist with when it comes to explaining Child Q's
10 deterioration? What was the cause of it insofar as you
11 were concerned as one of the treating doctors?

12 **A.** So the cause of it was unclear. It -- it
13 looked as though he was in discomfort and the signs that
14 were being reported to me, the observations that had
15 been written down suggested something to do with his
16 gastrointestinal tract and with that in mind, I carried
17 out some blood investigations and a blood gas I believe
18 and then an X-ray of his abdomen.

19 And it was that X-ray that looked unusual and
20 I then contacted the surgical team at Alder Hey who
21 looked at the X-ray because they could see it from --
22 they could see the same image from where they were and
23 then they organised his or they requested his transfer
24 to Alder Hey.

25 **Q.** Did you ever get a satisfactory explanation

236

1 for Child Q's repeated desaturations?

2 **A.** I don't think there was an explanation at the
3 time, but with an abnormal abdominal X-ray that would
4 potentially cause those desaturations.

5 **Q.** Could you be specific about what the X-ray
6 showed which would be the underlying cause for that?

7 **A.** Yes, and I -- I can't remember the exact
8 wording of it and it would be much easier with the
9 picture, but I believe that there was some bowel that
10 had moved to a position that it didn't normally occupy
11 and --

12 **Q.** Which could be caused by harm or some other
13 cause?

14 **A.** Yes.

15 **Q.** Ms Langdale asked you about the messages that
16 you had with Lucy Letby and you have expressed a degree
17 of contrition and embarrassment, understandably, about
18 that.

19 Can I just ask you about messaging generally.
20 These messages that the Inquiry has received are on
21 a platform called Facebook Messenger. Is that on your
22 personal phone or is it on a professional phone?

23 **A.** That will have been on a personal phone.

24 **Q.** Did you have a work phone?

25 **A.** No.

237

1 patients within a professional group, and your personal
2 interactions which will be about your own personal life
3 and et cetera ordinarily?

4 **A.** Yes.

5 **Q.** But what has happened on Facebook Messenger is
6 those two things have become blurred?

7 **A.** Yes.

8 **Q.** And you recognise I think that that's
9 inappropriate?

10 **A.** Yes, I do.

11 **Q.** Because you are discussing patients' names and
12 conditions with a member of staff in a personal
13 capacity?

14 **A.** Yes.

15 **Q.** Are you aware that for at least some of the
16 parents, and I am thinking in particular of Father N,
17 that's particularly difficult to have seen occur in this
18 case; that their child was the subject of private
19 messaging outside of the ordinary professional
20 communications?

21 **A.** Yes, I -- I can understand that and the
22 purpose of the messages at the time was to give clear
23 information that would help in the care of that baby on
24 a subsequent shift. That was the intention, nothing
25 else.

239

1 **Q.** Were you -- were there other platforms,
2 WhatsApp, et cetera, that you were using for ordinary
3 professional interactions about patients?

4 **A.** So there was no bespoke platform for
5 communicating, but WhatsApp was used.

6 **Q.** Were there particular groups that would be you
7 and the Consultants, you and your fellow Registrars, you
8 and the nursing team or was there just a -- how did it
9 work in practice?

10 **A.** There were often groups set up so that if
11 there was a gap on the SHO rota or on the Registrar rota
12 a message could be sent to the appropriate group and
13 say, "Can anybody cover" the gap that's come up at short
14 notice. That, that sort of messaging is -- is common.

15 **Q.** And was WhatsApp the way in which you would
16 have been contacted if you were out and about in the
17 hospital and you needed to be recalled urgently to the
18 ward?

19 **A.** No. So an urgent recall to the ward would be
20 through the bleep system. There was a baton bleep that
21 was passed from person to person, so that it was always,
22 always held by somebody.

23 **Q.** So is it right then that just in terms of
24 WhatsApp there is a dividing line between your
25 professional WhatsApp interactions, which may be about

238

1 **Q.** Well, it looks to some extent also like you
2 are just talking about what you are doing at work and
3 there isn't always a clinical imperative to the
4 messages, is that fair?

5 **A.** I think sometimes the -- what's going on.
6 Yes, that was the case.

7 **Q.** Well, you talk for example about cuddling
8 certain babies and things like that which clearly isn't
9 a medical process?

10 **A.** No.

11 **Q.** Is there anything you would like to say to the
12 parents whose babies appear on your private messages
13 with Lucy Letby?

14 **A.** Yes. Again, I have reflected on that for the
15 last six-plus years.

16 I fully accept that that's not the way that the
17 information should have been managed, but there was no
18 malice intended in it. It was done to share information
19 that would be helpful on a subsequent day, nothing more.

20 **MR SKELTON:** Thank you, doctor. Thank you,
21 my Lady.

22 **LADY JUSTICE THIRLWALL:** Thank you, Mr Skelton.

23 **MS LANGDALE:** My Lady, I have no further questions
24 for Dr U.

25 **LADY JUSTICE THIRLWALL:** Thank you very much.

240

1 Dr U, you are free to go. If you'll just stay
2 there for the moment. Do you want to take the next
3 statement now or do it tomorrow?

4 **MS LANGDALE:** Yes, I was going to ask Ms Bennett if
5 she would read the next witness evidence from
6 Ms Saunders.

7 **LADY JUSTICE THIRLWALL:** Thank you very much,
8 Ms Bennett.

9 **MS BENNETT:** My Lady, this is a statement that the
10 Inquiry has received from Erica Saunders, Director of
11 Corporate Affairs at Alder Hey Children's Hospital.

12 **LADY JUSTICE THIRLWALL:** Thank you.

13 **MS BENNETT:** "I Erica Saunders will say as follows:

14 "I am employed as Director of Corporate Affairs at
15 Alder Hey Children's Hospital Foundation Trust. This is
16 a board level executive position which covers
17 responsibility for the Trust's corporate governance,
18 regulatory risk and legal matters. Under this remit,
19 I am the Trust executive lead for Public Inquiries as
20 well as a range of other sensitive confidential matters
21 that may arise from the broad aspects of my role.

22 "Alder Hey Children's NHS Foundation Trust is
23 a specialist paediatric centre providing all aspects of
24 healthcare to over 450,000 children and young people
25 each year. The Trust employs a workforce of 4,500 staff

241

1 development.'

2 "On 8 December Dr U was informed that if Letby had
3 clearance to attend the Trust the visits could be
4 accommodated. Dr U responded to enquire as to the
5 checks Letby required in order to attend, ie a DBS
6 check. Dr U later e-mailed members of the HR team to
7 enquire as to whether Letby would require a honorary
8 pro forma. He provided Letby's email address to enable
9 direct communication and stated, 'If you need a in-house
10 signatory to confirm please send the pro forma to me.'"

11 Following questions from a recruitment officer as
12 to the nature of the activities she would be
13 undertaking, Dr U was informed on 9 December that Letby
14 would require a letter of access rather than a honorary
15 contract. Further, they would contact the Countess of
16 Chester Hospital to:

17 "Ask them to confirm Lucy's pre-employment checks.
18 Once they have confirmed I will let you know if we need
19 it apply for any outstanding checks ie a DBS."

20 A pro forma was received from the Countess of
21 Chester confirming the pre-employment checks undertaken
22 by them on Letby's appointment including a DBS. The
23 letter of access was issued to Letby and Dr U separately
24 on 9 December and contained the following condition:

25 "The observational visit will be for the period

243

1 who work across our community and hospital sites and as
2 a teaching and training hospital we provide education
3 and training to around 900 medical and dental students
4 and over 1,000 nursing and allied health professional
5 students each year.

6 "It is known that Lucy Letby attended the Trust in
7 order to undertake observational visits during the
8 period January to April 2017. The visits were
9 facilitated and arranged by Dr U who at that time was
10 a locum Consultant in diabetes and general paediatrics
11 at the Trust. This appeared to be the result of
12 a personal connection arising from a professional
13 relationship which developed when he and Letby worked
14 together at the Countess of Chester Hospital. To that
15 extent the request to visit Alder Hey was not made
16 directly to the Trust by Letby herself.

17 "The initial request made by Dr U with regard to
18 the visits was addressed to colleagues in the theatres
19 management team and education team on 7 December 2016 by
20 email referencing a prior conversation with
21 Mr Graham Lamont, a senior paediatric surgeon and then
22 Clinical Director. The email identifies Letby as
23 'a Band 5 nurse with an interest in NICU nursing of
24 post-operative babies and states that the purpose of the
25 visits was in order to facilitate her personal

242

1 1 January 2017 until 28 February 2017. During this
2 time, you must be supervised at all times. No direct
3 patient contact is permitted during your visit."

4 Dr U also sought an opportunity for Letby to
5 observe at ENT list. On 9 February Dr U e-mailed the
6 recruitment officer with a request to extend the letter
7 of access until May 2017 as Letby was "unable to get
8 across to Alder Hey but is now able to do so".

9 The letter was re-issued on the same day to the end
10 of May in accordance with this request. On 3 May 2017
11 Dr U sent a further email stating:

12 "Lucy is having a little trouble being released
13 from Chester to attend Alder Hey for the observation.
14 Would you mind extending the letter of authority through
15 to December for me?"

16 This was actioned on 4 May. The request by Dr U on
17 Letby's behalf was informal in nature. The
18 observational visits proposed did not fall under the
19 scope of the Trust's formal work experience policy thus
20 this was not applied.

21 The Trust frequently receives requests for
22 colleagues from many other organisations to visit our
23 services as can be seen from the exhibits. The
24 appropriate steps were taken to ensure both Dr U and
25 Letby understood the conditions that applied to the

244

1 visits.
 2 So far as the Trust has been able to ascertain, ie
 3 via documentary evidence, Letby attended a diabetes
 4 multi-disciplinary team meeting on 2 March 2017 at which
 5 her presence was minuted. In addition, it is understood
 6 that she may have attended an outpatient clinic with
 7 Dr U during March and a roadshow related to insulin
 8 pumps on 22 April.
 9 The visits were sponsored by Dr U, as can be seen
 10 by the email correspondence, and to that extent he was
 11 the responsible officer. Media reports following
 12 Letby's conviction last August that management at the
 13 Countess of Chester "wanted to find Letby a placement at
 14 Alder Hey".
 15 The Trust has no record of any approach from anyone
 16 at the Countess of Chester. Moreover, as described, the
 17 nature of the contact was ad hoc observational visits,
 18 not a placement or work experience. Trust senior
 19 management was unaware of the arrangements being made to
 20 visits by Dr U. Therefore, no enquires were made to the
 21 Countess of Chester regarding Letby's role, background
 22 or qualifications.
 23 Checks were made at the appropriate level, given
 24 the nature of the request as explained.
 25 The Trust took steps to establish the facts in
 245

1 relation to visits following Letby's arrest in 2018 and
 2 again following the verdicts in the criminal case. All
 3 written records have been checked where they exist.
 4 And that concludes the statement, my Lady.
 5 **LADY JUSTICE THIRLWALL:** Thank you very much
 6 indeed, Ms Bennett. So we will adjourn now until
 7 10 o'clock tomorrow morning. Thank you all.
 8 **(5.08 pm)**
 9 **(The Inquiry adjourned until 10.00 am,**
 10 **on Tuesday, 8 October 2024)**

INDEX

1
 2
 3 DR ZA (sworn) 1
 4 Questions by MR DE LA POER 1
 5 Questions by MR BAKER 66
 6 Questions by MR SKELTON 77
 7 DR V (affirmed) 81
 8 Questions by MR DE LA POER 81
 9 Questions by MR SKELTON 148
 10 Questions by MR BAKER 161
 11 Questions by LADY JUSTICE THIRLWALL 165
 12 DR U (affirmed) 167
 13 Questions by MS LANGDALE 167
 14 Questions by MR SKELTON 222
 15
 16
 17
 18
 19
 20
 21
 22
 23
 24
 25

LADY JUSTICE THIRLWALL: [40] 1/3 1/7 1/10 1/14 43/2 65/18 65/24 77/3 80/9 80/13 80/21 81/3 102/14 122/19 122/25 148/18 161/12 161/15 164/16 165/2 165/19 165/22 165/25 166/3 166/8 166/12 166/17 167/5 167/15 171/6 175/21 195/18 217/10 222/17 222/20 240/22 240/25 241/7 241/12 246/5 MR BAKER: [5] 66/3 77/1 80/8 161/16 164/14 MR DE LA POER: [14] 1/4 1/8 1/17 43/6 65/14 80/11 80/18 81/5 102/16 122/12 123/1 148/14 164/17 166/23 MR SKELTON: [5] 77/7 148/21 161/11 222/24 240/20 MS BENNETT: [2] 241/9 241/13 MS LANGDALE: [9] 167/11 167/18 171/11 175/22 195/20 217/12 222/11 240/23 241/4	10 September 2015 [1] 99/13 10.00 [1] 246/9 10.00 am [1] 1/2 10.30 [3] 71/25 72/12 72/21 10.45 [1] 136/25 100 [2] 45/4 45/7 1028 [1] 204/12 106 [2] 132/14 132/20 1071 [1] 208/17 10th [1] 63/18 11 [2] 169/9 199/25 11 May [1] 51/17 11.26 [1] 65/21 11.45 [1] 65/23 110 [3] 64/9 64/14 134/4 111 [2] 64/9 64/15 114 [1] 163/11 12 [1] 226/13 12 hours [2] 76/14 76/23 12 October [1] 103/4 12.30 [1] 72/7 12.50 [1] 155/14 1234 [2] 211/21 211/25 125 [1] 198/6 126 [1] 198/9 1274 [1] 212/22 12th [1] 103/8 13 [2] 132/18 223/21 13 August [2] 35/9 71/25 13 August 2015 [1] 32/9 13 July [1] 55/15 13 October [1] 102/8 13th [2] 103/9 103/15 14 [2] 152/15 202/9 14 April [1] 227/5 14 minutes [1] 155/9 14/15 April [1] 180/4 1410 hours [1] 69/25 14th [3] 227/12 228/25 233/7 15 [2] 153/7 153/10 15 minutes [2] 222/15 222/18 1500 [2] 76/12 76/20 15th [5] 227/13 229/8 229/15 230/16 233/7 16 [1] 17/5 16 May [2] 51/20 129/25 16th [1] 124/15 17 [2] 183/13 184/9 17 February [1] 63/15 19 [2] 203/11 227/5 19 January [1] 113/5 19 September [1]	59/17 19.20 [1] 178/9 1ml [1] 69/18 2 2 August [1] 69/9 2 March [3] 113/20 123/4 124/3 2 March 2017 [1] 245/4 2 o'clock [2] 76/9 120/20 2.53 pm [1] 167/8 20 [2] 65/20 173/23 2011 [1] 13/2 2015 [30] 2/6 4/16 7/6 7/16 9/1 18/23 19/16 21/9 30/5 32/9 42/8 42/12 43/7 46/17 46/18 82/1 82/4 89/19 92/18 93/7 97/24 99/13 102/5 149/1 164/21 167/25 168/9 177/3 192/10 192/15 2015/16 [1] 17/5 2016 [46] 4/16 5/9 7/16 9/1 9/23 10/12 13/12 42/8 44/20 46/24 46/25 47/18 48/14 48/22 60/1 77/14 82/11 85/23 109/21 109/23 123/4 124/5 126/20 126/21 126/25 145/23 148/2 167/25 168/3 168/9 171/12 171/18 183/17 183/18 183/21 183/21 190/5 192/22 192/24 193/23 194/11 214/19 217/5 223/5 223/24 242/19 2017 [12] 45/13 143/22 147/23 216/10 216/25 217/3 242/8 244/1 244/1 244/7 244/10 245/4 2018 [4] 47/15 168/4 222/4 246/1 2022 [1] 153/21 2024 [5] 1/1 1/19 81/7 167/20 246/10 21 [1] 229/7 2140 [1] 70/12 216 [3] 199/4 199/4 199/5 22 [3] 64/15 184/18 227/18 22 April [1] 245/8 22.20 [1] 76/8 22.46 [1] 201/5 2210 hours [1] 70/10 2220 [1] 76/21 23 [2] 174/13 184/18 23 June [7] 95/2 97/2	98/23 125/25 163/11 164/6 199/5 23 June 2015 [2] 19/16 164/21 23 May 2024 [1] 1/19 23rd [2] 52/24 130/17 24 hours [6] 16/9 88/2 114/17 114/18 115/7 178/6 24 months [1] 16/10 24th [4] 52/24 130/18 137/16 139/2 25 [4] 149/25 150/1 177/11 184/22 25 June [1] 201/5 25 October 2022 [1] 153/21 26 [1] 154/15 26 January [2] 60/15 143/22 26 November [1] 106/11 26 November 2015 [1] 30/5 26th [2] 60/14 144/21 27 [3] 177/12 184/25 204/12 27 January [1] 60/10 27 January 2016 [2] 9/23 10/12 27 June [5] 52/21 136/21 142/25 163/20 164/9 27th [3] 137/13 138/13 140/1 28 [2] 155/13 208/17 28 February 2017 [1] 244/1 28th [1] 142/13 29 [2] 156/12 156/14 29 July [2] 96/17 96/20 29 June [1] 53/20 29th [1] 142/13 3 3 August [1] 69/15 3 May 2017 [1] 244/10 3 November [1] 148/2 3 November 2016 [1] 145/23 3 September [1] 167/20 3.10 [1] 167/10 30th June [1] 142/13 323 [1] 200/1 324 [2] 200/21 200/21 33 [5] 16/5 16/7 181/14 198/10 211/21 330/331 [1] 200/25 331 [1] 200/25	334 [1] 32/16 337 [1] 33/23 34 [6] 67/24 90/13 212/19 212/20 212/22 234/16 36 [1] 189/13 37 [2] 75/16 187/20 39 [1] 35/4 4 4 August [2] 21/9 21/22 4 May [1] 244/16 4 o'clock [1] 130/23 4 pm [1] 229/3 4,500 [1] 241/25 40 [2] 185/8 188/6 45 minutes [1] 122/16 450,000 [1] 241/24 457 [1] 201/4 46 [1] 189/15 471 [1] 202/9 473 [1] 202/18 48 [1] 188/20 48 hours [2] 189/14 189/15 49 [1] 191/3 5 5 August [2] 32/3 32/5 5 July [6] 54/9 205/15 205/19 206/2 209/10 209/11 5 June 2024 [1] 81/7 5.08 pm [1] 246/8 52 [2] 102/11 102/16 53 [1] 102/18 57 [1] 185/16 6 6 July [2] 204/12 209/25 6 June 2017 [1] 45/13 681 [1] 203/11 691 [1] 204/2 7 7 days [1] 103/4 7 December 2016 [1] 242/19 7 October 2024 [1] 1/1 7 September [1] 75/21 8 8 December [1] 243/2 8 February [6] 112/19 113/7 113/20 123/13 123/22 127/2
---	--	--	--	--

8	absolutely [10] 31/16 31/18 37/4 41/1 43/6 109/3 109/20 137/11 166/23 233/17	acute [7] 11/18 11/21 11/25 12/3 31/17 154/22 174/2	133/4 133/22 134/8 134/11 135/22 136/2 139/15 141/11 142/20 142/24 143/2 149/6 150/2 154/17 162/23 164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	ahead [3] 8/21 85/21 225/12
8 February 2016 [1] 109/23	accept [11] 71/20 71/22 72/15 95/24 148/9 159/21 161/3 177/22 206/23 213/23 240/16	ad [2] 215/17 245/17	139/15 141/11 142/20 142/24 143/2 149/6 150/2 154/17 162/23 164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	air [4] 140/24 235/3 235/18 235/25
8 June 2015 [1] 149/1	acceptable [1] 58/20	ad hoc [2] 215/17 245/17	150/2 154/17 162/23 164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	al [1] 6/21
8 October 2024 [1] 246/10	accepted [2] 37/5 179/10	add [3] 138/16 218/24 221/25	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	alarm [1] 101/22
85 [1] 60/13	access [6] 22/15 216/12 219/13 243/14 243/23 244/7	added [1] 147/1	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	albeit [1] 201/22
9	accidental [3] 74/19 129/1 129/2	address [3] 89/5 208/23 243/8	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	Alder [15] 104/16 168/5 187/2 214/20 216/24 218/25 236/20 236/24 241/11 241/15 241/22 242/15 244/8 244/13 245/14
9 April [1] 181/20	accidentally [1] 36/10	addressed [1] 242/18	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	Alder Hey [14] 104/16 187/2 214/20 216/24 218/25 236/20 236/24 241/11 241/15 241/22 242/15 244/8 244/13 245/14
9 April 2016 [1] 48/14	accommodated [1] 243/4	adequately [2] 63/9 202/13	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	Alert [4] 70/13 164/22 232/13 234/23
9 August 2024 [1] 167/20	accompanying [1] 146/16	adjourn [1] 246/6	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	alertness [1] 153/18
9 December [2] 243/13 243/24	accord [4] 16/14 137/6 138/3 138/10	adjourned [1] 246/9	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	Alison [4] 51/18 124/10 124/24 125/7
9 December 2016 [1] 217/5	accordance [2] 14/10 244/10	adjournment [1] 122/23	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	alive [4] 133/14 161/23 164/1 191/6
9 February [1] 244/5	according [2] 38/2 147/22	admin [1] 218/9	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	all [90] 14/7 16/22 17/14 17/17 30/20 31/18 34/3 36/25 43/10 43/18 55/8 61/1 64/24 65/25 70/6 70/18 74/13 98/24 100/21 101/21 101/21 101/25 102/2 102/3 102/11 105/18 107/18 111/10 111/12 112/4 112/13 113/16 115/8 115/10 119/7 119/11 119/11 119/22 119/25 122/4 122/4 122/4 122/4 128/23 133/23 140/8 146/18 147/3 148/3 148/14 152/15 154/12 155/17 156/4 159/11 166/12 166/14 167/1 174/14 176/15 176/16 182/14 187/22 188/17 188/21 189/11 192/3 196/11 200/16 201/12 203/25 203/25 204/17 207/6 207/13 214/23 217/7 217/22 219/14 222/17 224/24 231/3 231/25 233/22 236/1 236/4 241/23 244/2 246/2 246/7
9 June [2] 89/19 150/2	accords [1] 6/16	administered [6] 33/2 191/19 196/18 224/3 232/6 234/3	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	almost [6] 10/22 31/9
9 to [1] 177/13	account [6] 57/18 69/7 87/12 87/23 193/5 200/17	administering [1] 36/22	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
9.20 [1] 229/2	accurate [2] 132/17 167/22	administration [6] 17/13 180/23 235/3 235/4 235/18 235/25	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
9.30 [1] 230/9	accusation [1] 51/9	administrative [3] 89/2 171/13 172/5	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
900 [1] 242/3	achieve [1] 183/10	adult [2] 7/22 8/17	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
94 [2] 197/21 197/22	acknowledge [2] 58/14 64/10	adults [1] 38/17	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
95 [2] 197/22 197/25	across [8] 14/7 16/22 41/18 133/6 135/18 146/17 242/1 244/8	advance [2] 61/13 170/19	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
9th [1] 178/9	act [11] 11/17 12/9 48/17 51/13 55/7 74/18 74/19 191/22 234/21 234/21 234/24	adversarial [1] 60/18	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
A	acted [1] 99/9	advice [2] 144/9 151/14	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
A's [7] 114/12 149/6 150/14 151/19 152/4 159/24 166/9	action [5] 49/7 51/1 114/9 233/18 235/4	advised [1] 85/18	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
AB [1] 27/3	actioned [1] 244/16	advocate [1] 6/21	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
abandoned [1] 226/10	actions [2] 141/16 204/17	affairs [3] 116/19 241/11 241/14	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
abbreviation [1] 36/2	active [1] 156/2	affect [3] 91/3 149/10 149/18	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
abdomen [15] 22/1 68/10 68/24 69/12 69/22 70/2 70/13 70/17 70/18 71/1 90/10 104/10 104/13 156/1 236/18	actively [2] 64/19 117/11	affected [3] 43/4 43/12 235/8	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
abdominal [7] 24/8 24/14 24/15 103/1 104/9 104/12 237/3	activities [1] 243/12	affirmation [2] 1/11 80/23	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
able [22] 6/20 7/2 36/20 46/10 59/4 60/6 62/15 102/21 106/15 107/22 126/6 136/12 168/25 183/10 190/8 190/9 225/6 226/5 232/10 235/13 244/8 245/2	activity [1] 57/4	affirmed [4] 81/1 167/13 247/6 247/11	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
abnormal [7] 72/10 73/8 229/25 231/16 232/5 232/11 237/3	actually [12] 54/23 97/11 118/3 128/6 133/15 133/20 158/19 165/18 198/2 205/13 208/13 217/11	afraid [2] 6/21 73/15	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
about [360]	acuity [3] 41/21 57/4 57/17	after [65] 10/10 14/13 21/11 37/25 43/23 44/25 45/6 52/20 65/20 66/20 72/14 76/5 76/14 83/12 89/25 93/17 109/7 109/11 113/16 115/23 116/9 118/10 121/5 121/11 122/7 122/7 122/9 127/13 133/2	164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
above [3] 215/13 226/14 229/7			164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
absence [1] 231/7			164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	
absent [1] 116/11			164/9 178/1 180/6 180/10 180/16 182/20 187/15 189/23 192/25 193/5 196/19 197/14 201/15 206/13 208/5 208/9 221/16 223/18 225/4 231/18 233/5	

A	angry [1] 144/22	44/15 112/12 140/4	appreciate [4] 71/7	222/17 223/9 227/12
almost... [4] 79/21	animated [1] 135/9	181/22 202/12 238/13	100/9 104/2 229/16	231/17 232/4 232/8
83/10 138/25 156/18	annual [4] 31/15 53/4	anybody's [1] 101/23	approach [4] 59/24	232/11 233/13 233/21
alone [1] 154/6	58/15 143/3	anyone [16] 15/19	100/23 111/14 245/15	234/23 236/7 237/20
along [6] 62/22 120/5	another [19] 20/16	28/16 79/18 79/19	approachable [1] 3/6	239/11 239/15 240/2
133/10 133/16 135/18	33/16 50/9 84/17	96/19 110/23 174/6	appropriate [18] 17/6	240/2 241/1
136/5	84/18 85/18 99/18	174/23 175/3 176/25	23/2 58/5 58/7 58/13	area [5] 17/3 84/2
alongside [1] 218/11	108/17 110/11 121/2	181/4 202/11 204/4	78/5 80/3 85/11 87/13	84/10 84/11 134/16
already [8] 13/19	142/24 143/15 150/24	206/16 219/4 245/15	100/14 102/22 131/15	areas [1] 83/24
26/8 26/10 51/5 63/25	158/10 189/13 216/21	anything [40] 7/13	186/8 219/14 219/15	aren't [2] 73/21
137/14 147/15 161/21	220/11 222/18 226/19	26/10 39/19 47/12	238/12 244/24 245/23	179/12
also [47] 6/24 8/14	answer [10] 50/15	47/25 52/3 56/17 58/9	appropriately [1]	arise [1] 241/21
9/9 9/12 9/14 10/8	74/20 77/22 79/15	59/12 101/9 110/18	70/2	arisen [1] 191/13
11/15 11/25 13/2	88/14 89/10 139/19	138/6 138/9 140/3	appropriateness [1]	arising [2] 114/9
16/17 20/15 24/6 31/5	152/3 152/8 184/11	141/20 146/14 146/21	204/20	242/12
42/16 47/19 48/3	answers [2] 165/5	157/17 160/20 163/23	approved [2] 216/16	arm [1] 90/11
49/21 54/12 54/17	223/14	166/8 182/1 186/6	219/9	arose [1] 80/6
65/5 70/22 71/17	antagonism [1]	188/25 189/5 192/5	approximately [1]	around [31] 5/9 8/25
80/18 90/16 104/4	169/11	192/6 192/8 193/15	70/12	10/25 53/4 69/4 83/12
114/17 114/18 147/17	antibiotics [2] 103/3	199/12 201/20 202/12	April [10] 48/14	85/13 85/17 97/11
149/18 153/14 159/13	103/4	212/14 219/6 221/24	124/5 177/13 180/4	100/15 101/3 106/2
159/23 160/13 161/17	anticipated [1] 87/18	226/8 226/9 235/24	181/20 223/24 227/4	107/2 108/7 117/9
161/24 164/3 165/10	anticipation [1]	236/8 240/11	227/5 242/8 245/8	126/5 126/5 127/24
177/17 181/13 188/6	153/19	anyway [1] 67/15	April 2016 [1] 124/5	144/6 154/1 154/8
211/17 223/7 227/5	anxiety [6] 153/18	apart [2] 118/18	are [144] 1/21 1/24	158/2 171/12 183/18
227/13 230/22 240/1	184/4 202/3 202/8	163/3	1/25 2/3 2/18 12/5	184/8 194/11 194/13
244/4	213/15 213/22	apnea [1] 154/22	18/21 18/23 26/15	194/14 209/7 231/10
alternate [1] 230/24	any [115] 3/6 5/25	apnoeic [1] 103/5	27/5 27/8 27/17 28/17	242/3
alternative [1] 85/19	6/15 7/23 8/9 10/4	apologies [1] 19/14	29/3 30/16 34/10	around July 2016 [1]
although [11] 4/5	12/8 14/1 14/22 15/1	apologise [3] 56/24	35/22 38/8 38/8 38/11	171/12
18/23 26/15 30/8	17/7 17/15 20/10	122/15 153/25	41/23 45/11 45/19	around June 2016 [1]
38/24 46/24 57/15	21/21 26/11 37/16	apology [2] 221/13	46/12 48/8 55/21 60/6	183/18
115/5 123/12 174/7	39/14 39/23 41/2	221/19	61/8 62/15 65/19 69/4	arranged [6] 31/21
221/10	42/13 44/5 44/5 44/14	apparent [2] 63/24	70/23 70/24 72/2 72/8	32/1 58/3 106/17
always [14] 4/21 5/7	46/8 46/22 47/18	97/5	72/21 73/21 74/2 76/3	108/10 242/9
6/21 18/13 31/9 83/13	50/20 51/14 51/16	apparently [1]	79/7 80/17 81/13	arrangement [1]
84/16 182/23 204/4	51/21 52/4 53/7 56/6	131/13	81/21 84/13 84/14	83/17
230/17 230/19 238/21	56/10 58/9 61/19 67/6	appear [9] 32/15	88/7 92/7 95/5 96/6	arrangements [5]
238/22 240/3	73/24 74/13 78/9 79/5	33/11 106/1 134/10	99/19 100/7 100/18	106/14 107/6 138/23
am [21] 1/2 63/16	82/7 82/8 83/4 86/8	146/14 158/22 232/5	106/17 106/19 106/20	139/1 245/19
65/21 65/23 84/14	89/1 90/3 91/6 91/17	233/7 240/12	107/5 108/11 113/18	arranging [1] 215/5
115/12 116/5 118/17	99/14 100/9 102/4	appearance [1]	113/21 113/23 113/25	arrest [4] 21/13
124/13 124/21 132/15	105/19 110/6 110/25	182/2	114/24 117/11 118/12	114/14 209/7 246/1
134/19 149/4 155/14	111/14 111/24 112/8	appeared [4] 119/21	123/11 127/9 128/10	arrested [4] 114/17
172/21 215/18 216/2	112/10 112/11 112/12	127/11 208/5 242/11	128/10 128/11 128/18	114/18 115/6 135/22
239/16 241/14 241/19	112/15 114/9 115/21	appearing [1] 135/9	129/9 131/1 131/2	arrests [1] 117/18
246/9	117/5 118/7 118/12	appears [9] 16/14	131/3 133/3 133/11	arrival [2] 155/25
among [1] 78/3	118/18 119/20 119/25	16/18 16/22 20/21	136/21 138/1 139/8	196/2
amongst [4] 77/16	120/1 120/1 120/4	55/24 113/3 119/6	140/18 141/14 148/14	arrive [1] 155/8
163/12 174/16 191/4	124/25 125/15 125/25	200/3 233/8	148/15 151/13 155/7	arrived [3] 89/25
amount [3] 33/19	126/2 128/5 128/18	appended [1] 113/1	155/8 155/12 159/6	90/8 135/21
202/3 214/16	130/2 133/24 134/15	appendix [3] 112/19	159/6 166/14 166/15	arriving [2] 155/14
Anaesthetist [1] 10/2	142/6 143/18 146/14	112/24 119/5	166/17 167/7 167/21	197/2
Anaesthetists [1]	159/14 175/8 176/8	appendix 1 [1] 119/5	172/19 172/23 173/3	as [248]
10/6	176/8 181/16 181/19	applied [6] 14/23	175/8 175/20 177/5	ASAP [1] 211/23
analogy [1] 18/17	182/1 182/3 182/6	15/4 41/17 86/22	177/6 178/25 179/20	ascertain [1] 245/2
analyse [1] 38/10	182/7 191/21 191/24	244/20 244/25	183/15 185/4 185/9	aside [1] 62/9
analysed [2] 87/6	191/24 192/3 193/4	apply [6] 15/2 16/22	185/21 185/23 186/15	ask [40] 1/8 14/19
98/13	199/19 204/18 207/12	87/2 88/3 88/17	194/16 196/12 198/7	17/3 28/2 60/20 64/13
analysis [6] 119/13	217/17 217/19 229/25	243/19	198/7 199/14 200/18	66/4 75/11 77/7 81/18
119/14 151/2 157/24	231/2 234/14 234/17	applying [1] 17/17	202/5 202/10 204/19	88/21 93/18 99/4
158/19 159/11	234/22 235/23 236/3	appointment [1]	205/24 212/13 212/14	112/7 128/23 129/20
anchor [1] 223/14	236/4 243/19 245/15	243/22	213/7 213/8 213/12	131/7 138/10 139/18
	anybody [7] 28/14	appraised [1] 52/4	215/19 217/14 222/13	139/19 142/12 145/18

A	Astha [3] 45/21 45/24 45/25	232/16	39/23 45/19 68/21 68/23 69/18 69/24 70/11 72/6 74/3 74/10 75/5 75/16 75/21 76/2 87/13 87/14 91/3 91/15 91/22 92/13 98/18 99/19 101/2 109/7 109/11 111/16 116/11 116/12 118/18 132/25 133/4 135/21 135/25 135/25 136/2 148/7 153/4 154/23 155/23 156/19 157/25 165/9 165/13 170/18 174/24 176/10 176/19 178/1 178/17 179/12 179/22 180/6 180/11 180/23 180/24 181/13 184/8 184/19 184/24 185/1 185/23 186/9 186/20 186/24 187/3 187/6 187/14 187/25 187/25 188/17 190/14 192/25 193/5 194/16 194/19 194/21 194/22 194/23 196/3 196/5 196/15 197/9 197/10 197/12 197/16 197/19 199/22 200/11 203/3 207/22 207/22 208/6 208/6 219/20 220/22 220/23 220/25 221/2 225/4 225/5 225/7 225/9 228/20 231/19 232/14 233/22 239/23	232/16	39/23 45/19 68/21 68/23 69/18 69/24 70/11 72/6 74/3 74/10 75/5 75/16 75/21 76/2 87/13 87/14 91/3 91/15 91/22 92/13 98/18 99/19 101/2 109/7 109/11 111/16 116/11 116/12 118/18 132/25 133/4 135/21 135/25 135/25 136/2 148/7 153/4 154/23 155/23 156/19 157/25 165/9 165/13 170/18 174/24 176/10 176/19 178/1 178/17 179/12 179/22 180/6 180/11 180/23 180/24 181/13 184/8 184/19 184/24 185/1 185/23 186/9 186/20 186/24 187/3 187/6 187/14 187/25 187/25 188/17 190/14 192/25 193/5 194/16 194/19 194/21 194/22 194/23 196/3 196/5 196/15 197/9 197/10 197/12 197/16 197/19 199/22 200/11 203/3 207/22 207/22 208/6 208/6 219/20 220/22 220/23 220/25 221/2 225/4 225/5 225/7 225/9 228/20 231/19 232/14 233/22 239/23	30/3 32/3 32/8 39/5 41/8 41/19 42/1 46/4 49/2 49/14 59/25 65/25 77/10 77/13 79/11 79/25 80/2 82/4 84/7 85/12 87/13 88/15 92/1 93/4 100/10 101/11 101/17 102/9 104/6 104/25 111/20 115/9 118/2 118/20 118/24 119/17 119/18 120/18 122/21 138/14 142/9 143/2 148/1 152/7 157/20 165/16 166/21 167/16 178/2 178/5 178/9 178/24 179/3 179/15 180/1 180/6 180/9 180/17 181/8 181/10 185/24 190/4 190/4 192/6 195/4 195/12 197/20 197/21 200/2 200/4 203/1 203/2 203/3 208/16 209/22 209/24 213/11 216/6 218/18 226/23 229/7 229/18 231/14 232/1 232/19 233/22
ask... [18] 148/21 154/20 160/19 161/17 161/18 164/23 166/8 168/10 173/13 173/17 202/22 212/23 216/20 223/12 236/2 237/19 241/4 243/17	at [461]	average [1] 202/20	Baby A [2] 91/22 165/13	background [13] 1/25 81/13 91/5 102/10 106/16 148/25 150/9 152/23 153/2 153/4 158/9 222/25 245/21		
asked [34] 6/10 27/25 51/21 56/20 67/3 102/17 121/17 125/19 129/3 137/18 139/10 141/17 145/14 147/2 150/17 152/19 152/25 153/2 157/12 157/18 166/19 171/14 183/2 186/2 186/6 194/6 201/1 203/14 209/3 215/24 228/2 231/7 234/12 237/15	at 10.30 [1] 72/21	avoided [1] 181/3	Baby B [1] 165/9	bad [5] 126/10 126/11 128/14 128/15 194/3		
asking [15] 32/22 98/16 125/11 137/12 137/20 139/4 152/2 185/8 198/3 198/11 198/13 198/14 201/7 201/9 202/5	at 6 July [1] 205/11	avoids [1] 71/13	Baby F [2] 72/6 74/3	BAKER [7] 66/2 66/4 77/4 161/14 161/15 247/4 247/9		
asks [2] 210/6 212/1	atmosphere [3] 60/19 168/8 170/25	aware [72] 12/20 13/1 13/3 13/5 19/7 22/7 23/23 42/13 42/20 44/8 46/21 46/23 49/3 49/22 52/2 52/17 82/8 82/10 85/22 86/6 91/23 91/25 92/14 92/23 98/9 101/17 102/6 103/19 104/4 108/23 112/8 124/9 124/12 124/13 131/20 131/22 137/11 146/10 147/17 153/14 160/25 165/13 165/18 165/22 169/10 171/13 173/3 176/6 179/11 179/13 179/14 179/17 179/19 180/11 185/23 189/25 190/3 191/10 193/11 193/13 194/17 202/2 202/25 203/4 207/3 209/14 222/5 222/5 231/19 233/9 235/6 239/15	Baby G [1] 75/21	band [2] 215/7 242/23		
aspects [3] 60/22 241/21 241/23	attached [2] 112/20 119/6	awful [1] 26/11	Baby I [3] 174/24 176/10 176/19	barrier [1] 79/22		
aspirates [3] 69/23 70/4 70/6	attack [1] 187/16	B	Baby L's [1] 225/9	base [1] 175/1		
aspirations [2] 200/13 219/5	attempt [3] 187/18 232/23 232/25	B's [9] 89/21 94/5 131/14 149/7 150/20 152/5 153/15 154/17 235/9	Baby M [1] 181/13	based [2] 46/7 218/4		
asps [2] 200/12 200/16	attempted [2] 74/9 75/4	babies [61] 12/10 12/13 22/5 36/25 44/11 44/17 44/25 50/19 50/24 53/11 56/15 57/22 57/23 57/23 59/15 65/12 83/12 86/10 91/9 91/23 92/11 92/15 97/1 101/18 110/7 113/16 117/20 122/5 123/16 126/8 127/15 128/3 131/3 140/4 141/4 170/14 173/18 176/16 185/21 192/1 198/11 201/16 205/3 205/24 207/15 208/9 209/12 210/19 210/22 212/24 214/12 215/9 217/20 223/1 224/13 225/14 231/16 235/12 240/8 240/12 242/24	Baby N [5] 184/8 184/19 184/24 186/9 193/5	basic [1] 159/7		
assert [1] 191/14	attendance [1] 9/23	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	Baby N's [1] 186/20	basically [7] 120/15 121/21 133/13 143/15 153/3 159/3 210/23		
assessed [1] 75/21	attended [16] 14/8 47/3 52/23 60/18 96/20 113/22 123/22 162/2 162/6 163/10 173/24 177/13 218/25 242/6 245/3 245/6	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	Baby O [7] 187/25 190/14 197/9 199/22 203/3 207/22 208/6	basis [6] 71/13 87/22 89/6 140/20 214/16 215/17		
assessment [1] 104/13	attendee [2] 109/24 113/24	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	Baby O's [3] 192/25 194/16 194/19	basis [6] 71/13 87/22 89/6 140/20 214/16 215/17		
assist [9] 19/11 74/12 75/13 76/7 102/23 142/2 219/1 230/12 236/9	attending [2] 99/20 163/12	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	Baby P [12] 135/21 135/25 136/2 187/25 194/21 194/22 194/23 196/3 196/5 200/11 207/22 208/6	baton [1] 238/20		
assistance [1] 151/10	attention [14] 8/25 9/6 16/3 45/2 51/22 83/13 95/8 126/25 127/10 128/8 128/11 130/2 132/15 171/22	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	Baby R [4] 197/10 197/12 197/16 197/19	be [260]		
assistant [1] 3/13	audible [2] 70/5 70/17	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	Beach [1] 150/4		
assisting [1] 149/8	audit [1] 218/2	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	bearing [9] 30/23 85/12 105/13 106/12 111/20 115/3 233/9 234/14 235/9		
associate [1] 128/15	audits [1] 217/25	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	became [10] 5/11 6/6 49/22 52/17 60/3 82/12 82/22 86/6		
associated [1] 127/21	August [13] 20/7 21/9 21/22 32/3 32/5 32/9 35/9 69/9 69/15 71/25 105/15 167/20 245/12	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	back [92] 5/1 7/13 12/15 13/9 18/5 24/23			
association [16] 44/20 50/8 50/21 55/2 55/4 95/14 98/24 119/22 120/4 127/16 127/17 128/9 206/3 206/17 207/1 209/16	authority [3] 217/1 217/5 244/14	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	back [92] 5/1 7/13 12/15 13/9 18/5 24/23			
assumed [1] 218/8	autonomous [1] 170/8	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	back [92] 5/1 7/13 12/15 13/9 18/5 24/23			
assuming [3] 107/16 215/18 228/20	autonomously [1] 170/11	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	back [92] 5/1 7/13 12/15 13/9 18/5 24/23			
assumption [4] 93/24 111/9 111/11 219/12	availability [2] 110/15 110/21	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	back [92] 5/1 7/13 12/15 13/9 18/5 24/23			
assure [1] 11/18	available [11] 17/12 25/17 107/5 110/16 174/21 179/6 180/3 189/13 205/2 211/23	back [92] 5/1 7/13 12/15 13/9 18/5 24/23	back [92] 5/1 7/13 12/15 13/9 18/5 24/23			

B	44/10 45/3 45/14	232/16 232/16 233/15	205/24 209/20 211/13	196/23 202/20 203/15
became... [2] 137/23	46/20 48/3 48/6 49/15	234/3 235/6 235/13	211/16 213/23 214/13	207/3 210/5 210/13
163/17	53/24 54/24 55/9	235/18 236/15 237/23	216/23 222/6 224/14	212/17
because [139] 2/19	55/19 55/23 55/25	238/16 240/17 245/2	226/5 226/23 232/10	bits [2] 56/7 206/9
4/3 5/13 6/6 6/8 6/13	56/3 57/6 57/16 61/3	246/3	236/14 244/12 245/19	blame [1] 191/10
7/24 8/12 11/20 12/2	63/9 63/17 63/18	before [50] 7/6 10/23	belief [2] 1/22 81/10	bleed [5] 70/12 70/15
15/21 16/24 18/20	63/25 64/1 67/8 67/21	12/7 13/23 30/3 32/20	believe [13] 9/10	184/12 185/12 228/23
22/20 26/14 27/14	68/17 71/18 71/21	32/21 35/6 41/24 43/7	32/17 54/15 90/12	bleeding [4] 68/17
30/6 33/8 33/19 34/5	73/2 73/7 73/11 74/18	43/13 45/5 49/15	142/13 179/1 183/19	68/18 68/19 228/6
34/11 36/14 36/19	74/23 77/19 78/8	52/20 61/9 63/25	193/23 198/19 220/12	bleeds [2] 68/21
36/22 38/8 38/12	78/18 78/22 80/5	69/10 82/22 82/22	232/18 236/17 237/9	228/8
38/14 39/7 39/9 39/11	81/25 83/21 84/5	83/21 85/23 87/17	believed [1] 64/20	bleep [3] 195/24
41/7 46/1 51/4 51/6	85/15 85/16 86/13	92/22 93/7 93/10 94/2	bells [1] 101/22	238/20 238/20
58/17 59/3 59/6 65/3	87/8 87/17 91/2 91/4	111/5 111/15 113/6	below [1] 70/10	bleeped [1] 195/25
67/15 68/20 69/3 71/7	91/15 91/25 94/13	113/7 116/9 118/19	Bennett [3] 241/4	block [1] 167/3
72/5 75/4 76/5 79/11	96/23 97/1 100/12	121/10 123/25 126/21	241/8 246/6	blood [33] 32/7 33/21
79/24 83/1 84/12	101/20 103/3 105/13	126/25 132/11 137/12	bereaved [1] 162/19	33/25 34/9 34/11 36/5
84/19 85/10 87/7	106/1 106/7 106/14	144/4 153/3 157/18	Bernie [1] 184/14	36/14 38/9 38/12
87/14 89/7 90/14 91/1	107/15 107/19 107/21	162/3 162/6 162/13	bespoke [1] 238/4	38/16 72/13 76/11
91/7 92/22 94/9 94/10	107/21 107/22 109/1	177/23 178/3 178/14	best [12] 1/22 26/12	76/19 76/23 155/6
94/12 98/17 101/14	109/5 109/5 109/15	183/16 192/25 195/9	81/10 97/4 120/12	158/13 177/14 177/15
104/8 106/25 107/22	110/6 111/22 113/12	before February 2016	136/7 151/17 162/17	178/18 179/17 185/2
108/9 108/12 108/13	117/2 118/4 118/7	[2] 126/21 126/25	181/6 185/5 191/7	224/2 226/17 226/22
108/15 109/5 109/6	118/14 119/11 119/13	beforehand [1]	212/14	226/23 228/21 229/10
110/16 110/25 111/9	120/5 120/17 121/1	177/19	better [7] 57/14	231/2 231/8 233/12
116/5 116/7 118/14	121/15 122/9 125/13	beg [1] 193/18	90/22 104/25 120/9	233/19 236/17 236/17
121/14 125/15 125/20	125/15 125/17 126/16	began [1] 142/21	196/22 196/23 199/13	bloods [10] 34/5 34/7
126/7 126/23 127/3	126/23 127/14 127/14	begging [1] 136/4	between [43] 2/22	34/10 36/18 45/21
128/3 128/12 128/24	130/18 131/14 131/22	begin [1] 235/17	3/8 3/19 4/15 5/5 5/8	76/3 90/9 177/24
130/13 130/24 131/22	135/19 140/10 140/14	beginning [3] 9/1	21/3 22/4 28/4 34/25	226/18 226/20
132/4 132/16 134/20	141/10 141/11 145/14	59/13 206/8	42/8 42/25 46/22 82/8	blotchiness [2] 90/3
137/9 139/7 139/12	145/16 146/7 147/17	begins [2] 69/17	85/24 91/23 92/20	156/1
141/18 152/2 157/2	149/16 151/7 153/14	69/17	92/24 94/5 95/14	blotching [2] 155/17
157/11 162/11 162/18	157/10 158/7 158/16	begun [2] 158/2	96/23 96/25 98/24	155/20
164/22 165/23 166/19	158/20 159/20 160/7	183/17	119/22 120/4 161/3	blotchy [1] 90/10
167/16 168/24 171/23	160/18 161/4 161/8	behalf [4] 66/4 77/7	161/6 161/24 166/4	blow [1] 210/14
172/11 178/17 178/25	162/7 162/16 163/6	161/17 244/17	167/25 168/3 169/13	blue [2] 103/5 194/19
182/3 184/4 186/5	165/14 165/16 166/5	behaving [1] 135/11	169/20 170/2 170/6	Blundell [1] 3/11
187/1 189/11 191/24	166/19 170/13 171/18	behaviour [5] 13/7	176/15 182/21 183/15	blurred [1] 239/6
195/1 195/3 195/14	171/19 172/9 172/12	13/19 162/10 163/1	183/21 199/22 211/6	board [3] 27/10
197/5 202/1 206/10	173/12 174/11 176/10	163/4	215/21 238/24	41/18 241/16
210/18 211/10 217/6	176/14 177/7 177/18	being [88] 4/21 5/10	between September	body [11] 33/6 48/4
217/15 218/23 224/13	177/24 178/10 178/11	7/21 10/18 11/24	2016 [1] 168/3	48/16 55/16 57/2
227/24 229/21 231/15	178/13 178/16 178/19	13/17 18/18 21/23	Beverley [3] 12/21	59/21 78/20 110/2
231/25 232/9 233/22	179/24 181/23 182/19	22/12 26/16 29/24	37/15 37/21	112/4 146/17 155/17
234/6 236/2 236/21	183/3 189/12 190/7	34/3 38/2 40/25 44/16	Beverley Allitt [3]	body's [1] 33/19
239/11	191/1 191/13 191/17	44/22 45/2 47/22	12/21 37/15 37/21	boiling [1] 18/18
because pm [1]	191/19 192/13 192/14	49/12 50/5 52/8 53/15	beyond [4] 55/4 84/1	bolus [1] 90/9
116/5	193/6 194/5 194/25	57/2 58/5 61/15 61/20	190/17 206/3	bookmark [1] 49/18
become [6] 88/4	195/8 195/13 198/19	62/8 69/24 71/2 83/9	big [7] 8/14 38/10	born [2] 188/8
92/23 163/19 213/14	199/1 199/16 199/18	87/5 89/3 91/24 97/18	84/2 118/15 139/10	198/22
222/4 239/6	200/16 202/22 202/25	98/24 100/23 105/10	197/1 198/22	both [27] 3/1 3/3 3/5
becoming [1] 30/8	203/8 204/4 205/8	106/25 108/21 116/4	bigger [4] 7/21 8/18	4/21 21/22 36/24
bed [1] 155/7	206/4 207/3 207/25	122/13 126/4 126/6	84/13 84/19	43/22 54/25 81/21
beds [1] 204/16	208/12 209/17 210/20	127/5 127/21 131/13	bills [1] 62/6	106/19 134/11 134/22
been [237] 2/6 3/25	213/9 218/1 218/9	133/23 135/24 137/6	birth [3] 204/16	139/22 139/24 140/11
6/21 8/3 15/5 17/16	219/8 219/14 220/3	143/12 144/23 145/22	205/2 227/24	140/12 140/12 160/5
18/6 18/6 18/8 18/10	220/3 221/8 224/8	146/8 147/23 147/24	bit [27] 24/10 29/13	172/16 173/16 195/14
18/13 19/4 23/24	224/10 224/16 224/18	149/14 154/8 154/18	37/11 52/8 81/19	200/20 205/3 206/10
24/21 25/2 25/4 25/14	225/1 225/18 225/22	156/20 157/12 162/15	85/21 93/5 102/12	208/6 209/2 244/24
25/16 28/5 28/15	226/7 226/9 226/9	171/14 171/16 171/22	121/2 134/17 141/19	bothered [1] 121/16
30/25 32/1 36/6 41/10	228/20 228/21 228/23	171/23 172/23 173/8	152/22 159/4 162/5	bottom [14] 20/15
41/13 41/25 43/21	229/4 230/7 230/7	177/16 185/3 186/23	163/4 167/16 170/7	68/21 99/24 114/12
	230/13 231/2 232/6	192/21 201/10 202/13	171/7 175/9 196/22	123/12 151/12 152/15

B	busier [1] 57/16	102/9 102/22 105/18	224/10 231/16 236/5	17/1 22/13 62/6 65/18
bottom... [7] 152/24	busy [6] 11/13 11/24	106/24 107/1 108/4	239/23	83/8 110/6 112/7
185/22 215/3 215/23	12/2 92/9 130/24	108/4 108/16 113/1	cared [1] 177/12	113/13 129/15 145/10
216/1 226/15 227/7	174/22	113/17 113/23 114/11	career [3] 12/12 73/9	171/10 171/20 173/11
bowel [5] 70/3 70/5	but [268]	115/10 115/17 115/17	219/6	183/1 192/4 222/3
70/14 70/17 237/9	bypassing [1] 211/14	116/24 117/13 117/15	careers [3] 4/21	231/9
Bowels [1] 70/3	C	117/25 118/12 119/2	12/13 78/11	certificate [2] 25/22
box [4] 27/11 66/1	C-peptide [10] 32/24	119/15 119/17 120/8	carefully [1] 148/23	30/25
135/1 135/5	33/8 35/1 35/23 38/22	120/12 120/23 120/25	carried [6] 56/22	certified [1] 27/21
boxes [2] 29/7	38/23 48/18 73/8 99/7	121/9 121/23 122/14	135/24 190/2 201/10	cetera [3] 184/15
134/25	124/7	122/16 124/1 125/18	225/5 236/16	238/2 239/3
brain [4] 228/4 228/7	C-peptides [1] 45/22	125/18 126/9 128/23	carry [4] 58/4 62/3	chain [1] 54/1
228/9 228/24	c-reactive [1] 75/23	136/3 136/5 136/24	136/21 213/21	Chair [2] 10/1 10/9
break [8] 38/14 65/19	calculations [2]	138/15 145/15 145/23	carrying [1] 54/9	challenge [3] 6/14
65/22 166/25 167/4	224/23 233/21	146/2 147/3 148/23	case [22] 12/20	6/20 7/2
167/6 167/9 222/13	call [25] 73/3 73/17	150/15 150/24 151/12	15/24 22/13 31/9	challenged [3] 83/2
breaking [1] 10/23	79/9 87/15 92/12	151/18 152/24 154/21	37/15 41/16 46/2	83/9 213/24
Brearey [36] 2/24	92/12 92/16 101/22	156/11 156/14 162/20	62/23 71/14 107/4	Chambers [4] 9/6
40/21 43/24 45/3	127/14 131/24 132/5	163/15 165/4 167/21	108/20 148/2 186/19	59/17 61/21 144/21
45/18 47/16 51/16	138/24 138/25 139/21	168/10 171/17 174/15	190/18 213/2 224/16	chance [3] 137/2
54/25 62/21 64/23	142/24 157/9 157/16	174/17 177/21 182/14	231/14 231/20 233/20	141/12 187/4
106/1 110/2 111/12	167/11 170/14 173/24	183/12 183/20 185/6	239/18 240/6 246/2	change [6] 18/11
112/7 121/6 121/18	186/1 232/21 232/23	187/19 191/11 191/14	cases [6] 13/9 21/3	79/14 120/8 123/24
124/10 124/22 125/6	232/25 233/1	196/20 200/7 201/11	107/2 114/7 119/23	124/2 207/6
125/10 130/1 130/8	called [17] 34/7	201/11 202/14 203/16	206/9	changed [6] 18/16
130/11 130/12 169/7	55/17 61/3 73/7 73/11	204/4 205/17 208/24	cast [1] 171/22	43/19 60/7 70/21
193/2 193/7 193/14	78/25 80/5 89/25	209/4 209/5 209/9	casual [2] 129/14	137/22 182/22
193/24 194/10 205/4	108/11 134/14 155/7	209/23 213/11 213/19	187/11	changeovers [1]
205/22 208/19 209/1	155/8 157/12 158/11	213/22 216/11 216/20	catch [1] 175/24	182/21
209/18 213/8	185/18 185/19 237/21	218/13 218/17 218/21	category [1] 189/6	changes [2] 113/21
Brearey's [1] 188/7	calls [1] 126/11	219/21 222/20 222/24	cause [37] 24/20	181/6
Brearey's [1] 112/12	calm [3] 162/21	223/12 223/25 224/6	25/10 25/20 25/22	changing [1] 18/21
breast [1] 69/18	184/15 212/7	224/15 225/11 225/11	26/1 27/15 27/20	channel [1] 85/11
breathing [2] 154/23	came [21] 15/6 32/8	227/1 227/21 229/10	67/16 90/23 115/19	Chaos [1] 197/23
196/25	33/14 46/18 47/11	230/12 230/14 236/8	115/23 116/3 116/10	characterise [1]
brief [1] 212/25	47/25 49/14 52/17	237/19 238/13 239/21	116/17 123/18 149/9	50/17
briefed [1] 145/15	77/13 86/5 94/16	244/23 245/9	149/18 156/18 158/4	characterised [1]
briefly [9] 1/24 18/24	103/19 144/3 145/6	can't [27] 19/9 28/7	159/11 169/18 181/17	38/5
48/14 63/7 75/8 81/12	157/20 178/23 180/16	28/16 35/20 42/15	183/5 188/24 189/1	chart [3] 119/6 119/8
149/25 234/11 236/2	197/6 202/22 203/3	44/11 44/18 51/19	189/10 194/9 197/18	191/20
brightness [1]	219/7	53/5 73/15 94/14	210/3 234/18 234/20	charted [1] 105/6
162/14	camera [1] 157/20	134/23 135/3 139/8	235/8 236/10 236/12	chasing [1] 150/6
bring [13] 9/20 15/25	camp [2] 5/23 6/1	140/10 143/18 151/21	237/4 237/6 237/13	chat [2] 175/10
26/25 35/3 42/22 45/9	can [176] 1/17 7/17	157/15 166/11 171/11	caused [17] 6/7	203/16
97/17 99/17 108/4	9/25 11/8 16/1 16/8	175/18 191/14 203/21	28/15 29/2 42/4 44/17	check [10] 13/25
112/22 123/10 135/19	17/2 18/17 19/11	217/20 221/10 228/1	49/23 54/24 68/11	27/8 34/3 39/22 52/25
145/19	19/13 19/15 19/23	237/7	156/24 157/7 158/16	60/11 84/7 219/11
bringing [3] 14/6	21/23 22/8 22/10 27/1	candidly [1] 37/5	158/24 177/16 185/12	228/22 243/6
117/5 132/3	27/6 27/6 27/12 27/23	capacity [2] 14/16	192/13 234/21 237/12	checked [5] 27/12
brings [3] 80/13	29/1 33/23 33/24 34/2	239/13	causes [1] 166/19	36/8 36/8 164/19
119/17 119/18	35/9 38/10 38/12	captured [1] 64/17	causing [7] 68/10	246/3
broad [1] 241/21	38/13 39/17 45/24	capturing [1] 135/10	76/17 104/15 127/8	checking [3] 179/21
broadly [1] 213/4	48/13 52/25 56/9	cardiac [1] 21/13	128/7 128/18 192/1	180/11 228/3
broken [1] 79/22	60/11 60/20 63/4 63/7	care [39] 8/3 8/6 8/16	CCTV [1] 58/20	checklist [1] 232/2
brother [1] 153/15	64/7 65/3 66/16 69/9	10/6 15/18 18/2 18/12	cease [1] 54/2	checks [6] 216/18
brought [1] 87/8	69/13 74/12 75/13	18/25 28/10 30/24	cells [1] 38/14	243/5 243/17 243/19
bug [1] 200/17	78/7 81/5 81/18 87/3	44/24 52/14 53/5 75/9	central [1] 57/10	243/21 245/23
build [1] 216/8	87/12 88/11 88/22	78/13 78/13 86/16	centre [2] 187/15	Chester [27] 2/7 2/23
building [1] 198/2	90/25 91/10 91/10	87/10 87/15 89/18	241/23	3/23 4/1 4/15 42/8
bullied [1] 64/19	94/25 95/5 95/12	106/13 109/1 109/4	cerebral [1] 33/25	48/21 164/20 167/25
bundle [3] 95/22	96/16 97/4 98/14	109/11 111/22 115/1	certain [7] 2/17 58/19	179/4 197/10 216/13
115/12 123/8	98/23 99/18 99/23	117/3 129/22 131/12	88/7 89/3 110/14	216/15 216/24 217/20
burn [1] 10/24	100/1 100/17 100/21	149/7 159/24 185/5	157/7 240/8	217/22 219/4 219/10
		187/2 215/6 216/7	certainly [18] 3/25	219/14 223/2 242/14

<p>C</p> <p>Chester... [6] 243/16 243/21 244/13 245/13 245/16 245/21</p> <p>Chief [1] 14/5</p> <p>Chief Executive [1] 14/5</p> <p>child [237] 2/4 16/10 21/8 21/13 21/25 22/20 23/12 23/20 23/22 25/25 26/8 26/24 28/1 28/19 28/23 30/2 30/4 30/24 31/2 32/3 32/4 32/11 36/5 36/19 36/24 41/3 41/5 41/6 41/16 42/12 42/17 42/20 42/22 42/23 42/23 43/7 43/23 44/6 45/9 46/5 46/9 46/12 48/13 48/17 50/10 52/11 52/12 52/24 52/24 54/10 54/10 66/5 66/8 66/21 71/3 71/23 72/2 75/9 75/9 75/15 79/19 81/23 87/17 88/2 89/18 89/21 90/1 90/4 90/16 91/18 92/4 92/7 92/13 94/5 94/5 94/13 95/14 95/15 96/21 99/4 99/5 99/13 99/23 100/11 100/13 101/5 101/12 102/6 102/6 102/17 103/1 104/1 104/3 104/4 105/6 105/11 105/14 105/20 106/12 106/13 108/19 108/22 108/22 109/1 114/10 114/12 114/19 114/25 115/5 115/8 115/17 115/22 116/25 117/2 117/6 117/7 117/21 117/21 118/2 118/3 121/11 124/5 125/23 125/24 129/22 129/23 130/5 130/16 130/18 131/11 131/11 131/12 131/13 131/14 131/16 131/17 131/20 131/20 132/7 132/8 132/11 134/6 134/8 135/13 135/17 136/10 136/18 141/8 145/22 145/25 146/19 146/19 148/11 148/11 148/22 148/22 149/1 149/2 149/6 149/7 149/10 149/15 149/18 150/3 150/14 150/17 150/20 150/22 151/19 152/4 152/5 152/20 153/4 153/15 153/15 153/19 153/21 154/11 154/17</p>	<p>158/3 159/13 159/14 159/17 159/24 160/1 160/13 160/13 161/20 161/25 163/10 164/10 173/23 174/3 176/2 177/11 177/13 177/14 180/8 180/13 180/16 181/13 181/17 182/2 182/4 182/10 182/10 182/12 182/15 184/8 187/9 187/11 187/19 187/20 188/7 188/8 188/21 191/5 200/22 204/15 209/7 223/12 223/15 223/16 224/8 225/25 229/10 229/15 229/18 233/15 234/12 234/12 235/9 236/2 236/5 236/9 237/1 239/18</p> <p>Child A [16] 92/4 94/5 94/13 95/14 114/10 148/22 149/1 149/15 150/3 150/17 150/22 153/15 153/21 159/14 159/17 160/13</p> <p>Child A's [6] 114/12 149/6 150/14 151/19 152/4 159/24</p> <p>Child B [25] 89/18 90/1 90/4 90/16 91/18 92/7 95/15 96/21 100/11 101/5 104/1 114/19 115/8 131/13 148/22 149/2 149/10 149/18 152/20 153/4 153/19 154/11 159/13 160/1 160/13</p> <p>Child B's [9] 89/21 94/5 131/14 149/7 150/20 152/5 153/15 154/17 235/9</p> <p>Child C [2] 115/17 115/22</p> <p>Child D [3] 99/13 99/23 100/13</p> <p>Child E [12] 21/8 21/25 25/25 28/19 28/23 30/2 36/24 42/23 66/5 66/8 71/3 105/14</p> <p>Child E's [11] 21/13 22/20 23/12 23/20 23/22 26/8 26/24 28/1 30/24 31/2 66/21</p> <p>Child F [16] 30/4 32/3 32/4 36/5 36/19 41/3 41/6 41/16 42/23 45/9 46/12 50/10 71/23 72/2 99/4 99/5</p> <p>Child F's [4] 32/11 41/5 46/5 46/9</p> <p>Child G [4] 42/12 75/9 75/9 75/15</p>	<p>Child I [16] 42/17 44/6 102/6 102/6 102/17 104/4 105/11 105/20 106/12 108/19 108/22 109/1 116/25 118/3 173/23 176/2</p> <p>Child I and [2] 117/21 118/2</p> <p>Child I died [1] 43/7</p> <p>Child I had [2] 103/1 174/3</p> <p>Child I on [1] 117/21</p> <p>Child I perhaps [1] 115/5</p> <p>Child I to [1] 117/6</p> <p>Child I's [8] 42/20 42/22 43/23 104/3 105/6 106/13 117/2 117/7</p> <p>Child L [8] 48/13 124/5 177/11 177/13 177/14 223/12 223/15 224/8</p> <p>Child L's [3] 48/17 229/10 229/15</p> <p>Child M [3] 182/2 182/4 234/12</p> <p>Child M's [2] 181/13 181/17</p> <p>Child N [5] 182/10 182/10 182/12 182/15 184/8</p> <p>Child O [19] 52/11 52/24 54/10 87/17 101/12 121/11 125/23 129/22 129/23 131/11 131/17 131/20 132/7 145/22 146/19 148/11 187/19 188/7 204/15</p> <p>Child O's [5] 130/5 130/16 130/18 188/21 191/5</p> <p>Child P [20] 52/12 52/24 125/24 131/11 131/16 131/20 132/11 134/6 134/8 135/17 141/8 146/19 148/11 161/20 161/25 163/10 164/10 187/20 188/8 200/22</p> <p>Child P's [3] 54/10 132/8 209/7</p> <p>Child Q [1] 236/2</p> <p>Child Q's [3] 236/5 236/9 237/1</p> <p>Child R [4] 131/12 135/13 136/10 136/18</p> <p>child's [4] 229/3 233/10 234/18 235/9</p> <p>children [21] 10/6 15/5 15/8 16/7 18/25 19/22 38/17 57/25 61/4 77/20 86/13 86/15 87/8 92/15</p>	<p>131/3 148/24 161/8 176/16 226/3 234/12 241/24</p> <p>children's [12] 8/13 10/7 79/8 169/20 175/12 176/17 180/21 194/25 225/3 241/11 241/15 241/22</p> <p>choice [1] 48/4</p> <p>choosing [1] 129/4</p> <p>chords [1] 185/3</p> <p>Chris [1] 138/21</p> <p>Christina [2] 137/9 138/22</p> <p>Christina Hurst [1] 137/9</p> <p>Christine [1] 136/24</p> <p>Christine Hurst [1] 136/24</p> <p>chronology [6] 8/23 30/3 97/16 100/18 117/10 125/24</p> <p>circulation [3] 19/20 196/25 226/11</p> <p>circumstance [1] 18/1</p> <p>circumstances [6] 12/19 58/20 78/4 88/23 120/12 166/9</p> <p>clarification [1] 227/18</p> <p>clarify [3] 164/24 165/4 219/21</p> <p>clear [12] 14/12 20/21 39/16 55/9 55/10 56/13 123/17 190/12 196/8 206/17 235/14 239/22</p> <p>clearance [2] 215/15 243/3</p> <p>clearer [1] 55/10</p> <p>clearly [9] 56/15 60/16 63/19 162/11 196/5 208/15 209/13 226/9 240/8</p> <p>clinic [2] 218/6 245/6</p> <p>clinical [30] 11/20 17/8 17/15 17/15 17/18 17/22 49/1 73/3 73/7 89/1 143/2 143/18 155/2 157/23 172/6 172/7 172/7 172/17 173/5 173/8 186/16 215/13 215/14 217/25 219/8 222/5 234/1 234/17 240/3 242/22</p> <p>clinically [3] 143/11 168/18 235/1</p> <p>clinician [1] 181/11</p> <p>clinicians [2] 170/7 174/16</p> <p>clock [2] 113/15 133/7</p>	<p>close [1] 10/8</p> <p>closely [2] 8/15 23/20</p> <p>closer [1] 177/9</p> <p>clot [1] 38/12</p> <p>clotting [1] 91/11</p> <p>cluster [2] 23/8 98/5</p> <p>co [1] 215/19</p> <p>co-ordinating [1] 215/19</p> <p>coagulation [2] 91/11 158/11</p> <p>coagulopathy [2] 155/6 160/12</p> <p>coch [1] 202/19</p> <p>code [1] 55/12</p> <p>cog [1] 8/14</p> <p>cohesive [1] 83/4</p> <p>cohesively [1] 6/13</p> <p>cohort [1] 92/17</p> <p>coincidence [2] 55/5 206/4</p> <p>collaboration [1] 170/12</p> <p>collaborative [4] 168/23 170/2 170/5 193/13</p> <p>collapse [28] 69/10 70/10 70/24 75/19 76/6 76/14 76/17 101/2 101/13 103/7 103/17 103/21 104/2 104/3 104/24 107/13 116/9 118/8 125/19 132/12 152/5 152/22 154/11 154/17 159/25 234/18 235/9 235/9</p> <p>collapsed [12] 15/6 42/17 75/15 75/22 76/9 87/8 122/5 132/25 133/1 149/3 154/7 159/18</p> <p>collapses [22] 17/25 42/5 42/12 42/13 44/21 51/21 55/4 63/9 104/17 104/21 105/3 105/8 107/12 107/15 107/17 115/4 117/22 118/19 125/1 125/11 126/2 137/19</p> <p>collapsing [1] 199/9</p> <p>collated [1] 192/21</p> <p>colleague [8] 9/11 12/10 20/14 21/15 79/18 83/16 86/17 154/18</p> <p>colleagues [45] 11/10 12/19 14/12 20/7 22/8 44/10 47/16 48/11 49/23 51/5 52/10 92/1 92/21 93/22 94/3 94/23 95/18 96/10 105/20 108/1 111/6 111/14</p>
---	--	--	---	---

<p>C</p> <p>colleagues... [23] 111/24 112/11 126/24 129/4 129/9 137/25 140/24 141/3 141/9 141/14 141/16 145/7 146/4 160/18 190/10 190/11 207/6 207/7 213/8 213/12 215/4 242/18 244/22</p> <p>collection [1] 185/14</p> <p>collective [5] 48/16 50/3 99/6 124/6 179/10</p> <p>collectively [2] 65/2 171/25</p> <p>College [3] 2/3 63/23 81/22</p> <p>column [1] 100/2</p> <p>come [57] 1/8 1/11 5/1 11/8 12/7 13/9 20/1 20/7 20/24 23/4 33/13 37/16 41/12 47/20 47/24 52/11 64/24 65/25 70/9 80/22 86/5 87/13 89/16 93/3 97/22 104/25 107/8 113/18 118/20 118/24 120/16 120/23 125/23 131/7 139/20 143/2 148/7 148/11 150/1 152/21 156/14 158/1 166/21 178/24 180/6 195/23 199/12 203/2 203/13 211/22 215/18 222/8 225/15 231/8 231/11 235/13 238/13</p> <p>comes [8] 38/12 194/19 203/1 216/6 226/23 232/19 235/19 236/9</p> <p>coming [12] 15/14 16/25 20/19 30/3 51/5 58/10 80/15 110/10 115/13 122/2 211/24 215/16</p> <p>commenced [1] 181/18</p> <p>comment [12] 6/15 28/21 59/19 83/4 83/6 133/25 161/21 179/8 219/18 220/14 221/11 221/16</p> <p>commented [1] 204/20</p> <p>comments [11] 29/23 58/19 120/3 126/17 127/4 128/20 129/11 129/19 138/16 140/7 179/19</p> <p>commissioning [1] 27/10</p>	<p>commitment [1] 121/3</p> <p>commitments [1] 110/13</p> <p>committed [1] 11/12</p> <p>committee [2] 10/2 10/9</p> <p>common [19] 11/16 17/12 17/14 30/9 37/22 39/4 45/2 49/12 91/9 93/7 127/11 140/13 160/7 160/7 185/20 186/14 224/5 225/13 238/14</p> <p>commonality [1] 95/9</p> <p>communicate [1] 159/24</p> <p>communicated [1] 73/17</p> <p>communicating [1] 238/5</p> <p>communication [8] 97/5 169/12 170/12 170/20 170/21 172/11 187/15 243/9</p> <p>communications [1] 239/20</p> <p>community [4] 16/12 51/11 84/21 242/1</p> <p>compartments [2] 228/6 228/23</p> <p>complete [7] 45/8 86/13 103/4 110/14 138/8 215/25 219/11</p> <p>completely [5] 41/17 71/22 74/16 80/4 143/11</p> <p>complex [1] 61/14</p> <p>complexity [1] 110/20</p> <p>complications [1] 88/7</p> <p>compromise [1] 116/12</p> <p>compulsory [1] 79/16</p> <p>concern [23] 17/18 17/22 20/19 21/24 28/8 28/14 49/13 51/7 59/14 77/16 85/25 109/14 111/16 112/13 112/15 120/1 146/7 149/16 150/10 192/14 209/15 209/21 228/21</p> <p>concerned [22] 20/2 20/22 20/24 44/16 53/10 59/6 86/7 86/9 86/20 90/18 90/19 97/8 106/5 130/6 141/3 145/8 167/22 168/9 192/4 201/16 212/17 236/11</p> <p>concerning [1]</p>	<p>129/21</p> <p>concerns [50] 5/10 13/18 13/21 13/22 14/6 20/11 43/25 49/22 51/4 52/2 58/8 58/12 60/3 62/3 63/19 63/25 64/3 64/18 64/21 65/2 65/7 78/11 78/14 82/18 86/6 91/24 105/20 111/25 125/25 129/18 139/22 139/24 140/2 140/25 141/22 145/15 146/15 147/8 147/14 147/18 147/24 164/11 188/9 191/9 191/11 191/14 207/4 207/7 207/11 209/19</p> <p>conclude [1] 121/4</p> <p>concludes [2] 65/14 246/4</p> <p>concluding [1] 64/8</p> <p>conclusion [4] 23/13 57/6 64/25 73/20</p> <p>concrete [1] 58/9</p> <p>condition [12] 32/11 149/13 149/17 150/10 150/13 151/20 158/10 158/10 188/8 234/1 234/2 243/24</p> <p>conditions [3] 217/14 239/12 244/25</p> <p>conducted [2] 13/25 41/11</p> <p>conducting [3] 192/11 194/24 217/25</p> <p>conduit [1] 221/21</p> <p>confident [2] 67/5 67/20</p> <p>confidential [2] 222/25 241/20</p> <p>confirm [5] 1/17 81/5 167/21 243/10 243/17</p> <p>confirmed [1] 243/18</p> <p>confirming [2] 139/1 243/21</p> <p>confirms [1] 24/17</p> <p>confused [1] 43/14</p> <p>connect [3] 104/23 128/24 159/13</p> <p>connected [2] 127/17 159/20</p> <p>connection [8] 8/10 24/22 94/20 96/25 96/25 129/17 151/19 242/12</p> <p>conscious [2] 147/4 196/12</p> <p>consecutive [2] 117/22 201/16</p> <p>consequences [1] 2/16</p> <p>consequent [3] 91/10 104/21 110/16</p>	<p>consequently [2] 82/19 82/20</p> <p>consider [5] 2/21 61/15 82/23 84/1 84/25</p> <p>consideration [1] 57/22</p> <p>considered [9] 50/11 62/25 89/21 90/24 190/23 191/7 191/21 214/15 235/25</p> <p>considering [2] 206/15 210/14</p> <p>consistent [3] 75/25 76/17 76/24</p> <p>consistently [1] 3/22</p> <p>constant [2] 59/2 59/5</p> <p>consult [1] 13/16</p> <p>consultant [58] 2/6 4/3 10/2 10/5 28/6 48/4 48/16 55/16 57/2 57/7 59/21 61/8 73/2 73/7 77/17 79/21 81/25 84/15 84/17 84/18 85/24 96/24 106/8 109/18 110/2 110/13 111/6 112/4 129/9 130/22 131/21 131/22 131/25 146/4 146/17 157/10 157/13 157/16 168/4 169/3 181/9 195/15 213/7 219/19 221/12 223/6 223/9 230/2 230/13 230/15 230/17 230/19 230/22 231/1 231/14 231/24 232/2 242/10</p> <p>consultants [44] 3/8 3/19 5/5 5/8 5/13 6/10 6/12 6/25 11/14 11/16 20/25 21/3 23/7 28/4 47/5 57/11 78/25 82/25 83/3 83/24 84/13 84/16 97/22 99/6 101/9 107/16 107/17 111/21 112/12 124/6 168/18 168/20 169/25 175/2 176/9 179/11 193/3 193/9 193/12 194/12 197/6 202/21 232/3 238/7</p> <p>consulted [4] 13/12 85/7 123/24 153/24</p> <p>contact [13] 10/4 79/20 130/8 216/12 217/7 217/15 217/24 218/5 218/5 219/13 243/15 244/3 245/17</p> <p>contacted [6] 40/21 45/14 74/24 195/24 236/20 238/16</p> <p>contained [2] 134/16 243/24</p>	<p>contemporaneous [1] 223/14</p> <p>content [3] 114/3 124/22 186/12</p> <p>contents [4] 1/21 81/9 167/21 221/20</p> <p>context [8] 21/7 23/16 24/25 51/10 78/14 126/14 129/5 152/18</p> <p>continuation [1] 224/10</p> <p>continue [6] 65/1 143/5 184/24 185/15 203/24 227/13</p> <p>continued [9] 13/20 55/2 62/3 64/21 204/10 206/3 206/11 206/13 235/15</p> <p>continues [2] 184/17 201/3</p> <p>continuing [2] 28/12 151/2</p> <p>contra [1] 25/10</p> <p>contra-indicate [1] 25/10</p> <p>contract [3] 215/22 216/11 243/15</p> <p>contribute [1] 117/25</p> <p>contributed [1] 234/2</p> <p>contributing [1] 117/11</p> <p>contribution [1] 99/1</p> <p>contrition [1] 237/17</p> <p>convenient [2] 65/17 166/24</p> <p>conversation [27] 43/24 66/19 67/12 72/9 72/13 72/22 131/19 134/21 136/23 136/25 137/2 137/13 137/17 138/4 138/11 139/3 144/9 187/12 194/11 194/12 194/17 206/11 206/18 210/22 213/18 214/23 242/20</p> <p>conversations [6] 20/10 44/14 129/14 129/15 175/23 177/3</p> <p>conviction [1] 245/12</p> <p>convince [1] 162/25</p> <p>Cooper [1] 205/5</p> <p>copied [3] 95/22 96/7 115/12</p> <p>copy [4] 9/9 32/17 96/2 233/3</p> <p>corner [1] 99/20</p> <p>corners [1] 171/8</p> <p>Coroner [27] 25/19 25/21 25/24 27/15 27/20 63/17 64/3 64/5 87/19 140/16 141/17 142/2 142/2 142/6 145/19 145/21 146/13</p>
---	--	---	---	---

C	84/5 86/25 105/17 111/24 129/12 144/6 152/4 160/12 166/10 169/1 189/1 201/25 Counsel [2] 77/22 144/25 Countess [30] 2/7 2/22 4/15 16/7 16/17 32/8 42/7 42/16 48/21 164/20 167/24 197/10 216/13 216/15 217/20 217/22 218/2 219/4 219/9 219/13 219/16 223/2 224/18 235/16 242/14 243/15 243/20 245/13 245/16 245/21 counting [1] 133/8 couple [8] 18/9 143/20 155/12 155/15 156/10 172/17 173/4 173/7 course [13] 5/1 28/13 41/5 44/14 86/7 131/11 156/22 159/7 183/3 204/6 222/19 234/14 235/3 Court [3] 1/5 4/11 80/19 cover [5] 11/17 12/3 182/23 218/2 238/13 covered [2] 176/18 181/23 covering [1] 31/17 covers [1] 241/16 CQC [3] 47/3 47/17 47/21 cranial [7] 227/19 227/25 228/5 228/15 228/19 229/22 230/3 crash [1] 170/14 created [1] 83/25 crime [2] 87/11 87/16 crimes [1] 11/11 criminal [6] 151/24 152/11 162/15 171/19 179/18 246/2 criteria [4] 27/9 27/11 27/17 98/20 criticising [1] 30/20 cross [4] 40/7 61/22 105/16 158/17 crossed [2] 40/9 105/9 Crown [3] 1/5 4/11 80/19 Crown Court [1] 80/19 CRP [6] 75/22 76/3 76/16 76/21 76/23 185/2 cry [1] 184/20 crying [1] 136/2 cuddling [1] 240/7 culture [5] 15/4 15/8	15/13 16/19 168/7 curiosity [1] 24/24 curious [6] 23/19 25/3 25/14 25/16 125/9 125/13 current [2] 178/7 180/11	D Dad [2] 135/25 136/2 daily [2] 214/15 222/2 damage [2] 116/6 116/9 data [5] 56/14 57/11 57/12 57/18 110/10 date [6] 53/6 82/22 123/12 142/17 186/24 215/18 dated [11] 1/19 63/14 72/12 81/7 113/5 113/20 123/3 145/23 164/20 167/19 167/20 Datix [12] 17/3 17/6 17/7 17/14 17/19 17/23 18/22 40/18 69/1 88/22 88/23 88/25 daughter [3] 154/5 154/7 154/7 David [2] 143/23 144/1 Davis [1] 150/25 day [47] 7/11 7/11 30/20 39/24 69/9 72/14 75/22 91/3 92/7 92/22 93/10 130/24 139/8 145/25 150/2 175/24 180/4 180/11 180/13 180/16 181/24 182/20 183/1 184/6 190/20 195/1 195/4 195/20 196/21 197/4 197/7 197/24 200/1 203/1 203/3 203/5 203/6 203/10 205/13 226/13 229/3 229/4 229/8 229/16 233/5 240/19 244/9 day shifts [1] 229/4 day's [1] 229/19 days [19] 42/17 57/14 94/1 103/4 105/7 106/19 106/22 149/2 180/2 201/16 202/12 203/14 216/10 226/24 229/18 229/18 230/23 231/20 232/19 daytime [2] 104/24 176/15 DBS [4] 216/18 243/5 243/19 243/22 De [11] 1/3 1/16 80/10 81/2 122/25	152/3 165/3 166/22 167/6 247/3 247/7 deal [18] 1/24 12/5 18/24 22/6 48/13 59/17 63/7 81/12 86/14 96/17 102/17 108/18 143/20 144/24 183/20 212/12 213/19 232/9 dealing [6] 8/23 136/7 180/8 196/25 224/23 225/1 dealt [6] 3/14 26/16 53/1 87/3 96/21 236/3 deanery [1] 3/24 Dear [1] 215/4 death [74] 16/9 16/10 16/11 22/20 23/12 23/20 23/22 23/25 24/19 25/20 25/22 26/1 26/24 27/7 27/15 27/21 28/18 30/24 31/2 42/20 42/22 43/23 44/6 54/10 66/21 66/23 67/16 87/20 92/4 93/9 100/24 101/10 105/20 107/9 116/2 117/7 123/18 130/5 130/9 130/16 130/18 131/11 131/14 148/7 149/6 149/9 150/14 151/19 152/4 154/3 164/5 165/9 166/9 176/2 176/6 176/11 176/20 176/23 177/1 188/22 189/10 189/24 189/25 190/23 191/5 191/13 192/19 192/25 194/16 194/19 195/4 199/22 201/25 205/3 deaths [70] 12/1 15/2 16/23 17/14 17/21 19/4 23/8 23/18 23/23 23/24 28/5 28/9 30/9 30/11 31/5 42/5 44/21 45/2 52/11 52/15 52/18 53/4 54/19 55/2 55/3 57/3 57/13 57/13 57/16 57/19 63/9 86/22 87/2 87/5 87/16 87/17 89/7 92/18 93/6 98/7 98/11 98/13 105/14 110/6 112/13 121/10 125/23 126/2 139/22 139/25 140/15 141/18 148/12 161/7 163/21 171/18 177/5 190/22 192/19 201/17 201/18 202/24 204/24 206/2 207/1 207/20 207/21 208/5 209/16 210/19 debrief [17] 41/3	41/6 41/10 41/16 174/7 174/8 174/9 174/12 174/15 174/19 174/20 174/23 182/3 182/7 199/11 199/14 212/11 December [12] 42/8 42/25 43/12 44/7 214/19 217/2 217/5 242/19 243/2 243/13 243/24 244/15 December 2015 [1] 42/8 December 2016 [1] 214/19 decide [1] 87/21 decided [5] 65/1 65/7 108/11 141/15 157/21 decides [1] 109/7 deciding [1] 218/10 decision [15] 26/12 40/17 66/7 66/11 71/4 71/9 71/12 74/16 80/1 109/5 109/8 109/9 109/10 135/14 157/24 decision-making [1] 157/24 decisions [1] 83/9 declared [1] 136/2 decline [3] 88/5 181/17 191/17 declined [2] 196/23 196/24 deep [1] 55/17 deeply [1] 36/23 defence [1] 163/3 defensive [1] 172/1 define [1] 88/1 definite [7] 44/9 51/6 51/11 58/8 58/9 60/9 77/23 definitely [5] 49/13 60/17 62/13 85/16 160/17 definition [1] 88/2 degree [3] 87/18 87/21 237/16 delayed [1] 199/12 deliberate [23] 12/24 28/15 40/25 41/1 44/16 46/6 49/23 50/11 54/20 54/24 55/7 59/15 74/18 105/10 127/9 128/25 146/5 158/17 160/21 180/23 191/21 234/7 234/20 deliberately [7] 12/19 36/12 36/22 74/4 141/4 206/5 232/7 deliver [2] 170/14 170/19 delivered [1] 198/1 delivery [2] 188/15
----------	--	---	---	--	---

D	116/4 116/17 118/7 118/19 123/16 123/18 130/5 132/8 174/6 181/14 187/16 197/19 236/10	130/12 134/10 135/1 139/24 141/25 145/6 148/1 162/22 162/24 163/19 163/23 165/17 166/8 169/17 172/24 173/7 174/14 174/23 175/1 175/3 175/5 176/8 176/19 176/19 176/23 189/22 190/10 192/16 192/20 193/6 193/12 193/20 195/21 195/22 195/23 196/10 196/19 197/13 198/1 198/12 199/24 203/10 203/25 204/3 206/20 207/17 210/15 210/16 211/15 213/7 213/11 220/22 221/4 221/6 235/18 236/25 237/24 238/8 244/18	87/14 88/2 88/6 died [27] 15/5 15/8 15/19 18/3 42/18 43/7 52/24 57/23 105/14 128/4 129/23 131/17 134/8 135/22 140/5 140/17 149/15 150/3 159/18 160/14 163/10 163/21 164/10 176/19 190/14 203/3 214/12 differ [1] 44/1 difference [2] 8/10 112/25 differences [1] 182/20 different [27] 5/15 5/20 20/25 30/22 37/2 40/16 50/14 51/14 60/25 82/15 107/16 108/15 109/12 111/21 111/22 147/14 150/7 153/8 169/3 175/23 178/25 179/1 182/22 205/7 205/8 219/17 231/13 differential [3] 90/24 158/4 158/6 differently [1] 142/8 difficult [12] 15/10 22/10 25/5 27/16 36/15 38/9 38/11 69/4 82/21 82/23 134/2 239/17 difficulties [3] 39/7 82/7 85/8 digest [1] 61/13 direct [8] 16/18 58/21 182/15 217/7 217/14 231/17 243/9 244/2 directed [2] 160/21 221/17 direction [1] 54/2 directly [3] 6/25 9/6 242/16 Director [4] 14/5 241/10 241/14 242/22 directorate [3] 8/4 8/7 8/13 directors [6] 7/5 9/22 14/14 51/17 62/16 63/2 disagree [2] 6/19 7/2 disagreed [4] 50/1 53/23 57/8 57/9 disappear [1] 158/12 disappeared [1] 157/21 disappearing [1] 158/1 disbelief [1] 133/15 disciplinary [1] 245/4 discolour [1] 154/25 discolouration [8] 21/19 22/1 22/2 22/7	67/25 68/7 68/10 156/17 discomfort [2] 78/1 236/13 discuss [10] 94/2 95/18 101/15 101/25 104/15 125/2 131/5 176/9 184/24 206/14 discussed [45] 21/23 25/24 27/14 36/5 39/21 54/20 58/25 72/15 72/24 87/6 91/24 92/2 92/18 93/22 98/24 99/14 99/19 114/7 118/15 118/22 119/12 122/7 123/21 124/24 130/16 130/18 131/10 138/6 141/19 150/16 151/13 157/4 160/18 174/6 176/14 176/25 177/7 206/10 207/14 207/15 208/13 209/6 209/9 209/13 230/1 discussing [12] 21/3 54/8 100/8 129/17 151/9 152/20 181/22 197/7 199/14 199/21 206/24 239/11 discussion [53] 19/7 19/10 21/11 28/6 36/4 41/13 44/3 46/22 51/16 55/11 67/15 85/17 87/19 93/23 93/24 101/25 105/19 111/23 114/8 115/8 115/18 115/22 116/8 116/15 116/25 117/6 117/9 117/20 118/1 118/11 119/21 119/23 121/6 121/10 128/6 138/23 149/12 149/22 165/12 176/13 177/10 181/17 181/19 182/1 182/8 191/4 193/21 199/16 206/18 207/4 208/14 215/21 235/12 discussions [19] 28/13 44/5 85/24 86/3 91/4 96/19 96/23 106/3 129/16 174/14 174/15 174/17 174/18 174/24 182/11 190/11 197/5 219/3 221/7 disinterest [1] 8/24 disinterested [1] 7/17 dismissed [4] 36/21 40/2 40/24 46/6 dismissive [1] 64/2 disorder [5] 91/2 91/12 155/6 160/24 161/2 displaced [1] 191/17
delivery... [1] 199/1 demonstrated [1] 192/2 denominator [1] 140/13 dental [1] 242/3 department [27] 3/12 3/21 4/2 5/4 7/8 7/19 7/22 7/25 8/17 9/7 9/19 11/6 11/7 16/12 23/10 30/11 31/6 31/8 41/17 41/23 41/23 42/3 48/5 61/18 82/5 87/3 218/1 department's [1] 8/10 departmental [2] 3/9 3/10 departments [2] 30/10 108/15 depend [2] 76/18 109/3 depending [1] 110/15 depends [1] 33/21 depth [1] 236/4 derive [1] 101/25 desaturations [2] 237/1 237/4 describe [7] 60/23 100/7 120/11 132/14 135/8 163/11 169/6 described [8] 4/16 39/24 39/25 48/14 99/6 124/5 161/24 245/16 describes [1] 137/5 describing [1] 63/21 description [2] 155/24 157/2 destination [1] 185/21 detail [13] 15/1 28/22 29/9 29/18 44/1 61/17 67/9 128/23 159/4 176/7 186/16 234/14 236/3 detailed [1] 189/19 details [7] 44/11 46/9 91/1 174/22 181/25 186/17 202/14 detect [1] 180/23 deteriorated [8] 22/21 23/1 91/18 102/7 123/17 174/3 183/6 194/24 deteriorates [1] 91/7 deteriorating [1] 104/5 deterioration [19] 89/12 89/22 90/21 103/22 115/19 115/23	deteriorations [11] 105/8 123/6 127/18 130/3 192/20 193/4 193/7 193/15 193/25 194/9 207/1 determine [1] 148/11 devastated [2] 26/9 190/12 devastating [2] 51/9 188/3 developed [1] 242/13 developing [1] 64/22 development [1] 215/10 development.' [1] 243/1 devices [1] 7/12 diabetes [4] 168/4 223/6 242/10 245/3 diagnoses [1] 160/11 diagnosis [6] 24/18 24/19 90/24 114/8 158/4 158/6 diagnostic [2] 159/9 159/25 diagnostically [1] 158/20 dialled [1] 233/22 diaries [1] 110/20 diastolic [1] 116/11 did [153] 3/1 5/4 6/13 7/12 8/12 9/5 10/2 10/7 11/19 11/23 13/16 14/1 14/8 14/11 14/12 15/2 17/5 19/3 20/10 21/21 24/13 28/13 29/21 31/4 33/1 34/3 37/8 37/22 39/11 39/19 40/7 42/22 42/24 44/15 44/22 45/21 47/14 51/16 52/19 53/3 56/17 56/18 56/19 56/21 56/24 57/18 59/21 61/25 62/18 63/8 63/11 64/11 72/9 73/12 73/24 83/1 83/18 85/1 88/16 89/13 90/3 90/5 91/17 91/19 93/20 94/6 94/7 95/15 98/10 99/3 102/15 105/2 105/19 110/3 111/5 111/14 112/10 112/15 113/9 114/23 116/21 117/24 117/25 118/17 119/8 124/2 124/19 125/2 125/5 125/25 126/3 127/20 128/9 130/8	30/5 37/2 37/16 37/18 46/7 47/12 50/20 51/3 52/2 56/22 57/21 58/8 60/2 60/16 64/10 68/3 72/11 74/1 74/13 74/14 74/17 77/23 79/12 79/12 87/24 88/1 92/5 93/19 94/4 95/15 98/19 98/20 99/2 101/9 101/16 102/3 104/20 104/23 105/15 106/11 107/13 109/12 112/3 113/14 115/7 115/14 118/18 120/23 124/21 124/21 125/2 125/20 127/3 127/3 127/13 128/23 128/24 129/21 130/13 130/24 134/20 139/18 139/25 142/4 142/19 143/2 146/19 146/25 147/9 147/16 147/19 154/5 158/17 159/13 163/22 166/4 170/10 173/6 173/19 173/25 174/8 174/9 174/19 178/22 182/2 182/3 186/25 186/25 187/8 189/2 189/6 192/3 197/1 197/3 197/11 199/9 199/12 200/17 201/18 201/19 201/24 203/6 203/11 206/18 207/20 207/22 211/14 211/18 212/14 212/23 214/18 217/23 219/7 221/7 225/6 225/25 232/24 234/16 237/10 die [5] 24/21 57/25		

D	189/20 190/25 199/13 201/6 203/14 203/21 206/2 206/6 206/13 207/7 210/7 211/25 212/2 212/14 214/6 217/9 217/17 217/22 220/7 220/14 221/19 221/24 223/15 225/24 226/22 228/3 236/15 239/10 241/2 241/3 244/8	207/5 228/11 231/9 233/22 234/4 doing [25] 7/1 11/14 11/24 33/19 36/11 47/18 50/6 59/14 82/16 87/4 94/11 94/11 97/4 127/5 128/21 140/22 147/15 162/20 169/17 192/15 210/21 213/9 213/17 229/4 240/2	229/17 230/15 231/24 232/2 234/13 234/15 235/13 237/2 done [52] 11/21 18/14 26/12 34/5 34/11 35/17 36/10 40/11 40/14 40/22 41/1 41/14 41/24 41/25 50/25 51/2 55/19 67/2 71/21 74/18 75/2 83/14 85/18 90/9 97/18 98/6 98/10 132/6 133/5 133/9 138/2 153/18 162/20 176/12 177/2 178/3 180/15 181/4 185/5 190/11 190/13 190/19 195/13 197/8 213/24 214/17 218/20 230/5 230/21 234/21 235/25 240/18	80/20 80/22 80/24 81/3 81/5 81/16 83/16 83/21 84/8 84/9 84/19 84/20 84/21 85/1 85/1 85/2 85/4 85/7 85/13 85/14 85/22 89/6 89/11 93/19 93/20 94/19 95/1 95/6 95/9 95/10 99/4 99/5 103/25 105/24 105/25 105/25 106/1 106/1 107/9 107/11 107/18 109/21 110/2 111/12 112/7 112/12 112/24 114/1 121/4 121/6 121/18 122/12 123/2 124/5 124/9 124/10 124/22 125/6 125/10 126/17 126/17 126/19 126/21 127/10 127/12 127/13 127/20 127/21 128/8 128/10 130/1 130/8 130/11 130/12 132/4 132/6 133/23 135/17 136/3 136/6 136/16 140/11 141/25 143/21 143/23 144/1 146/3 148/14 148/21 151/14 152/18 153/12 154/12 154/14 154/17 156/4 156/22 157/25 161/17 164/18 167/11 167/13 167/18 167/24 175/16 175/16 175/17 177/19 177/21 179/10 179/19 183/17 188/7 192/9 193/2 193/7 193/14 193/23 193/24 194/10 201/6 202/22 205/4 205/5 205/23 205/23 205/25 206/7 206/16 209/1 209/18 213/8 213/19 221/24 222/14 222/17 222/24 226/15 231/7 235/7 235/17 240/24 241/1 242/9 242/17 243/2 243/4 243/6 243/13 243/23 244/4 244/5 244/11 244/16 244/24 245/7 245/9 245/20 247/2 247/6 247/11 Dr Brearey [31] 2/24 40/21 43/24 45/18 47/16 51/16 54/25 62/21 64/23 106/1 110/2 111/12 112/7 121/6 121/18 124/10 124/22 125/6 125/10 130/1 130/8 130/11 130/12 193/2 193/7 193/14 193/24 194/10 205/4 209/1 209/18 Dr Brearey's [1]
display [1] 56/11 disruption [1] 166/20 disseminated [1] 158/11 distant [2] 52/9 171/8 distended [2] 70/3 70/14 distension [5] 69/12 70/17 103/2 104/9 104/12 distressed [3] 138/1 139/13 154/3 district [1] 181/7 distrustful [2] 63/16 63/22 dive [1] 55/17 dividing [1] 238/24 do [175] 4/13 6/15 8/9 10/20 11/9 12/12 12/14 12/15 13/5 16/14 17/24 18/5 18/9 20/5 23/19 24/16 24/24 25/2 25/6 25/8 26/10 27/16 28/12 30/23 35/5 36/15 37/3 40/13 41/3 41/10 41/18 44/20 45/1 45/5 47/22 48/19 51/5 51/11 51/20 51/23 52/3 52/21 53/7 54/2 54/19 59/19 62/12 71/20 73/16 75/9 76/1 79/5 79/13 79/20 80/2 81/3 82/17 83/4 85/7 85/14 86/8 86/13 86/16 86/18 91/8 92/14 95/21 97/4 98/3 99/10 99/13 99/21 105/15 106/25 107/1 107/23 108/13 109/14 115/5 115/11 115/21 117/5 118/9 118/20 120/20 123/6 124/7 125/21 129/3 129/7 131/6 131/6 134/25 137/19 137/25 140/3 140/22 142/7 142/9 142/25 143/16 143/18 147/12 148/9 149/10 149/18 150/6 150/14 151/23 152/9 154/2 154/7 155/9 155/21 155/23 156/22 158/10 160/3 168/15 170/1 170/9 171/17 172/3 172/4 172/8 172/24 172/25 174/13 176/25 177/8 178/2 179/20 181/2 181/21 182/6 182/9 183/7 183/8 185/12 186/8 186/20 187/12 188/3 188/11	do do [1] 131/6 doctor [31] 1/14 1/25 3/4 4/1 4/5 20/17 21/16 65/19 67/16 79/18 81/13 93/25 133/24 171/6 175/16 180/10 181/3 195/16 197/13 213/12 220/12 220/17 221/8 224/19 224/20 224/21 225/1 226/8 229/9 231/1 240/20 Doctor S [1] 175/16 Doctor V [1] 195/16 doctors [33] 3/19 3/21 3/23 3/24 7/1 11/15 45/25 49/7 79/7 83/13 109/12 119/14 131/6 131/25 165/23 168/19 169/2 169/19 169/21 170/2 174/16 175/11 175/13 181/11 182/22 191/4 191/25 193/21 195/8 196/5 205/22 213/8 236/11 doctors' [1] 11/17 document [12] 9/20 72/5 113/5 113/17 114/3 115/16 118/24 119/18 123/3 124/3 218/19 219/1 documentary [1] 245/3 documentation [6] 149/11 149/22 159/4 204/18 204/19 210/9 documented [4] 90/7 94/16 139/9 159/6 documents [4] 16/15 16/25 86/24 218/24 does [28] 2/17 10/25 11/2 16/21 42/1 75/4 84/24 87/1 89/10 92/6 111/22 116/1 126/20 126/25 128/13 137/6 138/3 138/10 151/18 153/22 157/13 164/21 187/13 209/18 213/3 214/8 215/25 226/11 doesn't [16] 16/24 24/18 75/3 87/2 87/13 100/20 127/5 128/17 138/14 165/19 187/12	don't [170] 6/7 7/14 13/4 14/11 14/12 18/19 20/12 23/22 29/19 35/15 37/20 41/4 42/24 43/2 43/9 43/17 44/3 47/18 47/20 48/10 51/12 52/22 53/1 62/13 64/13 67/9 71/5 73/10 74/8 74/14 78/9 78/13 79/11 79/13 83/6 83/7 83/15 88/10 88/11 90/13 92/12 92/23 93/18 93/21 94/18 95/19 95/20 96/19 97/9 100/9 100/17 102/19 102/21 107/6 108/9 110/5 113/12 113/24 116/24 117/9 117/11 119/10 120/18 122/8 123/23 124/4 125/21 128/5 129/13 131/18 132/3 133/17 133/19 134/19 137/25 138/20 140/17 142/6 142/17 142/23 142/25 143/9 144/8 144/10 144/16 146/14 146/21 147/19 149/20 149/23 150/15 152/9 154/9 155/10 156/22 156/24 156/25 157/22 158/14 158/18 158/22 163/2 167/1 172/1 172/12 172/15 173/2 173/10 174/5 174/10 174/25 174/25 175/5 176/13 176/24 177/2 177/10 178/3 179/6 181/22 181/24 182/1 184/24 189/7 190/8 191/24 192/22 193/11 197/3 197/17 200/8 201/14 201/19 203/4 203/4 203/7 203/19 204/3 206/20 208/12 208/23 209/14 209/20 210/13 212/4 216/22 217/17 217/21 220/9 220/19 220/19 220/23 221/6 221/18 221/20 222/13 223/16 223/17 224/14 224/19 227/23 229/17	229/17 230/15 231/24 232/2 234/13 234/15 235/13 237/2 done [52] 11/21 18/14 26/12 34/5 34/11 35/17 36/10 40/11 40/14 40/22 41/1 41/14 41/24 41/25 50/25 51/2 55/19 67/2 71/21 74/18 75/2 83/14 85/18 90/9 97/18 98/6 98/10 132/6 133/5 133/9 138/2 153/18 162/20 176/12 177/2 178/3 180/15 181/4 185/5 190/11 190/13 190/19 195/13 197/8 213/24 214/17 218/20 230/5 230/21 234/21 235/25 240/18 door [1] 84/1 doors [1] 134/13 double [1] 134/13 doubt [6] 25/11 39/14 46/12 146/9 204/18 235/19 doubts [1] 140/23 down [49] 1/15 9/25 10/1 10/17 11/8 11/17 17/2 21/6 27/24 34/2 38/14 46/11 56/9 64/7 69/2 75/20 81/3 83/19 96/16 100/2 104/18 110/20 113/17 119/18 126/13 134/23 141/23 144/3 146/2 147/19 150/24 151/12 155/25 158/22 159/5 159/8 179/7 184/17 184/25 185/16 200/21 200/25 225/16 227/18 230/5 231/2 233/13 233/19 236/15 Dr [223] 1/6 1/13 1/17 2/24 2/25 4/9 4/11 4/14 4/19 5/1 9/11 10/13 11/9 19/18 20/1 20/10 20/15 20/15 20/16 21/15 21/22 21/25 22/4 22/13 31/10 35/10 35/22 39/22 40/21 40/21 43/22 43/22 43/24 43/24 45/18 46/18 47/16 48/14 51/16 53/19 54/12 54/25 56/21 61/6 62/21 62/21 63/8 64/16 64/22 64/23 65/14 66/3 67/24 70/11 71/24 72/11 73/11 73/13 73/14 77/7 80/12 80/13	

D	213/19 221/24 222/24 240/24 241/1 242/9 242/17 243/2 243/4 243/6 243/13 243/23 244/4 244/5 244/11 244/16 244/24 245/7 245/9 245/20 247/11	dying [1] 87/14 dynamic [1] 33/20	102/4 107/3 121/14 130/19 135/16 142/13 159/14 176/16 176/17 181/3 188/10 189/1 206/5 217/18 225/2 232/7 234/9 elaborate [1] 219/21 electronic [4] 33/13 33/15 152/13 231/25 electronics [1] 233/3 else [15] 36/9 79/19 110/18 110/23 112/12 140/4 141/20 144/6 174/7 181/4 200/8 218/2 220/4 220/7 239/25 email [63] 9/5 9/10 9/12 10/13 10/14 19/18 20/4 20/5 21/18 22/8 22/15 45/9 45/18 46/3 51/20 51/23 53/19 63/13 63/14 95/2 95/6 95/11 95/19 95/23 96/10 96/11 100/5 110/9 111/9 115/9 115/11 115/11 124/3 124/13 124/22 125/5 125/9 129/25 164/20 193/2 193/6 193/6 193/11 193/16 193/20 194/10 208/18 208/22 208/23 208/24 210/15 210/16 211/6 215/2 215/4 215/13 216/2 216/21 242/20 242/22 243/8 244/11 245/10 emails [5] 20/21 22/4 54/2 214/22 217/17 embarrassment [1] 237/17 emergencies [1] 128/17 emergency [4] 7/22 8/17 16/12 90/1 Emma [1] 73/2 emotional [2] 163/18 163/19 emotionally [1] 164/10 employed [1] 241/14 employment [2] 243/17 243/21 employs [1] 241/25 enable [2] 79/6 243/8 enabled [1] 79/9 encountered [1] 142/15 encouraged [1] 225/15 end [23] 8/25 45/10 45/16 47/9 47/11 59/25 80/14 84/3 100/6 116/11 120/16	120/23 123/13 134/13 152/22 180/12 190/17 193/25 195/21 199/16 216/16 222/8 244/9 ending [1] 10/18 endured [1] 195/3 enough [14] 11/13 11/15 15/21 20/24 24/20 38/10 40/20 41/8 62/13 85/4 138/1 165/17 202/13 232/11 enquire [3] 215/5 243/4 243/7 enquires [1] 245/20 ensure [6] 31/1 49/7 50/25 122/17 191/7 244/24 ENT [1] 244/5 entailed [1] 78/8 entered [2] 60/19 230/10 enterocolitis [2] 22/3 67/1 entirely [3] 43/6 110/20 187/14 entries [1] 114/12 entry [8] 69/9 72/11 114/10 137/9 138/19 138/22 177/23 178/8 environment [2] 14/24 28/11 epiglottis [1] 185/1 episode [3] 34/14 41/7 100/3 episodes [3] 52/5 103/1 106/14 Erica [2] 241/10 241/13 Erica Saunders [1] 241/10 error [3] 17/14 211/4 234/21 errors [2] 17/15 89/1 escalate [1] 141/21 escalated [1] 109/15 escalating [1] 141/24 especially [3] 93/17 139/14 160/25 essential [1] 32/23 essentially [1] 87/7 establish [3] 14/1 148/7 245/25 et [3] 184/15 238/2 239/3 et cetera [3] 184/15 238/2 239/3 etc [2] 153/19 153/19 even [19] 17/21 65/12 105/9 105/16 115/23 120/1 120/21 126/13 129/1 129/2 132/3 139/9 140/20 146/25 174/15 174/18 186/23 187/5 220/9
Dr Brearey's... [1] 188/7		E		
Dr Brearley [1] 112/12		E's [13] 21/13 22/20 23/12 23/20 23/22 23/25 24/19 26/8 26/24 28/1 30/24 31/2 66/21		
Dr David Semple [2] 143/23 144/1		e-mailed [2] 243/6 244/5		
Dr Gibbs [14] 19/18 20/15 43/22 48/14 95/6 99/5 105/25 107/9 107/11 107/18 124/5 132/4 179/10 201/6	Dr Ukoh [2] 175/17 177/19	each [7] 97/9 145/9 160/6 169/4 175/24 241/25 242/5		
Dr Gibbs' [1] 179/19	Dr V [29] 80/20 80/22 80/24 81/3 81/5 81/16 94/19 95/10 103/25 109/21 112/24 114/1 121/4 122/12 123/2 124/9 133/23 141/25 143/21 146/3 148/14 148/21 151/14 152/18 153/12 156/22 161/17 164/18 247/6	earlier [19] 21/24 23/21 23/23 24/23 41/20 77/13 91/3 105/24 165/5 165/7 165/13 182/25 184/6 196/11 207/2 207/18 229/8 231/13 232/17		
Dr Harkness [7] 20/16 21/15 21/22 21/25 22/4 67/24 70/11	Dr ZA [23] 1/6 1/13 1/17 11/9 22/13 64/16 65/14 66/3 77/7 80/12 80/13 89/6 89/11 95/1 99/4 105/24 205/5 205/23 205/23 205/25 206/7 206/16 247/2	early [8] 44/19 76/3 102/7 103/14 145/7 190/15 198/2 207/5		
Dr Harvey [1] 56/21		easier [2] 79/21 237/8		
Dr Hawdon [2] 61/6 63/8		easiest [1] 91/8		
Dr Holt [4] 83/16 83/21 84/8 84/20		easily [1] 85/1		
Dr Howie [1] 84/9		easy [1] 171/9		
Dr Isaac [2] 85/4 85/7		eat [1] 175/13		
Dr Issac [8] 84/19 84/21 85/1 85/1 85/2 85/13 85/14 85/22	dramatically [2] 18/16 18/21	education [2] 242/2 242/19		
Dr Jayaram [17] 2/25 40/21 43/24 62/21 64/22 106/1 126/17 127/20 127/21 128/8 128/10 193/23 213/8 226/15 231/7 235/7 235/17	draw [4] 8/25 16/3 126/24 127/10	EF [1] 72/8		
Dr Lambie [10] 20/1 20/10 46/18 93/19 93/20 95/9 154/17 156/4 157/25 192/9	drawing [5] 9/6 61/21 128/11 130/1 132/15	effect [4] 116/10 137/24 170/1 177/23		
Dr Lambie's [2] 154/12 154/14	drawn [1] 51/22	effective [1] 112/3		
Dr Lewis [2] 73/11 73/14	draws [2] 95/8 95/14	effectively [2] 111/7 113/19		
Dr Lidden [4] 35/10 35/22 39/22 73/13	dress [1] 200/23	effort [1] 107/8		
Dr Lidden's [2] 71/24 72/11	drew [2] 45/1 128/8	eight [3] 94/15 114/24 214/16		
Dr Mayberry [2] 132/6 175/16	drink [1] 59/5	eight months [1] 114/24		
Dr Newby [9] 20/15 43/22 105/25 126/17 126/19 126/21 127/10 127/12 127/13	driven [1] 66/11	eight years [1] 214/16		
Dr Rackham [4] 135/17 136/3 136/6 136/16	driving [1] 15/14	eight/nine years [1] 94/15		
Dr Saladi [3] 9/11 10/13 53/19	drop [1] 48/9	Eirian [19] 5/21 6/5 6/11 53/9 82/24 83/7 113/8 118/9 124/25 130/2 130/9 163/13 163/20 163/23 163/25 164/11 169/24 203/13 219/4		
Dr U [33] 4/9 4/14 4/19 5/1 54/12 140/11 167/11 167/13 167/18 167/24 177/21 183/17	dropped [1] 196/22	Eirian Powell [13] 5/21 6/11 53/9 82/24 113/8 124/25 130/9 163/13 163/20 163/23 164/11 169/24 219/4		
	Drs [1] 169/7	Eirian Powell's [1] 130/2		
	drug [2] 17/13 89/1	either [25] 17/9 38/12 54/19 55/6 57/22 68/20 73/22 74/3		
	drugs [1] 196/17			
	due [6] 39/23 66/23 86/7 169/12 172/10 222/13			
	during [23] 2/9 9/5 11/10 13/12 47/23 48/1 49/21 50/17 72/7 83/8 118/16 161/22 177/12 184/14 194/5 197/6 204/10 217/8 223/1 242/7 244/1 244/3 245/7			
	during March [1] 245/7			
	duties [3] 49/1 172/4 173/5			
	duty [9] 80/1 93/25 103/19 137/19 139/4 142/1 142/1 227/3 229/14			
	DW [1] 151/13			

E	examination [2] 104/9 152/19	162/13 183/25 224/15 234/19 235/19	179/15 184/9 198/21 207/6 224/10 225/24 233/5	feeding [1] 112/3 feeds [2] 69/22 200/12
evening [5] 100/3 130/16 153/3 181/20 190/15	examine [1] 100/22	explained [12] 25/19 44/22 57/3 57/17 57/19 87/21 106/18	factor [3] 49/12 127/11 160/7	feel [10] 6/19 7/2 52/2 59/21 59/24 65/8 79/12 131/8 186/21 200/8
event [13] 86/9 89/1 89/2 89/11 91/15 101/15 162/24 176/10 177/7 181/19 182/6 191/8 191/16	examined [2] 69/25 71/2	158/25 160/11 183/2 231/13 245/24	factors [4] 54/18 116/12 116/14 118/12	feeling [6] 43/18 50/3 63/13 136/13 143/14 172/2
events [23] 8/25 17/17 34/3 46/20 50/5 97/16 100/19 101/21 117/10 139/7 143/20 146/3 174/16 187/21 192/13 192/18 192/19 193/8 194/4 195/1 197/17 214/9 223/17	examining [1] 190/23	explaining [1] 236/9	facts [7] 58/25 140/17 142/5 146/24 147/4 147/7 245/25	feels [3] 210/13 214/14 215/11
ever [18] 14/8 14/11 38/21 72/20 78/25 79/10 86/8 113/9 129/18 133/24 192/16 202/16 212/15 213/7 220/19 235/24 235/24 236/25	example [5] 37/19 89/1 115/18 128/14 240/7	explains [1] 178/7	failing [2] 159/21 159/23	fell [1] 193/5
every [8] 92/13 92/13 106/24 113/25 180/13 180/13 229/18 231/12	excellent [1] 188/8	explanation [9] 15/20 15/21 23/2 23/25 25/23 50/7 50/9 236/25 237/2	failure [6] 48/16 73/18 74/6 99/6 124/6 179/10	fellow [4] 81/22 175/14 193/3 238/7
everybody [4] 83/1 120/13 120/21 199/17	exchange [3] 63/5 67/7 201/12	explains [1] 178/7	fair [8] 20/6 30/14 50/17 67/7 69/6 69/7 135/9 240/4	felt [28] 4/22 6/23 7/23 10/22 13/17 15/16 15/22 23/2 23/25 58/7 58/16 61/1 62/7 64/4 65/12 82/19 140/15 147/14 170/25 171/1 171/15 171/23 171/25 172/11 173/5 173/8 214/6 214/13
everyone [11] 6/12 6/13 106/24 109/16 166/18 166/20 185/11 190/12 204/20 206/23 208/7	excited [1] 135/9	expressed [3] 63/13 69/18 237/16	fairly [3] 66/20 85/1 224/5	few [15] 44/23 48/25 60/20 70/10 92/20 126/16 127/14 133/12 133/20 138/16 143/1 144/5 152/21 180/2 222/11
everyone's [1] 210/14	excitement [1] 198/23	extend [1] 244/6	fairness [1] 26/2	fewer [1] 57/15
everything [9] 11/21 139/13 139/14 185/5 204/3 204/15 204/16 205/24 209/5	exclude [2] 24/18 160/10	extended [3] 47/19 48/24 190/18	faith [1] 85/9	fill [2] 17/6 17/22
evidence [44] 14/22 14/25 46/17 50/20 51/11 63/4 66/7 66/10 67/23 68/5 68/15 70/16 70/16 70/21 71/17 73/6 80/14 80/15 94/19 105/25 118/21 119/19 142/5 147/9 151/23 157/8 161/21 163/7 165/7 173/20 187/24 205/25 206/17 206/21 206/21 222/1 222/12 228/6 228/8 232/20 234/24 235/20 241/5 245/3	exclusion [3] 27/9 27/11 27/17	eyes [2] 194/6 194/7	fall [1] 244/18	filled [2] 17/7 26/22
exact [8] 22/11 35/20 44/11 84/6 100/6 144/8 192/23 237/7	execs [1] 144/10	executing [2] 217/1 244/14	falls [1] 189/6	final [5] 4/14 17/2 123/3 135/23 145/18
exactly [16] 6/3 6/13 28/7 44/18 50/6 53/6 61/17 78/7 86/5 87/1 129/12 142/24 143/9 149/20 173/10 201/14	exercise [2] 192/11 192/15	external [2] 78/20 110/9	false [1] 64/22	finally [4] 5/3 46/17 75/8 221/24
	exhausting [1] 13/22	externally [1] 33/3	familiar [2] 27/5 114/1	find [9] 3/1 71/15 71/17 74/25 92/20 94/4 194/2 208/20 245/13
	exhibits [1] 244/23	extra [1] 233/21	familiarise [1] 154/21	finding [1] 155/2
	exist [1] 246/3	extracts [1] 183/15	families [4] 66/5 66/5 86/15 161/18	findings [1] 104/10
	existed [1] 38/24	extraordinary [1] 97/25	family [7] 26/15 66/12 66/14 72/2 77/8 79/19 224/14	fine [5] 32/19 96/1 108/6 108/6 217/13
	exogenous [6] 33/5 36/6 45/23 74/10 75/4 232/6	extreme [1] 57/24	fantastical [1] 36/12	finger [1] 15/11
	expand [2] 152/16 171/17	extremely [4] 26/15 34/6 146/18 154/2	far [25] 8/13 8/18 39/4 39/22 55/4 55/10 85/3 86/7 86/20 92/20 119/15 130/6 165/17 167/22 168/8 169/9 171/8 173/3 191/10 191/18 191/19 192/4 196/3 210/5 245/2	finish [8] 118/23 122/17 137/10 198/2 200/9 204/7 213/19 222/21
	expanded [1] 83/24	eyes [2] 194/6 194/7	father [5] 66/16 72/8 224/13 225/9 239/16	finished [2] 120/13 235/15
	expect [8] 23/24 33/8 34/16 36/17 61/14 88/1 88/4 144/2	Facebook [4] 183/15 183/17 237/21 239/5	fast [2] 18/22 29/6	first [44] 1/4 3/13 9/4 12/8 19/23 24/11 31/6 34/22 44/18 60/19 92/24 99/19 101/13 102/13 104/3 108/12 121/9 121/25 123/20 137/8 137/16 138/18 143/10 143/21 144/24 148/17 152/15 154/11 155/16 155/21 156/3 158/8 167/19 176/2 182/14 214/23 215/23
	expected [13] 27/8 27/9 27/9 29/9 41/6 57/19 61/9 61/12 87/21 87/24 158/12 179/25 232/12	facilitate [2] 215/9 242/25	father N [1] 239/16	
	expecting [1] 178/10	facilitated [1] 242/9	fault [2] 43/7 43/16	
	experience [30] 3/25 4/4 5/17 5/18 6/16 9/19 10/25 12/15 29/14 30/11 38/2 64/17 78/9 117/6 118/1 126/9 131/13 133/23 135/10 141/7 144/19 162/19 168/25 169/22 170/1 187/22 214/19 224/22 244/19 245/18	facing [2] 58/24 217/19	faulty [1] 74/21	
	experienced [3] 58/10 82/4 201/23	fact [42] 14/9 19/3 22/8 27/19 30/25 38/1 41/18 44/22 46/5 51/8 55/1 62/24 70/25 93/14 94/4 99/9 104/4 108/1 109/17 110/5 114/23 114/24 115/22 119/21 123/13 127/10 131/17 139/9 142/19 154/6 159/10 159/17 164/22 164/24 176/16	fear [1] 136/10	
	experiences [1] 145/10		Feb [1] 216/10	
	explain [12] 55/1 78/7 88/8 130/20 140/10 145/7 160/13		February [16] 47/18 63/15 109/23 112/19 113/7 113/20 123/3 123/13 123/22 126/20 126/21 126/25 127/2 147/23 244/1 244/5	
			February 2016 [1] 47/18	
			February 2017 [1] 147/23	
			feed [1] 103/2	
			feedback [1] 3/22	

F	17/19 17/23 26/22 27/1 27/3 33/1 40/18 88/23 112/18 153/8 181/9	future [3] 79/6 79/14 181/3	209/3 210/23 235/20 239/22	2/21 8/20 12/4 12/5 18/23 28/2 28/2 30/2 30/20 39/8 43/12 45/10 55/19 63/12 65/19 77/10 82/3 84/25 85/10 89/16 91/12 93/18 97/12 109/18 109/21 111/13 112/10 112/15 114/6 120/18 123/11 125/16 125/21 134/19 134/24 135/17 136/10 136/11 136/20 139/18 140/5 141/23 143/13 143/14 148/21 150/1 152/1 152/14 152/21 155/4 156/14 160/16 166/17 173/17 178/4 185/3 185/4 185/25 189/13 195/21 197/20 198/22 200/2 200/23 201/11 203/21 204/7 208/19 209/24 210/1 210/5 210/24 210/25 212/17 212/20 229/20 240/5 241/4
first... [7] 218/17 218/18 222/3 223/12 223/21 224/1 230/9	Form AB [1] 27/3 forma [4] 215/25 243/8 243/10 243/20	G	given [32] 12/15 22/14 23/20 36/6 36/7 41/5 48/5 50/23 63/18 74/3 74/12 74/23 79/24 90/9 96/24 104/12 107/20 110/5 118/21 119/19 122/15 131/19 132/6 157/8 160/25 161/21 165/16 173/20 222/1 224/11 225/14 245/23	gone [19] 17/9 48/10 55/4 68/8 94/22 96/10 127/15 138/14 140/6 141/1 160/9 165/16 192/6 201/20 206/3 217/15 226/10 229/22 230/4
Firstly [6] 2/24 9/5 39/17 45/24 60/23 123/21	formal [3] 98/5 160/9 244/19	gap [4] 12/16 86/18 238/11 238/13	gives [1] 184/11	good [21] 1/7 3/16 3/22 32/17 70/1 83/1 85/9 133/17 141/10 144/10 169/10 169/19 171/8 187/21 188/9 192/2 199/10 199/11 202/13 204/19 208/12
fit [1] 98/20	formality [1] 101/3	gas [4] 133/5 133/9 133/17 236/17	giving [8] 38/10	gossipped [1] 207/23
fitted [1] 24/3	formas [1] 216/4	gastric [2] 68/18 70/12	glad [4] 185/10 197/16 197/19 199/7	got [25] 3/20 3/22 7/20 35/12 39/3 39/5 43/14 68/8 92/25 102/19 107/23 120/13 142/20 166/21 169/14 171/7 173/4 173/14 185/11 196/15 196/22 196/23 200/7 214/22 217/10
five [4] 114/11 205/14 226/24 231/20	formed [1] 62/23	gastrointestinal [2] 68/18 236/16	glucose [21] 33/17 33/18 33/21 33/23 34/3 34/6 35/15 35/18 36/19 45/19 177/15 178/18 179/22 224/2 224/2 224/24 225/5 233/12 233/19 233/21 233/23	gotten [1] 120/21
five days [2] 226/24 231/20	forms [1] 88/22	gather [2] 98/7 175/9	GMC [1] 3/22	governance [2] 106/25 241/17
five lines [1] 114/11	forum [3] 62/14 97/19 102/4	gathered [1] 88/14	go [97] 4/3 16/4 24/23 32/3 32/16 33/23 42/1 59/4 62/21 69/6 74/8 80/17 84/7 90/25 95/2 95/17 102/9 104/25 107/22 110/17 111/11 114/5 115/17 117/13 119/1 120/7 120/20 121/3 123/11 126/9 130/24 135/20 141/23 148/17 150/9 151/12 152/13 153/7 155/12 155/25 156/6 156/11 166/15 168/10 169/25 173/23 174/8 174/9 174/19 174/21 175/6 179/3 180/9 183/12 184/18 184/25 185/7 185/16 185/22 187/19 194/25 195/4 195/12 195/21 195/25 197/21 198/5 199/3 199/25 200/21 201/4 203/11 204/12 205/17 205/20 208/16 208/24 209/2 209/22 211/20 212/12 212/19 213/1 215/2 215/20 217/4 218/13 218/16 218/18 223/21 225/6 225/12 226/13 227/5 229/7 232/1 241/1	GP [1] 224/21
Five to [1] 205/14	forward [15] 1/8 1/11 10/16 28/3 30/3 46/24 102/5 109/21 116/23 118/6 125/16 136/20 208/20 208/22 210/16	gave [10] 54/1 66/7 173/19 173/20 186/17 195/11 205/25 208/10 210/20 216/18	glad [4] 185/10 197/16 197/19 199/7	grade [1] 4/17
fixed [1] 160/23	forwards [1] 212/21	Gen [1] 200/17	glucose [21] 33/17 33/18 33/21 33/23 34/3 34/6 35/15 35/18 36/19 45/19 177/15 178/18 179/22 224/2 224/2 224/24 225/5 233/12 233/19 233/21 233/23	gradual [2] 18/20 41/20
flag [2] 46/10 89/2	found [11] 3/6 15/5 62/24 75/15 84/25 93/22 102/24 103/5 133/14 135/7 218/13	general [11] 12/18 50/3 75/11 84/9 84/11 120/3 168/4 172/2 181/8 223/7 242/10	glad [4] 185/10 197/16 197/19 199/7	gradually [3] 18/15 49/1 88/5
flagged [4] 17/12 18/22 75/7 232/12	foundations [3] 224/21 241/15 241/22	generally [13] 3/20 7/19 11/24 131/1 168/22 169/8 170/3 170/4 170/5 170/25 176/23 180/19 237/19	glad [4] 185/10 197/16 197/19 199/7	Graham [1] 242/21
flavour [1] 114/6	four [9] 27/8 28/5 28/9 44/5 97/1 98/24 107/15 107/15 144/7	Gen [1] 200/17	glad [4] 185/10 197/16 197/19 199/7	granted [1] 83/11
fleets [1] 187/10	frame [2] 152/8 200/8	generated [1] 93/23	glad [4] 185/10 197/16 197/19 199/7	grateful [1] 135/5
flexibility [1] 108/7	frank [1] 64/5	generous [1] 167/5	glad [4] 185/10 197/16 197/19 199/7	grave [2] 139/22 139/24
florid [2] 90/7 157/5	frankly [1] 80/15	genuine [1] 62/7	glad [4] 185/10 197/16 197/19 199/7	
flow [1] 116/11	free [3] 80/17 166/15 241/1	genuinely [1] 64/20	glad [4] 185/10 197/16 197/19 199/7	
fluctuate [1] 45/20	frequently [2] 85/4 244/21	gestation [3] 57/21 198/7 227/23	glad [4] 185/10 197/16 197/19 199/7	
fluid [4] 33/25 90/9 228/6 228/23	fresh [1] 209/5	gestational [1] 75/17	glad [4] 185/10 197/16 197/19 199/7	
focus [4] 117/7 152/13 152/15 171/20	friction [1] 169/18	gesture [1] 214/14	glad [4] 185/10 197/16 197/19 199/7	
focused [3] 2/18 100/13 102/18	Friday [5] 131/21 131/24 132/5 138/25 194/23	get [23] 21/8 36/15 38/15 39/11 47/12 59/5 88/5 104/25 108/12 108/13 114/5 139/8 141/13 143/16 152/7 155/7 157/19 196/16 197/10 214/19 225/4 236/25 244/7	glad [4] 185/10 197/16 197/19 199/7	
focusing [5] 2/10 45/17 60/22 85/22 157/23	friday [5] 131/21 131/24 132/5 138/25 194/23	gets [4] 75/5 179/2 180/20 232/18	glad [4] 185/10 197/16 197/19 199/7	
follow [9] 39/8 42/11 67/19 89/10 125/18 126/20 126/25 138/25 233/11	friend [1] 79/19	getting [12] 7/25 15/17 15/18 39/6 140/7 149/8 161/23 186/2 187/1 198/15 198/18 214/11	glad [4] 185/10 197/16 197/19 199/7	
follow-up [2] 39/8 233/11	friendly [4] 4/24 5/9 168/22 169/8	Gibbs [15] 19/18 20/15 43/22 48/14 95/6 99/5 105/25 107/9 107/11 107/18 124/5 132/4 169/7 179/10 201/6	glad [4] 185/10 197/16 197/19 199/7	
followed [7] 14/22 14/25 116/7 139/14 189/22 211/13 211/16	friends [2] 4/23 187/12	give [21] 24/12 26/2 64/16 67/4 106/16 109/10 142/17 148/10 151/14 153/19 154/13 154/14 158/14 186/14 189/1 202/14 206/21	glad [4] 185/10 197/16 197/19 199/7	
following [17] 28/18 44/5 92/7 93/23 105/20 118/5 124/24 125/14 143/1 183/5 191/5 204/21 243/11 243/24 245/11 246/1 246/2	frivolous [1] 187/11	Gibbs' [1] 179/19	glad [4] 185/10 197/16 197/19 199/7	
follows [5] 29/17 63/5 63/23 93/17 241/13	frog [2] 18/18 18/18	give [21] 24/12 26/2 64/16 67/4 106/16 109/10 142/17 148/10 151/14 153/19 154/13 154/14 158/14 186/14 189/1 202/14 206/21	glad [4] 185/10 197/16 197/19 199/7	
food [1] 175/13	front [1] 119/7	gibbs' [1] 179/19	glad [4] 185/10 197/16 197/19 199/7	
fool [1] 201/1	full [3] 31/6 172/15 222/5	gibbs' [1] 179/19	glad [4] 185/10 197/16 197/19 199/7	
footed [1] 128/16	fully [2] 49/2 240/16	gibbs' [1] 179/19	glad [4] 185/10 197/16 197/19 199/7	
footprints [1] 200/23	function [1] 148/6	gibbs' [1] 179/19	glad [4] 185/10 197/16 197/19 199/7	
forensic [3] 65/11 189/16 189/19	further [27] 25/18 35/25 54/1 65/16 80/11 83/20 95/18 100/25 103/22 108/16 141/16 148/15 150/24 160/16 161/7 164/23 183/6 185/16 200/21 200/25 213/1 215/21 221/6 227/18 240/23 243/15 244/11	gibbs' [1] 179/19	glad [4] 185/10 197/16 197/19 199/7	
forgive [2] 59/20 117/14		gibbs' [1] 179/19	glad [4] 185/10 197/16 197/19 199/7	
forgot [1] 143/11		gibbs' [1] 179/19	glad [4] 185/10 197/16 197/19 199/7	
form [13] 17/6 17/7		gibbs' [1] 179/19	glad [4] 185/10 197/16 197/19 199/7	

G	hands-on [1] 143/18	Harvey [8] 51/18 54/1	144/16 144/16 144/25	102/10 103/5 103/8
great [1] 183/20	handwriting [1] 227/10	56/20 56/21 124/9	145/3 145/6 145/12	104/10 104/16 104/21
greater [1] 108/7	handwritten [2] 90/20 104/7	124/23 125/6 144/21	145/14 145/16 145/16	126/23 128/9 134/20
grew [1] 184/3	happen [13] 28/12	has [75] 6/11 20/1	159/18 183/2 183/5	135/5 135/8 137/14
grievance [5] 204/9	38/11 68/19 79/6	33/2 33/6 34/8 38/7	184/10 186/2 186/6	137/17 137/20 137/23
213/2 213/3 213/5	105/1 126/8 128/13	48/14 55/25 63/17	193/3 194/2 196/6	138/9 139/4 139/19
213/10	138/24 143/13 174/14	63/17 67/17 67/18	196/8 196/22 201/9	140/3 140/9 143/3
Griffiths [2] 205/5	189/23 206/18 225/17	74/3 76/20 82/24	225/9 226/17 231/9	143/10 149/18 152/21
205/22	happened [48] 22/11	82/24 90/6 96/4 99/5	231/9 235/19 235/19	154/3 154/5 154/7
group [13] 14/2	28/11 34/10 36/13	101/1 105/25 112/18	236/13 242/13 243/8	154/7 163/4 164/1
18/13 53/8 65/2 77/8	36/25 37/24 44/9	112/19 112/25 120/16	245/10	164/2 173/8 173/11
77/17 78/3 82/19	44/13 48/7 57/14	120/21 120/23 124/5	he'd [3] 22/5 41/7	176/20 176/23 177/1
171/25 192/10 193/13	65/11 79/3 91/22 94/1	126/7 126/8 127/14	183/3	184/1 184/19 185/8
238/12 239/1	98/9 98/11 101/16	131/5 138/15 140/10	he's [10] 4/22 19/22	186/9 197/22 198/12
groups [4] 97/9	103/17 104/23 108/25	150/3 150/7 154/20	19/23 95/9 133/14	200/9 202/2 202/10
169/14 238/6 238/10	110/12 131/5 132/1	157/8 157/25 158/3	133/17 161/22 185/4	204/10 206/3 208/4
growing [4] 44/12	133/22 139/13 140/11	158/24 165/14 169/24	185/10 197/14	208/10 208/11 208/11
50/21 51/7 77/25	143/1 146/25 147/10	178/2 179/10 185/12	head [4] 27/18 52/22	208/13 208/14 208/23
grown [1] 37/21	157/2 185/19 186/14	186/14 187/24 191/13	136/4 203/22	210/15 210/23 211/2
guilt [1] 213/23	189/3 189/6 189/8	200/11 203/13 204/4	heading [3] 27/7	211/5 211/7 211/13
gynaecology [1] 218/1	189/20 193/4 196/7	206/23 211/6 211/22	108/19 114/6	211/18 213/5 213/9
	197/2 197/3 197/12	212/18 212/20 213/9	headmaster's [1] 61/3	213/10 214/2 214/9
	197/14 205/14 213/14	215/4 215/15 218/20	Heads [1] 144/15	214/18 215/9 215/18
	230/25 231/23 233/20	222/11 224/10 228/20	health [7] 2/4 81/23	216/8 216/12 216/20
	239/5	228/21 231/1 231/12	184/1 202/2 213/15	218/12 218/22 218/24
	happening [20] 24/25 34/23 39/1	233/2 233/2 233/15	228/3 242/4	219/5 219/6 219/20
	41/21 52/9 101/18	237/20 239/5 241/10	healthcare [2] 12/14	220/8 220/15 220/22
	104/18 105/3 105/21	245/2 245/15	241/24	221/14 242/25 245/5
	106/6 107/14 118/13	hasn't [4] 76/3	hear [12] 7/10 73/1	here [34] 7/4 11/3
	125/3 126/1 126/6	166/23 228/23 231/2	73/6 121/24 127/20	16/1 30/2 32/22 32/23
	141/24 143/15 178/4	have [407]	141/9 144/19 171/9	45/9 62/9 69/3 69/9
	196/11 197/13	haven't [6] 14/25	172/21 173/6 193/20	69/15 85/21 92/7
	happens [7] 17/8	107/22 126/23 153/24	232/24	97/23 100/7 114/24
	79/10 106/23 125/19	165/16 179/7	heard [20] 2/24 5/12	133/11 133/14 143/13
	155/4 159/17 227/1	having [40] 3/25	7/13 23/7 46/17 49/11	161/23 163/17 164/1
	happy [5] 6/24 6/25	13/25 15/5 22/8 24/17	53/8 63/4 70/14 83/16	166/20 185/16 186/12
	65/6 82/5 171/1	24/18 41/16 54/19	84/8 99/4 105/24	196/12 196/20 197/14
	hard [6] 18/21 29/6	57/6 58/11 63/8 70/1	126/20 126/24 127/10	199/6 199/14 215/21
	29/10 97/7 202/11	72/12 76/1 76/2 85/8	132/23 133/24 144/18	218/19 219/12 231/9
	210/14	85/17 95/11 96/11	185/1	herself [1] 242/16
	harder [1] 26/11	105/6 126/24 127/13	hearing [2] 4/8 28/14	Hey [14] 104/16
	Harkness [7] 20/16	134/9 141/1 141/8	heart [2] 116/6	187/2 214/20 216/24
	21/15 21/22 21/25	142/1 142/22 158/16	155/17	218/25 236/20 236/24
	22/4 67/24 70/11	179/21 180/5 184/20	heat [1] 18/19	241/11 241/15 241/22
	harm [26] 12/20	194/3 201/15 206/2	heavy [1] 128/16	242/15 244/8 244/13
	28/15 44/16 46/6	213/24 216/23 217/23	held [1] 238/22	245/14
	49/23 50/11 54/20	219/3 232/6 244/12	help [16] 3/9 7/17	hide [2] 11/23 147/20
	54/24 59/15 74/4	Hawdon [2] 61/6	27/1 27/12 40/6 41/15	high [9] 28/8 32/24
	86/14 97/18 105/10	63/8	45/24 110/1 121/9	34/17 34/20 34/21
	109/15 126/14 127/9	hawk [1] 200/20	148/10 153/19 186/16	35/23 45/19 45/22
	128/7 128/25 129/1	Hayes [1] 168/5	190/16 211/13 226/10	233/25
	129/2 146/5 158/17	Hayley [1] 205/5	239/23	higher [5] 14/4 33/8
	160/21 177/16 192/1	he [68] 4/5 4/16 10/5	helped [2] 160/1	109/18 146/9 202/20
	237/12	10/8 10/9 22/20 23/1	199/7	highest [1] 79/8
	harmed [3] 13/4	51/21 56/20 56/21	helpful [9] 18/6 18/10	highlight [1] 226/14
	86/14 223/2	56/24 61/21 63/17	101/20 159/20 186/18	highlighted [1] 113/10
	harming [9] 12/10	70/11 70/12 95/8	199/20 223/13 232/17	highly [2] 23/8 148/9
	12/13 12/24 50/18	107/9 121/21 121/24	240/19	Hill [2] 13/2 13/4
	50/24 53/11 77/19	122/7 122/9 124/13	helps [1] 185/24	him [30] 4/20 4/22
	79/19 141/4	124/23 124/24 125/10	her [98] 1/6 1/8 6/11	4/24 10/8 10/11 20/2
	Harold [1] 37/23	130/13 132/4 132/7	20/11 20/19 45/2 55/5	24/20 74/4 78/3
		132/12 133/1 133/14	58/20 59/3 76/5 76/8	121/17 121/20 121/25
		135/18 135/21 136/2	84/9 85/17 93/21	122/1 128/9 130/13
		136/10 144/5 144/7		

<p>H him... [15] 132/25 133/3 136/3 136/5 145/4 145/14 147/5 182/20 183/7 183/7 183/8 185/6 196/16 197/11 200/23 himself [1] 145/6 hindsight [18] 24/19 25/5 31/3 40/12 40/13 91/21 100/18 104/19 105/4 125/12 129/6 129/7 140/19 186/10 202/6 211/3 214/1 219/10 his [22] 4/14 10/14 41/9 47/16 51/17 51/20 51/22 63/20 66/23 72/16 130/1 144/9 149/2 159/25 179/16 179/22 185/2 185/12 236/15 236/18 236/23 236/23 history [1] 153/5 hits [1] 10/23 hoc [2] 215/17 245/17 hold [1] 164/21 holds [1] 32/18 holiday [3] 198/20 203/1 203/2 Holt [4] 83/16 83/21 84/8 84/20 home [7] 16/11 41/9 62/4 87/8 87/11 155/7 218/12 honest [1] 124/21 honestly [2] 95/19 158/15 honorary [6] 215/22 215/25 216/4 216/11 243/7 243/14 hope [6] 21/7 38/5 137/1 199/7 200/23 202/16 hopefully [2] 32/18 64/6 hoping [1] 149/25 hormones [1] 33/20 hospital [40] 2/7 2/23 3/14 7/24 8/11 14/24 15/3 15/5 15/6 15/9 15/19 15/22 16/12 16/19 45/6 46/9 47/21 78/16 87/9 107/21 146/9 150/7 155/8 157/12 168/5 175/8 179/15 180/5 198/22 229/4 231/12 232/22 233/6 238/17 241/11 241/15 242/1 242/2 242/14 243/16 hospital's [2] 15/25</p>	<p>16/21 hospitals [2] 88/17 181/8 hot [4] 169/3 230/2 230/20 231/24 hour [1] 226/12 hours [23] 2/14 16/9 31/19 69/25 70/10 76/14 76/23 88/2 102/7 103/14 114/17 114/18 115/7 133/21 139/11 140/5 140/5 141/2 155/15 178/6 182/25 189/14 189/15 house [1] 243/9 how [82] 3/1 11/9 12/9 17/25 18/20 23/1 27/1 31/4 31/14 31/21 33/11 36/5 36/24 42/2 60/23 61/18 62/5 63/12 73/6 79/9 79/14 85/6 86/14 87/25 91/2 92/9 106/16 119/2 126/5 131/3 134/10 135/10 136/13 138/23 139/13 141/21 142/24 146/24 147/10 148/7 148/11 156/19 156/25 162/17 162/18 163/22 169/6 169/15 175/5 181/1 181/2 183/2 184/19 186/6 186/14 186/20 190/1 191/7 191/11 191/12 195/23 196/6 196/10 196/20 197/12 198/1 198/25 199/1 201/23 202/11 204/3 204/19 207/10 214/5 214/12 214/12 218/21 222/9 230/6 232/2 233/21 238/8 how's [1] 186/2 however [5] 75/5 108/11 147/9 158/12 164/18 Howie [1] 84/9 HR [2] 219/15 243/6 huddle [3] 46/19 46/21 192/11 huge [2] 29/14 85/8 Hurst [10] 136/24 137/1 137/9 138/4 138/8 138/15 138/22 139/4 140/1 141/11 Hurst's [1] 138/17 husband [1] 62/5 hypo [1] 35/12 hypoglycaemia [11] 177/18 177/24 178/16 178/24 224/9 224/15 226/18 226/20 232/14 233/10 233/16 hypoglycemia [4] 34/8 35/24 41/8 72/10</p>	<p>hypoglycemic [3] 32/4 34/14 45/21 hypoxic [2] 116/6 116/8 I I accept [1] 72/15 I actually [3] 133/20 165/18 208/13 I add [1] 138/16 I added [1] 147/1 I agree [3] 83/6 188/7 233/24 I agreed [1] 25/21 I also [5] 9/12 47/19 65/5 161/17 164/3 I am [15] 63/16 84/14 115/12 116/5 118/17 124/21 132/15 134/19 149/4 172/21 215/18 216/2 239/16 241/14 241/19 I apologise [2] 122/15 153/25 I appreciate [4] 71/7 100/9 104/2 229/16 I are [1] 138/1 I arrived [1] 90/8 I ask [5] 1/8 66/4 77/7 168/10 223/12 I asked [3] 56/20 121/17 201/1 I assumed [1] 218/8 I be [1] 65/6 I beg [1] 193/18 I believe [11] 9/10 32/17 54/15 179/1 183/19 193/23 198/19 220/12 232/18 236/17 237/9 I call [1] 167/11 I called [1] 185/18 I came [3] 47/25 49/14 94/16 I can [27] 19/11 22/10 88/11 90/25 98/14 100/17 100/21 102/9 105/18 107/1 108/4 115/10 119/15 120/23 120/25 124/1 125/18 125/18 128/23 145/15 147/3 150/15 177/21 183/20 202/14 209/23 239/21 I can't [21] 19/9 28/7 28/16 35/20 42/15 44/11 44/18 51/19 53/5 73/15 94/14 134/23 135/3 139/8 140/10 151/21 157/15 166/11 203/21 221/10 237/7 I carried [2] 225/5 236/16</p>	<p>I certainly [1] 145/10 I completely [1] 143/11 I continued [1] 64/21 I could [4] 65/8 75/2 110/17 183/4 I couldn't [6] 46/8 84/5 86/25 129/12 144/6 166/10 I deal [1] 232/9 I decided [1] 65/7 I deeply [1] 36/23 I definitely [1] 60/17 I did [15] 39/19 45/21 52/19 53/3 56/18 63/11 90/5 91/19 93/20 99/3 126/3 135/1 195/22 211/15 221/6 I didn't [42] 7/9 24/22 26/10 29/19 50/20 72/11 93/19 101/16 102/3 104/20 104/23 107/13 113/14 120/23 124/21 127/3 127/3 127/13 128/23 128/24 130/24 139/18 142/4 146/25 147/16 147/19 163/22 173/6 186/25 186/25 187/8 197/1 197/3 201/18 201/19 207/20 207/22 211/14 217/23 221/7 225/6 232/24 I disagreed [1] 57/9 I discussed [1] 25/24 I do [13] 4/13 20/5 44/20 51/23 76/1 85/7 115/11 118/20 142/25 155/23 182/9 221/19 239/10 I don't [129] 6/7 7/14 13/4 14/11 14/12 20/12 23/22 29/19 35/15 37/20 41/4 42/24 43/17 44/3 47/18 47/20 48/10 52/22 53/1 62/13 64/13 67/9 71/5 73/10 74/14 78/9 78/13 79/11 79/13 83/6 83/7 83/15 88/10 90/13 92/23 93/18 93/21 94/18 95/20 96/19 97/9 100/17 102/19 102/21 107/6 108/9 110/5 113/12 117/9 117/11 119/10 120/18 122/8 123/23 124/4 125/21 128/5 129/13 131/18 132/3 133/19 134/19 138/20 140/17 142/6 142/23 142/25 143/9 144/8 144/16</p>	<p>146/21 147/19 149/20 149/23 150/15 152/9 154/9 155/10 156/25 157/22 158/14 163/2 167/1 172/1 172/12 172/15 173/2 173/10 174/10 174/25 174/25 176/13 176/24 177/2 177/10 179/6 181/24 190/8 191/24 192/22 197/3 197/17 201/14 201/19 203/4 203/4 204/3 206/20 208/12 209/14 209/20 210/13 220/9 220/19 220/19 220/23 221/6 221/18 221/20 223/16 223/17 224/19 227/23 230/15 231/24 232/2 234/13 235/13 237/2 I email [1] 215/4 I Erica Saunders [1] 241/13 I ever [1] 14/11 I examined [1] 71/2 I explained [1] 231/13 I felt [8] 4/22 23/2 23/25 58/7 61/1 64/4 65/12 140/15 I finished [1] 235/15 I forward [1] 210/16 I found [3] 3/6 62/24 133/14 I fully [1] 240/16 I gather [1] 98/7 I gave [2] 186/17 208/10 I genuinely [1] 64/20 I get [1] 108/13 I go [1] 155/25 I got [3] 92/25 166/21 196/15 I had [33] 3/4 3/6 4/20 5/7 24/15 40/24 48/25 62/23 91/21 91/25 94/12 118/1 121/3 128/14 128/15 133/21 137/14 139/15 140/9 140/20 140/23 142/5 153/4 153/6 183/2 183/7 190/7 192/6 194/25 196/6 197/1 197/17 231/24 I hadn't [10] 71/1 92/22 139/9 140/3 147/3 192/5 192/5 192/7 201/19 234/22 I have [33] 43/14 65/15 77/1 80/11 84/5 90/5 90/23 94/16 94/16 95/22 111/15 115/12 116/7 120/20 122/14 127/15 132/24</p>
--	--	---	--	--

I	I need [2] 110/11 201/6	I stayed [1] 196/24	199/11 199/15 201/15	185/25 186/3 200/20
I have... [16] 137/4	I not [1] 25/23	I still [1] 163/4	206/8 206/11 207/2	210/7 216/12 226/7
148/15 149/22 153/23	I noticed [1] 29/4	I suddenly [1] 143/17	207/21 209/2 211/12	243/18
155/24 156/25 157/15	I obviously [1]	I suggest [1] 209/4	214/23 215/22 215/23	I wish [1] 37/1
162/13 164/14 165/16	141/19	I summarised [1]	216/14 220/24 221/16	I won't [3] 202/16
181/16 212/15 222/2	I only [2] 124/13	218/25	222/4 225/24 226/20	224/7 236/7
235/24 240/14 240/23	236/2	I suppose [1] 166/3	227/3 227/7 227/13	I wonder [3] 65/16
I haven't [6] 14/25	I perceived [1]	I suspect [3] 194/8	230/3 232/21 233/5	171/6 200/16
107/22 126/23 153/24	162/18	194/15 229/21	233/20 235/17 239/8	I wondered [1] 166/4
165/16 179/7	I picked [1] 184/2	I tell [1] 66/16	240/5	I worry [1] 63/17
I helped [1] 199/7	I presume [1] 206/14	I tend [1] 107/1	I thought [12] 24/20	I would [38] 6/19 7/1
I honestly [1] 95/19	I presumed [4] 187/1	I then [1] 236/20	25/20 40/25 50/2 76/4	8/20 15/25 26/24 29/9
I hope [4] 21/7 38/5	187/8 198/15 225/17	I think [190] 3/11	87/20 87/23 91/15	47/20 48/10 61/12
137/1 202/16	I probably [7] 48/2	4/24 6/20 7/19 8/12	104/8 142/7 186/18	61/14 61/15 65/6 65/8
I imagine [1] 222/15	52/8 92/1 121/2	13/3 14/11 15/15	198/18	75/10 82/23 112/22
I interpreted [1]	125/12 139/10 140/19	15/18 15/22 18/11	I took [2] 122/6	118/23 123/9 129/20
36/24	I processed [1]	22/13 23/23 27/2	207/17	131/21 139/17 142/7
I invite [1] 122/16	125/14	27/14 31/25 33/22	I understand [4]	142/12 144/11 145/18
I just [31] 24/10 26/2	I promise [1] 24/12	41/14 41/19 41/21	94/19 158/18 184/3	157/4 157/6 158/15
36/21 46/4 52/25	I provided [1] 222/6	43/4 43/14 44/8 45/3	218/20	160/18 162/18 168/22
60/11 60/20 64/2	I put [1] 126/13	46/1 47/15 47/25 48/2	I understood [4] 52/1	180/7 180/10 220/10
76/20 77/10 81/18	I raised [1] 47/17	48/8 49/6 51/4 52/8	66/10 197/7 221/8	226/10 229/24 232/1
94/25 105/17 108/18	I recall [3] 72/12	54/25 58/14 60/9	I very [1] 62/2	232/12
121/23 126/19 128/20	169/15 205/9	60/10 60/13 63/23	I want [5] 30/22	I wouldn't [8] 90/25
134/20 135/7 136/4	I recognised [1]	64/21 66/13 67/20	107/2 152/7 161/18	94/12 94/13 157/1
136/4 136/10 142/23	104/17	70/25 71/20 72/14	212/11	172/1 179/25 180/9
143/12 144/14 164/22	I recounted [1] 164/1	76/5 77/22 78/24 83/3	I wanted [4] 4/2	228/18
165/4 208/14 222/24	I regret [1] 32/16	83/10 83/21 84/20	46/10 139/17 140/23	I'd [25] 3/3 4/4 12/11
234/11 237/19	I rejected [1] 40/9	85/6 85/9 85/16 87/4	I was [72] 12/22	14/19 23/22 37/1
I knew [7] 26/8 94/15	I remember [10]	87/24 88/14 90/5	12/25 13/3 13/5 19/6	41/19 46/6 54/22 64/8
94/17 131/24 166/7	60/15 83/9 85/3 110/8	90/20 91/3 91/14	19/9 23/1 23/23 31/5	87/17 88/21 126/4
179/18 186/6	119/12 133/7 134/19	91/21 91/25 92/19	37/25 42/24 43/5 44/8	133/5 135/17 139/3
I know [15] 15/1 25/6	135/23 144/3 172/23	92/23 93/15 94/9 97/8	44/8 46/3 49/5 66/13	141/17 141/17 148/22
47/15 53/3 55/23	I remembered [1]	97/13 98/6 98/9 98/12	82/10 86/24 93/24	153/3 184/2 207/2
72/11 93/21 108/12	203/9	100/15 101/12 101/19	94/10 94/11 104/18	213/14 220/9 226/9
116/7 126/9 129/20	I remind [1] 175/19	102/2 102/9 102/24	110/16 118/16 125/13	I'd had [1] 220/9
129/20 147/1 221/12	I returned [1] 53/6	103/14 104/17 104/21	130/24 131/24 132/5	I'd left [1] 207/2
222/12	I reviewed [1] 76/5	104/22 106/18 107/7	139/13 140/11 140/19	I'd reviewed [1]
I learned [1] 92/24	I said [13] 62/22	107/9 107/24 109/3	146/21 147/2 147/4	153/3
I left [3] 120/9 121/3	110/17 115/10 122/1	109/8 109/15 111/9	147/20 160/20 160/22	I'll [14] 24/12 29/13
206/11	122/8 133/8 133/10	116/9 118/2 118/4	160/23 162/15 168/25	84/6 88/15 93/5 136/8
I looked [1] 180/5	133/16 163/25 163/25	118/9 118/14 118/16	174/11 180/8 182/18	137/10 143/16 145/1
I lost [1] 65/12	164/2 165/13 232/17	118/18 119/13 120/3	183/8 184/14 190/8	154/14 154/20 166/20
I made [2] 40/17	I sat [1] 134/23	121/14 124/25 125/12	191/10 192/4 193/11	208/20 227/17
201/1	I saw [3] 29/19 103/8	126/16 127/22 128/12	194/24 195/24 195/25	I'm [103] 2/21 6/3 7/4
I may [6] 100/15	143/10	128/12 129/11 129/19	197/16 197/18 197/19	8/20 12/4 26/14 27/5
118/21 144/14 177/9	I say [1] 45/16	130/20 131/18 132/2	202/2 203/4 206/8	28/1 28/2 32/22 33/22
207/3 223/18	I see [2] 186/18	133/1 133/15 134/22	206/10 206/20 208/10	40/12 43/9 45/4 45/7
I mean [19] 4/12 6/1	222/14	135/15 135/25 139/3	209/14 210/22 213/17	48/14 55/19 60/17
36/3 67/14 71/4 72/18	I sent [1] 211/12	139/7 143/10 145/9	213/17 219/8 220/19	62/9 65/24 67/20 69/3
73/12 94/14 96/6	25/11/12	146/22 147/11 147/13	221/12 224/23 225/4	73/15 81/16 82/3
98/14 100/17 107/20	I should [13] 25/14	148/15 148/16 149/6	241/4	84/14 87/12 88/10
112/2 116/1 120/17	25/22 51/2 64/10	153/20 153/23 154/12	I wasn't [17] 4/23	89/16 91/23 94/10
127/25 131/21 141/25	65/13 66/14 72/15	155/9 159/3 159/13	46/9 46/23 49/2 53/5	94/17 95/12 95/22
176/23	72/24 75/7 140/21	160/17 160/23 161/3	98/9 101/17 113/14	97/18 97/23 98/16
I meant [1] 180/2	147/12 195/25 215/14	163/25 165/9 165/12	140/7 140/22 160/24	99/16 102/3 107/3
I might [1] 120/18	I shouldn't [1] 211/9	166/17 168/12 168/14	165/13 179/13 179/19	107/16 110/19 113/25
I misheard [1] 165/6	I sorry [1] 225/11	169/24 171/8 172/19	207/19 213/18 222/5	115/14 123/6 136/1
I missed [1] 170/17	I sort [2] 18/17 133/6	172/22 173/1 173/16	I went [5] 62/4	136/20 137/12 139/16
I misunderstood [1]	I spent [1] 197/4	173/20 178/8 182/24	101/13 134/18 139/11	144/16 148/21 149/25
165/11	I spoke [4] 25/19	183/2 183/17 184/2	208/10	151/22 152/1 152/2
I must [2] 46/1	137/8 138/20 139/12	185/14 190/15 191/15	I were [2] 22/10 62/6	152/14 152/20 154/9
173/13	I start [1] 183/16	192/22 193/24 194/5	I will [11] 111/11	157/5 157/5 157/6
	I started [1] 181/20	195/16 197/4 199/2	137/5 139/19 178/5	157/15 157/22 159/5

<p>I</p> <p>I'm... [39] 160/20 160/22 165/8 166/7 173/17 174/25 176/21 176/22 176/24 180/3 181/6 185/4 186/22 189/25 189/25 190/1 190/6 190/6 190/21 191/15 191/20 193/1 194/1 194/1 199/7 200/8 203/7 203/16 206/20 207/14 207/15 209/12 209/13 222/7 222/7 228/13 228/20 231/12 233/12</p> <p>I'm afraid [1] 73/15</p> <p>I's [8] 42/20 42/22 43/23 104/3 105/6 106/13 117/2 117/7</p> <p>I've [51] 6/10 9/12 16/24 27/14 32/19 32/21 35/6 37/20 38/5 50/14 64/18 88/14 90/6 90/20 90/22 97/7 97/7 102/17 102/19 102/24 102/24 104/6 104/9 104/14 106/18 107/22 113/11 126/3 130/20 137/10 138/14 138/21 138/22 141/12 141/13 155/23 165/15 166/19 185/1 186/5 186/13 200/7 208/18 214/15 214/17 222/4 227/4 229/1 229/21 229/22 230/4</p> <p>I've explained [1] 106/18</p> <p>I've since [1] 208/18</p> <p>Ian [7] 51/18 54/1 56/20 124/9 124/23 125/6 144/21</p> <p>Ian Harvey [7] 51/18 54/1 56/20 124/9 124/23 125/6 144/21</p> <p>idea [8] 26/9 36/11 36/21 58/10 106/19 140/15 141/10 158/16</p> <p>ideal [1] 107/19</p> <p>identifiable [1] 56/14</p> <p>identification [1] 80/20</p> <p>identified [16] 97/1 99/20 113/2 113/23 115/19 115/24 116/17 117/15 117/25 120/6 122/3 123/18 149/17 161/4 161/8 172/12</p> <p>identifies [1] 242/22</p> <p>identify [6] 60/6 91/1 111/17 118/12 118/18 183/4</p> <p>ie [4] 113/9 243/5</p>	<p>243/19 245/2</p> <p>if [238] 3/6 6/25 7/12 9/20 9/25 10/16 12/9 12/12 12/14 13/20 14/1 16/1 17/17 17/21 18/6 19/11 19/13 20/13 24/20 26/19 26/25 27/6 33/22 33/23 36/5 36/16 39/17 40/24 40/25 41/3 41/10 41/17 47/23 49/18 50/14 52/4 56/20 59/1 59/11 62/2 62/6 63/17 64/5 64/21 65/9 65/12 65/16 67/15 69/2 69/6 69/22 74/2 74/20 75/13 78/10 79/9 79/18 79/23 80/1 83/4 85/1 86/16 87/14 88/9 88/10 88/11 88/11 89/3 90/12 91/21 91/23 91/25 94/20 95/2 95/11 95/24 96/9 97/17 97/18 98/14 100/1 100/17 101/20 101/23 102/9 102/22 102/22 104/10 106/5 107/2 107/14 108/25 109/7 109/10 109/14 111/10 114/5 116/23 117/13 118/17 118/21 119/1 119/4 120/1 120/21 122/20 123/8 124/21 125/2 126/19 128/14 131/15 134/23 139/3 139/4 139/9 139/15 139/24 140/9 140/19 142/6 143/1 144/16 145/14 145/19 145/22 146/13 149/20 151/12 152/13 152/16 154/13 155/12 156/11 156/21 157/3 157/10 157/18 160/9 160/19 160/20 165/20 166/18 166/20 167/7 167/15 171/6 171/24 173/23 174/5 174/15 174/18 175/23 176/25 177/7 178/3 178/6 178/9 178/13 178/16 179/7 180/15 180/19 183/4 183/12 183/20 184/8 184/14 184/18 184/24 185/7 185/16 185/25 186/6 186/23 189/12 195/8 197/21 198/5 199/3 199/25 200/7 200/16 200/21 201/4 202/4 202/9 202/11 202/12 203/11 203/14 203/21 204/12 204/18 205/17 205/20 207/2</p>	<p>207/5 207/24 208/16 208/24 209/22 210/5 211/20 212/19 213/20 215/2 215/20 217/4 218/13 218/16 218/17 219/15 220/9 222/13 223/25 225/9 225/21 226/8 226/9 226/13 226/14 227/5 227/12 228/10 229/7 229/14 231/21 232/15 233/17 234/16 235/6 238/10 238/16 241/1 241/4 243/2 243/18</p> <p>ignored [1] 64/19</p> <p>ill [1] 15/21</p> <p>image [1] 236/22</p> <p>images [1] 229/23</p> <p>imagine [1] 222/15</p> <p>immediate [2] 96/22 233/11</p> <p>immediately [5] 28/18 47/12 109/16 137/23 226/5</p> <p>impact [1] 172/8</p> <p>imperative [1] 240/3</p> <p>implicate [1] 127/4</p> <p>implicated [1] 128/6</p> <p>implicit [1] 26/14</p> <p>implied [1] 13/19</p> <p>implies [1] 138/18</p> <p>implying [3] 127/17 138/1 138/9</p> <p>importance [1] 34/12</p> <p>important [14] 7/24 11/18 26/15 30/17 31/22 31/22 34/10 54/7 58/14 71/10 73/16 118/21 121/24 132/17</p> <p>impossible [4] 36/23 37/12 40/4 46/8</p> <p>impressed [1] 185/11</p> <p>impression [4] 7/6 7/9 145/17 210/20</p> <p>imprinted [1] 139/8</p> <p>improve [2] 61/18 104/24</p> <p>improved [1] 91/16</p> <p>improvement [1] 61/16</p> <p>improving [1] 90/17</p> <p>inadvertently [1] 232/7</p> <p>inappropriate [6] 58/5 135/7 162/14 163/5 187/14 239/9</p> <p>incident [7] 17/8 98/8 98/12 98/16 100/25 142/12 164/2</p> <p>incidents [7] 12/2 17/11 89/3 89/8 147/2 163/7 164/4</p>	<p>include [1] 209/5</p> <p>included [7] 8/16 19/18 115/18 123/5 137/10 147/3 147/12</p> <p>including [4] 66/5 141/7 168/19 243/22</p> <p>incompetence [3] 54/20 55/7 206/5</p> <p>inconsistent [2] 29/24 70/23</p> <p>incorrect [1] 191/18</p> <p>increase [7] 18/20 41/20 42/4 54/15 57/3 57/4 69/23</p> <p>increased [4] 49/1 57/17 69/22 153/17</p> <p>increasingly [1] 30/8</p> <p>incredible [1] 79/12</p> <p>indeed [12] 27/23 77/3 80/14 80/16 81/21 96/16 103/21 154/1 161/6 165/3 166/13 246/6</p> <p>indicate [2] 25/10 232/6</p> <p>indicated [1] 59/21</p> <p>indication [1] 228/12</p> <p>indictment [3] 99/18 110/7 173/18</p> <p>individual [1] 128/16</p> <p>individually [2] 97/8 145/9</p> <p>induction [1] 190/7</p> <p>infection [12] 75/20 76/3 76/24 91/6 91/10 103/3 104/22 158/7 158/9 189/12 228/17 228/18</p> <p>inflammatory [1] 185/3</p> <p>inflicted [2] 105/10 158/17</p> <p>inform [1] 87/20</p> <p>informal [5] 85/24 174/18 175/10 176/13 244/17</p> <p>informally [1] 193/14</p> <p>information [39] 20/8 29/7 55/16 56/10 61/14 64/6 67/4 101/19 125/14 131/2 132/2 133/21 139/17 142/4 145/3 148/10 160/24 165/15 187/1 187/5 187/11 192/12 192/17 192/21 199/20 205/1 206/22 208/3 208/11 214/11 216/18 219/24 221/22 223/1 225/14 227/15 239/23 240/17 240/18</p> <p>informed [6] 78/18 78/22 124/25 193/4 243/2 243/13</p>	<p>infrequently [1] 38/18</p> <p>initial [6] 135/19 181/14 181/17 209/7 221/16 242/17</p> <p>initially [5] 60/2 64/19 83/20 83/23 150/3</p> <p>initiated [1] 226/23</p> <p>INQ [1] 99/17</p> <p>INQ0000698 [1] 149/25</p> <p>INQ0000194 [1] 69/2</p> <p>INQ0000569 [2] 183/13 208/17</p> <p>INQ0000698 [1] 154/15</p> <p>INQ0000859 [2] 32/15 35/4</p> <p>INQ0001169 [1] 223/15</p> <p>INQ0001445 [1] 208/25</p> <p>INQ0003190 [1] 112/23</p> <p>INQ0003217 [1] 113/22</p> <p>INQ0003250 [1] 16/4</p> <p>INQ0003251 [1] 123/10</p> <p>INQ0005121 [1] 205/19</p> <p>INQ0005445 [1] 99/17</p> <p>INQ0005890 [1] 45/10</p> <p>INQ0006078 [1] 63/14</p> <p>INQ0006458 [1] 55/20</p> <p>INQ0008605 [1] 145/20</p> <p>INQ0010269 [1] 152/12</p> <p>INQ0012016 [1] 26/25</p> <p>INQ0017868 [1] 9/21</p> <p>INQ0025743 [2] 19/12 95/1</p> <p>INQ0100851 [1] 218/13</p> <p>INQ01078321 [1] 217/4</p> <p>INQ0107841 [1] 215/20</p> <p>INQ0107842 [1] 216/21</p> <p>INQ01078440001 [1] 215/3</p> <p>Inquest [3] 209/3 210/1 210/25</p> <p>Inquiries [1] 241/19</p> <p>inquiry [26] 1/18 14/22 15/1 32/18</p>
--	--	--	---	---

I	183/6	181/13 182/10 199/1 206/4 210/7 236/4	158/2 158/2 159/7 159/10 159/23 162/7 171/9 177/22 178/4 183/12 185/7 185/20 186/14 198/23 198/24 202/12 203/21 205/13 205/19 209/2 210/5 210/5 212/19 214/15 224/20 228/7 229/10 231/13 231/21 235/24	115/9 125/25 136/21 142/13 142/25 149/1 150/2 163/11 163/20 164/6 164/9 164/21 183/17 183/18 183/21 194/14 199/5 201/5 June 2015 [1] 18/23 June 2016 [2] 183/17 183/21 junior [26] 3/4 3/19 3/20 3/24 4/1 4/5 4/6 7/1 11/15 11/17 45/25 49/7 168/19 169/1 169/2 169/19 169/21 175/11 175/12 181/11 193/21 224/19 224/20 225/1 226/8 231/1
inquiry... [22] 55/25 57/1 73/1 73/6 77/23 81/6 94/7 94/9 96/4 105/25 108/19 112/18 113/13 129/8 157/8 164/23 167/19 176/6 187/24 237/20 241/10 246/9	interventions [1] 218/10	involvement [9] 42/23 98/17 101/14 173/17 182/4 182/7 182/15 182/15 194/21	items [2] 209/13 209/15	juniors [3] 129/17 129/18 132/5
insight [1] 210/23	into [37] 8/3 9/1 44/6 46/24 47/20 49/4 57/18 57/22 61/3 61/10 70/9 84/6 87/12 90/25 91/2 95/22 98/8 104/6 112/10 112/16 115/12 127/1 134/13 141/1 150/9 152/7 155/4 157/12 188/18 190/14 193/5 193/5 196/12 207/20 210/23 222/25 228/23	IOs [1] 209/8	its [3] 68/21 101/1 224/15	just [243] 3/9 7/17 7/23 8/20 9/20 9/25 11/3 12/2 13/16 15/25 16/3 18/9 19/11 20/20 21/6 21/9 21/24 22/6 23/4 23/6 23/12 23/16 24/10 24/11 24/23 26/2 26/24 26/25 27/12 28/2 28/17 29/1 29/6 29/8 29/10 29/13 30/2 31/14 31/14 32/14 35/3 36/12 36/21 36/22 37/2 37/4 37/11 37/23 39/16 40/6 40/10 41/15 43/14 45/8 45/9 46/4 47/22 51/7 52/25 54/22 55/19 55/20 60/11 60/20 60/22 63/12 63/16 64/2 64/8 64/14 64/15 64/16 65/20 75/13 76/7 76/20 77/10 77/10 78/7 79/12 81/18 82/23 83/22 83/22 85/12 85/22 88/11 88/15 89/7 89/8 92/21 93/5 93/9 93/12 94/25 95/24 97/23 98/14 99/17 100/10 100/13 100/22 101/10 102/17 103/25 105/13 105/17 106/16 108/1 108/18 109/17 110/1 112/22 115/16 116/5 118/20 118/23 119/1 119/2 119/14 119/19 120/11 121/4 121/9 121/23 122/16 123/10 126/19 127/23 128/20 128/23 132/22 133/7 133/9 133/13 134/8 134/20 135/2 135/6 135/7 136/1 136/4 136/4 136/8 136/10 137/5
insofar [3] 102/6 169/14 236/10	intestines [1] 68/21	irrelevant [1] 153/5	IUGR [1] 116/11	
inspection [1] 58/4	intimidating [1] 144/23	irrespective [1] 16/11	J	
instance [1] 186/5	introduced [1] 145/6	is [401]	Jackie [1] 3/11	
instead [1] 203/14	intubate [1] 183/7	is May 2017 [1] 216/25	Jackie Blundell [1] 3/11	
instruction [1] 195/11	intubated [1] 90/9	Isaac [2] 85/4 85/7	jaded [2] 63/16 63/21	
insufficient [1] 39/5	intubation [1] 184/14	Isaacs [1] 84/9	Jameson [3] 10/2 10/3 10/18	
insulin [43] 12/23 13/2 13/5 32/23 33/2 33/5 33/5 33/20 34/16 34/19 35/1 35/23 36/6 36/6 36/9 36/22 38/22 38/23 39/23 45/22 45/23 48/17 71/23 73/1 73/8 74/3 74/10 75/4 99/5 99/7 124/7 179/1 179/16 180/23 231/20 232/6 232/10 232/17 233/18 233/24 234/3 235/3 245/7	invasive [2] 15/16 15/23	ischemic [2] 116/6 116/8	Jan [1] 216/10	
insult [1] 82/20	inventory [1] 174/3	isn't [25] 23/12 39/9 56/11 67/15 68/11 68/14 70/19 71/10 71/15 71/15 88/1 101/3 127/25 130/22 159/8 183/23 189/13 189/18 198/3 198/23 211/23 227/7 236/3 240/3 240/8	Jan/Feb [1] 216/10	
intended [1] 240/18	investigate [3] 91/17 108/16 160/16	isolation [1] 23/13	January [9] 9/23 10/12 60/10 60/15 113/5 143/22 222/4 242/8 244/1	
intensity [2] 196/19 196/21	investigated [3] 63/10 149/15 191/13	Issac [8] 84/19 84/21 85/1 85/1 85/2 85/13 85/14 85/22	jaundiced [1] 228/21	
intensive [5] 44/24 109/11 187/2 215/6 216/7	investigating [2] 108/20 149/8	issue [12] 17/18 17/22 25/21 25/22 33/16 40/23 74/9 75/5 85/6 85/6 85/22 216/12	Jayaram [18] 2/25 40/21 43/24 62/21 64/22 106/1 126/17 127/20 127/21 128/8 128/10 169/7 193/23 213/8 226/15 231/7 235/7 235/17	
intention [1] 239/24	investigation [5] 29/21 82/15 142/3 151/20 234/4	issued [2] 243/23 244/9	jigged [1] 100/20	
intentions [1] 26/13	investigations [9] 25/17 36/2 100/25 177/24 183/4 189/11 226/18 226/21 236/17	issues [8] 3/6 7/13 7/23 8/16 8/18 47/8 97/17 111/3	Jo [1] 3/12	
interact [1] 162/19	investigative [1] 58/6	it [650]	Jo Moore [1] 3/12	
interactions [5] 28/1 161/19 238/3 238/25 239/2	investigatory [1] 150/8	it rung [1] 9/18	job [10] 4/3 49/6 62/1 62/3 62/6 64/20 65/12 138/10 203/21 204/19	
interest [2] 215/8 242/23	invite [1] 122/16	it's [95] 18/20 19/15 22/10 22/14 22/25 25/5 27/2 27/16 29/23 31/21 32/15 34/9 34/10 35/7 36/2 38/7 38/17 43/6 49/18 50/2 53/1 57/24 58/14 59/20 60/13 63/14 68/20 71/17 72/21 72/21 73/16 73/22 74/6 78/24 86/16 87/25 87/25 90/13 98/23 102/11 107/20 108/15 111/11 113/6 113/12 114/11 117/14 124/22 126/12 132/17 132/17 134/15 145/23 147/22 152/14 153/8 153/8 154/13 154/15 155/10 156/3 156/6 156/14 158/1 158/1	jobs [1] 13/20	
interesting [1] 208/21	invited [1] 207/25	it's [95] 18/20 19/15 22/10 22/14 22/25 25/5 27/2 27/16 29/23 31/21 32/15 34/9 34/10 35/7 36/2 38/7 38/17 43/6 49/18 50/2 53/1 57/24 58/14 59/20 60/13 63/14 68/20 71/17 72/21 72/21 73/16 73/22 74/6 78/24 86/16 87/25 87/25 90/13 98/23 102/11 107/20 108/15 111/11 113/6 113/12 114/11 117/14 124/22 126/12 132/17 132/17 134/15 145/23 147/22 152/14 153/8 153/8 154/13 154/15 155/10 156/3 156/6 156/14 158/1 158/1	joined [2] 8/16 197/6	
interests [2] 10/10 111/7	involve [2] 78/12 86/16	it's [95] 18/20 19/15 22/10 22/14 22/25 25/5 27/2 27/16 29/23 31/21 32/15 34/9 34/10 35/7 36/2 38/7 38/17 43/6 49/18 50/2 53/1 57/24 58/14 59/20 60/13 63/14 68/20 71/17 72/21 72/21 73/16 73/22 74/6 78/24 86/16 87/25 87/25 90/13 98/23 102/11 107/20 108/15 111/11 113/6 113/12 114/11 117/14 124/22 126/12 132/17 132/17 134/15 145/23 147/22 152/14 153/8 153/8 154/13 154/15 155/10 156/3 156/6 156/14 158/1 158/1	joint [1] 97/14	
internal [5] 16/7 68/11 78/17 79/25 153/10	involved [44] 15/17 15/17 15/18 18/24 19/9 30/24 41/2 43/23 44/4 44/10 46/2 52/14 53/5 53/20 53/25 54/9 55/6 55/15 75/8 85/14 85/15 89/18 94/13 104/2 106/2 106/13 107/8 108/25 111/22 114/21 117/2 129/22 149/3 149/7 149/8 150/13 151/13 159/24	judgment [1] 104/20	jolliness [1] 162/14	
interpret [1] 48/17		July [16] 54/9 55/15 96/17 96/20 142/19 168/4 171/12 171/18 204/12 205/11 205/15 205/19 206/2 209/10 209/11 209/25	judgment [1] 104/20	
interpretation [3] 167/6 231/3 235/8		July 2018 [1] 168/4	July [16] 54/9 55/15 96/17 96/20 142/19 168/4 171/12 171/18 204/12 205/11 205/15 205/19 206/2 209/10 209/11 209/25	
interpreted [3] 36/24 37/1 230/7		jump [2] 8/20 45/10	jumping [1] 85/21	
interpreting [2] 33/17 34/12		June [36] 7/6 18/23 19/16 20/20 45/13 52/21 53/20 81/7 82/11 85/23 89/17 89/19 95/2 97/2 97/24 98/23 100/6 105/14	June [36] 7/6 18/23 19/16 20/20 45/13 52/21 53/20 81/7 82/11 85/23 89/17 89/19 95/2 97/2 97/24 98/23 100/6 105/14	
intervened [1] 143/16				
intervention [1]				

J	139/3 158/8 192/20 235/4	81/10 96/24 110/25 173/3 181/1	245/12	legal [1] 241/18
just... [97] 137/12	knew [30] 10/4 10/11 12/23 26/8 29/20 49/7	knowledgeable [1] 58/10	late [2] 184/6 190/14	legible [1] 33/12
138/25 139/20 140/4	50/6 59/2 92/3 94/15	known [15] 91/21	later [43] 4/8 29/5	legitimate [2] 162/24 163/2
140/7 140/10 140/13	94/17 131/15 131/24	94/12 94/13 94/20	29/20 37/22 59/16	length [2] 168/24
141/11 141/25 142/23	131/25 132/7 141/17	101/20 116/4 117/22	60/17 64/19 72/14	233/18
143/12 143/13 143/20	141/19 146/7 160/13	151/18 166/6 186/23	76/23 85/7 101/14	lesions [1] 228/8
144/11 144/14 145/1	166/7 179/18 186/6	187/5 187/7 198/25	103/22 114/17 114/18	less [14] 8/13 11/20 11/25 25/12 25/13
145/5 145/19 146/23	191/12 197/9 197/12	220/10 242/6	114/24 115/7 124/14	31/6 32/17 57/24 65/3
147/21 147/21 148/1	203/2 207/19 211/7	knows [2] 148/3	125/22 133/1 134/23	75/23 76/16 76/24
148/25 152/1 152/18	211/10 221/14	202/11	139/12 141/2 147/1	166/19 185/2
152/24 153/9 153/11	know [146] 4/12 5/20	L	147/2 147/17 149/2	lesser [1] 31/5
153/11 154/10 154/20	6/7 6/17 8/2 15/1	L's [5] 48/17 225/5	155/15 167/4 174/7	lesson [1] 159/3
154/23 155/23 157/6	15/24 25/6 27/16 32/4	225/9 229/10 229/15	178/23 179/9 179/23	let [8] 19/11 75/11
157/23 158/25 160/11	33/18 35/17 37/20	La [11] 1/3 1/16	180/2 180/2 182/24	76/7 137/10 139/19
160/22 163/5 164/2	40/13 41/3 47/15	80/10 81/2 122/25	183/10 192/22 221/10	164/19 180/6 243/18
164/17 164/18 164/19	48/15 52/21 52/22	152/3 165/3 166/22	221/19 226/24 232/19	let's [8] 35/3 73/20
164/22 165/4 165/17	53/3 53/19 55/15	167/6 247/3 247/7	232/20 243/6	99/17 113/21 123/10
166/20 166/24 167/15	55/21 55/23 58/3	lab [4] 38/10 39/4	latest [3] 49/11 49/18	149/24 167/6 223/20
171/7 171/25 172/11	58/12 58/23 61/17	231/17 232/22	49/21	Letby [94] 5/10 5/14
174/11 175/6 175/24	62/12 65/15 72/11	laboratories [1]	latter [2] 192/24	11/12 13/18 28/22
177/22 183/16 183/21	73/12 74/14 78/13	231/22	193/23	29/11 44/21 50/18
184/20 185/10 186/2	79/11 79/13 83/7 85/7	laboratory [4] 32/8	Lavender [2] 134/14	53/11 54/18 54/24
190/14 192/18 194/6	88/10 92/10 92/13	73/4 74/24 74/25	164/4	58/8 58/15 59/11
196/6 200/23 203/13	93/6 93/18 93/19	labour [5] 71/5 170/6	Lavender Suite [1]	59/14 65/9 77/11
203/15 204/7 206/21	93/21 97/9 100/17	170/10 170/15 225/3	164/4	77/19 82/14 82/18
208/14 211/22 213/22	100/19 102/19 102/21	lack [6] 50/9 50/22	lawyers [1] 163/3	108/20 109/10 113/15
216/9 217/10 217/13	105/14 107/6 108/9	97/5 97/10 170/21	lead [9] 2/25 2/25	119/22 120/2 122/4
218/17 222/24 223/13	108/12 109/9 109/13	172/10	91/10 98/10 107/1	126/25 127/11 127/21
223/21 225/10 226/13	111/6 113/12 116/7	Lady [29] 1/4 65/16	111/13 215/13 215/14	128/9 132/16 132/23
226/14 226/14 227/17	120/19 122/2 123/6	77/1 80/8 80/11 80/18	241/19	133/11 134/10 134/18
227/21 228/3 228/13	123/13 125/2 126/3	102/22 122/14 122/16	leader [3] 44/24	141/3 142/15 142/18
229/21 233/12 234/11	126/9 127/23 128/14	123/1 148/16 161/11	109/6 186/4	161/19 161/25 163/1
234/19 237/19 238/8	128/22 129/20 129/20	161/16 164/14 164/17	leader's [1] 109/14	163/8 163/24 164/7
238/23 240/2 241/1	134/19 134/20 135/4	165/1 166/23 167/2	leaders [1] 64/23	164/12 171/12 172/3
JUSTICE [2] 165/1	140/17 142/7 142/18	167/3 167/11 175/18	leading [2] 83/8	172/9 172/24 173/14
247/10	144/10 144/16 145/5	195/17 217/12 222/11	89/12	182/11 182/19 183/16
K	147/1 147/13 147/16	240/21 240/23 241/9	leads [1] 134/12	183/18 184/1 186/5
Karen [5] 211/22	147/19 149/4 156/24	246/4 247/10	learned [1] 92/24	197/20 200/3 201/5
211/24 212/18 216/15	163/2 163/22 164/19	laid [1] 134/16	learning [6] 61/16	202/25 206/2 206/6
219/3	167/1 167/24 172/1	Lambie [10] 20/1	107/4 182/7	206/25 207/18 207/24
Karen Reece [1]	172/13 172/15 172/25	20/10 46/18 93/19	least [13] 5/14 20/21	209/23 212/1 215/7
216/15	173/10 174/10 174/25	93/20 95/9 154/17	78/16 98/7 107/16	219/5 219/9 219/19
keen [2] 66/13	175/1 176/5 176/20	156/4 157/25 192/9	118/15 127/18 144/7	219/25 220/15 220/17
193/14	176/23 176/24 176/25	Lambie's [2] 154/12	175/18 176/10 178/11	221/1 221/11 221/13
keep [12] 81/18	178/3 179/9 186/25	154/14	187/4 239/15	221/18 237/16 240/13
139/17 144/9 144/11	186/25 187/16 189/2	Lamont [6] 214/24	leave [16] 19/14 46/4	242/6 242/13 242/16
146/22 147/5 171/7	189/6 189/7 189/8	215/4 215/11 215/19	47/19 48/24 53/4	242/22 243/2 243/5
194/6 194/7 197/11	189/22 190/25 193/2	217/18 242/21	58/15 77/14 120/23	243/7 243/13 243/23
204/14 207/18	193/3 193/6 193/7	LANGDALE [6]	120/24 143/3 154/5	244/4 244/7 244/25
keeping [1] 101/10	193/14 194/10 197/3	167/14 167/17 229/16	166/19 198/2 205/17	245/3 245/13
Kelly [4] 51/18	197/11 197/20 201/14	234/13 237/15 247/12	225/7 226/5	Letby's [16] 49/11
124/10 124/24 125/7	201/18 201/25 201/25	large [5] 19/14	leaves [1] 167/2	54/16 113/2 113/10
kept [4] 31/19 52/4	202/19 203/6 209/22	183/22 190/15 200/12	leaving [4] 20/14	127/2 134/4 141/7
65/24 186/24	210/13 213/3 220/7	200/16	120/12 133/14 164/1	162/10 206/1 209/16
killer [5] 219/20	220/19 221/4 221/7	largely [1] 213/15	left [20] 7/12 46/18	243/8 243/22 244/17
220/22 220/24 220/25	221/12 221/18 221/19	121/12 121/13 121/13	47/11 72/15 84/5	245/12 245/21 246/1
221/2	221/20 222/12 222/13	121/14 162/5 183/6	100/2 120/9 120/11	letter [15] 63/18 64/4
killing [1] 50/24	231/24 232/2 243/18	192/9 202/12 214/16	120/14 120/21 121/3	146/16 216/12 217/1
Killingback [1]	knowing [3] 73/10	240/15 245/12	122/9 126/19 133/2	217/5 219/13 221/13
218/18	170/15 170/18	last August [1]	152/16 154/7 206/11	221/19 221/20 243/14
kind [9] 13/6 17/12	knowledge [9] 1/22		206/13 207/2 207/5	243/23 244/6 244/9
29/6 91/12 126/12	13/6 37/21 37/22		left-hand [1] 100/2	244/14

L	221/14	205/24 229/15 233/8	40/17 49/3 56/1 57/11	231/21 244/22
letters [1] 63/5	linked [1] 23/22	236/13 236/19 236/21	58/1 58/19 66/8 73/3	March [9] 42/8 42/25
level [24] 24/24 28/8	linking [1] 43/17	looking [41] 12/15	79/21 106/15 109/5	48/22 49/2 113/20
28/22 29/17 31/15	list [6] 9/25 17/11	18/5 19/24 20/20	109/8 113/21 123/25	123/4 124/3 245/4
32/23 32/24 33/9	113/24 175/19 218/19	37/25 39/18 43/10	126/4 127/4 127/16	245/7
33/17 33/18 34/4 34/6	244/5	44/25 45/11 46/19	129/12 129/19 138/22	March 2016 [1] 42/8
36/19 45/22 79/8	listed [1] 60/17	71/23 79/11 80/2	141/8 141/21 145/21	mark [1] 28/17
106/7 119/10 135/13	listen [1] 60/3	90/12 91/2 93/4 95/10	145/24 153/14 154/11	marker [2] 34/22
171/22 179/1 231/20	listened [2] 13/17	105/4 109/11 111/20	155/2 161/22 171/24	34/25
233/25 241/16 245/23	59/21	113/16 118/23 142/9	185/25 200/11 201/1	markers [1] 103/3
Level 2 [1] 119/10	listening [1] 60/7	178/1 179/23 180/7	233/2 234/17 242/15	marks [2] 90/23
levels [4] 34/16	lists [1] 10/7	180/9 180/10 180/12	242/17 245/19 245/20	90/23
34/20 57/12 57/14	literally [1] 157/11	180/16 180/18 182/19	245/23	massive [2] 212/9
Lewis [3] 73/2 73/11	little [16] 24/10 29/13	186/12 192/11 197/18	mailed [2] 243/6	214/14
73/14	37/11 81/19 85/21	204/24 208/9 223/19	244/5	masters [1] 218/11
liaise [1] 108/14	93/5 133/1 137/23	225/4 228/13 231/18	main [1] 85/6	maternal [2] 153/5
Lidden [4] 35/10	171/7 175/9 184/23	looks [8] 138/20	144/9 169/11	158/9
35/22 39/22 73/13	196/22 196/23 216/23	153/20 184/12 199/4	mainly [3] 110/17	matter [6] 21/23
Lidden's [2] 71/24	234/13 244/12	212/25 230/10 230/25	major [2] 74/6 74/9	96/22 109/12 127/25
72/11	live [1] 65/9	240/1	make [23] 6/15 13/21	164/17 219/17
life [2] 37/19 239/2	Liverpool [5] 32/8	loop [2] 48/6 219/11	14/8 24/22 28/21	matters [4] 12/5
light [3] 34/12 37/2	39/4 39/13 179/3	lose [1] 62/6	31/22 51/9 79/9 79/15	144/24 241/18 241/20
221/25	232/18	loss [1] 134/15	87/16 99/2 101/24	may [92] 1/8 1/19
like [66] 8/20 12/1	lives [1] 79/9	lost [3] 65/12 94/17	106/15 120/8 133/25	11/11 13/7 18/22 25/9
14/19 15/25 17/13	Loads [1] 200/9	228/21	134/16 134/25 135/1	27/25 28/15 31/10
18/22 26/9 26/24	location [1] 185/21	lot [22] 6/8 8/15	162/16 166/4 201/9	31/15 31/17 34/9
39/25 54/6 54/22 60/2	locations [1] 179/1	12/11 29/7 45/21	224/1 232/11	44/16 46/24 49/15
61/2 61/3 64/8 65/25	locking [1] 133/7	56/14 57/22 63/4	makes [2] 202/20	49/23 50/18 50/24
67/8 74/14 74/17 79/6	locum [3] 168/4	83/12 83/13 88/3	208/19	50/24 51/17 51/20
79/13 82/23 85/11	223/5 242/10	110/12 121/16 169/16	making [10] 71/12	53/11 54/24 56/7 57/3
88/21 89/6 89/10	long [15] 3/3 22/12	171/20 191/4 196/4	107/7 129/8 131/18	64/3 77/19 100/15
97/17 100/20 106/21	62/5 76/5 84/1 97/7	210/21 210/21 213/16	134/24 135/5 157/24	102/14 111/25 112/13
108/10 112/22 115/10	121/15 138/22 142/24	222/9 224/22	159/5 190/18 229/9	116/14 118/21 120/17
118/23 134/14 135/4	152/19 213/1 215/15	lots [1] 186/15	malice [1] 240/18	121/1 124/9 124/16
138/6 138/20 140/13	225/25 226/7 226/10	loud [2] 53/10 141/2	manage [3] 131/4	129/25 138/2 144/14
142/12 144/15 145/18	longer [2] 36/4	low [14] 32/24 34/6	191/7 198/1	149/9 149/10 149/16
148/22 151/18 153/20	189/15	34/9 34/11 34/16	managed [5] 143/19	150/13 152/8 152/11
157/17 168/21 169/7	look [57] 9/25 23/20	34/18 34/19 34/20	160/10 168/19 179/22	153/7 154/10 164/23
170/13 183/25 184/12	24/13 25/25 30/22	35/18 35/21 35/23	240/17	165/5 165/6 167/11
184/15 193/3 200/20	32/14 33/13 34/9	177/14 178/17 179/22	management [21]	167/11 173/1 174/10
203/21 210/13 213/20	39/17 46/10 58/11	Lucy [24] 5/10 11/12	3/14 6/1 6/23 7/4 7/10	174/20 174/22 177/2
214/13 214/14 215/10	65/11 69/1 73/21 82/3	11/23 13/18 29/11	8/11 14/4 51/25 52/7	177/9 177/22 187/5
215/18 219/6 220/18	85/12 98/5 100/20	44/21 50/5 55/3 58/8	79/25 85/9 146/9	189/15 192/1 194/9
230/10 240/1 240/8	109/7 110/10 111/15	58/15 59/14 65/9	171/15 210/11 219/16	194/11 194/14 199/20
240/11	113/21 116/24 118/2	126/5 161/19 161/25	224/24 225/5 232/3	202/21 203/7 205/8
liked [1] 6/24	118/7 118/9 127/8	164/12 184/23 215/7	242/19 245/12 245/19	207/3 209/17 216/25
likely [15] 24/2 25/12	146/13 149/24 151/18	215/16 216/23 237/16	manager [6] 3/9 3/10	217/3 223/12 223/18
25/13 44/25 78/15	152/11 154/10 156/6	240/13 242/6 244/12	3/12 5/20 40/23 82/19	223/20 225/21 227/24
104/13 165/19 182/5	162/24 175/19 177/21	Lucy Letby [16] 5/10	managers [4] 3/13	231/19 234/1 234/2
195/15 205/21 209/2	178/2 179/5 180/5	11/12 13/18 29/11	59/25 60/24 85/10	234/11 234/24 235/18
209/3 210/9 216/10	192/6 201/12 202/9	44/21 58/8 58/15	managers' [1] 7/7	238/25 241/21 244/7
224/20	202/21 213/2 214/6	59/14 65/9 161/19	managing [3] 195/7	244/10 244/10 244/16
like [1] 18/17	214/8 217/13 223/13	161/25 164/12 215/7	219/9 225/6	245/6
likes [1] 230/25	223/20 228/5 228/7	237/16 240/13 242/6	mandatory [1] 86/11	May 2016 [1] 194/11
line [9] 10/17 61/22	228/7 228/11 229/18	Lucy's [1] 243/17	manipulated [1]	maybe [13] 118/18
69/17 113/25 147/14	229/18 229/19 233/12	lunch [1] 122/17	222/7	125/16 125/18 127/12
225/25 226/7 226/10	looked [30] 10/10	luncheon [1] 122/23	manner [3] 135/6	147/16 160/19 168/25
238/24	24/15 24/16 36/5 71/1	M	162/21 162/22	170/13 178/6 179/8
lines [7] 70/10	83/12 95/1 98/8 104/6	M's [2] 181/13 181/17	manufactured [1]	199/12 199/18 222/6
114/11 120/5 133/10	123/9 132/12 144/8	machine [1] 8/14	179/16	Mayberry [2] 132/6
133/17 135/18 196/17	144/16 145/3 145/12	mad [1] 184/20	many [13] 57/13 73/7	175/16
link [6] 22/4 161/3	178/5 178/9 180/5	made [44] 8/9 22/1	83/9 120/18 139/7	me [69] 16/24 19/11
161/6 166/4 192/12	190/7 196/6 201/15	25/12 26/10 29/23	181/7 184/21 197/5	22/1 22/3 22/25 30/19
	204/15 204/17 205/2		198/25 199/1 230/3	33/22 37/24 59/20

M	medication [2] 36/7 191/18	212/23 243/6	41/12 45/3 50/1 50/2 61/25 71/18 72/18 73/25 79/2 79/15 91/1 91/2 94/2 101/22 119/11 119/13 120/18 126/1 127/8 131/8 131/10 149/17 158/19 159/11 161/1 163/5 166/24 176/11 178/9 181/2 192/12 192/17 200/7 206/4 208/20 209/6 214/12 224/16 228/2 228/10 230/13 235/7	mistaken [1] 234/7 mistakes [1] 171/24 mistook [1] 202/7 misunderstood [1] 165/11 Mmm [5] 115/20 117/1 117/4 117/16 163/14 module [1] 218/11 moment [19] 23/4 60/6 60/9 60/19 65/17 80/6 93/3 95/25 100/22 139/20 153/11 154/6 166/24 167/15 172/20 184/20 205/18 223/25 241/2 moments [1] 214/8 Monday [5] 1/1 52/21 138/19 138/24 164/9 Mondays [1] 2/13 monitoring [1] 196/6 month [3] 59/16 176/3 192/23 months [5] 16/10 49/1 114/24 139/15 139/15 Moore [1] 3/12 morbidity [6] 92/19 97/13 97/21 106/17 106/23 107/7 more [78] 23/24 24/10 25/2 25/14 25/16 29/9 30/9 31/21 33/12 37/11 37/12 38/9 39/6 40/11 44/10 44/22 44/25 46/8 47/12 48/8 49/13 50/21 52/5 52/8 57/24 60/4 67/4 67/6 67/11 69/4 77/1 83/12 83/24 90/7 96/13 97/14 97/15 107/23 108/18 110/13 110/17 118/6 118/10 125/13 126/6 126/13 128/23 129/3 129/20 133/15 134/17 140/24 143/20 144/24 157/4 159/4 159/4 164/14 169/1 170/7 171/14 171/20 171/21 172/19 172/22 172/24 175/9 186/6 189/8 190/21 194/4 196/17 196/17 212/24 222/4 223/18 224/19 240/19 Moreover [1] 245/16 morning [26] 35/9 71/25 72/7 76/9 95/2 103/23 130/17 131/1 141/12 152/4 182/25 183/5 184/7 194/23 195/13 197/23 205/25 206/7 225/15 225/17 227/6 229/1 229/2
me... [60] 60/10 62/21 75/11 75/13 76/7 81/18 93/18 94/2 95/24 99/4 101/15 104/15 105/24 108/4 115/13 117/14 119/17 119/18 121/16 129/18 134/25 138/19 139/4 139/10 139/18 140/5 154/13 159/3 162/16 164/2 166/24 168/23 173/1 177/4 180/6 183/2 186/6 192/5 197/2 199/7 202/12 203/13 203/15 208/9 208/19 210/20 211/22 211/24 217/2 219/23 220/1 220/24 221/24 224/18 225/8 226/5 226/8 226/11 236/14 244/15	medicine [4] 7/22 8/17 159/8 204/18 Medland [2] 64/11 144/25 meet [1] 212/12 meeting [126] 9/22 10/3 30/4 31/1 31/12 47/21 47/24 48/7 51/17 52/21 52/23 53/7 53/15 54/23 55/9 55/11 55/15 57/2 57/11 58/1 59/14 59/16 59/20 59/20 60/10 60/15 60/18 61/10 61/20 64/11 96/17 96/20 96/22 97/21 98/15 98/16 98/20 99/12 99/15 99/21 100/7 100/10 100/13 106/10 106/24 107/10 107/11 107/22 107/25 108/2 108/8 109/23 110/12 111/5 111/8 111/15 112/2 112/5 112/10 112/16 112/19 113/1 113/7 113/22 114/23 119/6 119/8 119/9 119/20 120/9 120/11 120/13 120/16 120/19 120/22 120/24 121/1 121/6 121/7 122/6 123/21 124/20 124/22 124/23 125/3 125/6 127/1 139/11 141/2 141/6 141/15 141/21 142/22 143/21 143/24 144/2 144/12 144/20 144/25 145/8 145/17 161/24 162/23 163/10 163/12 163/18 163/19 176/14 204/14 204/22 204/23 205/9 205/12 205/18 206/1 206/7 206/9 206/16 207/3 207/5 207/24 208/4 209/10 209/11 212/20 245/4 meetings [15] 2/17 14/7 30/16 31/23 48/8 92/19 97/14 97/15 106/17 106/23 107/7 146/4 162/2 162/6 213/24 meets [2] 27/9 27/11 meltdown [1] 212/9 member [13] 2/3 50/24 79/19 81/22 86/9 86/17 118/14 120/1 128/13 133/12 146/18 209/21 239/12 members [6] 79/7 133/12 192/3 207/14	memory [16] 29/7 64/15 94/25 100/20 132/22 134/9 134/24 135/1 135/5 151/17 151/21 153/22 157/5 157/14 177/10 223/22 mental [4] 101/11 184/1 202/2 213/15 mention [3] 62/2 62/8 155/20 mentioned [18] 21/18 44/19 49/11 92/8 99/23 107/24 121/7 126/3 127/13 135/16 135/18 140/9 140/21 157/1 173/8 193/24 203/8 206/6 mentioning [4] 44/20 93/21 131/17 156/23 mess [2] 175/12 203/22 message [31] 151/4 183/13 184/9 184/18 184/18 184/22 185/16 195/25 197/21 197/22 198/5 198/6 198/15 198/18 199/3 199/5 199/25 200/21 202/9 202/18 203/11 204/2 204/10 204/12 205/12 205/14 205/17 211/21 212/22 220/24 238/12 messages [20] 182/24 183/12 183/20 183/22 184/5 185/8 186/12 187/10 197/20 204/7 208/16 211/20 212/20 213/4 213/16 237/15 237/20 239/22 240/4 240/12 messaging [13] 182/11 183/15 183/18 183/22 186/9 198/12 199/23 200/22 207/17 213/11 237/19 238/14 239/19 Messenger [2] 237/21 239/5 met [4] 53/9 63/24 124/10 125/10 microphones [1] 171/8 mid [2] 156/1 199/9 middle [8] 4/17 9/3 63/14 84/4 120/24 192/23 193/22 229/12 midnight [3] 157/12 223/25 224/17 midwives [3] 169/10 170/6 170/10 might [46] 12/19 15/10 23/15 31/9	mind [45] 27/19 30/23 37/16 39/19 40/7 40/7 40/9 42/22 46/4 50/23 56/15 60/14 70/22 85/13 88/12 91/5 91/13 101/17 105/9 105/13 105/16 106/12 111/20 115/3 121/15 125/14 127/2 139/7 139/8 140/6 140/23 152/8 158/17 160/21 167/2 190/9 200/9 209/5 212/12 217/1 233/9 234/14 235/9 236/16 244/14 minds [1] 55/13 mindset [1] 160/22 mine [2] 84/3 145/11 minute [2] 59/19 65/19 minuted [1] 245/5 minutes [10] 55/11 59/20 60/16 73/4 122/16 133/8 152/21 155/9 222/15 222/18 mirror [1] 67/15 misheard [1] 165/6 misinterpretation [1] 65/4 misinterpreted [1] 37/5 misled [1] 222/6 mismanagement [2] 191/9 191/12 misremembered [1] 46/1 misrepresentation [1] 65/4 miss [1] 17/10 missed [3] 170/17 180/22 199/12 misses [1] 17/15 missing [2] 160/20 160/24 misstate [1] 44/4 mistake [3] 117/14 214/15 225/22	

<p>M</p> <p>morning... [3] 229/25 230/8 246/7</p> <p>mornings [1] 117/22</p> <p>mortality [24] 30/4 30/16 49/4 54/16 92/19 96/17 96/20 97/13 97/21 99/12 106/10 106/17 106/23 107/7 108/1 108/8 109/22 114/7 202/19 202/23 205/6 205/18 205/19 207/25</p> <p>mortgage [1] 62/5</p> <p>most [13] 24/2 31/22 39/4 60/9 104/13 114/11 168/11 168/12 182/5 195/15 201/22 210/9 216/9</p> <p>mostly [1] 87/16</p> <p>mother [10] 66/16 67/2 72/7 72/8 91/1 151/7 154/1 154/8 157/8 225/9</p> <p>Mother A [1] 157/8</p> <p>Mother E [2] 67/2 72/7</p> <p>mother's [5] 149/13 150/9 150/11 151/19 157/16</p> <p>mouth [3] 68/17 68/19 70/15</p> <p>move [16] 10/16 12/4 18/23 27/6 28/3 30/3 102/5 107/1 107/5 109/21 115/16 116/23 136/20 145/22 166/21 218/8</p> <p>moved [17] 8/3 84/6 101/10 108/21 172/4 172/5 172/6 172/10 172/12 172/17 173/4 173/8 173/12 197/19 202/25 203/6 237/10</p> <p>movement [1] 70/1</p> <p>moving [3] 46/24 82/14 203/10</p> <p>Mr [43] 1/3 1/16 10/2 10/3 10/18 66/2 77/4 77/5 77/6 80/10 80/10 81/2 102/21 122/25 144/3 148/16 148/19 148/20 152/3 161/13 161/14 161/15 165/3 165/6 166/22 167/6 214/24 215/4 215/11 215/19 217/18 222/11 222/22 222/23 240/22 242/21 247/3 247/4 247/5 247/7 247/8 247/9 247/13</p> <p>Mr Baker [4] 77/4 161/14 161/15 247/9</p>	<p>Mr De La Poer [8] 1/3 80/10 81/2 122/25 165/3 166/22 167/6 247/7</p> <p>Mr De La Poer's [1] 152/3</p> <p>Mr Graham Lamont [1] 242/21</p> <p>Mr Jameson [2] 10/3 10/18</p> <p>Mr Lamont [4] 215/4 215/11 215/19 217/18</p> <p>Mr P Jameson [1] 10/2</p> <p>Mr Semple [1] 144/3</p> <p>Mr Skelton [15] 77/5 77/6 80/10 148/16 148/19 148/20 161/13 165/6 222/11 222/22 222/23 240/22 247/5 247/8 247/13</p> <p>Mr Suter [1] 102/21</p> <p>Mrs [3] 138/15 138/17 139/4</p> <p>Mrs Hurst [2] 138/15 139/4</p> <p>Mrs Hurst's [1] 138/17</p> <p>Ms [16] 137/1 138/4 138/8 140/1 141/11 167/14 167/17 218/18 229/16 234/13 237/15 241/4 241/6 241/8 246/6 247/12</p> <p>Ms Bennett [3] 241/4 241/8 246/6</p> <p>Ms Hurst [5] 137/1 138/4 138/8 140/1 141/11</p> <p>Ms Killingback [1] 218/18</p> <p>MS LANGDALE [6] 167/14 167/17 229/16 234/13 237/15 247/12</p> <p>Ms Saunders [1] 241/6</p> <p>much [48] 7/9 7/11 7/11 7/14 8/19 11/8 15/2 23/15 27/23 28/9 33/21 36/4 42/2 61/1 61/2 62/2 62/23 67/9 77/3 80/9 80/14 80/16 80/21 81/21 84/14 90/7 90/22 96/16 102/3 122/12 125/22 134/21 157/4 161/12 165/2 166/13 174/7 184/16 186/13 190/1 212/23 228/11 232/10 233/21 237/8 240/25 241/7 246/5</p> <p>multi [2] 78/15 245/4</p> <p>multi-disciplinary [1] 245/4</p>	<p>multiple [1] 104/23</p> <p>mum [2] 135/25 149/17</p> <p>mums [1] 56/14</p> <p>murder [3] 74/9 75/4 187/18</p> <p>murdered [2] 146/19 149/1</p> <p>must [12] 15/19 26/16 46/1 55/6 79/20 83/21 122/9 151/18 173/13 203/23 217/6 244/2</p> <p>my [162] 1/4 3/4 3/25 4/3 5/1 5/18 9/18 12/12 14/11 17/1 19/14 24/23 27/18 29/4 37/24 39/8 39/19 40/9 43/6 43/16 44/10 46/4 47/16 48/10 48/11 49/1 51/5 52/9 52/22 52/25 56/15 60/11 62/3 62/4 62/6 62/23 62/25 64/20 65/12 65/16 66/3 70/25 72/13 73/18 76/19 77/1 80/8 80/11 80/18 83/8 83/9 83/20 88/25 90/5 90/20 90/20 91/5 91/12 92/1 93/3 94/11 95/10 100/20 101/17 102/9 102/12 102/20 102/22 104/7 104/9 104/13 104/14 105/9 106/18 108/9 115/12 116/18 117/12 117/14 119/5 120/15 120/22 120/25 121/15 122/14 122/16 123/1 123/8 125/14 126/4 127/18 136/4 137/9 137/10 137/16 137/25 138/19 139/6 139/8 140/2 140/2 140/5 140/21 140/23 140/24 140/24 141/13 141/13 141/16 141/22 146/23 147/1 147/6 147/15 148/16 155/25 158/17 159/4 159/5 160/18 160/21 161/11 161/16 162/19 163/5 163/6 164/14 164/17 165/4 165/15 166/23 167/2 167/3 167/11 168/24 168/24 168/24 175/18 178/1 179/5 181/20 185/2 186/13 195/17 196/14 200/7 202/14 203/22 209/11 211/4 213/12 217/12 217/24 219/12 222/3 222/11 224/25 240/21 240/23 241/9 241/21</p>	<p>246/4</p> <p>my Lady [25] 1/4 65/16 77/1 80/11 80/18 102/22 122/14 122/16 123/1 148/16 161/11 161/16 164/14 164/17 167/2 167/3 167/11 175/18 195/17 217/12 222/11 240/21 240/23 241/9 246/4</p> <p>myself [6] 54/25 65/9 131/24 139/17 168/19 201/1</p> <p>N</p> <p>N's [1] 186/20</p> <p>nagging [1] 46/5</p> <p>name [11] 49/11 66/3 113/2 113/10 127/2 164/21 192/12 195/18 220/9 221/7 229/9</p> <p>named [4] 14/15 120/2 173/18 181/9</p> <p>namely [2] 33/17 234/3</p> <p>names [5] 112/20 172/15 173/4 175/18 239/11</p> <p>naming [1] 186/15</p> <p>narrative [2] 64/22 229/11</p> <p>nasogastric [1] 69/23</p> <p>naturally [1] 137/6</p> <p>nature [8] 50/4 57/16 59/6 213/17 243/12 244/17 245/17 245/24</p> <p>naughty [1] 61/4</p> <p>navigate [1] 69/4</p> <p>near [2] 17/10 17/15</p> <p>NEC [25] 22/3 24/3 24/8 24/16 24/17 24/20 25/10 25/20 66/24 67/5 67/20 67/21 67/23 68/10 68/14 68/15 68/19 68/23 70/6 70/16 70/19 70/23 70/24 71/12 71/15</p> <p>necessarily [5] 1/24 87/2 127/8 128/18 229/17</p> <p>necessary [4] 15/23 162/3 162/7 222/14</p> <p>necrotising [2] 22/2 67/1</p> <p>need [35] 33/18 38/15 40/13 43/2 51/11 58/25 59/2 61/15 64/13 75/3 75/10 86/12 90/13 109/9 109/12 110/10 110/11 112/3 113/25 116/24 129/7 131/8</p>	<p>143/16 201/6 204/14 207/18 213/2 215/25 216/11 224/2 227/25 229/17 233/22 243/9 243/18</p> <p>needed [17] 10/23 65/1 83/25 89/13 97/20 110/14 110/14 158/14 160/5 160/16 161/4 169/17 176/12 196/15 197/10 226/9 238/17</p> <p>needing [2] 196/8 202/16</p> <p>needles [1] 38/15</p> <p>needs [2] 190/23 234/4</p> <p>neither [2] 93/25 140/3</p> <p>neonatal [55] 2/25 6/20 11/4 18/11 19/4 30/4 30/9 30/16 36/14 44/17 49/4 72/3 85/25 86/22 87/2 87/3 87/5 92/11 93/6 96/15 96/17 96/20 97/15 97/25 98/10 99/12 105/22 106/6 106/10 108/1 108/8 109/22 111/13 116/3 126/1 134/13 168/8 170/12 171/20 171/21 176/17 180/20 191/25 194/1 194/3 194/4 195/1 196/1 204/23 205/9 215/6 216/7 225/7 230/2 231/18</p> <p>neonate [1] 91/6</p> <p>neonates [8] 18/13 38/7 38/18 87/25 88/3 88/4 177/5 224/5</p> <p>network [1] 202/20</p> <p>never [9] 7/13 37/23 37/23 38/23 73/10 94/12 105/9 185/1 213/11</p> <p>new [2] 31/7 180/18</p> <p>Newby [9] 20/15 43/22 105/25 126/17 126/19 126/21 127/10 127/12 127/13</p> <p>news [1] 162/8</p> <p>next [20] 19/13 20/13 48/25 69/7 76/20 131/1 133/20 135/25 136/11 156/11 183/1 195/20 197/8 200/1 218/15 225/17 229/2 229/3 241/2 241/5</p> <p>NHS [2] 27/10 241/22</p> <p>nice [2] 202/19 212/23</p> <p>NICU [2] 215/8 242/23</p>
--	--	---	---	--

N	164/8 164/14 165/12 171/1 171/3 171/4 173/1 175/4 175/5 179/13 179/18 180/2 180/7 181/16 186/10 187/8 188/9 191/8 191/11 191/12 191/14 191/16 193/11 201/9 201/19 201/24 202/1 202/1 203/7 203/15 207/11 212/4 212/13 213/14 215/12 217/7 217/14 218/6 219/7 219/16 220/9 220/13 227/15 227/23 228/18 229/21 230/15 230/19 232/25 233/8 233/17 234/24 235/19 237/25 238/4 238/19 240/10 240/17 240/23 244/2 245/15 245/20 nobody [3] 50/6 83/1 93/14 Nods [23] 26/23 37/10 55/22 73/5 75/24 82/13 99/8 101/4 112/21 117/23 121/8 130/4 141/5 143/25 146/6 146/12 154/19 155/19 160/8 162/1 162/9 163/9 177/20 noise [1] 167/16 nominated [1] 48/9 non [14] 11/20 11/25 30/6 58/24 68/24 99/18 172/6 172/7 172/17 173/5 173/8 188/24 234/18 234/20 non-clinical [4] 172/6 172/7 172/17 173/5 non-indictment [1] 99/18 non-tender [1] 68/24 non-urgent [2] 11/20 11/25 none [3] 78/24 129/17 235/20 nor [1] 93/25 normal [12] 24/16 24/18 25/9 36/16 36/19 131/4 163/1 179/5 181/7 201/9 211/14 233/20 normally [5] 78/10 128/13 180/7 231/17 237/10 not [180] 6/3 6/16 6/18 6/18 6/21 11/3 14/23 15/23 15/24 19/9 22/7 24/8 25/23 27/18 28/1 28/5 30/20 31/10 31/18 32/22 37/8 37/20 38/2 38/7	38/17 39/6 39/19 39/23 40/12 40/24 43/9 43/13 43/21 45/4 45/7 46/24 55/12 58/12 59/21 60/7 60/17 63/11 66/11 68/12 68/15 70/2 70/3 70/14 70/16 71/2 72/20 72/21 72/21 72/24 73/12 75/1 76/5 76/16 76/24 82/10 85/2 86/16 86/22 87/6 87/12 87/21 88/16 89/7 89/13 90/17 91/19 91/23 93/7 94/10 95/8 95/17 95/22 97/18 104/19 106/24 107/3 109/17 110/19 110/25 115/11 115/12 119/8 120/21 124/1 126/6 127/8 127/17 131/4 131/13 133/14 138/9 140/21 146/15 147/11 147/22 157/5 157/7 157/21 159/24 160/20 161/22 162/17 162/18 162/21 164/1 164/17 166/7 170/13 171/9 174/11 174/15 176/21 176/22 176/24 179/11 179/21 179/22 180/3 180/24 181/6 181/11 186/11 187/5 188/24 188/25 189/11 189/15 190/6 191/20 191/23 192/18 193/1 193/13 193/16 193/19 194/25 195/18 195/21 197/12 197/14 200/2 202/13 203/7 203/13 206/21 207/3 207/11 207/14 207/15 209/6 209/14 210/9 215/22 216/11 217/9 217/18 217/18 218/15 219/11 220/13 220/13 230/3 231/1 231/9 231/20 232/8 232/10 235/7 235/24 235/25 240/16 242/15 244/18 244/20 245/18 note [32] 29/2 29/4 29/18 35/5 35/12 71/24 72/18 76/8 76/11 76/19 76/20 76/21 137/9 138/19 138/22 150/3 154/16 154/21 155/13 155/16 156/7 156/10 159/8 178/8 223/24 226/15 226/17 229/1 229/2 229/9 229/22 233/2 noted [6] 35/16 68/17 75/22 105/2 125/16	157/25 notes [54] 28/22 29/15 29/25 32/15 33/12 33/13 35/3 90/20 104/7 118/3 119/6 135/16 136/25 139/5 149/21 150/20 151/21 153/24 154/10 154/13 154/14 154/24 155/4 155/11 155/12 155/21 158/19 159/14 159/19 165/17 177/21 178/2 178/6 179/7 190/19 191/20 204/25 205/1 208/14 209/6 209/10 209/22 223/13 223/19 224/1 224/8 227/8 229/15 229/24 230/5 230/11 231/10 233/7 236/7 nothing [12] 12/13 29/6 29/10 92/3 127/22 136/11 139/6 179/8 201/24 203/25 239/24 240/19 notice [3] 29/2 124/2 238/14 noticed [5] 25/9 29/4 71/1 199/18 233/9 notification [1] 27/10 notified [1] 125/11 November [5] 30/5 44/6 106/11 145/23 148/2 now [107] 1/17 3/7 4/5 6/10 7/3 7/15 8/2 9/20 9/22 11/9 12/4 15/24 19/13 20/5 21/8 21/21 22/19 24/6 26/22 27/24 28/2 28/5 30/8 32/14 35/3 35/24 39/16 41/2 41/23 42/7 43/20 44/1 45/13 46/7 48/21 52/14 54/9 57/1 63/16 68/10 70/15 72/2 76/1 82/22 83/16 85/12 85/21 89/16 92/6 92/17 95/12 96/15 97/20 99/12 99/14 100/19 105/4 105/6 106/10 106/12 111/20 112/18 113/5 114/10 114/18 115/22 116/1 117/20 118/2 120/23 122/20 123/20 125/18 129/20 129/20 132/14 136/20 141/24 142/8 142/24 143/13 153/7 159/19 165/8 165/13 165/17 166/10 166/14 167/6 177/10 179/20 186/18 187/16 190/4 203/16 204/19 209/4 214/6 214/8	214/14 214/24 216/3 219/22 223/9 241/3 244/8 246/6 number [26] 12/5 31/5 42/4 42/17 44/21 60/22 82/1 83/24 105/3 105/7 105/7 106/13 110/14 117/21 123/15 144/19 173/19 173/21 185/8 187/25 190/15 198/6 201/18 204/8 218/24 236/7 number 1 [1] 123/15 numbered [1] 133/4 nurse [19] 13/1 13/3 65/10 82/18 84/17 109/7 143/15 157/19 172/16 208/8 212/15 215/7 216/7 220/11 220/11 220/13 220/14 220/17 242/23 Nurse T [1] 172/16 nurseries [1] 133/3 nursery [4] 133/4 133/6 196/4 223/17 Nursery 1 [1] 133/6 Nursery 2 [1] 196/4 nurses [32] 5/14 5/19 5/25 6/4 6/19 6/20 6/22 44/23 46/19 82/19 83/11 93/25 119/15 162/20 164/3 165/23 169/10 169/19 169/21 170/3 171/15 171/21 171/25 172/8 172/14 174/16 176/9 182/21 191/25 192/10 195/8 196/5 nurses' [1] 6/8 nursing [15] 5/5 5/8 29/14 40/23 46/22 109/6 120/4 133/13 205/1 207/19 215/8 219/15 238/8 242/4 242/23 nutshell [1] 20/4
			O	
			o'clock [5] 76/9 120/20 122/14 130/23 246/7 O's [8] 130/5 130/16 130/18 188/21 191/5 192/25 194/16 194/19 oath [2] 1/11 80/22 obligated [2] 79/23 80/1 obscuring [1] 185/2 observation [7] 118/4 215/6 216/8 216/9 216/24 219/8 244/13 observational [6] 214/19 217/6 242/7	

<p>O</p> <p>observational... [3] 243/25 244/18 245/17</p> <p>observations [3] 29/3 118/8 236/14</p> <p>observe [3] 215/11 234/17 244/5</p> <p>observed [4] 188/25 192/7 192/10 201/20</p> <p>observing [1] 216/5</p> <p>obstetric [4] 97/14 106/20 107/25 217/25</p> <p>obstetrician [3] 151/5 221/8 221/13</p> <p>obstetricians [1] 8/15</p> <p>obstetrics [2] 8/6 108/14</p> <p>obtain [1] 36/15</p> <p>obvious [4] 165/5 171/1 188/9 224/9</p> <p>obviously [25] 4/11 6/17 11/3 15/21 15/23 29/13 36/18 66/20 67/10 67/11 91/6 91/9 96/21 100/5 100/24 117/2 135/21 141/19 148/6 153/17 155/24 178/22 202/6 231/19 232/5</p> <p>occasion [1] 162/11</p> <p>occasionally [1] 169/11</p> <p>occasions [1] 83/10</p> <p>occupy [1] 237/10</p> <p>occupying [1] 217/19</p> <p>occur [4] 13/7 30/9 33/2 239/17</p> <p>occurred [10] 37/23 42/14 46/21 86/22 89/9 92/22 164/6 166/24 176/2 205/18</p> <p>occurrence [1] 38/6</p> <p>occurrences [1] 93/7</p> <p>occurring [4] 30/11 101/21 194/4 235/14</p> <p>occurs [1] 72/22</p> <p>October [7] 1/1 43/7 102/5 102/8 103/4 153/21 246/10</p> <p>odd [2] 48/3 185/1</p> <p>off [14] 27/18 39/3 42/25 43/12 49/16 52/22 157/19 183/4 184/14 200/10 219/14 222/21 226/2 229/11</p> <p>offer [1] 131/7</p> <p>offered [2] 110/15 184/2</p> <p>offering [1] 219/12</p> <p>offers [1] 111/10</p> <p>office [16] 61/3 72/13 83/18 83/20 84/6 84/9</p>	<p>84/16 85/2 85/4 175/1 175/6 175/11 193/22 205/9 218/4 218/5</p> <p>office-based [1] 218/4</p> <p>officer [11] 87/19 136/24 137/12 138/21 140/1 140/16 141/20 142/22 243/11 244/6 245/11</p> <p>offices [9] 83/17 83/18 83/23 83/25 84/12 84/13 84/18 144/4 144/5</p> <p>often [7] 30/12 36/15 39/3 85/2 184/5 231/13 238/10</p> <p>Oh [9] 121/21 122/1 126/11 126/18 143/13 143/17 180/5 184/23 192/7</p> <p>okay [29] 4/16 38/20 43/8 53/3 76/10 76/13 76/22 77/1 81/20 90/15 95/4 95/7 108/3 108/3 118/25 122/1 136/21 164/25 166/16 182/18 184/10 185/4 185/9 185/10 199/9 200/18 200/24 211/6 220/21</p> <p>old [1] 231/21</p> <p>older [1] 38/16</p> <p>Olivier [1] 212/11</p> <p>on [381]</p> <p>on on [1] 227/5</p> <p>on-call [10] 92/12 92/12 92/16 101/22 127/14 131/24 132/5 142/24 157/9 157/16</p> <p>on-calls [1] 126/11</p> <p>once [5] 8/16 37/13 126/17 233/18 243/18</p> <p>one [77] 3/24 4/5 5/14 7/15 10/5 14/1 16/3 36/9 41/3 44/23 45/25 50/2 59/18 60/13 62/19 62/24 74/25 77/10 79/15 84/4 84/5 84/14 84/15 84/18 92/9 95/5 99/19 106/8 108/13 108/18 108/21 109/24 110/13 111/17 112/25 113/19 113/20 113/23 114/12 115/5 117/17 117/20 118/18 122/3 130/23 130/23 131/10 135/3 136/1 136/11 138/17 144/5 145/22 148/25 154/13 155/16 158/7 164/17 165/4 172/15 175/18 176/10 187/7 188/17 191/12 201/22</p>	<p>205/4 205/23 207/10 215/23 216/22 217/10 224/1 230/22 233/8 234/6 236/11</p> <p>onerous [2] 226/3 226/4</p> <p>ones [3] 23/21 128/18 201/23</p> <p>ongoing [1] 15/7</p> <p>only [30] 5/9 6/17 15/4 18/17 18/24 22/14 65/8 84/15 94/11 95/8 101/13 104/1 105/4 115/4 117/8 124/13 138/18 140/21 154/6 178/6 180/7 180/15 196/21 202/25 203/5 206/8 207/10 216/5 234/6 236/2</p> <p>onwards [2] 204/6 204/16</p> <p>open [6] 59/13 61/15 70/3 84/2 194/6 194/7</p> <p>openly [2] 118/15 146/8</p> <p>operative [2] 215/8 242/24</p> <p>opinion [5] 62/25 83/14 117/12 163/5 163/6</p> <p>opinions [4] 62/23 78/12 116/10 117/10</p> <p>opportunity [12] 24/12 71/14 71/17 137/1 139/16 141/6 141/9 152/10 180/22 199/17 215/10 244/4</p> <p>opposed [3] 33/5 57/15 110/23</p> <p>options [2] 13/22 27/8</p> <p>or [232] 1/11 6/16 10/4 12/13 14/2 14/9 14/23 16/11 16/12 17/9 17/15 18/25 19/9 22/3 25/10 28/4 34/17 34/20 38/13 39/23 40/21 41/18 42/23 43/13 44/19 45/5 46/22 50/1 52/20 53/22 54/20 55/7 55/24 57/7 57/19 57/19 58/5 58/9 58/12 59/5 60/6 60/25 61/10 65/4 65/10 69/17 72/6 72/24 73/13 73/22 74/6 74/18 75/1 76/8 76/9 78/11 80/22 84/16 85/1 85/18 85/19 86/14 86/17 86/21 87/6 87/8 87/9 87/19 87/21 90/3 90/23 91/11 91/11</p>	<p>94/7 96/25 97/25 100/13 101/21 104/7 105/21 107/4 108/4 110/14 111/1 111/3 112/12 113/6 113/16 116/9 117/7 119/8 120/5 121/11 121/14 125/6 125/18 126/2 126/10 126/17 127/23 128/14 128/16 128/17 128/22 129/1 129/2 130/8 130/17 131/7 131/8 133/19 134/15 135/16 141/22 142/13 144/7 144/15 146/16 147/16 149/8 155/5 155/15 158/17 158/24 160/19 163/24 165/10 167/3 169/22 169/25 170/1 170/13 171/24 172/11 172/25 173/14 174/11 174/21 174/24 175/1 175/9 175/9 176/8 176/9 176/16 176/17 178/4 180/20 181/4 181/12 181/19 182/8 182/11 182/15 182/16 184/8 185/14 186/4 187/7 189/22 190/7 190/9 191/9 191/12 191/17 191/20 191/25 192/12 192/20 192/25 193/3 193/7 193/15 194/14 195/4 195/8 195/11 197/12 198/13 199/12 201/21 202/13 204/8 205/6 206/5 206/18 206/24 207/1 207/24 208/13 210/20 213/11 215/17 215/22 216/18 218/1 218/5 219/1 219/4 219/4 219/5 219/6 219/15 221/18 221/25 221/25 222/14 222/18 224/21 225/3 226/12 226/19 227/23 228/8 228/21 230/23 231/7 232/7 232/13 233/3 234/7 234/21 235/3 236/4 236/23 237/12 237/22 238/8 238/11 241/3 245/18 245/22</p> <p>or June [1] 194/14</p> <p>oral [1] 187/24</p> <p>orally [1] 157/9</p> <p>order [11] 1/5 4/12 19/5 22/11 51/13 177/15 211/12 215/9 242/7 242/25 243/5</p> <p>ordered [3] 177/18 178/11 178/20</p> <p>ordering [1] 226/17</p> <p>ordinarily [1] 239/3</p>	<p>ordinary [2] 238/2 239/19</p> <p>ordinating [1] 215/19</p> <p>organisation [1] 13/23</p> <p>organisations [1] 244/22</p> <p>organised [4] 102/1 231/7 232/3 236/23</p> <p>original [1] 165/17</p> <p>other [60] 5/25 6/3 6/10 12/2 12/14 18/1 20/16 23/7 23/16 26/3 26/5 33/20 39/23 43/18 50/22 53/8 71/18 77/8 93/22 97/9 101/18 101/18 110/13 112/12 131/15 132/1 133/12 140/14 140/25 155/6 160/5 160/6 162/2 162/20 163/13 164/3 165/14 165/23 170/6 172/16 174/14 175/24 176/8 187/7 193/9 193/12 205/1 209/13 209/13 209/15 213/17 218/10 226/3 228/8 228/8 234/11 237/12 238/1 241/20 244/22</p> <p>others [6] 5/12 86/6 144/21 174/21 183/10 199/18</p> <p>otherwise [4] 180/12 192/14 211/8 226/2</p> <p>our [46] 1/4 3/12 3/20 4/21 7/11 7/12 8/23 9/4 12/7 13/19 15/7 18/4 30/3 31/6 33/14 36/16 45/25 52/2 58/12 59/13 59/14 60/3 62/3 62/5 63/18 63/19 63/25 64/3 64/4 65/1 80/18 89/16 110/15 125/24 141/21 145/10 145/15 145/16 147/8 147/8 147/14 147/17 166/25 194/6 242/1 244/22</p> <p>out [56] 2/14 10/24 14/3 14/8 14/9 14/17 25/5 38/13 38/16 48/6 50/12 53/10 54/10 56/11 58/4 58/17 59/4 61/20 62/5 63/19 68/19 71/15 74/25 92/20 94/5 97/11 97/20 111/10 116/21 118/13 121/18 122/2 134/16 135/24 141/2 144/12 161/23 166/21 168/7 168/17 172/10 172/20 177/11 177/16 190/2 194/19 197/10</p>
--	---	--	--	---

O	142/22	211/21	191/3	217/19 217/24 218/4 244/3
out... [9] 201/10 209/23 213/2 213/3 213/10 217/21 226/11 236/17 238/16	paediatrics [8] 2/4 3/1 8/2 81/23 107/1 168/5 223/7 242/10	page 334 [1] 32/16 page 34 [3] 212/19 212/20 212/22	paragraph 52 [2] 102/11 102/16	patient-facing [1] 217/19
outcome [2] 49/3 65/13	page [91] 10/16 10/17 16/5 16/7 19/13 19/14 20/13 20/14	page 39 [1] 35/4 page 4 [4] 27/6 69/2 69/3 185/7	paragraph 53 [1] 102/18	patients [11] 6/22 12/20 12/24 13/4 18/13 37/25 176/16 186/15 232/9 238/3 239/1
outpatient [2] 218/1 245/6	27/6 32/16 35/4 64/15 69/2 69/3 69/7 87/1 95/3 100/1 102/11	page 5 [5] 10/16 116/23 152/13 153/9 197/21	paragraph 85 [1] 60/13	patients' [1] 239/11
outside [6] 4/23 13/23 15/6 36/17 58/11 239/19	102/15 102/16 114/5 115/17 116/23 117/13 117/13 117/15 119/2 119/4 123/11 132/18	page 6 [1] 117/13 page 7 [6] 102/11 102/16 117/15 123/11 145/22 198/5	paragraphs [2] 64/9 64/14	pattern [3] 2/9 55/5 125/16
outstanding [2] 18/2 243/19	145/22 149/25 150/1 152/13 152/15 153/7 153/9 153/9 153/10 154/15 155/13 156/11 156/12 156/14 177/23	page 9 [3] 119/4 199/4 199/5	pardon [1] 193/18	patterns [1] 202/21
over [31] 18/12 18/15 42/17 48/25 60/3 64/17 88/5 100/1 105/7 114/5 115/9 117/13 118/2 119/1 121/2 122/17 147/10 155/17 182/22 183/3 185/7 195/14 198/5 199/3 199/25 201/4 202/11 213/1 214/17 241/24 242/4	183/13 183/14 184/17 185/7 185/7 185/16 197/21 198/5 198/5 199/3 199/4 199/5 199/25 199/25 201/4 202/9 203/11 204/12 205/20 205/20 208/17 208/25 211/21 212/19 212/20 212/22 215/23 216/1 216/21 217/13 218/13 218/14 218/15 218/18 218/18 218/19 223/21 226/13 227/5 227/17 227/18 228/11 228/13 229/7 230/14	pages [3] 113/2 155/13 156/10	parents [26] 12/13 26/8 28/1 36/25 72/16 78/11 94/17 131/16 134/5 134/15 134/18 134/21 135/2 156/12 156/17 156/21 157/3 161/25 162/7 162/19 165/25 186/20 197/9 225/14 239/16 240/12	pausing [3] 195/3 225/10 227/21
overall [4] 7/24 29/11 170/23 170/24	page 1 [2] 205/20 208/25	paid [1] 83/13	part [28] 2/11 6/1 8/12 9/4 16/4 16/25 29/10 33/1 34/7 42/1 57/3 84/21 86/3 93/24 111/18 113/12 119/8 123/8 159/21 176/18 188/15 190/6 206/18 208/11 211/4 213/14 216/8 223/6	pay [1] 62/5
overheard [3] 126/4 126/15 220/4	page 11 [1] 199/25 page 12 [1] 226/13 page 13 [2] 132/18 223/21	panel [1] 211/22	part-time [1] 2/11	PDP [1] 216/9
overleaf [1] 212/19	page 14 [2] 152/15 202/9	panic [1] 214/9	participated [1] 59/8	peaceful [2] 134/17 162/21
overlooking [1] 28/10	page 15 [2] 153/7 153/10	panicking [1] 214/3	participating [1] 54/12	peak [1] 41/21
overnight [3] 185/18 186/2 197/4	page 19 [2] 203/11 227/5	paper [2] 181/10 233/3	particular [22] 4/5 11/19 14/15 20/1 28/4 46/2 56/10 61/19 98/4 111/16 111/16 111/25 120/1 120/4 127/23 128/16 161/19 182/16 182/18 225/8 238/6 239/16	Pen [1] 200/17
overview [1] 20/14	page 2 [5] 95/3 183/13 216/21 218/14 218/18	paperwork [1] 200/9	particularly [5] 90/18 90/19 146/22 209/7 239/17	people [30] 6/17 11/24 14/2 31/22 44/5 54/23 58/10 95/6 97/8 101/18 121/1 126/11 128/15 128/17 131/15 140/14 140/25 144/19 163/13 174/20 175/19 184/21 187/25 190/16 192/16 196/4 202/4 202/20 205/21 241/24
overwhelm [1] 41/17	page 2-3 [1] 218/13	paragraph [27] 19/24 36/3 60/13 67/24 90/13 102/11 102/16 102/18 132/14 132/20 132/24 134/4 163/11 168/10 168/15 169/9 173/23 174/13 177/11 177/12 181/14 187/20 188/6 188/20 191/3 191/15 234/16	people's [1] 110/20	peptide [10] 32/24 33/8 35/1 35/23 38/22 38/23 48/18 73/8 99/7 124/7
overwhelmed [1] 41/22	page 21 [1] 229/7 page 22 [2] 64/15 227/18	paragraph 10 [2] 168/10 168/15	perceived [3] 7/21 8/18 162/18	perception [2] 5/13 145/12
overwhelming [1] 189/12	page 25 [2] 149/25 150/1	paragraph 106 [2] 132/14 132/20	perfect [1] 204/20	perform [1] 230/4
own [17] 7/12 9/18 16/1 16/21 33/19 54/22 62/23 86/6 101/1 134/9 155/21 159/19 163/18 182/14 187/6 224/25 239/2	page 26 [1] 154/15 page 27 [1] 204/12 page 28 [2] 155/13 208/17	paragraph 11 [1] 169/9	performed [2] 178/25 229/23	performing [1] 202/13
P	page 29 [2] 156/12 156/14	paragraph 110 [1] 134/4	perhaps [8] 26/6 29/24 44/1 108/16 113/6 115/5 136/7 209/23	perinatal [5] 97/13 106/17 106/22 107/6 107/24
P's [3] 54/10 132/8 209/7	page 3 [2] 115/17 205/20	paragraph 114 [1] 163/11	period [49] 2/10 2/18 7/16 9/5 11/11 28/18 41/24 42/24 43/13 43/23 44/6 45/6 45/11 45/17 47/19 47/23 48/1 48/6 48/11 48/24 49/10 49/19 49/22 50/18 53/3 59/25 60/7 64/17 83/7 84/20	
paediatric [16] 9/7 10/22 11/5 11/6 11/7 42/2 48/5 82/4 84/2 106/20 106/22 168/1 193/22 224/22 241/23 242/21	page 33 [3] 16/5 16/7	paragraph 20 [1] 173/23		
paediatrician [8] 52/21 61/8 81/25 84/21 85/13 92/10 110/11 129/9		paragraph 23 [1] 174/13		
paediatricians [8] 53/8 53/9 85/25 86/12 96/24 106/8 109/18		paragraph 25 [1] 177/11		
		paragraph 27 [1] 177/12		
		paragraph 33 [1] 181/14		
		paragraph 34 [3] 67/24 90/13 234/16		
		paragraph 37 [1] 187/20		
		paragraph 40 [1] 188/6		
		paragraph 48 [1] 188/20		
		paragraph 49 [1]		

P	place [22] 16/11 26/7 26/20 41/3 46/21 47/14 47/15 53/17 82/5 93/9 107/25 109/23 111/15 115/9 117/7 121/10 174/12 210/10 214/9 221/18 222/10 223/18	127/9 132/2 144/22 145/7 146/3 159/14 160/15 164/6 196/8 198/12 199/21 204/6 206/23 206/25 207/7 207/11 219/17 221/10 221/17 225/18 233/1	potential [7] 86/14 96/25 97/18 149/18 151/19 155/5 212/25 potentially [6] 37/16 40/20 79/23 89/12 211/1 237/4	110/6 110/11 122/4 157/3 163/13 192/17 205/6 206/8 206/10
period... [19] 84/24 85/23 88/5 97/24 133/2 135/22 147/11 152/19 154/2 213/1 222/9 223/1 224/8 226/6 226/12 227/2 229/5 242/8 243/25	placement [2] 245/13 245/18	pointed [1] 118/13	presentation [12] 24/2 55/16 55/24 56/1 56/22 94/6 107/4 114/13 121/2 122/8 134/5 141/7	presentation [12] 24/2 55/16 55/24 56/1 56/22 94/6 107/4 114/13 121/2 122/8 134/5 141/7
period January [1] 242/8	plan [10] 6/23 49/7 103/3 125/16 125/20 135/19 141/15 141/21 228/15 228/19	points [4] 63/19 114/9 199/19 214/3	presented [3] 61/11 64/3 117/10	presented [3] 61/11 64/3 117/10
period November [1] 44/6	planned [2] 8/6 228/19	police [23] 13/24 15/17 29/5 29/21 39/18 45/13 53/20 53/24 68/2 78/12 78/16 78/20 78/25 79/20 80/3 87/10 87/15 94/6 94/11 147/1 173/19 218/12 222/3	preset [3] 106/19 106/21 106/22	preset [3] 106/19 106/21 106/22
permanent [2] 10/10 68/12	plans [2] 144/11 219/5	policy [14] 12/5 13/10 13/12 13/16 14/9 14/17 14/19 15/2 16/1 16/7 16/17 16/22 17/3 244/19	pressing [1] 222/15	pressing [1] 222/15
permitted [3] 217/8 217/15 244/3	platelet [1] 91/11	pondered [1] 133/20	pressure [5] 9/7 38/15 42/2 62/21 170/21	pressure [5] 9/7 38/15 42/2 62/21 170/21
persist [1] 65/13	platform [2] 237/21 238/4	poor [2] 184/23 185/3	pressures [1] 11/10	pressures [1] 11/10
persistent [1] 60/4	platforms [1] 238/1	poorly [2] 88/4 184/4	presumably [16] 33/12 38/6 61/13 109/17 155/7 156/4 162/2 162/6 162/23 174/17 198/21 200/13 217/18 218/22 226/3 231/8	presumably [16] 33/12 38/6 61/13 109/17 155/7 156/4 162/2 162/6 162/23 174/17 198/21 200/13 217/18 218/22 226/3 231/8
person [11] 10/3 14/2 31/6 47/8 107/8 133/24 169/4 178/14 216/4 238/21 238/21	played [1] 227/24	poor [2] 184/23 185/3	presume [2] 206/14 232/1	presume [2] 206/14 232/1
personal [13] 43/1 126/9 142/1 163/6 163/8 215/9 237/22 237/23 239/1 239/2 239/12 242/12 242/25	please [59] 1/9 1/10 1/14 1/18 2/21 9/21 10/16 10/16 13/10 16/5 26/25 27/6 28/3 29/1 32/14 32/16 35/4 45/9 64/14 64/16 66/1 69/1 69/2 69/3 69/7 81/5 88/21 88/22 89/16 95/3 102/5 108/18 112/22 116/23 119/4 122/20 132/22 134/9 135/4 136/3 136/5 136/18 143/21 149/25 152/12 152/17 154/15 155/13 168/11 187/19 203/19 208/17 215/20 218/15 218/17 223/15 225/12 226/14 243/10	poorly [2] 88/4 184/4	presumed [6] 180/10 187/1 187/8 198/15 225/17 231/25	presumed [6] 180/10 187/1 187/8 198/15 225/17 231/25
personally [1] 164/7	plus [3] 75/16 198/10 240/15	posed [1] 86/9	prevent [3] 177/16 181/4 236/1	prevent [3] 177/16 181/4 236/1
perspective [4] 83/5 165/4 215/12 232/4	pm [9] 115/19 116/5 122/22 122/24 141/18 167/8 167/10 229/3 246/8	position [12] 6/3 14/1 20/20 28/3 44/4 65/10 92/3 101/8 181/4 223/16 237/10 241/16	pre [4] 108/11 111/3 243/17 243/21	pre [4] 108/11 111/3 243/17 243/21
perspectives [1] 112/4	PNNMs [1] 108/11	positive [8] 3/5 3/15 4/3 4/22 5/9 50/7 50/20 171/1	pre-awareness [1] 111/3	pre-awareness [1] 111/3
pharmacist [1] 69/16	Poer [10] 1/3 1/16 80/10 81/2 122/25 165/3 166/22 167/6 247/3 247/7	possibilities [4] 73/21 74/3 74/13 234/7	pre-decided [1] 108/11	pre-decided [1] 108/11
phased [2] 48/25 49/10	Poer's [1] 152/3	possibility [16] 38/24 46/6 50/1 50/3 50/11 54/18 62/7 74/15 74/17 74/23 105/10 105/18 146/5 161/1 215/5 234/23	pre-employment [2] 243/17 243/21	pre-employment [2] 243/17 243/21
phases [1] 126/10	point [49] 10/23 10/24 32/23 34/6 36/18 44/19 47/20 50/8 52/1 52/3 57/10 58/1 58/15 58/18 65/6 65/8 71/5 72/3 78/22 90/19 94/10 97/16 113/11 121/5 121/16 125/24 126/11 127/7	possible [5] 37/3 155/5 184/16 185/5 204/3	previously [8] 23/16 43/21 92/9 92/17 152/10 162/20 190/8 235/10	previously [8] 23/16 43/21 92/9 92/17 152/10 162/20 190/8 235/10
phone [12] 138/24 138/25 141/11 185/20 186/1 213/18 231/22 232/21 237/22 237/22 237/23 237/24	Poer's [1] 152/3	possibly [3] 36/13 63/16 201/24	primarily [1] 82/17	primarily [1] 82/17
phoned [2] 203/13 231/17	point [49] 10/23 10/24 32/23 34/6 36/18 44/19 47/20 50/8 52/1 52/3 57/10 58/1 58/15 58/18 65/6 65/8 71/5 72/3 78/22 90/19 94/10 97/16 113/11 121/5 121/16 125/24 126/11 127/7	post [2] 215/8 242/24	print [1] 152/14	print [1] 152/14
photo [1] 157/19	plus [3] 75/16 198/10 240/15	post-operative [2] 215/8 242/24	prior [15] 2/6 16/10 70/24 82/1 111/23 118/8 143/23 163/7 164/6 183/1 197/2 198/20 215/24 224/7 242/20	prior [15] 2/6 16/10 70/24 82/1 111/23 118/8 143/23 163/7 164/6 183/1 197/2 198/20 215/24 224/7 242/20
photograph [2] 157/13 157/21	pm [9] 115/19 116/5 122/22 122/24 141/18 167/8 167/10 229/3 246/8	postmortem [20] 25/25 26/6 26/9 26/19 26/20 66/8 66/11 66/15 67/2 67/17 67/21 71/4 71/9 71/13 71/14 71/20 87/22 115/24 116/3 123/19	private [2] 239/18 240/12	private [2] 239/18 240/12
phrase [2] 37/12 61/19	Poer's [1] 152/3	postnatal [2] 225/2 225/6	pro [5] 215/25 216/4 243/8 243/10 243/20	pro [5] 215/25 216/4 243/8 243/10 243/20
physically [3] 38/8 92/13 104/3	point [49] 10/23 10/24 32/23 34/6 36/18 44/19 47/20 50/8 52/1 52/3 57/10 58/1 58/15 58/18 65/6 65/8 71/5 72/3 78/22 90/19 94/10 97/16 113/11 121/5 121/16 125/24 126/11 127/7	pot [1] 18/18	pro forma [3] 215/25 243/8 243/10	pro forma [3] 215/25 243/8 243/10
pick [9] 17/11 89/3 89/5 97/17 98/10 108/13 141/10 147/21 199/19	Poer's [1] 152/3		probably [45] 31/3 40/22 41/22 43/4 48/2 52/8 66/23 67/9 67/14 82/19 88/3 91/8 92/1 92/20 94/24 101/12 101/19 107/15 107/20	probably [45] 31/3 40/22 41/22 43/4 48/2 52/8 66/23 67/9 67/14 82/19 88/3 91/8 92/1 92/20 94/24 101/12 101/19 107/15 107/20
picked [2] 184/2 230/8	point [49] 10/23 10/24 32/23 34/6 36/18 44/19 47/20 50/8 52/1 52/3 57/10 58/1 58/15 58/18 65/6 65/8 71/5 72/3 78/22 90/19 94/10 97/16 113/11 121/5 121/16 125/24 126/11 127/7			
picture [7] 29/11 38/3 45/8 157/18 197/1 222/5 237/9	Poer's [1] 152/3			
pictures [1] 29/8	point [49] 10/23 10/24 32/23 34/6 36/18 44/19 47/20 50/8 52/1 52/3 57/10 58/1 58/15 58/18 65/6 65/8 71/5 72/3 78/22 90/19 94/10 97/16 113/11 121/5 121/16 125/24 126/11 127/7			
PICU [1] 185/18	Poer's [1] 152/3			
pink [2] 70/13 156/2	point [49] 10/23 10/24 32/23 34/6 36/18 44/19 47/20 50/8 52/1 52/3 57/10 58/1 58/15 58/18 65/6 65/8 71/5 72/3 78/22 90/19 94/10 97/16 113/11 121/5 121/16 125/24 126/11 127/7			
PJ [2] 10/18 10/22	Poer's [1] 152/3			

P	21/21 95/17 115/7 prompted [4] 40/18 94/2 115/13 228/10 proof [3] 51/6 58/9 77/23 proper [1] 26/17 properly [2] 153/25 159/6 proposed [1] 244/18 prospectively [1] 72/20 protect [1] 203/15 protected [1] 225/4 protection [2] 79/24 80/19 protective [1] 195/7 protein [1] 75/23 protocol [1] 15/17 protocols [2] 190/1 190/3 provide [3] 164/23 202/14 242/2 provided [9] 1/18 18/12 55/25 61/5 81/6 115/1 179/9 222/6 243/8 provides [1] 21/7 providing [2] 213/18 241/23 pry [1] 43/10 public [2] 79/7 241/19 pull [1] 190/9 pulmonary [1] 184/12 pumps [1] 245/8 purple [6] 71/1 154/25 155/16 155/20 156/17 157/25 purplish [1] 67/25 purpose [5] 120/22 124/19 130/20 239/22 242/24 purposes [1] 88/25 purpura [2] 100/3 100/11 purpuric [2] 19/24 95/10 purpuric-looking [2] 19/24 95/10 pursuing [2] 147/8 147/13 push [1] 79/25 push-back [1] 79/25 pushed [2] 66/14 191/18 pushing [1] 65/7 put [26] 15/11 27/1 28/22 55/19 56/10 75/20 90/21 90/22 102/25 118/6 126/13 138/15 138/21 142/6 147/19 152/18 159/4 162/16 170/20 181/2	183/7 196/16 197/17 209/7 218/21 218/23 putting [5] 18/17 62/21 100/18 104/18 192/16 Q Q's [3] 236/5 236/9 237/1 QC [1] 64/11 qualification [1] 44/24 qualifications [1] 245/22 qualified [1] 81/13 quality [2] 19/15 32/17 quantify [1] 126/7 quarter [3] 152/16 152/16 153/9 quarters [1] 10/17 Queen's [1] 144/25 Queen's Counsel [1] 144/25 question [18] 18/12 24/11 24/24 31/18 39/8 75/11 90/22 90/23 93/4 95/11 102/18 116/18 119/5 164/18 178/1 204/4 216/4 232/15 questioned [1] 162/15 questions [51] 1/16 5/2 27/25 32/22 60/20 65/15 65/16 66/2 66/4 77/2 77/6 77/7 80/11 81/2 93/19 98/17 99/4 129/4 129/21 138/10 139/10 148/14 148/16 148/20 148/21 152/3 152/3 161/14 161/17 161/18 164/15 165/1 166/14 167/14 171/14 202/5 210/10 212/13 222/12 222/23 240/23 243/11 247/3 247/4 247/5 247/7 247/8 247/9 247/10 247/12 247/13 quick [3] 98/11 196/7 201/2 quickest [1] 91/8 quickly [5] 22/21 23/1 158/2 158/13 185/11 quiet [7] 60/5 60/8 60/9 134/14 144/9 144/12 184/20 quieter [1] 186/1 quite [30] 4/24 6/22 6/23 6/24 15/10 18/16 28/8 29/7 36/3 38/11 38/13 48/3 61/24	63/18 64/1 64/4 71/10 82/21 94/10 98/15 101/16 144/8 145/3 152/14 152/18 185/10 187/11 187/21 209/2 224/20 quote [1] 110/12 quote [2] 132/16 145/1 quoting [1] 62/9 R R's [1] 197/9 Rackham [4] 135/17 136/3 136/6 136/16 raise [9] 7/12 13/20 47/7 64/21 65/1 100/12 102/3 192/3 219/17 raised [9] 5/10 7/23 38/1 43/25 47/17 103/2 146/7 209/18 209/20 raising [9] 13/18 13/22 62/3 64/18 65/7 78/11 78/14 82/18 147/14 rang [1] 101/22 range [1] 241/20 rare [6] 38/6 38/7 38/16 177/5 177/7 198/23 rash [32] 19/8 19/24 21/22 22/5 90/3 90/7 90/10 90/21 91/23 92/24 95/10 96/13 115/8 115/12 156/23 157/3 157/4 157/13 157/20 157/25 158/5 158/12 158/16 158/24 159/10 159/18 160/6 160/10 160/14 166/7 235/6 235/11 rashes [5] 91/25 129/16 161/7 235/12 235/14 rate [3] 18/15 155/18 202/19 rates [1] 202/23 rather [14] 15/20 33/25 64/23 76/19 80/1 101/10 170/15 170/17 170/18 199/13 209/24 214/5 232/10 243/14 ratio [2] 34/25 48/18 ray [14] 24/8 24/14 24/15 24/17 24/18 24/21 25/9 70/22 184/12 236/18 236/19 236/21 237/3 237/5 RCPCH [6] 58/3 59/9 61/6 63/8 146/10 211/18	re [1] 244/9 re-issued [1] 244/9 reach [1] 23/15 reached [4] 65/13 75/16 123/2 160/14 reaction [2] 52/7 54/5 reactive [1] 75/23 read [12] 16/24 61/9 61/13 86/25 104/6 149/22 150/15 153/11 157/16 209/23 222/16 241/5 reading [7] 29/14 35/20 86/24 155/11 177/14 218/11 233/13 readings [2] 38/19 179/22 ready [3] 167/7 198/15 198/19 real [4] 37/19 62/7 70/23 189/16 realise [3] 18/19 24/7 74/9 realistic [3] 47/22 74/15 74/17 realistically [1] 107/20 reality [2] 51/14 67/14 really [26] 7/9 7/10 7/13 15/4 24/23 31/25 55/20 70/21 93/4 94/1 94/18 98/16 116/18 125/21 126/8 126/10 126/11 128/14 148/2 157/15 157/22 172/21 213/8 213/12 222/7 234/6 reappear [1] 231/9 reason [20] 34/5 39/14 59/3 97/5 98/16 104/8 104/13 104/19 109/4 109/9 109/10 131/10 131/15 140/21 149/14 152/2 157/1 228/2 228/12 235/14 reasonable [4] 58/12 71/13 87/23 133/9 reasonably [1] 132/12 reasons [3] 34/9 79/2 224/9 reassurance [1] 211/15 reassure [2] 208/11 211/13 reassuring [5] 91/14 162/21 201/19 202/1 202/10 recall [59] 9/13 19/9 20/5 28/7 28/16 42/15 43/17 44/11 44/18 44/20 45/1 45/5 46/14
----------	--	---	---	--

R	191/19 191/20 230/7 235/7	regarding [2] 66/8 245/21	135/23 136/4 137/20 142/23 142/23 142/25	112/5 177/1 201/25
recall... [46] 51/19 51/20 51/23 53/5 53/7 54/2 61/19 66/17 67/9 67/23 72/12 73/10 73/15 75/9 76/1 93/21 96/19 117/11 117/25 120/25 123/23 124/1 131/18 148/25 149/23 151/22 154/18 166/11 169/15 171/11 173/2 174/5 179/6 182/1 190/8 192/23 205/9 209/20 221/11 223/16 223/17 224/14 224/19 227/23 230/15 238/19	recording [1] 72/22	regardless [1] 72/23	142/25 143/9 143/12 144/3 144/8 144/14 145/2 145/10 145/16 149/10 149/11 149/19 149/20 149/20 150/14 150/15 151/23 152/4 153/21 154/2 154/8 155/9 155/10 156/22 156/23 156/25 157/15 157/22 166/10 172/23 174/25 177/2 181/21 181/22 181/24 206/6 209/9 212/7 212/11 223/15 227/21 228/1 237/7	reputation [1] 3/23
recalled [2] 235/7 238/17	records [12] 69/4 69/8 143/1 149/24 152/11 152/20 179/21 181/2 223/14 229/3 229/19 246/3	Registrar [14] 90/6 90/8 131/20 154/18 168/1 168/11 168/13 182/19 188/17 201/22 223/3 229/14 230/24 238/11	157/22 166/10 172/23 174/25 177/2 181/21 181/22 181/24 206/6 209/9 212/7 212/11 223/15 227/21 228/1 237/7	request [11] 181/9 204/21 217/21 219/7 228/10 242/15 242/17 244/6 244/10 244/16 245/24
recalling [1] 45/19	recounted [4] 145/10 164/1 164/4 219/23	Registrars [6] 20/22 169/1 175/5 175/14 176/8 238/7	177/9 203/9	requested [8] 158/13 177/25 178/11 178/13 178/14 178/17 179/24 236/23
recap [1] 222/24	recounting [2] 145/11 164/11	regret [2] 32/16 36/23	remembered [5] 47/23 143/17 177/8 177/9 203/9	requests [2] 225/2 244/21
receive [3] 39/23 60/16 231/11	recovered [2] 41/7 158/3	regrets [1] 222/9	remembering [1] 43/5	require [2] 243/7 243/14
received [20] 12/8 12/11 71/24 73/17 86/8 96/11 103/5 105/25 112/18 125/5 125/9 129/25 187/24 208/22 233/2 233/6 233/6 237/20 241/10 243/20	recovers [1] 101/2	regulatory [1] 241/18	remembers [1] 157/9	required [15] 17/25 26/20 88/24 98/3 181/18 185/25 189/18 189/20 215/22 218/10 218/23 229/23 233/11 233/21 243/5
receiving [6] 9/13 51/20 54/3 73/4 74/10 90/1	recruited [4] 216/1 216/3 243/11 244/6	rejected [3] 40/8 40/9 50/12	remind [4] 22/3 136/8 137/5 175/19	requires [1] 100/25
recently [5] 8/3 9/12 22/14 113/11 121/13	recurrent [1] 103/1	related [3] 119/1 158/9 245/7	reminder [1] 152/2	research [3] 13/25 84/17 235/19
recipient [1] 186/16	red [2] 113/3 113/10	relation [10] 38/21 38/23 45/8 50/10 99/7 101/9 106/12 171/14 214/22 246/1	reminding [1] 75/10	resolved [4] 100/3 156/18 158/2 234/1
recite [1] 190/8	redacted [12] 41/9 46/3 56/16 56/21 56/21 62/20 64/12 84/7 106/21 223/9 223/10 232/4	relationship [19] 3/5 3/7 3/15 3/16 3/18 4/19 4/23 4/25 5/4 5/7 5/11 7/14 10/8 82/25 168/20 168/23 169/6 170/2 242/13	remiss [1] 219/11	resonate [1] 10/25
recognise [4] 35/5 73/18 80/2 239/8	reference [12] 10/18 14/8 56/22 69/15 69/24 90/12 114/19 115/6 117/14 154/14 200/11 214/2	relationships [10] 2/22 5/3 6/7 7/3 82/3 82/9 169/11 169/13 169/20 170/6	remission [1] 147/4	respect [4] 66/13 154/11 161/7 179/12
recognised [3] 89/8 104/17 233/10	refer [3] 87/1 219/18 234/16	relatively [9] 10/7 11/16 22/14 24/16 31/7 38/6 38/16 63/7 158/2	remit [1] 241/18	respite [1] 109/11
recognising [2] 37/4 159/18	referenced [1] 54/15	relay [1] 139/25	remote [1] 105/9	respond [3] 174/2 198/9 226/5
recollect [1] 148/23	referencing [1] 242/20	released [2] 216/23 244/12	remove [3] 56/20 213/22 228/1	responded [1] 243/4
recollection [17] 14/12 19/12 21/21 47/18 99/14 100/10 115/7 115/21 117/5 137/7 138/3 138/11 138/20 181/16 187/21 209/11 223/18	referred [11] 27/2 71/24 90/6 104/14 144/4 190/22 191/1 206/1 219/20 220/21 220/23	relevant [6] 11/11 78/14 100/12 100/19 129/8 148/9	repeatedly [2] 42/17 159/10	responding [1] 215/14
recommendations [1] 118/6	referring [5] 1/5 41/19 83/7 84/14 204/22	reliant [1] 75/1	replacement [1] 196/25	response [6] 63/20 78/5 78/16 159/9 224/11 228/16
recommended [1] 215/4	refined [1] 221/17	reliable [1] 75/1	replied [1] 138/8	responsibility [7] 79/8 101/23 102/2 179/21 231/6 231/10 241/17
reconfigure [1] 166/18	reflect [3] 88/15 133/22 221/25	relieve [1] 168/25	reply [1] 153/24	responsible [6] 108/21 181/10 201/17 230/19 231/15 245/11
record [7] 101/11 112/19 113/18 116/14 145/6 233/1 245/15	reflected [4] 162/12 162/23 222/2 240/14	reluctance [1] 232/5	report [6] 17/14 63/8 115/19 116/3 119/10 169/2	rest [5] 185/23 190/20 196/21 197/4 235/20
recorded [8] 35/13 35/15 35/22 89/14	reflecting [1] 103/25	remainder [1] 227/16	reported [14] 17/13 17/16 89/4 89/7 98/7 98/12 141/17 147/24 156/3 159/10 175/19 195/19 219/18 236/14	restricted [1] 171/13
	reflection [2] 213/23 214/17	remained [1] 69/22	reporting [2] 140/15 175/20	result [27] 33/24 34/13 34/19 39/1 39/2 39/5 39/7 72/24 73/4 73/8 76/2 82/14 99/5 99/7 101/9 179/3 180/19 189/13 193/16 193/17 193/19 226/22 231/14 231/21 232/10 233/24 242/11
	reflections [2] 79/5 186/13	remaining [1] 190/19	reports [4] 61/9 61/12 61/17 245/11	resulted [1] 170/14
	refresh [5] 64/15 94/25 132/22 151/17 223/21	remark [2] 141/8 221/15	represent [2] 48/10 111/7	results [50] 32/15 33/11 33/15 33/17 35/13 36/5 36/15 37/6
	refreshed [1] 134/9	remarks [2] 64/9 126/4	representation [1] 111/12	
	Reg [2] 155/24 155/25	remember [76] 22/11 35/20 46/8 48/2 53/13 60/15 83/9 85/3 90/25 92/23 94/14 94/18 95/19 110/8 115/11 119/10 119/12 119/15 120/18 122/8 128/5 129/13 132/3 133/7 134/19 134/23 135/3	representatives [1] 48/9	
	regard [5] 10/11 12/16 26/17 223/13 242/17		represented [3]	

R	225/2	72/7 92/14 103/8	9/21 21/15 35/4 39/18	211/11 212/3 212/5
results... [42] 38/2	revive [1] 152/8	110/9 194/24 225/15	56/7 60/24 60/25 61/2	212/10 215/14 216/14
38/25 39/11 41/12	Richard [1] 66/4	225/16 229/25 230/8	64/24 100/16 127/16	217/9 217/17 218/4
46/5 71/23 72/10	Richard Baker [1]	230/11 230/13 230/18	135/1 145/24 151/2	220/22 221/9 221/25
72/13 73/1 73/19	66/4	230/20 230/22	153/9 158/3 160/14	234/15 238/13 240/11
177/18 178/11 178/22	rid [1] 139/8	route [3] 85/19 85/19	161/1 195/14 212/13	241/13
178/24 179/6 179/6	right [78] 2/1 2/11	217/16	224/14 235/10 236/22	saying [25] 6/22 9/14
179/9 179/11 179/14	19/1 22/17 22/21 34/2	routes [1] 211/15	244/9	9/17 28/16 35/22 42/2
179/15 179/23 179/25	35/1 42/9 45/10 45/16	row [1] 99/19	sample [4] 32/7 39/5	53/10 62/22 64/2
180/8 180/12 180/13	50/12 52/15 52/17	Royal [3] 2/3 81/22	179/2 232/18	96/18 110/9 118/1
180/16 180/18 180/24	58/23 73/12 73/22	179/2	samples [5] 36/14	126/18 127/23 128/10
181/8 229/10 230/1	74/2 78/24 81/14 82/1	run [5] 122/14 128/15	38/10 38/12 150/17	133/8 135/6 136/13
230/6 231/2 231/8	84/4 84/23 89/24	170/15 194/3 229/11	190/18	144/10 156/23 165/8
231/11 231/17 231/23	90/10 96/9 97/19	rung [1] 9/18	sank [1] 133/19	184/19 193/3 201/5
232/3 232/8 232/11	98/15 99/20 102/8	running [2] 7/11 47/8	sat [3] 134/23 146/4	214/2
232/16 233/13	102/9 106/5 108/3	S	184/20	says [32] 69/21
resus [1] 199/10	109/24 109/25 127/13	sadly [3] 87/18 88/6	satisfactory [1]	90/14 107/2 116/6
resuscitate [1]	129/23 132/9 141/16	135/21	236/25	137/2 137/18 137/22
196/14	142/17 142/20 145/25	safe [4] 140/24	satisfied [2] 52/6	138/8 149/12 149/21
resuscitated [3]	147/11 148/5 153/8	197/11 197/12 197/14	56/3	150/16 153/14 197/25
132/25 133/3 196/9	153/9 156/1 156/1	safeguarding [13]	Saturday [1] 230/23	199/8 200/6 200/19
resuscitation [15]	156/3 166/10 166/12	12/8 12/9 12/11 16/6	Saunders [3] 241/6	200/25 202/12 202/15
15/7 18/1 89/13 103/6	168/2 168/6 170/20	51/10 78/4 78/11	241/10 241/13	203/20 207/10 209/23
131/23 135/24 149/3	170/20 173/22 174/18	78/17 84/22 85/7	save [1] 167/3	209/24 210/4 210/12
161/22 173/24 190/16	179/20 183/18 194/2	85/14 86/7 86/12	saw [6] 29/19 38/17	212/8 212/8 212/16
199/16 201/21 201/23	195/23 196/3 198/21	safely [4] 13/12 14/3	70/22 85/6 103/8	212/18 212/22 226/20
208/12 208/13	205/17 213/5 214/25	14/9 14/17	143/10	228/15
resuscitations [2]	216/22 218/7 220/2	safety [6] 11/18	say [127] 6/17 6/18	SB [1] 208/18
206/22 209/12	220/5 221/1 222/17	11/22 47/8 74/6 74/9	20/6 22/7 22/19 24/6	scan [2] 229/23
retired [1] 214/24	224/4 226/1 227/4	75/5	24/12 24/13 28/14	230/5
retraining [1] 218/9	227/14 227/20 229/12	said [91] 6/12 6/13	29/17 32/16 40/11	scary [1] 144/23
retrospect [1] 154/16	238/23	39/18 41/20 54/23	41/2 45/16 45/20	scenario [1] 39/9
retrospectively [3]	right-hand [3] 99/20	57/2 59/11 61/6 61/17	47/12 54/14 54/17	scene [5] 87/11
72/18 155/14 180/9	196/3 229/12	61/20 61/21 61/24	56/17 56/19 62/13	87/16 196/2 196/13
return [5] 48/25	rightly [2] 104/7	62/22 63/1 64/18	62/15 62/18 63/15	196/19
49/10 58/20 142/19	141/22	66/19 66/23 67/1 67/4	76/20 82/11 90/16	scheduled [1] 31/12
233/19	ring [2] 6/24 64/23	67/19 68/2 71/7 77/13	96/15 100/9 100/14	school [1] 61/4
returned [5] 48/21	ringing [1] 203/22	77/23 83/1 89/7 90/6	100/21 102/15 102/18	science [1] 159/9
53/6 58/24 180/14	rise [2] 122/16	93/25 104/1 110/17	105/8 105/18 105/24	scientist [2] 73/3
189/12	122/20	115/10 121/20 121/21	109/19 111/15 115/10	73/8
returning [2] 198/16	risen [1] 76/4	121/24 121/25 122/1	118/21 120/8 125/18	scientists [2] 232/21
198/19	risk [6] 13/20 62/4	122/7 122/8 122/9	125/18 126/11 126/21	232/22
revalidation [3]	64/21 86/9 149/18	128/8 129/13 132/6	127/13 128/9 128/24	scope [1] 244/19
218/24 219/1 219/2	241/18	132/16 132/24 133/8	130/9 130/12 130/13	screen [12] 34/8
review [28] 49/4	roadshow [1] 245/7	133/10 133/13 133/16	132/8 132/23 133/17	35/12 55/20 56/10
54/10 63/23 70/11	role [13] 58/24 82/15	134/25 135/4 136/3	134/19 134/20 141/9	108/5 150/1 156/14
107/24 109/22 110/15	171/13 172/5 172/7	136/4 136/8 136/9	147/3 150/10 156/22	177/18 178/10 178/16
111/18 111/21 113/7	173/9 213/9 214/10	137/24 139/12 141/2	158/15 162/5 163/17	178/24 209/24
113/14 113/15 113/19	217/19 218/9 227/24	141/12 143/16 146/14	163/23 164/5 168/22	scroll [4] 19/13 20/13
113/25 118/5 122/2	241/21 245/21	147/21 152/4 152/10	169/2 169/9 169/19	69/2 113/2
123/2 125/15 127/1	roles [1] 172/18	155/23 157/6 157/17	170/5 170/25 171/11	scrub [1] 225/24
127/7 204/21 204/24	roll [1] 144/15	163/3 163/24 163/25	172/2 172/7 172/8	scrutiny [2] 189/16
204/25 205/6 205/19	rolling [1] 106/19	163/25 164/2 165/10	181/15 183/21 184/9	189/19
207/20 207/25 212/7	room [11] 60/19 65/3	165/13 169/25 196/11	184/22 184/25 185/13	searching [1] 65/5
reviewed [6] 76/5	84/20 120/22 133/2	203/15 205/21 205/25	185/17 188/6 188/20	second [12] 34/25
76/7 153/3 153/4	135/23 166/18 175/3	206/16 208/14 219/16	188/23 191/3 191/11	80/18 108/13 113/24
204/16 229/23	196/4 197/5 204/16	219/19 220/13 220/14	193/19 198/17 199/6	114/10 136/1 154/13
reviewer [1] 110/10	rooms [3] 84/3 175/3	220/15 220/18 221/1	199/17 200/1 200/15	155/21 167/20 192/6
reviewers [3] 59/11	218/6	221/2 221/4 229/16	201/8 201/24 202/18	219/18 219/24
63/24 212/12	rota [4] 31/14 46/19	232/17	203/18 203/24 204/13	secondly [2] 40/10
reviewing [3] 12/1	238/11 238/11	Saladi [3] 9/11 10/13	205/11 205/11 205/25	123/24
12/2 24/19	rotate [1] 3/24	53/19	206/24 207/17 208/17	secretaries [1] 84/2
reviews [2] 213/25	rotating [1] 181/11	same [26] 9/11 9/21	210/2 210/8 210/13	section [4] 123/4
	round [15] 71/25		211/5 211/8 211/11	123/6 123/14 163/15

S	Semple [3] 143/23 144/1 144/3	83/23 168/18	218/9 218/11 218/19 218/23 218/25 219/1 219/19 220/1 220/3 220/21 220/22 220/23 221/21 221/22 241/5 243/12 245/6	195/4 195/12 211/7 211/9 234/3
see [105] 9/25 10/20 16/8 19/11 19/15 19/23 21/23 22/2 22/9 22/10 24/16 26/25 27/7 29/21 29/25 33/23 33/24 35/9 46/20 61/12 61/16 68/3 69/9 69/13 75/13 90/3 92/8 95/5 98/23 99/18 99/21 99/23 100/1 102/22 111/17 113/9 113/23 114/7 114/11 115/17 116/24 117/15 119/4 119/8 123/14 129/7 131/7 136/24 137/1 137/3 140/25 145/23 150/3 150/24 151/13 152/10 152/24 154/21 155/22 156/11 156/15 158/18 163/15 165/17 168/15 171/24 177/23 178/2 178/6 178/10 179/5 179/23 180/6 180/13 181/14 183/4 184/8 186/18 189/20 192/17 200/7 201/5 201/11 203/12 204/3 205/21 208/24 211/22 212/8 212/20 215/3 215/13 216/1 217/4 218/16 218/19 222/14 224/1 229/9 229/10 229/20 230/14 232/9 236/21 236/22	send [7] 9/5 179/2 205/12 210/15 211/14 216/21 243/10	several [5] 4/1 4/20 10/7 44/10 182/24	she'd [5] 139/10 173/12 198/19 203/6 208/5	show [1] 143/2
seeing [5] 76/1 115/6 117/24 119/10 180/24	senior [24] 4/17 4/21 5/25 6/4 7/3 7/7 7/10 8/10 51/25 52/7 52/20 53/9 59/25 60/24 79/7 154/18 168/11 168/13 171/21 214/24 223/2 229/14 242/21 245/18	severe [1] 24/20	she's [13] 126/7 126/18 127/23 127/24 128/22 128/22 128/22 143/13 143/17 157/10 198/3 212/16 217/15	showed [1] 237/6
seek [1] 94/25	sense [5] 9/3 44/9 44/12 77/25 169/13	Share [6] 2/13 84/13 89/5 141/7 175/3 240/18	sheet [1] 199/5	showing [2] 24/8 76/23
seeking [2] 11/3 46/14	sensible [2] 41/25 122/17	shares [1] 84/18	sheets [1] 185/22	shown [1] 159/17
seem [7] 37/2 46/8 74/14 74/17 87/13 129/21 228/11	sensitive [1] 241/20	sharing [2] 85/3 131/2	shift [19] 44/24 108/21 109/6 109/14 113/16 177/12 180/1 181/20 181/24 181/24 182/19 182/20 183/1 186/3 186/4 186/4 224/18 228/25 239/24	shows [2] 24/17 72/5
seemed [14] 29/6 29/8 36/12 36/23 45/20 54/6 57/13 58/13 60/2 60/4 61/1 61/2 85/10 173/11	sent [26] 9/10 39/3 53/19 86/24 95/6 96/9 113/13 124/3 124/13 124/23 146/17 179/2 179/15 183/4 193/2 193/6 194/10 194/12 209/1 211/9 211/12 215/2 226/21 232/18 238/12 244/11	she [165] 5/23 11/24 37/22 44/22 44/23 46/1 46/18 50/6 55/6 58/17 58/23 59/1 75/15 75/19 75/22 75/22 76/8 77/19 82/24 83/3 85/3 85/15 85/18 93/21 93/21 103/2 103/5 104/8 104/22 104/24 104/25 107/14 109/4 118/16 126/7 127/14 127/16 127/17 128/6 128/21 133/13 133/15 134/24 135/2 135/6 135/10 137/5 137/18 137/18 137/22 138/8 138/9 138/18 138/18 140/12 140/13 141/8 143/2 143/5 143/5 143/11 143/18 154/2 154/2 154/5 154/6 154/20 154/24 155/2 157/9 157/20 161/22 162/22 172/6 172/17 173/1 173/4 183/2 184/4 184/11 186/5 192/10 197/25 198/3 198/12 199/8 200/4 200/4 200/6 200/7 200/11 200/19 200/21 200/25 201/12 201/14 201/16 201/16 202/3 202/4 202/4 202/15 203/2 203/3 203/10 203/11 203/15 203/20 203/22 204/6 204/7 204/9 204/9 206/4 207/25 208/1 208/9 208/9 208/10 209/24 210/4 210/6 210/12 210/19 210/20 211/17 211/17 211/18 212/8 212/8 212/16 212/20 212/22 213/3 213/3 213/9 213/24 214/2 215/10 215/15 215/25 216/7 216/11 217/6 217/18 217/20 217/23 217/25	shocked [2] 145/3 145/13	shut [1] 60/5
seems [4] 79/12 100/19 165/19 206/23	sentences [1] 18/9	ships [1] 37/23	shipped [1] 199/5	sick [7] 44/25 87/9 92/15 92/15 126/8 127/15 128/17
seen [34] 9/10 9/12 22/5 22/8 22/8 32/19 32/20 32/21 35/6 38/21 38/25 63/8 95/11 100/5 100/11 100/15 113/11 115/9 117/21 126/23 132/11 140/3 155/25 157/17 166/5 166/5 178/13 192/5 192/6 199/18 229/1 239/17 244/23 245/9	separately [4] 20/25 97/22 131/7 243/23	SHO [2] 35/10 238/11	shifting [1] 199/5	side [8] 26/3 26/5 30/22 62/19 90/10 196/3 196/24 229/12
seemingly [1] 100/19 100/19 165/19 206/23	sepsis [5] 49/8 75/25 76/17 155/5 160/12	short [10] 19/5 36/3 65/22 133/2 137/23 164/17 167/9 169/17 229/22 238/13	shirts [12] 11/18 44/23 122/5 126/8 181/12 181/12 190/17 203/1 203/5 203/6 203/11 229/4	sidelined [1] 8/19
seemingly [1] 100/19 100/19 165/19 206/23	September [16] 4/16 46/18 59/9 59/17 75/21 99/13 100/8 167/20 167/25 167/25 168/3 176/1 183/21 192/10 192/15 223/5	shortly [3] 13/10 52/18 132/11	Shipman [1] 37/23	signatory [1] 243/10
seemingly [1] 100/19 100/19 165/19 206/23	September 2015 [3] 4/16 167/25 192/10	should [77] 12/9 14/2 14/6 17/7 17/16 24/21 25/2 25/4 25/8 25/14 25/21 25/22 26/16 26/20 30/25 32/1 37/8 38/3 40/11 40/14 40/18 40/19 40/21 40/22 41/1 50/25 51/2 53/20 53/24 54/2 54/7 64/10 65/13 66/14 71/20 72/15 72/24 73/17 75/7 80/5 83/14 85/14 91/20 96/10 96/23 97/22 102/1 102/13 106/7 106/14 107/19 109/1 109/15 115/13 115/14 124/25 125/12 129/3 129/8 130/18 133/11 140/21 147/12 161/8 170/13 189/23 190/11 190/13 190/22 190/22 195/25 197/8 215/14 215/22 222/15 225/18 240/17	SHO [2] 35/10 238/11	signed [5] 30/24 145/23 218/16 218/20 219/14
seemingly [1] 100/19 100/19 165/19 206/23	septic [1] 68/11	shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	significance [6] 24/7 71/2 73/19 159/19 224/15 231/3
seemingly [1] 100/19 100/19 165/19 206/23	sequence [1] 146/3	shocked [2] 145/3 145/13	shocks [2] 145/3 145/13	significant [9] 12/16 33/16 42/25 48/1 67/11 105/2 112/25 182/4 214/17
seemingly [1] 100/19 100/19 165/19 206/23	sequences [1] 181/12	shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	significantly [1] 116/13
seemingly [1] 100/19 100/19 165/19 206/23	serious [13] 40/20 43/25 75/5 75/20 89/12 98/8 98/12 98/15 106/14 127/25 129/5 129/14 187/15	shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	signpost [1] 131/9
seemingly [1] 100/19 100/19 165/19 206/23	seriously [1] 62/25	shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	signs [8] 24/8 24/17 24/21 118/19 159/25 234/17 234/21 236/13
seemingly [1] 100/19 100/19 165/19 206/23	service [4] 3/1 10/22 12/3 218/3	shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	similar [7] 8/15 9/15 64/4 65/10 146/11 159/18 161/7
seemingly [1] 100/19 100/19 165/19 206/23	services [1] 244/23	shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	similarities [1] 91/22
seemingly [1] 100/19 100/19 165/19 206/23	session [1] 167/1	shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	similarity [2] 92/24 94/5
seemingly [1] 100/19 100/19 165/19 206/23	sessions [1] 215/11	shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	similarly [2] 145/24 235/10
seemingly [1] 100/19 100/19 165/19 206/23	set [8] 168/7 168/17 177/11 177/16 188/17 217/14 217/21 238/10	shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	Simon [2] 64/11 144/25
seemingly [1] 100/19 100/19 165/19 206/23	sets [2] 148/16 198/25	shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	simply [1] 101/10
seemingly [1] 100/19 100/19 165/19 206/23	seven [4] 21/2 65/2	shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	since [7] 3/4 147/15 162/12 186/13 208/18 222/3 222/3
seemingly [1] 100/19 100/19 165/19 206/23		shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	Sincerely [1] 202/16
seemingly [1] 100/19 100/19 165/19 206/23		shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	single [2] 166/25 167/3
seemingly [1] 100/19 100/19 165/19 206/23		shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	singled [1] 172/9
seemingly [1] 100/19 100/19 165/19 206/23		shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	sister [2] 149/2 149/2
seemingly [1] 100/19 100/19 165/19 206/23		shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	sit [7] 1/15 7/4 27/19 81/3 84/2 144/12 175/22
seemingly [1] 100/19 100/19 165/19 206/23		shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	site [1] 226/7
seemingly [1] 100/19 100/19 165/19 206/23		shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	sites [1] 242/1
seemingly [1] 100/19 100/19 165/19 206/23		shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	sits [1] 23/15
seemingly [1] 100/19 100/19 165/19 206/23		shocks [2] 145/3 145/13	shocks [2] 145/3 145/13	sitting [6] 99/13 115/21 116/1 121/1 134/21 135/3

S	133/21 145/7 150/6 150/10 150/17 151/14 153/19 158/8 158/13 158/16 160/24 161/17 161/18 165/5 168/25 169/18 171/15 172/8 173/18 179/3 179/20 183/4 184/2 190/4 197/5 206/4 210/23 214/3 214/19 215/5 215/11 221/10 221/17 225/18 232/12 233/1 234/11 235/9 236/17 237/9 237/12 239/15 240/1	133/11 sooner [1] 85/15 sorry [38] 65/24 69/7 81/16 81/17 81/20 94/18 99/16 102/12 102/12 102/15 103/11 115/15 118/25 122/1 127/12 136/1 151/22 154/9 157/15 157/22 162/5 170/17 172/21 173/6 173/11 174/25 184/14 184/18 194/1 198/17 213/19 217/12 218/17 220/13 222/7 225/11 227/17 232/24	95/8 131/18 174/6 174/10 spending [1] 140/5 spent [1] 197/4 spinal [1] 33/25 spoke [14] 14/14 25/19 66/20 129/18 131/16 137/8 137/11 138/18 138/20 139/12 156/11 156/17 156/21 207/13 spoken [10] 73/13 95/9 106/7 133/5 135/17 137/14 139/1 141/13 143/23 146/8 spokesperson [1] 48/4 sponsored [1] 245/9 ST4 [1] 70/11 stabilise [1] 177/15 stabilised [1] 156/19 stable [6] 32/12 35/24 132/12 133/18 185/18 188/13 staff [19] 5/6 5/8 10/11 50/24 57/15 86/9 86/17 109/6 112/20 118/14 120/1 120/5 133/13 146/18 207/15 209/21 215/7 239/12 241/25 staffing [8] 9/7 10/1 10/9 54/18 57/12 57/14 119/13 119/14 staffs [1] 128/13 stage [6] 23/20 28/9 28/16 29/12 50/25 52/6 stages [2] 4/14 111/22 stand [2] 116/21 213/11 standing [2] 133/7 134/23 stands [2] 23/12 61/20 start [15] 65/20 85/20 87/9 89/17 102/16 119/4 122/20 143/14 152/22 154/14 167/7 183/1 183/16 184/8 200/1 started [5] 83/22 85/9 92/18 176/1 181/20 starting [3] 154/12 187/20 196/16 starts [2] 35/12 183/13 state [4] 33/20 40/7 50/23 116/18 stated [2] 181/21 243/9 statement [84] 1/19	1/21 3/8 6/11 7/16 13/11 21/12 22/7 22/19 24/6 28/21 29/5 40/11 47/2 47/17 52/25 53/2 54/14 59/18 60/11 62/8 64/10 67/24 81/7 81/9 82/11 89/18 90/5 90/14 90/20 94/7 94/9 94/12 96/18 102/10 102/12 102/20 104/14 106/18 121/5 126/4 130/15 131/19 132/15 135/8 135/16 136/9 137/10 138/17 139/21 142/14 142/18 143/22 144/15 145/2 145/21 145/24 146/16 146/24 146/24 147/7 147/7 148/1 163/12 164/24 165/15 168/7 168/11 173/24 187/19 188/7 202/14 202/17 209/4 210/10 216/14 219/18 222/12 222/16 234/15 236/4 241/3 241/9 246/4 statements [11] 92/25 93/1 94/7 94/11 145/19 146/13 147/1 147/12 167/19 173/19 173/21 states [1] 242/24 stating [1] 244/11 status [1] 185/23 stay [6] 13/10 30/2 166/19 166/20 211/6 241/1 stayed [3] 190/16 190/17 196/24 step [3] 58/6 58/7 58/13 Stephen [1] 208/19 Stephen Brearey [1] 208/19 Stepping [2] 13/1 13/4 steps [8] 30/25 37/8 51/25 73/24 74/13 91/17 244/24 245/25 Steve [2] 45/3 46/10 stick [1] 172/20 sticks [1] 56/15 still [19] 17/22 42/11 57/23 68/5 72/2 72/8 121/1 123/12 131/11 156/7 160/12 163/4 180/4 191/6 197/18 206/25 207/21 212/14 217/23 stood [1] 56/11 stop [11] 28/12 54/8 65/6 65/7 88/11 98/14 121/23 126/19 136/12
----------	---	---	--	---

S	suffered [1] 75/19 suffering [1] 224/9 suffice [1] 150/10 sufficient [1] 64/6 sufficiently [1] 23/19 sugar [5] 34/9 34/11 34/13 35/24 177/14 suggest [5] 22/4 44/15 144/11 172/25 209/4 suggested [8] 45/22 47/9 82/24 169/24 173/1 194/2 195/11 236/15 suggesting [3] 40/12 53/20 180/3 suggestion [2] 39/13 119/25 Suite [2] 134/14 164/4 summarised [1] 218/25 summary [9] 61/5 64/16 67/7 88/22 114/7 114/8 144/1 144/18 197/1 sums [1] 36/4 Sunday [1] 230/23 sunk [1] 125/22 supervise [2] 107/3 217/14 supervised [5] 59/1 143/12 143/18 217/7 244/2 supervising [1] 59/3 supervision [4] 58/21 59/2 59/6 143/6 supplemental [1] 233/23 support [9] 10/23 131/8 147/9 184/3 184/3 200/9 213/10 213/15 222/6 supported [3] 168/23 214/18 226/7 supporting [1] 225/8 supportive [6] 3/21 4/2 204/5 213/5 213/16 214/14 suppose [1] 166/3 supposed [2] 220/8 221/4 sure [34] 6/3 13/21 26/14 27/5 31/22 45/4 45/7 48/15 94/10 95/12 97/18 101/24 106/15 113/25 139/16 140/22 159/5 160/20 166/7 176/24 180/2 181/6 185/4 186/22 190/6 190/6 191/21 193/1 201/9 206/20 207/14 207/15 207/19 231/12	Surely [1] 189/5 surface [1] 41/12 surgeon [2] 214/24 242/21 surgeons [1] 104/16 surgical [2] 215/12 236/20 surprise [4] 16/21 16/24 92/6 111/23 surprised [2] 23/1 93/5 surprising [2] 38/2 93/14 surrounding [1] 161/20 survey [1] 3/23 suspect [7] 79/18 155/5 194/8 194/15 229/21 234/17 235/18 suspected [4] 12/10 160/15 228/16 235/20 suspended [2] 172/3 172/4 suspicion [3] 70/4 106/7 192/14 suspicious [10] 77/11 80/6 140/3 140/20 147/8 163/8 164/7 191/9 191/12 192/4 suspicious [6] 139/6 140/19 188/25 189/7 189/8 193/15 Suter [1] 102/21 sworn [3] 1/13 167/12 247/2 symptoms [2] 70/24 234/22 synthetic [1] 179/16 system [13] 17/3 17/12 17/15 17/16 18/22 33/15 92/12 119/2 195/24 196/6 231/13 232/1 238/20	200/23 213/3 213/10 223/25 224/7 226/11 227/17 236/7 241/2 taken [20] 6/4 30/25 32/7 34/7 37/9 58/16 62/9 76/3 76/19 83/11 92/1 93/9 97/20 100/23 115/9 139/11 214/9 227/4 229/1 244/24 takes [2] 107/25 179/3 taking [15] 5/19 13/23 29/8 38/9 46/21 51/25 62/25 69/3 79/7 87/12 190/4 190/18 193/5 213/2 213/5 talk [13] 6/6 6/8 152/22 156/19 162/3 162/7 175/9 193/12 199/7 199/10 203/10 212/6 240/7 talked [5] 21/25 119/7 121/21 129/16 146/5 talking [18] 7/4 19/22 19/23 28/17 55/12 55/21 97/8 97/23 106/1 114/25 128/3 129/10 130/1 149/4 150/22 165/8 176/22 240/2 talks [1] 20/16 tangible [1] 29/10 tasks [4] 11/20 196/15 226/3 226/4 teaching [1] 242/2 team [26] 17/24 73/13 78/17 84/22 130/22 131/25 131/25 133/5 133/10 171/1 176/15 176/15 185/23 188/15 192/3 197/8 207/19 216/3 219/16 231/18 236/20 238/8 242/19 242/19 243/6 245/4 teams [1] 106/20 technical [1] 39/7 telephone [1] 233/1 telephoned [2] 73/2 180/20 tell [43] 13/11 13/16 16/18 21/11 29/1 30/5 33/22 43/2 46/25 47/2 47/7 66/16 67/3 67/6 84/5 86/25 88/23 89/17 103/21 105/6 121/4 121/24 129/12 130/15 132/23 134/8 139/18 139/21 139/25 143/22 144/6 145/1 146/19 174/5 174/13 174/21 177/17 182/14	187/20 211/2 218/21 219/21 225/9 telling [5] 67/24 127/9 146/15 184/19 203/13 ten [2] 122/20 122/21 tend [3] 97/14 106/25 107/1 tender [2] 68/24 104/10 tenet [1] 159/8 tension [1] 16/18 terms [18] 2/9 2/16 5/3 5/19 12/18 24/24 27/13 28/10 40/10 63/1 80/19 124/6 144/13 147/24 159/14 173/23 231/6 238/23 terrible [3] 13/7 100/25 143/14 terrified [1] 143/12 tertiary [1] 160/19 test [12] 73/22 73/25 74/2 74/20 74/25 76/11 76/19 76/23 177/18 179/15 179/23 180/24 testing [1] 226/23 tests [3] 178/10 178/19 178/25 text [2] 19/15 100/2 texting [1] 213/11 than [35] 15/20 23/24 29/9 31/6 32/17 33/25 37/13 43/18 48/9 52/9 55/11 64/23 75/23 76/16 76/19 76/24 80/1 83/12 85/15 101/10 110/13 110/18 125/13 126/13 170/15 170/17 170/18 185/2 194/4 199/13 202/20 209/24 214/5 232/10 243/14 than 1 [4] 75/23 76/16 76/24 185/2 thank [56] 1/14 11/7 17/2 27/23 46/11 46/16 48/13 56/9 64/7 65/14 66/3 77/1 77/3 80/8 80/8 80/9 80/14 80/15 80/21 81/4 81/21 96/15 113/17 119/17 122/12 123/1 146/2 148/18 152/17 154/15 161/11 161/11 161/12 161/16 164/14 164/16 165/2 166/12 166/16 167/12 167/18 175/21 185/10 202/17 217/12 222/20 223/20 227/1 240/20 240/20 240/22 240/25 241/7 241/12 246/5 246/7
----------	--	---	---	--

<p>T</p> <p>that [1660]</p> <p>that E [1] 204/4</p> <p>that's [96] 2/12 4/2 19/2 20/4 22/22 27/14 31/14 31/14 32/19 33/25 34/8 34/22 35/5 37/20 38/6 40/12 42/10 43/16 52/16 60/11 68/11 68/15 76/4 76/16 81/8 81/15 81/20 82/2 82/17 84/19 84/23 86/13 86/18 89/15 89/20 91/7 100/15 102/9 105/18 108/6 108/6 109/11 109/25 111/9 111/11 113/12 134/14 139/5 142/7 147/24 149/1 149/21 150/1 154/16 156/3 159/16 159/21 162/17 162/18 166/3 167/5 168/2 168/6 169/15 171/4 171/5 173/22 185/25 186/22 189/4 189/18 199/9 203/1 203/3 205/20 208/18 216/22 216/22 217/3 223/4 223/8 224/4 225/17 226/1 226/22 226/23 227/7 227/18 227/20 231/5 231/20 235/22 238/13 239/8 239/17 240/16</p> <p>That's May 2017 [1] 217/3</p> <p>theatre [5] 215/6 215/11 215/16 216/8 216/9</p> <p>theatres [1] 242/18</p> <p>their [33] 5/12 6/21 14/16 38/8 52/14 52/15 52/18 53/5 79/8 82/20 83/14 85/25 92/2 106/7 111/7 112/4 118/8 133/6 133/11 148/7 148/12 163/21 172/15 175/13 186/24 187/1 187/6 190/17 197/19 216/16 231/3 232/3 239/18</p> <p>them [87] 3/3 3/5 3/6 3/17 6/14 6/18 7/10 7/13 14/16 26/11 34/12 36/17 36/20 38/19 39/6 39/14 41/13 43/17 47/9 61/1 66/20 67/2 67/6 67/12 67/20 72/9 72/25 82/4 83/2 86/14 89/5 92/2 92/21 93/22 104/18 110/11 125/10 131/7</p>	<p>131/9 134/11 134/20 134/25 135/20 139/9 139/9 140/11 140/12 140/12 140/17 147/3 147/19 149/1 156/23 157/6 158/14 168/25 173/14 173/15 177/22 178/15 179/7 185/24 186/15 188/10 188/18 190/7 190/9 190/9 191/7 200/20 201/2 206/10 207/12 209/8 209/20 209/23 210/21 214/10 225/8 225/9 231/3 231/19 233/2 233/8 236/8 243/17 243/22</p> <p>thematic [14] 49/4 109/22 111/18 111/21 113/7 113/14 113/15 113/19 118/5 122/2 123/2 125/15 127/1 127/7</p> <p>theme [3] 9/21 89/4 117/24</p> <p>themes [4] 111/17 117/15 117/17 120/7</p> <p>then [124] 24/21 25/24 27/8 29/23 31/4 37/22 40/25 41/1 42/18 60/3 62/3 63/5 64/6 64/16 64/19 65/3 67/3 67/10 69/15 69/16 69/24 70/9 71/23 74/12 83/23 84/1 84/4 85/17 87/9 88/5 88/6 89/5 89/6 90/22 90/23 91/9 92/11 92/15 98/13 99/23 104/22 107/8 107/15 109/15 111/11 114/15 118/24 119/4 122/10 123/8 125/18 133/1 134/10 135/22 138/21 138/22 139/19 140/7 140/16 140/25 141/1 141/10 142/7 143/3 143/15 143/17 143/19 145/7 145/14 149/25 151/12 152/13 155/25 156/6 156/10 156/19 157/2 157/19 160/6 164/5 166/21 174/21 178/10 178/19 180/19 181/10 183/5 184/13 184/19 185/2 186/3 188/23 190/3 193/17 196/16 196/20 196/22 196/23 197/14 199/19 201/4 202/18 206/11 210/6 212/19 216/21 217/4 218/10 222/20 223/20 227/1 229/2 229/24 230/1</p>	<p>230/20 232/19 232/22 232/25 233/22 236/18 236/20 236/23 238/23 242/21</p> <p>there [341]</p> <p>there's [33] 46/11 48/2 69/15 69/16 69/24 70/17 74/9 84/1 84/3 84/15 84/15 84/17 86/11 86/14 123/4 157/1 157/2 158/10 159/10 159/10 174/15 178/3 183/22 205/23 212/2 212/4 212/25 214/2 215/21 220/25 222/12 224/1 234/6</p> <p>therefore [3] 55/5 100/14 245/20</p> <p>these [43] 16/24 18/15 20/21 22/3 33/17 37/1 45/2 55/1 65/12 92/25 93/1 98/7 98/10 98/17 101/20 105/3 106/16 106/18 106/20 112/13 113/16 122/5 126/2 129/13 129/14 140/4 140/7 147/2 151/21 152/2 163/7 183/15 188/13 192/18 204/24 210/18 210/22 213/7 214/8 230/6 232/4 232/8 237/20</p> <p>they [186] 3/12 6/4 6/5 6/13 6/18 6/23 6/23 6/24 6/25 7/2 7/23 8/18 13/5 15/21 27/19 30/10 31/15 31/17 32/15 34/21 38/8 38/10 39/3 39/3 41/11 42/14 43/21 43/23 44/16 47/9 47/11 52/1 52/2 53/10 55/9 59/3 59/3 60/2 60/4 60/24 62/12 62/15 62/17 62/19 62/20 62/22 64/1 66/19 72/6 72/21 72/23 80/5 83/1 83/11 87/3 88/4 88/5 88/6 89/7 89/8 89/8 92/19 97/14 97/15 97/19 104/20 104/21 105/21 106/5 107/3 107/4 107/5 107/13 107/14 108/11 108/12 108/14 108/14 109/8 111/25 116/14 117/10 117/11 128/18 128/20 129/14 129/15 131/8 131/16 131/23 133/5 133/11 135/4 140/17 140/17 141/19 150/16 155/5</p>	<p>157/17 157/17 157/18 160/25 161/1 163/21 164/21 165/10 168/23 169/25 170/7 170/10 171/23 171/23 171/24 171/25 172/9 172/11 173/10 173/11 174/22 175/2 177/2 177/6 177/14 178/13 178/23 179/24 180/3 185/11 186/23 186/25 187/2 187/5 188/13 188/14 190/6 192/11 192/14 192/19 197/7 197/9 197/11 197/12 200/16 206/14 206/15 206/24 207/24 208/8 208/8 209/17 210/19 212/6 212/23 214/12 214/12 218/12 222/8 224/21 225/15 225/16 225/18 225/21 226/4 226/4 227/24 230/8 230/23 231/8 231/11 231/15 232/1 232/5 232/11 232/12 232/16 233/5 233/6 233/7 236/21 236/22 236/22 236/23 236/23 243/15 243/18 246/3</p> <p>they'd [9] 38/19 63/25 72/14 73/10 90/9 94/17 187/8 195/8 199/17</p> <p>they'll [1] 106/22</p> <p>they're [7] 36/14 72/20 84/19 108/10 127/5 230/10 231/25</p> <p>they've [2] 150/17 230/7</p> <p>thing [17] 15/10 25/6 41/25 83/10 91/8 91/14 92/8 113/13 118/14 118/15 126/12 145/18 147/12 165/4 184/23 198/13 230/9</p> <p>things [52] 7/20 7/21 8/1 12/1 17/13 18/14 18/16 18/21 22/11 31/17 31/21 36/24 38/11 39/16 41/21 43/18 43/19 51/6 61/18 71/18 82/12 82/22 91/9 91/12 93/20 101/24 120/8 122/3 126/5 126/8 138/17 138/24 142/8 143/14 146/24 147/10 151/15 155/16 158/8 158/25 159/20 162/4 163/25 184/15 194/8 194/8 206/3 209/5 213/17 222/8 239/6 240/8</p>	<p>think [296]</p> <p>thinking [18] 15/18 36/10 46/7 101/11 116/5 126/13 134/19 140/6 157/6 157/23 159/9 160/10 173/10 180/5 190/21 206/24 206/25 239/16</p> <p>thinks [2] 47/17 213/1</p> <p>third [2] 14/19 219/24</p> <p>thirdly [1] 124/2</p> <p>THIRLWALL [2] 165/1 247/10</p> <p>this [262]</p> <p>those [89] 3/2 6/1 7/4 13/9 13/20 14/6 14/15 25/23 28/2 28/13 30/16 34/10 35/17 37/5 41/11 42/13 44/5 53/4 55/8 61/8 61/12 61/17 62/18 63/1 73/19 74/12 78/4 79/6 84/13 84/18 86/3 91/12 97/1 98/13 99/19 106/2 115/4 116/14 120/5 127/3 129/11 129/19 130/19 131/4 139/7 139/7 139/25 139/25 140/20 144/5 146/13 146/15 147/12 148/14 148/24 159/20 159/23 161/6 161/8 166/14 169/13 172/19 172/23 174/22 175/18 176/8 177/2 178/10 178/19 179/11 179/21 179/23 179/25 180/24 187/10 190/19 207/7 209/14 209/18 214/8 223/20 228/7 232/16 233/13 234/21 234/22 235/14 237/4 239/6</p> <p>though [7] 94/19 132/3 137/9 140/20 199/4 212/25 236/13</p> <p>thought [39] 5/7 6/5 23/6 24/2 24/20 25/20 26/5 39/24 39/25 40/24 40/25 50/1 50/2 50/18 53/24 55/6 76/4 87/20 87/23 88/23 91/15 97/7 104/8 105/15 138/15 139/15 140/25 142/7 148/3 159/5 163/4 186/18 191/25 192/7 198/18 200/2 201/17 216/15 228/18</p> <p>thoughts [3] 25/24 92/2 141/13</p> <p>thrashing [1] 97/11</p>
--	---	--	--	---

T	85/11 86/21 88/6 88/16 90/8 91/14 91/19 91/24 93/25 97/6 97/10 97/25 100/16 100/21 100/24 101/8 102/4 104/4 104/8 105/1 105/5 106/2 107/5 110/17 116/21 118/8 118/13 118/16 120/17 120/17 121/15 122/13 122/17 124/12 124/20 125/3 125/13 125/22 129/12 129/21 133/2 133/19 133/21 133/21 134/2 135/15 136/20 137/8 137/19 138/18 139/21 140/2 140/22 141/23 142/4 143/4 146/25 147/11 147/16 147/16 151/4 152/5 155/3 155/21 156/20 157/20 158/3 158/6 158/15 160/23 161/4 161/9 168/12 169/17 174/11 174/12 174/14 174/22 177/9 179/3 180/9 180/24 182/20 186/9 186/17 186/24 187/6 189/10 190/2 190/4 190/9 194/11 194/13 194/14 194/16 195/15 196/10 196/14 199/19 202/7 203/22 204/10 205/2 205/13 207/13 209/21 211/10 211/12 211/23 213/1 213/16 214/6 214/18 215/6 217/19 217/24 219/5 219/10 221/10 222/10 222/14 225/13 226/6 226/12 227/2 229/5 229/17 230/21 231/4 231/8 231/10 231/19 233/13 233/16 234/14 235/10 235/15 235/23 237/3 239/22 242/9 244/2	today [10] 1/4 4/8 16/25 80/15 122/16 122/18 126/18 128/22 212/18 222/21 together [16] 27/1 29/8 46/20 53/9 97/22 135/20 141/13 175/9 175/22 181/2 185/11 192/17 197/17 218/21 218/23 242/14 toilet [1] 59/4 told [42] 21/18 24/5 39/21 43/22 49/15 50/10 54/8 63/17 63/25 64/1 82/24 93/16 94/4 101/1 104/1 109/1 114/21 115/3 131/12 131/13 143/8 144/1 146/10 147/23 173/14 192/9 194/25 195/20 206/7 208/9 219/8 220/1 220/3 220/8 220/14 220/17 220/19 220/21 221/12 224/14 225/18 225/21 tolerating [1] 69/18 tomorrow [4] 198/8 203/16 241/3 246/7 tone [7] 60/23 60/25 61/2 61/24 70/1 137/22 144/20 tonight [1] 203/14 Tony [4] 9/6 59/17 61/21 144/21 Tony Chambers [4] 9/6 59/17 61/21 144/21 too [5] 63/16 179/21 186/13 191/18 232/10 took [22] 5/14 5/15 41/3 47/15 53/17 62/2 62/19 109/23 111/15 117/7 121/10 122/6 174/12 207/17 221/18 222/10 223/18 226/2 226/4 226/6 235/17 245/25 tool [1] 131/2 top [11] 19/15 27/7 27/18 52/22 95/5 99/20 153/7 153/9 181/9 227/15 228/13 topic [4] 8/24 12/4 108/18 121/4 topics [1] 77/10 total [1] 222/15 touch [1] 234/13 towards [4] 7/7 59/25 99/24 221/17 tract [2] 68/18 236/16 trail [1] 181/10 trainee [7] 3/22 7/1 20/16 107/3 150/4	150/24 224/21 training [13] 3/4 4/14 12/9 12/12 12/16 33/1 86/8 86/12 86/18 168/24 215/14 242/2 242/3 transcript [2] 116/7 157/16 transcription [1] 153/8 transfer [3] 41/8 185/24 236/23 transferred [5] 72/6 72/6 135/13 185/21 197/16 transient [3] 68/7 68/13 68/14 transport [3] 133/5 133/10 197/8 traumatic [3] 187/22 188/1 195/9 traumatised [1] 188/21 travelled [1] 187/9 treat [1] 95/15 treated [2] 179/22 233/15 treating [3] 92/7 151/7 236/11 treatment [3] 90/1 90/21 117/6 trends [2] 97/17 202/21 trespassing [1] 222/25 trial [6] 147/3 151/24 152/12 162/15 171/19 179/18 trick [1] 212/13 tried [3] 130/20 162/13 171/19 triggered [1] 78/8 triggering [1] 78/9 triplets [6] 188/13 197/23 198/1 198/3 198/21 198/25 trips [1] 198/7 trouble [2] 216/23 244/12 true [6] 1/22 9/18 40/7 81/9 118/3 167/21 truly [1] 112/2 trust [19] 7/21 14/5 58/3 79/25 82/15 215/16 241/15 241/19 241/22 241/25 242/6 242/11 242/16 243/3 244/21 245/2 245/15 245/18 245/25 Trust's [2] 241/17 244/19 try [10] 7/12 23/6 28/12 93/5 96/11	100/22 152/7 152/14 162/24 162/25 trying [14] 12/3 37/11 51/5 146/22 147/5 147/20 151/17 162/16 183/7 189/9 203/15 210/23 230/6 233/12 tube [1] 191/17 tubed [1] 155/23 Tuesday [1] 246/10 turn [7] 18/19 21/8 64/14 90/13 100/1 227/1 234/11 Turning [1] 7/3 twice [1] 126/18 twin [9] 94/17 114/17 114/18 114/25 115/6 131/14 132/1 149/2 165/14 twins [2] 160/25 165/10 two [57] 3/2 13/9 14/15 20/21 38/11 39/16 62/9 62/18 63/1 73/21 74/2 77/10 84/13 84/16 90/23 91/23 94/1 108/15 113/6 113/19 135/20 139/11 140/4 140/14 141/2 144/24 147/2 148/15 148/24 149/2 153/20 159/20 161/4 161/6 163/7 163/25 167/19 169/14 172/20 172/23 182/21 191/6 196/12 201/15 204/24 205/24 208/9 209/12 210/19 210/22 212/23 216/10 218/19 224/13 229/4 234/6 239/6 two days [2] 94/1 149/2 two hours [2] 139/11 141/2 two weeks [1] 113/6 two years [1] 153/20 two-page [1] 218/19 type [1] 158/16 typed [1] 205/1
	timed [7] 72/12 72/18 72/20 72/21 76/11 76/21 136/25 timeline [6] 9/4 12/7 18/12 41/22 43/15 89/16 times [15] 4/1 4/20 73/7 104/23 107/21 108/12 127/14 169/11 175/23 178/25 182/22 210/3 217/7 218/25 244/2 timing [2] 108/8 117/17 timings [1] 171/12 tirelessly [1] 204/1	U Ukoh [2] 175/17 177/19 ultrasound [8] 227/19 227/25 228/5 228/15 228/20 228/22 229/22 230/3 unable [2] 183/8 244/7 unacceptable [1] 234/9 unaware [5] 165/8 165/9 165/10 177/17 245/19		

U				
uncertain [1] 67/16	114/14 115/4 123/5	244/7 246/6 246/9	60/4 64/16 67/3 67/4	35/21 37/1 37/5 42/25
unclear [1] 236/12	130/2 130/6 132/9	until May 2017 [1]	79/24 80/13 81/6	48/1 54/6 55/10 55/10
uncomfortable [1]	140/18 141/18 176/6	244/7	82/18 82/24 83/23	56/13 56/15 59/13
50/8	176/11 177/4 181/19	untoward [2] 98/15	85/18 88/23 89/17	60/15 60/18 61/1 61/2
uncomfortableness	188/3 188/22 189/2	118/19	94/4 101/1 101/21	62/2 62/22 72/17 75/8
[1] 51/8	189/5 189/19 189/23	unusual [22] 18/14	101/21 102/2 102/3	75/15 77/3 80/9 80/14
unconscious [1]	192/13 192/18 192/19	18/16 22/20 23/8	103/22 104/1 105/6	80/16 80/21 81/12
55/7	193/8 193/15 199/22	35/23 36/15 57/24	107/18 110/1 111/10	81/21 85/2 87/9 91/9
undated [1] 218/20	202/24 210/19	70/5 72/17 94/1	111/12 114/21 115/3	96/16 100/19 102/13
under [13] 11/10	unexpectedly [5]	101/20 116/2 116/18	120/12 121/5 121/9	106/14 112/25 119/22
14/17 16/10 27/7 42/3	91/18 102/7 104/5	162/11 180/19 182/2	121/24 127/9 130/15	122/12 122/19 123/13
49/6 108/19 114/6	123/17 132/25	198/13 198/24 231/21	131/7 131/12 132/23	127/25 129/5 129/5
117/20 119/23 143/6	unexplained [17]	235/6 235/11 236/19	134/8 139/21 139/25	130/24 132/8 134/21
241/18 244/18	50/4 55/3 57/20 87/25	unusually [2] 231/16	143/22 144/5 144/7	135/7 135/9 137/6
underestimating [1]	140/18 141/18 177/5	233/25	145/1 145/9 153/19	137/13 142/8 144/10
110/19	188/3 188/22 189/2	unwell [2] 183/3	166/25 167/2 174/5	144/17 144/17 144/22
undergone [1]	189/5 189/19 189/23	196/5	174/13 177/17 182/14	144/22 148/23 161/12
178/17	191/8 192/18 192/19	up [59] 9/20 13/12	187/20 187/22 191/21	163/17 165/2 166/12
underlying [1] 237/6	210/3	15/25 17/12 18/19	192/9 193/24 206/7	167/5 170/2 171/7
understand [34] 7/17	unfair [1] 32/22	18/22 26/25 33/13	211/6 218/21 219/21	176/6 184/4 186/22
17/5 23/6 24/10 27/1	unhappiness [2]	33/14 35/3 36/4 37/21	230/4	187/22 188/21 196/7
27/12 30/19 37/11	44/13 172/3	39/8 45/9 54/1 55/20	use [5] 7/15 15/8	196/7 198/23 204/4
40/6 41/15 58/19	unhappy [6] 162/3	60/5 64/14 81/19 83/8	83/18 85/2 142/6	206/16 207/21 208/5
94/19 96/11 100/23	162/8 172/9 172/14	89/2 89/3 89/5 90/13	used [13] 7/18 8/24	208/12 208/15 210/20
101/16 110/1 113/8	172/22 173/11	97/17 97/17 98/10	12/23 13/2 13/5 37/12	232/17 240/25 241/7
119/2 124/19 141/25	unit [58] 5/20 11/4	99/17 101/12 112/22	39/6 83/3 100/6 131/2	246/5
145/5 158/18 160/1	19/4 23/24 30/9 36/9	114/11 120/14 120/21	210/10 219/1 238/5	via [1] 245/3
160/3 176/19 184/3	41/9 44/17 58/18 72/3	123/10 125/24 132/3	useful [1] 182/6	victimised [1] 64/20
186/16 192/16 192/20	73/3 86/1 86/23 87/14	138/25 141/10 145/19	using [5] 17/16	view [17] 3/18 5/14
198/12 208/19 218/20	87/15 92/11 93/6	147/21 150/6 171/7	195/24 214/5 216/8	5/15 5/20 8/9 11/9
230/6 239/21	97/25 105/22 106/6	175/24 180/12 184/2	238/2	14/16 19/14 49/25
understandably [2]	116/3 126/1 130/25	186/17 186/24 188/17	usual [2] 61/10	53/22 58/4 70/25
154/3 237/17	134/13 135/13 150/8	195/21 199/12 199/19	229/11	90/19 97/16 132/2
understanding [20]	154/8 161/7 168/8	216/8 225/6 225/8	usually [4] 29/25	142/1 185/2
16/15 17/1 51/24	170/12 171/20 171/21	230/8 233/11 235/13	68/23 108/11 230/1	viewing [1] 179/11
86/21 88/16 88/22	174/17 176/17 180/13	238/10 238/13	uttered [1] 133/16	viewpoints [1] 58/11
88/25 108/9 120/9	180/20 182/23 185/24	Upadastra [1] 175/16		views [3] 6/8 26/15
120/15 120/22 120/25	187/2 191/25 192/3	update [1] 186/2	V	204/17
127/19 141/22 143/4	192/13 194/1 194/3	updated [3] 94/16	vacant [1] 11/17	visible [1] 114/15
146/23 147/6 147/15	194/4 195/1 196/1	123/14 225/16	vaguely [1] 144/14	visit [6] 217/6 217/8
169/22 217/24	204/23 205/10 207/21	updates [1] 186/14	valuable [1] 99/1	242/15 243/25 244/3
understands [1] 57/1	212/24 215/7 216/7	upfront [1] 170/16	various [4] 2/22 14/7	244/22
understood [9] 50/14	217/21 220/25 221/2	upon [9] 46/19 48/17	138/24 160/11	visited [1] 47/3
52/1 66/10 160/6	225/7 231/18	59/19 99/9 117/7	varying [1] 116/10	visiting [2] 87/11
178/19 197/7 221/8	Units [1] 71/16	155/25 162/12 171/17	veins [2] 38/8 38/14	215/17
244/25 245/5	unknown [1] 229/9	221/25	venous [1] 196/17	visits [11] 242/7
undertake [2] 204/8	unless [2] 67/19	upper [1] 68/18	ventilated [1] 196/16	242/8 242/18 242/25
242/7	108/10	upset [8] 137/6	ventilation [1] 181/18	243/3 244/18 245/1
undertaken [1]	unlikely [1] 36/12	163/17 163/19 207/21	ventilator [1] 183/8	245/9 245/17 245/20
243/21	unlucky [1] 126/7	208/5 208/7 208/10	verdicts [1] 246/2	246/1
undertaking [2]	unnatural [5] 15/20	210/21	verge [1] 212/9	vocal [1] 6/4
204/8 243/13	39/19 40/1 112/13	upsetting [1] 186/22	version [8] 112/24	voice [2] 81/19 171/7
unease [3] 44/9	126/2	urgency [1] 58/17	112/25 113/9 113/9	volume [2] 183/22
44/12 50/4	unpack [2] 29/13	urgent [7] 8/3 8/16	113/22 115/11 123/3	196/25
uneasy [2] 171/16	93/5	11/20 11/25 51/1	123/20	vomit [1] 75/20
171/21	unpredictable [3]	107/23 238/19	versions [1] 113/19	vomits [1] 204/21
unexpected [43]	18/14 18/15 169/16	urgently [1] 238/17	versus [1] 18/18	
16/9 16/9 16/22 27/10	unravelled [1] 147/10	us [88] 1/17 3/9 6/20	very [108] 1/7 1/24	W
27/11 34/23 38/19	unsure [1] 190/1	7/2 7/17 13/11 13/16	3/6 4/6 6/4 7/11 7/11	wait [4] 51/11 63/19
50/4 51/21 55/3 57/19	until [17] 60/16 65/13	16/18 21/7 21/11 24/5	8/14 8/19 9/14 9/18	167/15 199/13
87/25 88/1 89/11	94/6 101/12 105/1	27/1 27/12 29/1 30/5	11/8 11/13 15/2 15/16	waiting [2] 65/25
89/22 101/15 104/20	125/22 125/24 133/21	39/21 40/6 41/15 43/2	15/23 16/3 20/2 23/15	211/23
	143/15 147/22 167/4	43/22 45/24 46/25	27/5 27/23 28/9 30/11	wake [1] 225/8
	189/8 191/13 244/1	47/2 47/7 49/15 50/10	33/20 34/8 35/18	walked [1] 133/6

W	watching [1] 200/20	136/5 139/6 139/12	92/25 94/6 94/7 94/7	which [113] 2/19 6/1
walking [1] 196/12	water [1] 18/18	140/10 140/15 145/25	94/10 94/15 100/24	8/16 10/9 11/18 12/19
want [27] 24/13 26/2	way [40] 6/5 10/17	146/11 147/3 149/24	101/2 101/24 103/19	15/23 17/8 17/12 21/8
26/6 26/10 30/22	12/24 25/10 37/16	157/25 158/1 164/3	106/22 107/21 108/13	21/23 22/1 22/2 22/11
39/17 44/4 60/2 61/16	55/6 64/10 73/21	164/4 172/7 178/8	113/20 119/20 120/13	24/15 24/16 25/20
71/5 107/2 108/18	100/20 114/11 129/11	184/16 188/8 188/13	121/9 122/5 123/25	30/5 30/23 35/3 36/6
134/25 144/19 152/7	129/13 129/19 131/8	190/24 194/8 202/4	124/2 125/5 125/9	38/13 39/25 43/25
152/9 154/5 161/18	133/6 133/11 134/16	205/13 205/23 209/15	125/19 125/20 126/5	44/3 45/18 49/25
184/20 199/9 207/22	135/1 135/2 135/10	209/17 213/4 214/20	127/14 127/20 128/8	51/21 53/4 53/6 53/7
211/22 212/6 212/11	136/7 140/4 141/23	222/3 222/13 222/16	129/9 129/22 131/16	56/21 59/17 60/11
234/13 234/16 241/2	142/6 142/10 148/25	226/4 233/15 240/1	133/2 134/5 135/17	61/24 62/22 68/17
wanted [18] 3/24 4/2	152/1 164/18 167/1	240/7 241/20	135/21 135/23 136/13	70/2 70/10 70/22
13/21 24/10 46/10	181/10 187/7 187/12	went [29] 17/9 32/7	142/14 143/10 145/17	72/14 75/21 84/14
52/3 60/4 89/2 139/17	195/7 206/5 211/14	39/3 39/22 43/9 49/16	146/17 148/1 151/23	86/22 87/11 87/11
140/23 164/22 170/7	212/13 213/10 225/3	59/18 61/10 62/4	152/19 153/23 156/21	88/3 91/10 91/10
175/23 191/6 206/14	238/15 240/16	93/22 101/13 110/9	159/5 162/15 163/19	93/23 95/11 101/2
207/24 219/20 245/13	ways [1] 58/16	110/23 111/5 118/9	164/10 165/7 165/15	102/12 102/15 104/15
wanting [1] 193/7	we [403]	118/16 127/1 134/5	171/12 172/3 172/6	104/19 106/11 107/25
ward [42] 5/3 16/13	we'd [6] 13/18 28/8	134/18 139/11 142/18	172/17 173/4 175/14	109/7 109/7 113/1
28/3 37/24 40/23 57/7	61/3 100/5 133/9	145/17 157/19 181/8	177/13 177/21 178/1	113/20 113/20 118/5
71/24 72/7 82/18	183/3	204/9 208/10 209/8	179/23 181/19 186/1	118/15 119/7 124/24
92/11 92/14 97/25	we'll [13] 4/8 5/1 13/9	211/17 218/12	191/12 192/20 203/3	126/8 128/6 128/17
103/8 131/3 142/15	13/10 32/14 45/9 86/5	were [373]	205/11 205/11 206/19	133/9 133/14 134/16
169/20 170/6 170/10	93/3 113/18 114/5	weren't [31] 2/19 6/4	209/4 212/12 214/6	135/3 135/6 141/2
170/15 175/12 176/17	139/20 166/21 167/7	6/25 7/24 9/23 11/13	218/4 218/12 221/11	142/13 145/16 149/10
180/21 193/22 194/24	we're [13] 8/23 11/3	13/17 18/24 30/10	231/8 231/11 235/19	149/12 149/17 150/7
194/25 225/2 225/3	30/2 45/10 45/16	41/2 52/14 57/17	236/9 242/13	151/13 152/15 152/20
225/3 225/7 225/15	63/12 84/25 85/21	61/22 86/3 87/5 104/3	whenever [3] 17/8	153/7 153/9 155/12
225/16 229/25 230/8	109/21 128/3 132/17	106/2 112/8 128/21	53/17 113/3	158/11 162/14 163/4
230/11 230/13 230/17	137/11 141/23	129/14 129/15 157/17	where [41] 12/4	165/17 172/14 185/24
230/20 230/22 232/23	we've [14] 5/12 23/7	168/12 174/21 179/14	15/13 18/1 18/13	208/19 219/19 220/3
232/25 238/18 238/19	27/15 35/12 46/17	179/17 182/11 188/13	18/19 39/21 39/24	224/8 224/22 226/2
wards [1] 195/14	53/7 63/4 144/4	206/25 225/21 226/4	42/24 48/11 57/24	229/7 229/8 234/9
warning [3] 154/22	144/18 164/19 165/12	what [294]	63/24 84/2 84/8 84/11	234/17 237/6 237/12
154/24 232/13	171/7 214/22 229/1	what's [16] 34/7 36/1	85/23 100/6 102/17	238/15 238/25 239/2
was [846]	Wednesdays [1] 2/13	69/8 118/13 143/13	102/19 110/13 114/8	240/8 241/16 242/13
wasn't [78] 4/6 4/23	week [19] 52/24	156/24 157/7 180/6	126/10 134/15 152/8	245/4
6/23 15/3 15/7 17/1	92/10 128/14 142/21	185/19 189/18 189/20	156/7 160/15 162/3	whichever [2] 1/12
18/4 30/10 31/3 36/8	143/3 169/3 169/4	201/12 208/19 229/20	162/7 163/12 177/23	186/4
39/2 44/24 46/2 46/9	192/9 195/15 195/16	230/25 240/5	186/16 186/25 190/22	while [3] 8/23 29/4
46/23 48/11 49/2	230/2 230/2 230/16	whatever [7] 23/13	192/11 193/23 203/2	133/1
51/15 53/5 56/7 58/15	230/20 230/20 231/15	91/15 106/6 128/20	205/4 206/9 209/8	whilst [5] 100/18
58/17 59/18 62/23	231/16 231/24 232/20	159/5 205/1 213/10	221/18 236/22 246/3	101/22 147/7 201/1
65/9 74/21 76/1 87/5	weekend [1] 230/22	WhatsApp [5] 238/2	whereas [3] 8/6	213/17
96/21 97/10 97/25	weeks [9] 21/9 21/24	238/5 238/15 238/24	18/21 32/24	white [1] 154/25
98/9 99/9 101/6	23/16 75/16 113/6	238/25	whether [58] 6/15 8/9	who [94] 3/9 4/12
101/17 113/14 118/13	113/6 126/10 128/15	whatsoever [1]	14/23 19/9 28/4 39/22	4/22 5/19 7/4 7/25
118/15 118/22 120/2	143/1	125/25	40/1 40/10 43/12	10/3 10/6 13/2 13/4
121/7 122/6 123/20	weight [2] 188/9	wheeled [1] 135/24	44/19 45/5 54/24	14/1 15/19 44/3 44/24
127/18 130/16 137/8	227/24	when [129] 5/9 6/17	57/18 58/12 62/15	45/1 45/1 45/24 46/1
137/16 139/16 140/7	welcome [1] 188/17	6/18 6/22 7/23 8/12	72/23 73/24 74/25	46/18 46/19 46/20
140/13 140/22 145/16	Welfare [1] 16/7	13/17 14/14 17/5 20/7	78/7 78/13 85/5 86/21	48/13 51/5 55/8 59/2
147/4 147/20 148/4	well [73] 3/20 10/11	21/8 25/24 28/7 29/20	87/20 89/3 89/4 92/21	62/12 70/11 73/3
148/4 154/2 160/24	22/13 34/2 35/24	31/12 32/11 33/2	93/4 93/18 94/15	75/16 79/7 86/13 87/8
164/2 165/13 179/13	36/19 41/8 42/3 53/25	33/13 33/16 34/8	94/17 97/9 97/20	91/6 92/10 95/9 95/14
179/19 180/22 186/19	67/3 70/13 73/20 75/9	35/17 42/16 43/23	102/18 102/21 107/18	95/15 96/19 96/21
188/1 191/17 191/18	75/11 76/7 79/15 88/3	44/18 46/20 47/3	108/20 111/17 112/11	107/8 107/17 108/25
200/4 202/4 202/23	93/3 94/25 95/21	49/11 49/14 57/22	113/12 113/12 116/8	109/6 111/24 114/21
203/8 204/9 207/19	95/24 97/23 100/14	60/7 62/18 63/24	118/7 118/12 126/2	115/6 119/15 126/15
209/9 211/3 213/18	104/7 108/16 110/8	64/18 66/19 71/2	146/16 149/9 167/1	128/3 131/3 137/18
219/15 222/5	113/25 118/1 119/14	75/22 76/2 76/18	167/3 171/23 171/24	139/4 140/14 141/11
watched [2] 171/16	120/8 122/8 122/9	77/13 83/21 83/24	172/10 172/11 181/16	142/18 143/8 144/6
171/24	122/19 125/19 126/7	85/3 85/8 86/5 86/6	190/8 207/19 215/21	149/4 154/17 157/10
	132/12 135/19 136/1	86/25 90/16 92/12	222/14 243/7	159/23 160/13 160/14

W			
who... [31] 168/18 169/3 175/2 175/14 175/19 176/9 185/19 190/22 191/6 192/17 195/11 207/10 209/7 213/8 216/15 220/7 220/7 220/10 220/13 220/14 221/4 221/18 224/19 226/8 230/2 230/12 230/13 230/15 236/20 242/1 242/9	154/17 164/23 178/5 181/23 185/14 185/25 186/3 186/6 195/13 199/15 200/20 202/19 209/2 210/7 210/9 210/10 212/6 215/16 216/4 216/9 216/12 224/18 225/1 226/7 229/9 231/22 232/20 233/19 235/19 237/23 239/2 241/13 243/18 243/25 246/6	work [33] 2/19 4/23 30/20 31/6 49/2 49/10 53/6 82/5 85/1 118/10 118/17 143/2 143/5 143/18 169/16 170/10 175/5 175/6 176/1 181/6 198/16 198/19 200/8 203/25 210/14 215/15 236/1 237/24 238/9 240/2 242/1 244/19 245/18	Wow [1] 198/1 write [2] 159/4 221/13 writing [3] 65/3 155/15 159/5 written [20] 69/8 104/9 154/16 154/20 155/14 155/24 156/25 158/22 179/7 187/24 204/25 208/15 221/19 229/21 229/24 230/5 231/2 233/13 236/15 246/3 wrong [17] 17/9 17/9 26/12 33/22 40/12 40/17 73/22 73/25 74/16 102/19 140/6 142/10 144/14 166/22 201/20 203/25 212/14 wrongly [2] 104/7 141/22
who'd [3] 44/10 57/23 64/24	Williams [2] 205/5 205/22	workday [1] 30/6	X
whoever [4] 73/16 219/9 231/1 233/1	wish [1] 37/1	worked [13] 3/3 4/20 6/12 8/14 62/5 167/24 168/3 170/24 177/15 202/11 212/15 225/5 242/13	x-ray [14] 24/8 24/14 24/15 24/17 24/18 24/21 25/9 70/22 184/12 236/18 236/19 236/21 237/3 237/5
whole [7] 11/4 11/6 11/7 106/21 130/14 135/6 212/24	wishes [3] 66/12 66/14 167/3	workforce [1] 241/25	Y
whom [1] 172/16	within [23] 3/23 7/21 11/24 13/6 13/22 14/4 28/14 59/19 73/3 73/13 87/3 155/8 155/8 176/2 180/1 187/10 215/15 218/2 223/17 228/6 228/7 228/8 239/1	working [23] 2/9 2/10 2/13 3/1 3/5 3/16 4/22 4/24 9/19 10/8 31/10 42/12 42/16 55/5 58/16 65/10 169/10 169/20 171/2 174/12 176/23 180/4 226/8	yeah [49] 43/15 96/1 96/1 96/3 96/3 96/5 96/8 98/6 100/4 102/24 102/24 103/7 107/12 123/9 126/22 126/22 126/22 126/22 128/5 128/5 128/23 129/6 133/8 136/15 136/17 136/19 136/22 137/8 137/14 144/16 148/4 148/5 149/23 150/12 150/21 150/23 150/23 151/1 151/6 151/8 153/23 156/8 156/13 156/16 165/24 165/24 172/6 172/19 216/18
whose [6] 101/23 135/14 230/2 231/10 231/15 240/12	without [11] 71/13 138/1 152/9 154/24 155/4 186/15 186/15 212/17 222/25 224/22 225/8	workload [5] 97/10 169/1 169/12 169/15 186/1	year [11] 47/14 84/6 106/21 108/12 121/12 121/13 121/13 121/14 121/14 241/25 242/5 years [9] 2/7 29/5 82/1 94/15 120/18 153/20 194/5 214/16 240/15
why [68] 4/2 7/17 13/16 18/9 26/6 28/11 28/11 34/9 37/12 37/20 51/3 53/5 59/3 63/21 74/12 74/14 79/2 84/19 91/17 105/15 109/4 110/1 110/3 110/3 115/5 118/11 125/6 125/10 125/10 128/10 128/10 129/4 139/18 139/25 140/17 146/15 146/19 147/3 147/19 157/1 159/2 163/18 163/22 166/4 166/4 172/24 174/8 174/8 174/10 178/4 178/14 186/11 191/23 195/3 195/5 198/12 202/22 203/22 206/13 207/17 208/3 210/1 210/15 210/16 211/2 211/8 224/15 235/14	witness [40] 1/4 1/18 1/21 3/8 6/11 7/16 13/11 21/12 22/6 22/19 24/6 28/21 29/5 40/11 47/2 47/16 59/18 62/8 64/9 65/25 67/24 80/18 80/20 81/6 89/17 94/6 96/18 102/23 107/13 108/17 121/5 130/15 132/15 135/8 136/9 142/14 143/22 163/12 167/12 241/5	workloads [1] 11/14	yes [514]
wid [1] 28/6	witnessed [3] 107/17 130/14 234/22	works [1] 119/3	yesterday [2] 135/1 209/6
wider [1] 16/15	witnesses [2] 53/8 122/15	workshop [2] 47/3 47/5	yet [1] 76/4
widespread [4] 90/8 116/6 154/25 157/24	women [3] 8/13 62/10 62/18	world [2] 107/19 188/18	you [1253]
will [77] 1/5 2/10 16/4 21/6 21/8 23/4 27/25 30/10 32/16 33/2 33/11 33/13 42/11 65/15 65/20 67/3 67/4 73/1 73/6 81/12 81/18 88/3 101/14 107/3 107/4 109/7 111/11 112/7 115/16 118/20 118/24 119/4 121/23 122/19 122/20 125/17 131/6 135/19 135/20 137/5 139/19 142/19	won't [5] 150/9 202/16 215/16 224/7 236/7	worried [12] 64/2 141/14 144/8 144/17 146/18 192/5 201/6 202/4 203/17 211/17 213/9 213/12	you'd [6] 47/23 100/10 132/11 141/11 195/3 196/11
	wonder [4] 65/16 171/6 178/14 200/16	worry [7] 28/9 63/17 184/4 201/24 203/19 210/5 210/18	you'll [6] 33/22 46/25
	wondered [1] 166/4	worrying [2] 201/13 201/14	
	word [7] 7/18 8/24 83/3 100/6 213/22 214/5 226/19	worse [1] 88/5	
	wording [2] 15/1 237/8	worst [1] 162/17	
	words [10] 7/15 18/1 54/22 134/9 137/24 155/6 160/5 163/18 174/14 194/2	worth [2] 85/17 154/12	
		would [224] 1/10 4/16 6/12 6/19 6/24 7/1 8/20 11/17 15/25 17/18 17/22 17/24 18/2 18/6 18/8 18/10 23/24 25/12 25/25 26/24 29/9 33/8 34/16 36/17 37/24 38/16 38/18 38/19 41/5 41/14 41/16 41/22 41/25 47/20 47/23 48/1 48/2 48/3 48/10 51/8 55/9 59/1 59/5 60/23 61/9 61/10 61/12 61/14 61/15 61/16 62/4 64/6 64/20	
		wouldn't [23] 36/20 41/24 59/4 67/5 68/19 70/6 72/17 74/21 90/25 94/12 94/13 100/14 131/14 157/1 158/12 172/1 174/8 179/25 180/9 187/6 192/14 207/25 228/18	

Y
you'll... [4] 126/10
 148/25 185/5 241/1
you're [30] 6/18 6/18
 19/18 22/7 67/16
 90/12 92/12 92/15
 93/4 93/18 98/14
 139/18 148/4 152/19
 152/20 155/14 155/15
 167/22 168/8 179/11
 180/4 193/13 199/21
 200/24 207/10 209/1
 209/3 213/4 224/10
 227/13
you've [37] 1/18
 14/15 24/5 29/23
 31/25 32/20 37/12
 38/1 38/1 39/21 39/24
 39/25 49/15 55/23
 56/3 71/7 79/2 94/4
 104/1 114/21 115/3
 131/12 137/1 152/10
 153/14 158/25 160/11
 161/21 162/2 162/6
 162/12 168/7 173/4
 173/7 173/20 208/22
 215/24
young [1] 241/24
your [243] 1/22 1/25
 2/9 3/7 3/18 4/19 5/17
 6/16 7/6 7/7 7/15 8/10
 8/25 9/11 10/13 10/25
 11/10 12/15 12/16
 12/18 13/6 13/11
 13/25 14/15 15/11
 16/3 16/14 19/11 20/7
 20/14 21/11 21/15
 22/6 22/19 23/6 24/6
 24/24 26/5 27/19
 28/14 28/21 29/2 33/1
 35/3 37/16 39/18 40/6
 40/7 40/11 42/22
 42/23 45/1 45/6 47/2
 48/24 49/22 50/14
 50/23 51/24 53/1 54/5
 54/14 54/22 55/12
 58/4 59/18 59/24 62/1
 62/8 64/8 64/9 64/15
 64/16 64/17 66/10
 67/23 68/2 68/5 70/21
 70/22 73/9 73/20
 73/20 76/8 76/11
 76/20 76/21 77/11
 78/17 80/14 80/15
 81/10 81/12 81/19
 82/11 83/16 86/6
 86/18 86/21 88/14
 88/15 88/21 89/10
 89/17 90/14 94/6
 94/19 94/22 94/25
 95/18 96/10 96/18
 96/24 98/17 101/5
 105/16 105/19 107/25

111/5 111/14 111/18
 111/24 112/11 117/5
 118/22 121/5 126/24
 127/2 129/4 129/9
 130/15 131/12 131/12
 132/14 132/15 132/20
 132/22 133/23 134/4
 134/9 134/9 135/8
 135/10 136/8 137/7
 137/22 138/3 138/10
 139/21 141/3 141/7
 141/9 142/1 142/14
 142/18 143/4 143/22
 144/19 144/25 145/1
 145/7 145/12 145/19
 146/4 147/23 151/17
 153/22 155/12 155/13
 155/21 156/10 157/23
 157/23 158/4 159/8
 159/14 159/19 159/21
 161/19 163/7 163/11
 163/18 163/24 164/11
 164/21 165/5 165/7
 168/7 168/10 168/20
 169/6 169/13 169/21
 170/1 171/7 173/3
 173/17 173/24 181/1
 181/4 182/14 187/19
 190/10 190/10 193/18
 194/7 194/21 196/2
 204/19 204/21 206/17
 207/6 207/6 209/5
 210/9 212/12 213/7
 213/23 216/2 216/14
 217/8 217/9 217/17
 219/18 222/24 223/14
 223/21 226/2 227/8
 227/10 229/8 232/4
 232/22 234/15 235/8
 236/3 237/21 238/7
 238/24 239/1 239/2
 240/12 244/3
yourself [16] 18/25
 52/6 56/4 63/21 68/3
 112/8 112/15 125/25
 142/1 154/21 162/25
 172/25 183/16 190/4
 204/14 207/18
yourselves [1] 21/4
Z
ZA [23] 1/6 1/13 1/17
 11/9 22/13 64/16
 65/14 66/3 77/7 80/12
 80/13 89/6 89/11 95/1
 99/4 105/24 205/5
 205/23 205/23 205/25
 206/7 206/16 247/2
zone [1] 134/14