

Tuesday, 8 October 2024

(9.59 am)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: Good morning, my Lady, may I call Dr McCormack and can he be sworn.

LADY JUSTICE THIRLWALL: Yes, certainly. Who is going to -- ah, there you are. Thank you, Mrs McQueen.

DR JIM McCORMACK (affirmed)

LADY JUSTICE THIRLWALL: Thank you, Dr McCormack, Ms Langdale will be asking the questions.

Questions by MS LANGDALE

MS LANGDALE: Dr McCormack, can you give us your qualifications, please.

A. I qualified in medicine from Queen's University, Belfast in 1982. I did a further postgraduate degree in MD at Queen's University in 1997 and I became a member of the Royal College of Obstetricians and Gynecologists in 1987 and was conferred fellow of the Royal College of Obstetricians in 1999.

Q. Dr McCormack, you provided a statement to the Inquiry dated 7 June 2024. Can you confirm whether the statement is true and accurate as far as you are concerned?

A. Indeed it is true and accurate. Do you think

1

well to having been an associate Medical Director at some point. You tell us further up, I should say, by 2015 you'd had 23 years Consultant clinical experience in obstetrics and gynaecology, but you also say at important professional responsibilities at one point you were an associate Medical Director. Can you tell us when that was?

A. I've forgotten the exact year but with introduction of the new Consultant contract and I was employed as an Assistant Medical Director for approximately six months to interact with all the Consultant staff, make them familiar with the actual contract and ensure they understood what was involved before they considered moving to the new contract. Once the contract had been introduced, then my tenure in that post stopped.

Q. Was that something you were interested in as a role? What were the expectations of that even as a short-term role?

A. I -- I think I may have showed some knowledge of the different attributes of the new contract at that time and they have may felt it was -- I was a good person to select and do that job.

Q. You were the ...?

A. A good person --

3

I could speak to the mothers before we carry on?

LADY JUSTICE THIRLWALL: Yes, of course.

MS LANGDALE: Yes, you may.

A. I just wanted to say I read all of their mothers' and family transcripts and found it very moving and compelling to hear them all tell their experiences. I wanted to start my evidence today by expressing my sincere sympathy to them all for their terrible loss and suffering, and commend the enormous strength and resilience they've shown in coping with the unimaginable events following. Thank you very much.

Q. Dr McCormack, we sent you indeed some of the transcripts of evidence and I will return to those in a while, if I may. When I am asking you questions the link seems pretty good now and the signal --

A. Yes.

Q. -- but if it drops and you can't hear me raise your hand and I will do the same for you; okay?

A. I will.

Q. I will also do the same if I think -- and I don't want to overspeak when we're not in the same room -- if I think I need to move on to something else. So it's questions as well as gestures to look out for if you would.

In your statement at paragraph 12, you refer as

2

Q. Good person.

A. -- to select with that knowledge to do that job or undertake that job.

Q. You tell us the responsibilities at paragraph 16, chair of the women and children's governance board, firstly.

A. Yes.

Q. And also lead obstetrician for perinatal mortality morbidity meetings?

A. Indeed.

Q. Can we look at one of those meetings, just to see what they look like. The perinatal morbidity and mortality meetings, and the INQ reference number is 0003294/1. So 0003294, page 1.

This is what we see, and indeed on page 2 we see a reference to Child A.

Can you tell us what the purpose of the meetings were and who was invited? And if we go back to page 1, if we look at the date, in fact the date of the meeting is 24 June 2015, so I assume the period of assessment is March to June 2015?

A. Will I give you some context to the perinatal meetings and their organisation?

Q. Yes, what was the -- what was the aim and who attended?

4

1 **A.** Okay. Well, the meetings were organised in
2 advance because we chose days where there was no
3 clinical activity to allow members of staff to attend.
4 So each year there were 12 days in the calendar year
5 that clinics were stopped and I would have chosen four
6 of those days for the use for perinatal mortality
7 meetings. So they were chosen in advance and then
8 confirmed with Dr Brearey that they suited for him and
9 then allocated those days.

10 At each of the meetings, secondly, my Registrar was
11 allocated to secure the most recent of the still births
12 to be presented and he would have prepared a complete
13 PowerPoint presentation for those with all the events,
14 and the same with the paediatric Registrar.

15 At that time -- at that time I was also inviting
16 the pathology Consultants from Alder Hey hospital and
17 they would have been invited about three weeks prior to
18 the meeting, if there happened to be a pathology
19 presentation for those particular deaths.

20 Following the meeting -- these were prepared by
21 Dr Brearey and myself. You haven't got any of the ones
22 that I prepared for the stillbirths, but all the reports
23 you have, with the exception I think of three, are from
24 the perinatal meetings and these are his summary of the
25 events that took place.

5

1 **A.** All the available -- it was a compulsory
2 attendance for anybody who wasn't actually working or on
3 annual leave, so any of the junior staff Consultants
4 would attend. On average we would have had an
5 attendance of, I don't know, 15/20 people.

6 **Q.** And that's anybody who had been involved in
7 the care of the baby, was that the expectation?

8 **A.** No, it was meant to be all the junior staff
9 that were available and all the Consultant staff
10 available because it was a -- very much a learning
11 exercise environment --

12 **Q.** If we look at Baby A --

13 **A.** -- and a very open and transparent discussion
14 of events.

15 **Q.** Let's just look at what it says about Baby A
16 then if we go back to page 2. If it's a learning
17 environment, we see here it says "awaiting pm".

18 There's not a lot you could learn at that point,
19 could you, without knowing forensically --

20 **A.** No --

21 **Q.** -- about that death?

22 **A.** -- and that's absolutely correct in that
23 particular scenario. But the letter that would have
24 gone out would have enumerated the 3, 4, or 5, 6
25 learning points from that particular meeting, and

7

1 These summaries are very brief, they were meant to
2 be brief, they are meant to be an aide memoire for staff
3 to look at and be able to recall exactly what was
4 happening, because don't forget the perinatal mortality
5 meetings were to review for learning, and the
6 environment was one of expected entirely natural deaths.
7 And, in addition to that document that you put up,
8 Dr Brearey would also have sent a letter or a note to
9 all the members of staff with the three or four or five
10 learning points from the meeting. And the purpose of
11 the meeting was entirely a learning environment.

12 And the last point I would make about it is that
13 within the hospital we had an intranet and we had
14 an S-drive for the Women's and Children's directorate so
15 all this material for learning, the summary items, the
16 concerns about learning, the presentations from each of
17 the two doctors at a particular meeting would all have
18 been put on the intranet because not all staff that were
19 involved may not have been able to attend because
20 obviously they may be covering the neonatal unit or the
21 labour ward.

22 **Q.** The meeting record -- just pausing there,
23 Dr McCormack, the meeting record doesn't record who did
24 attend it, but you're telling us, you and Dr Brearey
25 could invite people and routinely did invite people?

6

1 Dr Brearey would have sent that out to all the other
2 Consultants and to all the junior staff.

3 **LADY JUSTICE THIRLWALL:** Would he have done that
4 before or after the meeting?

5 **A.** It was done after the meeting, my Lady.

6 **MS LANGDALE:** That can come down now, thank you,
7 Ms Killingback.

8 Were you aware the way that event is described at
9 the meeting with the line in situ that that was a sudden
10 and unexpected death of a stable baby?

11 **A.** Like it's nine years ago now, and I -- I can't
12 particularly recollect the exact discussions, but that
13 would -- I am certain would have been something that
14 Dr Brearey would have highlighted and the junior doctor
15 who was presenting the case would have highlighted at
16 the meeting.

17 **Q.** Because we know that after Baby A's death,
18 members of the medical and clinical staff were shocked,
19 upset. One of the younger doctors took some time off.
20 It was an unexpected death of a neonate. That's a rare
21 event, isn't it? An unexpected and unexplained death.

22 **A.** Yes, certainly on talking to the other
23 paediatricians that -- I think that would be the case.
24 I'm not sure whether that's just bridging into the
25 neonatology expertise as opposed to me being an

8

1 obstetrician.

2 **Q.** Can we go to paragraph 33, please, of your
3 statement if you have it with you.

4 **A.** I have.

5 **Q.** You say that, in your experience at the
6 hospital, the relationship between the obstetric team
7 and the NNU has always been very good and that was
8 unchanged in 2015 and 2016, and there would have been
9 daily clinical care discussions which would usually have
10 occurred as necessary between the obstetric Consultant
11 who was managing the labour ward and the equivalent
12 Consultant on-call for the NNU.

13 You've highlighted communication between you and
14 Dr Brearey, which I take was very good from what you're
15 saying?

16 **A.** Yes, and that refers to the actual on-call
17 Consultant obstetrician on the labour ward, and if he
18 had concern about any of the patients on the labour ward
19 he would have been able to have direct conversation
20 whoever was the neonatal Consultant on-call. But the
21 working relationship that obstetrics had with the
22 neonatal unit I would have described as excellent, and
23 this was something -- I have been a Consultant for
24 23 years now, we all knew each other well and we would
25 have worked well in certain situations, for instance you

9

1 previous structure with a separate
2 Women's and Children's division might have allowed more
3 focused discussions of the issues at that management
4 board level.

5 So can you expand on that, why do you think it
6 would have been better retrospectively to have
7 a different structure? Set that out.

8 **A.** Well, I'm not convinced that it would have
9 been because the structure that we had in 2015 had been
10 changed in 2010, it was a structure that we were very
11 familiar with and --

12 **Q.** Was that driven by cost or anything else, why
13 was it changed, do you know?

14 **A.** I think it was changed for financial reasons.
15 We used to have a separate director -- directorate for
16 Women's and Children's, which includes neonates, paedes
17 and gynaecology, and with our own directorate manager,
18 Clinical Director, et cetera, and they changed that and
19 integrated the departments to then two directorates then
20 to Planned Care and Urgent Care.

21 And -- but we'd been working in that environment
22 then for four years by the time it was 2015, and I think
23 that I thought that even within the environment we got
24 we still had good contact with the paediatricians, and
25 we had good links still with senior management in the --

11

1 had a witness, the teamworking, if you were on the
2 labour ward and there happened to be a collapsed baby
3 and the team came in to -- to resuscitate, or for that
4 matter an elective section, and -- and I had no concerns
5 about the working relationship between ourselves and
6 them.

7 **Q.** Can you tell me a bit about the layout of the
8 Consultant offices and the administration, the
9 opportunity for what I would call corridor conversations
10 or informal conversations when you're passing each
11 other?

12 **A.** We were very fortunate because our building
13 really was all very close to each other. So the
14 neonatal unit was next to the labour ward, and our
15 offices were very close to that building. The ground
16 floor had all the neonatal offices and the top floor had
17 all the obstetric offices. And it wasn't unusual for me
18 to walk downstairs and speak to John Gibbs or one of the
19 others about a particular issue I was concerned. Our
20 relationship for discussing things was very good.

21 **Q.** So things that were worrying them they could
22 share with you and vice versa, and did?

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

24 **Q.** That's how concerns were raised informally.
25 More formally, at paragraph 51, you comment on the

10

1 in Planned Care. Our divisional Medical Director in
2 Planned Care in fact was a gynaecologist, and our Head
3 of Midwifery sat on the QSPEC board as well. So I don't
4 have concerns about -- about -- about -- about those
5 changes.

6 Obviously if you said to me now and we were going
7 to redo it by choice I think we would choose to have
8 neonates within -- within our own directorate but --

9 **Q.** As it was before the financial motivated
10 changes?

11 **A.** Sorry, Ms Langdale?

12 **Q.** You'd have it as it was the prior structure
13 if --

14 **A.** Yes, yes, I think we would. And I -- I don't
15 know whether it has changed to that now. I imagine it
16 has. But the point I was making was when you asked
17 would it have made any difference with very like-minded
18 individuals surrounding you, and I think the only
19 example I can give you in relation to that would be, for
20 instance, the governance board.

21 Now, the governance board at the time in 2015 had
22 very like-minded individuals around the table. We had
23 the lead in obstetrics, we had the lead gyaeny, we had
24 the Head of Midwifery we had the lead paediatrician we
25 had the lead nurse in paediatrics, and so that was an

12

1 environment that I thought would have allowed
2 appropriate discussion. But, you know, I -- I was
3 conscious that wasn't the case, because --

4 **Q.** Did you have discussion on that lead
5 governance board about sudden and unexpected deaths on
6 the neonatal unit and whether someone might be causing
7 them?

8 **A.** No, definitely not. And that's exactly what
9 I was just going to say was that if -- if -- in my
10 preparation for my evidence and looking at all the other
11 evidence like it is clear that Dr Brearey and
12 Dr Jayaram, you know, were relentlessly pursuing
13 directly to Senior Executives their concern about harm
14 to babies and possible causes of the deaths.

15 Well, I never saw that at the governance board,
16 so --

17 **Q.** Let me ask you about the women and children's
18 care governance board for now, if I may.

19 **A.** Yes.

20 **Q.** And you tell us at 52 -- paragraph 52:

21 "It did include staff from obstetrics, paediatrics
22 neonatology and gynaecology within the board."

23 A few questions I may of some of the meetings. If
24 we could go to INQ0004235, first of all, at page 2,
25 box 7. While we're finding that, Dr McCormack, I'm

13

1 that we ever regularly had at our perinatal meetings
2 would have been the pathologist, which was -- which was
3 a very valuable input to our meetings --

4 **Q.** Indeed. Let --

5 **A.** -- and, and we only properly started that not
6 more than two or three years before 2015.

7 **Q.** Can I ask you then to contrast in the same
8 document -- sorry, Ms Killingback, if we can have it
9 back at page 3, so 0004235 for Baby A.

10 We see here reference to documentation excellent,
11 multi-disciplinary working was excellent, clear reviews,
12 precise managements, excellent escalation from midwifery
13 to medical staff when there were concerns, no issues
14 with any element of care, will be subject to neonatal
15 review and will be discussed at perinatal mortality
16 review meeting.

17 No mention there of external or pathology or the
18 invitation for someone elsewhere to investigate at that
19 point.

20 **A.** No.

21 **Q.** Can you explain the difference in approach for
22 the committee, understand that in principle?

23 **A.** Because this, this was part of the risk
24 management review of the deaths, so when a neonatal
25 death occurred, and I may not be completely clear with

15

1 certainly not going to ask you about the details of
2 a particular case this far away and one that doesn't
3 impact on the Inquiry. What I want to ask you about is
4 the rationale behind it.

5 So at paragraph 7, reference to a stillbirth:

6 "Waiting to find out how it will be taken forward
7 in relation to an investigation. OSR completed and it
8 highlighted issues with care provider decision-making.
9 An ethos of transparency external reviewer to analyse
10 this case as no one in the Trust outside of the division
11 with expertise to review the case."

12 So what was the basis in principle for taking cases
13 to external investigation, and was that simply something
14 that fell within the obstetric team to investigate?

15 **A.** I -- I can't recollect what that --

16 **Q.** That can come down, now thanks.

17 **A.** -- particular stillbirth was and what the
18 issue was in relation to expertise, and it would be very
19 unusual for us to do that. There was a climate --
20 an increasing climate for stillbirth reviews and
21 stillbirth learning meetings to include an external
22 reviewer, and that was one of the reasons why we
23 considered the two different reviews with an external
24 attending to it.

25 But, for our own purposes, the only external person

14

1 the neonatal structure, and you can confirm that with
2 one of the neonatologists, but a Datix would have been
3 issued, and the Datix was just a paper record of --
4 a computer record of a concern about risk, and one of
5 the risk team then would have sent that to Dr Brearey
6 who was the lead in clinical risk, and he would have
7 prepared for the purposes of the risk team an SBAR. And
8 in cases where there was concern about the obstetric
9 management he would ask us to do an OSR. And this is
10 the OSR report which I think I did on Child A.

11 And could I point out, in my statement, I'm not
12 sure what page it is, it's on item 69 where I said
13 I hadn't done an SR, I apologise, and in fact when
14 I started to look through evidence I realised the only
15 one I did was Child A.

16 So this is a summary of me sitting with the notes
17 to look through the obstetric notes for the benefit --
18 for the benefit of the paediatricians to know were there
19 any serious risks that could have had an effect on the
20 neonatal care afterwards. But this --

21 **Q.** So when you -- sorry, Dr McCormack, can I just
22 focus on what it says:

23 "No issues with any element of care provided."

24 Were you commenting on antenatal care? Because it
25 was not within your remit, was it, to comment on

16

1 anything post delivery if you were not present for that
2 care or didn't know what happened in that care?

3 **A.** Well, I -- I wouldn't -- I wouldn't comment on
4 any. So once the baby is born, then all the care is the
5 care of the paediatricians and neonatologists. So any
6 report you would have of an obstetrician would stop at
7 the delivery. So that review that you see and read
8 there under "Obstetrics Secondary Review Actions" is
9 just referring to the care that Mother A had during her
10 pregnancy and looking to see was there any issues with
11 that care that could have been relevant for the outcome
12 post-natally?

13 **Q.** Was a neonatologist present at the meeting?
14 It can go down now, thank you.

15 **A.** No, not the all.

16 **Q.** Why not? Sorry, pausing there, why not?
17 You've got a situation where you know that the antenatal
18 care has been excellent, you say, and this baby has died
19 and it's an unexpected and unexplained death.

20 **A.** Well, this -- this -- this isn't actually --
21 this was no -- I tell a lie. The -- the -- the SBAR
22 would have had the risk manager added and would also
23 have had the Head of Midwifery. So the three of us sat
24 down and then discussed the case, and then I would have
25 prepared the -- the report that you've just read.

17

1 unexpected and unexplained. What was being said --
2 leaving aside the structure and the governance and the
3 process, what was he saying to you?

4 **A.** Well, for me to reflect now what was actually
5 discussed, and I haven't got a record of it, it's
6 extremely difficult, quite honestly.

7 **Q.** Sometimes we have a sense, though, don't we?
8 We have a moment where we remember something really
9 significant was told to us or we were worried or
10 professionally curious enough to go back again and say,
11 "What was that about?"

12 **A.** Well, I -- I am certain -- I would think that
13 the key features in each of the cases would have been
14 discussed at the perinatal meeting, and the nature that
15 it was unexpected, sudden, failure to respond to
16 resuscitation, all the things that we have read in
17 various reports from the paediatricians would have
18 been -- would have been discussed at the perinatal
19 meeting. And, like, it's very difficult to think back
20 but I don't think at any case -- in any of those cases
21 there was a feeling or a concern that these deaths had
22 been caused by intentional harm.

23 **Q.** I will go to that later, if I may. I just
24 want to deal with concerns so unexpected unexplained, do
25 you know when a rash was discussed with you? Was

19

1 But the report was directed to midwifery care and
2 obstetric care up to the point the baby had safely
3 delivered. And after that time -- so I wouldn't have
4 commented on it being unexpected, I wouldn't have
5 commented on it being a neonatal death at all, and --

6 **Q.** Would you have asked about it as a matter of
7 professional curiosity? You've looked after this
8 patient, she has had her babies, would you just ask and
9 say, "What do you think happened there then?" You've
10 got an informal arrangement --

11 **A.** I might have been part of a discussion at one
12 of the perinatal meetings, there's no doubt about that,
13 and I chaired it and would engage different people to
14 make comments. But in respect of the -- of my request
15 to review the case, the case would only be reviewed
16 entirely relating to clinical matters in obstetrics, and
17 the Head of Midwifery at that particular -- was looking
18 at issues relating entirely to midwifery care, as she
19 will tell you in due course, I'm sure.

20 **Q.** I'm sure that was the process. I am asking
21 now about the excellent communication that existed
22 between the groups and informal conversations, and you
23 said concerns in the perinatal mortality morbidity
24 meeting may have been raised. What concerns were said?
25 You said earlier to me that Dr Brearey would have said

18

1 that -- who raised that? When was that raised with you?
2 That's a feature -- as you say we've all read about that
3 and --

4 **A.** That -- that wouldn't have been discussed with
5 me at any stage.

6 **Q.** Right. So at no stage that.
7 What about -- you mentioned --

8 **A.** Being quite frank, Ms Langdale, I wouldn't
9 have had a serious conversation with the paediatricians
10 in relation to those features.

11 **Q.** No, I'm just asking whether their concerns
12 were shared with you. I'm not suggesting you sat down
13 with a paediatrician --

14 **A.** I'm certain -- I'm certain that with the
15 peculiarity of the rash and the rareness of it and them
16 unable to explain it and even at a senior level unable
17 to explain it I'm sure it was mentioned at the meeting.

18 **Q.** Right. And equally we know Dr Gibbs, as far
19 as Baby C was concerned, was curious and had never seen
20 in a natural disease process after the resuscitation for
21 the heart to effectively start again. Did he share that
22 concern with you?

23 **A.** No, he didn't. But I -- I obviously have seen
24 that on the evidence that's been given.

25 **Q.** Yes.

20

1 A. And I -- I didn't actually consider the cause
2 of death in relation to Baby C because of the -- how ill
3 Baby C was during her pregnancy.

4 Q. I will go to Baby C later, if I may. Let me
5 stay with neonatal minutes Women and Children's Care
6 Governance Board.

7 A. Okay.

8 Q. Can we go, please, to 0004249. This is the
9 minutes of the Women and Children's Care Group for
10 22 October, page 2, and we see under "Neonatal" 47 -- 47
11 incidents reported. Do you see at the top of the page?

12 A. Could you make it -- yes, thank you.

13 Q. Not, it's number 47. "Neonatal", here we go.

14 A. 47 incidents reported. Yeah.

15 Q. That's not the section I want, sorry. Yes, it
16 is. 47 incidents reported. Two moderate harm incidents
17 relate to neonates that sadly died --

18 A. Yes.

19 Q. -- and the five top categories are said to
20 relate to seven babies with feeding problems. Is
21 moderate harm an appropriate category for a baby death,
22 do you think?

23 A. No, definitely not --

24 Q. Just continue for a moment, Dr McCormack. The
25 categorisation of baby death appears through the

21

1 describe which -- what description they want to use for
2 it.

3 Q. So it sounds like you'd agree there should be
4 a clearer process to accurately categorise deaths within
5 this system and it may well have been helpful, wouldn't
6 it, to have an unexpected and unexplained death
7 category, for example? That can be taken down?

8 A. I think there actually is one.

9 Q. You think that's --

10 A. I'd have to -- I'd have to look at the Datix,
11 but I think there is an opportunity to tick that box as
12 well. You -- like, you can confirm that with the risk
13 team when you're talking.

14 Q. If we can go to a meeting, January 2016,
15 INQ0004293, page 2. We see at box 7, "Child D Case
16 Review":

17 "Need clarification on approved abbreviations. DP
18 will check what are classed as the approved
19 abbreviations."

20 There appears there to have been a concern that
21 abbreviations were adopted without standard uniform
22 application. Do you know what that was about and do you
23 think there should have been a standard application?

24 A. Well, that -- that was a review undertaken by
25 Dr Brigham. And in fact when I was looking at that case

23

1 documents to have been interpreted differently. So we
2 know for Baby D it records the risk grading as actual
3 harm none, no harm caused. So there doesn't seem to be
4 consistency. Was there consistency and do you think the
5 categories were always described appropriately?

6 A. No, I don't at all and -- and that was
7 allocated by the risk team. Not by any of the medical
8 staff.

9 I think there was several boxes on the Datix form
10 that had to be completed and those -- those -- that
11 terminology has resulted from ticking whichever box they
12 have ticked --

13 Q. So it's not a medical person necessarily?

14 A. -- and on reflection it's entirely

15 inappropriate.

16 Q. So it sounds like that's a matter for the risk
17 team, is it, if they're ticking the boxes, you don't
18 think medical team?

19 A. No, none of the medical team have produced
20 that. This report is from the risk team, their
21 quarterly trend analysis, and they will have ticked the
22 box on that Datix report "Moderate harm". And if you
23 look at, for instance, the Datix report that you
24 showed -- that you've got in the pile from C or A you
25 will see those boxes where they can tick those to

22

1 recently that was a locum on that night, and the locum
2 used abbreviations that were not accepted practice. And
3 that was the comment Dr Brigham made in her OSR report.

4 So they -- they were -- staff were highlighted
5 that. But that particular night it was a locum doctor
6 on.

7 Q. We'll come to the Brigham report in
8 a moment -- that can go down, thank you -- but there was
9 a lot of review of notes and record-keeping and learning
10 in that sense within the Brigham review, wasn't there,
11 but not anything addressing causation of deaths or what
12 they might represent, nothing of that type?

13 A. I think that's correct, and that still falls
14 back to the fact that in -- in Dr Brigham's review it
15 was an antenatal and midwifery review. Again, it wasn't
16 reviewing the -- the clinical care or clinical outcome
17 of the babies after they were delivered because that
18 would have been the remit of the neonatologists. So
19 that particular report entirely was to address were we
20 missing something antenatally or was there something
21 antenatally that could have contributed to the deaths,
22 and that was the purpose of the review.

23 Q. And we know -- I was going to come to that
24 later but you're dealing with it now, Dr McCormack,
25 thank you -- the learning from that was very much

24

1 directed to antenatal care or, in the case of Baby D,
2 record-keeping. It was not examining forensically, or
3 in any sense attempting to, the causation of deaths in
4 the babies on the indictment that were included in that
5 review.

6 **A.** I would have --

7 **Q.** It was really an obstetric review -- it was an
8 obstetric review, wasn't it?

9 **A.** It was a what?

10 **Q.** It was an obstetric review really, not
11 a neonatal --

12 **A.** It was an obstetric review. But you -- you --
13 you talk there about the learning. Like, there was very
14 significant learning from that particular report. There
15 were two essential: one intrapartum death and one
16 neonatal death from hypoxia during their -- all from
17 misinterpretation of a CTG. And you can see in
18 Dr Brigham's learning thing two or three pages are to
19 try and address that particular element of care. And
20 I'm just highlighting that the review was to address
21 obstetric issues. And there were bigger obstetric
22 issues relating to that particular report.

23 But you're perfectly right, the report doesn't
24 address any issues relating to the cause of death with
25 the neonates.

25

1 represent who goes to these serious incident reviews?

2 **A.** Well, the serious incident panel is a specific
3 panel and it includes usually the Nursing Director and
4 Medical Director, and I assume those other people. So
5 at that particular one I interpreted when I read and
6 looked at that document that only three people were at
7 that particular -- and I know in fact from other
8 evidence that Mr Harvey actually wasn't present at that
9 meeting.

10 **Q.** And the meeting looks as though it's 2 July.
11 It's just a point to clarify. You say in your statement
12 the SI meeting on 2 August, you mean this one
13 presumably, 2 July? Or was there another meeting, as
14 far as you were concerned? I haven't seen anything to
15 suggest there was, Dr McCormack. I just want to clarify
16 at paragraph 55 you say --

17 **A.** Yes, I think that's an error because I'm
18 talking about the panel relating to when Child C was
19 discussed, and there only was one serious incident
20 panel, and I think Baby C was discussed at that meeting.
21 So my apologies for that, that is -- I think that is --

22 **Q.** And did you have any input into that?

23 **A.** No. That's decided by the risk team, so under
24 review of the SBARs going back from Dr Brearey and from
25 Jo Davies -- Dr Davies did that report for the OSR. So

27

1 **Q.** And we see the fact that it was called an
2 obstetric and neonatology review appears to have created
3 a sense of false reassurance that some of those neonatal
4 deaths were considered or scrutinised in the sense of
5 understanding the cause of death, and they were not,
6 that was not the purpose of that review.

7 **A.** I'm not sure I would agree with that. Right
8 from the onset, the purpose of our review would be to
9 look to make sure that our care didn't impact on any of
10 the neonatal deaths. And -- and the review that we
11 would have done would have been entirely confined to
12 obstetric care and midwifery care for that reason.

13 **Q.** So it looked at whether obstetric care could
14 cause the death but nothing in neonatal care or pursuant
15 to the delivery of the babies?

16 **A.** Absolutely, because we hadn't got the
17 expertise to comment or review relating to neonatal
18 care.

19 **Q.** Going back to your statement, Dr McCormack,
20 paragraph 54. You raise the Datix management form that
21 was raised in respect of Baby C. And if we can go to
22 that document, it is INQ0003229. It begins on page 1.

23 And if we go to page 2, we see your name.

24 And we see at page 3 the SI panel meeting.

25 Can you just tell me, the ticks, does that

26

1 those two reports would have gone back to the risk team,
2 they make a decision that, look, this needs further
3 review, and it will be assigned then to -- to have
4 a serious incident panel.

5 I think in this case, because of the time frame for
6 the three deaths, I -- I think that the -- they --
7 they've reviewed all three at the same time.

8 **Q.** Dr McCormack, I don't need to take you to
9 it -- the document can come down -- but we know at that
10 serious incident panel the name of the investigating
11 officer Debbie Peacock:

12 "Report on STEIS. No."

13 And there's comments:

14 "Awaiting pm but likely acute bowel distension
15 sepsis."

16 So no report on STEIS. Did you understand what
17 should be reported through the STEIS system? What was
18 the --

19 **A.** I couldn't tell you right now but there was
20 a list of events that should be reported through STEIS.

21 **Q.** You looked after Mother C in her pregnancy and
22 she described the antenatal care that you provided very
23 positively, and we know that you had a meeting with
24 Mother C after the death of Baby C, and you have
25 attached -- and we see your notes of that meeting and

28

1 what was said.

2 You were able in the meeting with Mother C, weren't
3 you, to explain and discuss how it was that the baby was
4 preterm delivery and had severe intrauterine growth
5 restriction. You were able to discuss that with her,
6 the antenatal issues and the birth at 30 weeks. But you
7 were not able to discuss death, were you, or to
8 understand the death at that point; is that right?

9 **A.** Yes, that -- that's absolutely correct. The
10 reason that I saw Mother C back for her review was
11 specifically to review the pregnancy. It had been
12 a very difficult pregnancy and it would be not
13 frequently that we see a baby with growth restriction
14 from 18 weeks, and it was important for me to see her
15 back because it was highly likely she was going to have
16 the same problem next time.

17 And, secondly, I knew the cause of the growth
18 restriction because of the placental biopsy and
19 examination of the placenta, and that condition really
20 causes a very abnormal change in the placenta which
21 results in the placenta not working well. And --

22 **Q.** You --

23 **A.** -- and I wanted to discuss that with her. And
24 in mums that do have that there are other blood tests
25 that --

29

1 about that death before you speak with her?

2 **A.** Well, I wouldn't per se have addressed the
3 issue of the actual death. I -- I -- and I can't be
4 certain, but I may have discussed that death with
5 John Gibbs before I spoke with Mother C., but from what
6 I was going to say it wasn't actually strictly
7 necessary.

8 **Q.** So Dr Gibbs tells us that that was an
9 unexpected and unexplained death. So he has told you
10 that as well, presumably, if you're talking to him
11 before you speak to Mother C.

12 **A.** Yes, he -- well, I think that would have been
13 pretty clear when we -- when we discussed it at the
14 perinatal meeting. I don't remember -- I don't
15 recollect a specific discussion with John Gibbs, and
16 I wouldn't have had -- I wouldn't have needed to discuss
17 any element of the neonatal care with what -- with what
18 I was going to discuss with Mother C.

19 My brief was a very clear brief on what elements
20 I needed to go back over with Mother C and -- and make
21 sure she understood why Baby C was -- was -- was
22 restricted, that it was likely to happen again and our
23 plans for her future pregnancy.

24 **Q.** If -- if --

25 **A.** I -- I honestly wouldn't have addressed with

31

1 **Q.** Don't worry, I'm not going to ask you about
2 those -- I'm not going to ask you about those, thanks,
3 Dr McCormack, it's what you were discussing.

4 You tell us in your statement you weren't aware of
5 the circumstances in which Child C died until evidence
6 was presented at the criminal trial.

7 **A.** My apologies for that. I -- I -- I didn't
8 realise what the circumstances you were asking.
9 I thought you were asking the circumstances relating to
10 how the perpetrator had caused the death. I obviously
11 was aware of the collapse, the failure to resuscitate,
12 and I had been present at the perinatal meeting when it
13 was discussed. So when -- when I read that
14 circumstances I was thinking in my mind that, you know,
15 in relation to whatever mode of -- method had been used
16 to actually kill Baby C, and that's when I answered that
17 that's what I was saying. I obviously was aware of the
18 sequence of events after delivery because as we've
19 discussed in relation to perinatal meetings.

20 **Q.** So who told you what about Baby C, which
21 Consultants or doctors discussed his death with you?
22 I mean, you're meeting Mother C, you're discussing
23 future pregnancies, presumably as a matter of --
24 professionally, even if it's not your expertise,
25 neonatology, you want to understand as much you can

30

1 her issues relating to the neonatal death. I just
2 wouldn't have discussed that, and still don't discuss
3 that with --

4 **Q.** Even if you knew about it -- my question,
5 Dr McCormack, for you and other doctors is if there are
6 concerns that it's an unexpected and unexplained death
7 and you don't know, you just don't know --

8 **A.** Yes.

9 **Q.** -- wouldn't you share with the parent that you
10 don't know, who may then say, "Well, how are you
11 investigating? How are we going to find out? I want to
12 know"? Is that a conversation or do you just not say
13 much about the bits you don't know?

14 **A.** Well, it's not the bits you don't know, it's
15 the bits that you don't really have an expertise in.

16 So the neonatal team would be responsible for that
17 degree of discussion. And I certainly would have
18 empathised with Mother C in relation to Baby C, but
19 I wouldn't have addressed cause of death, possible cause
20 of death with her at that meeting, I wouldn't have -- it
21 wouldn't be considered to be an area that an
22 obstetrician would discuss. And -- and being absolutely
23 open and honest with you, I never ever considered that
24 this death could have been from deliberate and --

25 **Q.** At this point -- at this point when it's

32

1 unexpected and unexplained -- I understand you're not as
2 an obstetrician able to say this is what happened, but
3 don't we defer to other experts -- I might say to
4 someone "Well, I'm not the commercial lawyer you need to
5 go and find one" -- that when someone's asking you about
6 something or you realise it overlaps with the area
7 you're talking about you defer to another expertise or
8 discuss who they might get the answers from.

9 **A.** And I think that would be very valuable, and
10 I'm absolutely certain that the paediatricians would
11 have done that and would have discussed that with the
12 network and shared the concerns about the different
13 things. But I -- I have to -- I have to say that that
14 discussion and that professional discussion I wouldn't
15 have undertaken it with Mother C because it was --

16 **Q.** Would you have undertaken it with Dr Gibbs and
17 say, "Well, who are you going to find out then? What
18 pathology -- are you going to make sure you speak to
19 a pathologist", clinical pathological interaction?

20 **A.** Well, the difficulty with mother -- sorry --
21 sorry --

22 **Q.** With Dr Gibbs. If you wouldn't have said it
23 to Mother C, would you have said it to Dr Gibbs, "Who
24 are you going to get to investigate the death?" Just
25 look at the -- to see what's being done around finding

33

1 unexplained, don't you, whatever the age of the
2 prematurity or the age?

3 **A.** I --

4 **Q.** You're not the only one to express that view,
5 Dr McCormack, but I'm challenging the view if you're
6 a premature baby you are more likely to die, therefore
7 I'm not going to scrutinise when there's a death of
8 a stable baby that wasn't actually very sick --
9 premature but not very sick.

10 **A.** And I accept what you say. I'm only saying
11 that in -- in Baby C's case there was a post-mortem
12 report that actually had a cause of death. So -- and
13 I know there's some debate about the interpretation of
14 it, but to look at it, it's not as if the pathologist is
15 saying this is unexplained --

16 **Q.** I was challenging your -- sorry, pausing
17 there, Dr McCormack, we'll deal with that later -- I was
18 challenging your assertion because the baby was
19 premature. But you agree with me that's
20 a generalisation and there is a need to be more
21 specific?

22 **A.** Yes.

23 **Q.** In terms of Mother C, finally, she was having
24 regular appointments with you at the time the
25 announcement was made that the RCPCH were going to be

35

1 out, or did you think that was not a matter for you?

2 **A.** Well, it -- it -- it was a matter for our
3 learning and, and I -- I can't actually remember but
4 I think it was George Kokai that did the pathology
5 report who would have been most likely at the perinatal
6 meeting. And I think there would have been less of that
7 discussion because, certainly from my perspective when
8 I saw the post-mortem result and the immaturity of
9 baby's lungs, like, I presumed that this was a death
10 entirely consistent with prematurity. And I knew that
11 this baby was very sick. I knew that it had abnormal
12 doppler. I knew there was no (inaudible).

13 I knew that the growth of the baby was very
14 abnormal, it was small, and that is a baby for me that
15 when I saw that post-mortem I would have said to myself,
16 "Right, well, that's typical with my experience with
17 that sort of mother -- with that sort of outcome."

18 **Q.** It's a requirement, isn't it, not to apply
19 general principle looking at patients whether they're
20 babies, whether they're the elderly? You could say old
21 people die but they don't always die unexpectedly or in
22 an inexplicable fashion, do they? The fact as a group
23 they're vulnerable to death doesn't mean we say they're
24 old, they've died. You need to examine the cause of
25 deaths particularly if they are unexpected and

34

1 coming involved, and there was an investigation into
2 deaths at the hospital.

3 We've seen the communications, you may have been
4 aware of it at the time how the hospital announced they
5 were going to downgrade and that there was going to be
6 an investigation. And Mother C remembers discussing
7 that with you in her subsequent pregnancy and saying how
8 let down she felt to read about that RCPCH investigation
9 in the paper, and you said to her that the Consultants
10 had been told all the patients had been informed about
11 the RCPCH investigation, those parents who would have
12 been affected, whose babies had died in the period that
13 the press announcement was referring to.

14 Can you remember her raising that with you in the
15 subsequent pregnancy and you saying you thought that she
16 and indeed others who were impacted upon would have
17 known about this?

18 **A.** Well, my only recollection of any discussion
19 about the RCPCH report would have been when I was at the
20 board meeting on 30 June. And I -- I do remember as
21 part of that meeting them discussing communications and
22 press releases, and it was only to that extent, and
23 I certainly would have expected there to be an adequate
24 communication with mum, and certainly it's very -- very
25 unreasonable to find that she discovered it in the

36

1 press. But I don't actually recollect that conversation
2 with --

3 **Q.** It sounds like you thought it, so you may well
4 have said it.

5 **A.** Indeed.

6 **Q.** So she's right about that, that's something
7 you were concerned about you were at that meeting, the
8 communication strategy meeting --

9 **A.** Yes.

10 **Q.** -- and it was obvious they should know, isn't
11 it, all those parents that were affected and should have
12 known before, arguably, if there were concerns still
13 about the deaths?

14 **A.** Absolutely. Absolutely. There should have
15 been full warning of what was expected so that they
16 could prepare for that information.

17 **Q.** You were also providing antenatal care,
18 weren't you, for the mother of O, P and R triplets? And
19 Mother O, P and R says that at every scan you would
20 express disbelief she was still pregnant and
21 successfully carrying the boys as close to term as
22 possible. Does that resonate with you, this is
23 a naturally conceived triplets not as rare for you as
24 the rest of us but still pretty rare I'm assuming?

25 **A.** Indeed, and I would have seen Mother O, P and
37

1 this: did at any point you think it was sensible to
2 suggest care at another hospital, Liverpool Women's
3 Hospital and to have delivery there, or did you ever
4 question whether the Countess was the right place for
5 her or them to have their children?

6 **A.** Well, I think probably the opposite. I think
7 I -- I -- I would have said to the mother frequently
8 I thought it was unlikely that she was going to deliver
9 in Chester, because for her to deliver in Chester we
10 needed three baby cots, and at that time, in 2015 --
11 pardon me -- we were having great difficulties managing
12 our high risk pregnancies and often had to move them to
13 another hospital.

14 So I wouldn't have been concerned with her
15 delivering in Chester. My only concern was I would only
16 know a day before or the morning before whether or not
17 there was three available cots there.

18 **Q.** So the questions --

19 **A.** I say --

20 **Q.** So why not encourage her to be elsewhere?

21 That's the point, if you were concerned about the
22 services, why not say "Don't" -- from the outset, "Don't
23 have them here, go to Liverpool Women's Hospital"?

24 **A.** Well, I think it may well be the same case in
25 another unit. So Liverpool Women's could be completely
39

1 R very frequently in the pregnancy. There's no way to
2 assess that the babies are growing normally without
3 regular scans, so I would have had very frequent scans
4 with her where I would have had the opportunity to
5 discuss issues with her or address any concerns she had.

6 And there always will have been a risk of her going
7 into premature labour, but we would have considered
8 34 weeks as term with a triplet pregnancy, so once it
9 got to that stage, then she would have been delivered by
10 the fact she was 34 weeks, which is the time we would
11 have considered appropriate for ending the pregnancy
12 with a triplet pregnancy.

13 **Q.** Mother O, P and R says you were a huge part of
14 her pregnancy, she put all her trust in you and she felt
15 like you looked after her very well in that antenatal
16 period.

17 **A.** Well, it's that bond that occurs I think.

18 When you're seeing mothers we -- we are -- we are in
19 a very special place and build up upon over the weeks
20 you are looking after a mother, so I would -- I would
21 entirely agree with that.

22 **Q.** You were involved in November 2015 in that
23 Bringham review we've referred to stillbirth and neonatal
24 deaths, and that's November 2015. A question from
25 Mother O, P and R's perspective and our perspective is
38

1 full, and I -- I would have said to her that I couldn't
2 have said to her which unit she would go to. Like to
3 get three cots available for a triplet pregnancy it
4 might be difficult.

5 **Q.** The review that was conducted in 2015. We can
6 go to INQ0003222, page 1, review of neonatal deaths and
7 stillbirths.

8 Page 1 and 2 is the summary, Dr Sarah Bringham's
9 summary.

10 Go to page 2. Results, 18 cases identified.

11 We know that within this review babies A, C, D and
12 E were included, Baby I wasn't, even though the date of
13 death preceded it.

14 I think we've agreed it largely focused on
15 antenatal care obstetrics and not certainly
16 investigations that needed to be conducted for the
17 deaths I've referred to. But did the fact --

18 **A.** -- focused on midwifery and antenatal care.

19 **Q.** Yes. But the fact that it was even being done
20 at all, did that worry you that this needed to be done
21 at all? It can be taken down now, thank you.

22 **A.** Well, the reason that we under -- we undertook
23 the review was because we were aware of the increasing
24 deaths. I think -- in the previous years I think we had
25 nine or eight stillbirths and, at that stage, we had 12
40

1 stillbirths. The expected stillbirth rate at 2015 was
 2 about four per thousand, so we should have had 12. And
 3 the same for paediatrics, we should have had six. So we
 4 decided that we would review -- and you will remember
 5 I mentioned the need for an external assessor at reviews
 6 and so we thought it would be entirely appropriate to
 7 undertake it.

8 But just to give you some idea with the clinical
 9 variation of the stillbirths, that --

10 **Q.** Don't worry, sorry, Dr McCormack, I need to
 11 move you on there, if I may, I don't need to know about
 12 that variation, but can I take you to paragraph 69 of
 13 your statement. You say:

14 "I did attend discussions with doctors on the NNU
 15 in respect of the deaths of the babies named on the
 16 indictment after their deaths. I would have been
 17 present when some of these deaths were discussed jointly
 18 with the Neonatal Team at the PNM. If requested, some
 19 of the deaths were also reviewed at Obstetrics Secondary
 20 Review by the Clinical Lead but I was not involved with
 21 those discussions."

22 **A.** That is the correction I made earlier to
 23 you --

24 **Q.** Yes.

25 **A.** -- that I've said there I was not involved in

41

1 to babies because there had been a number of unexpected
 2 and unexplained events and they had started to think the
 3 unthinkable, a group of nurses.

4 **A.** Yes.

5 **Q.** September 2015. You're doing your review --
 6 or the Head of Midwifery is, November 2015. Are you
 7 hearing conversations or discussions about the
 8 "unthinkable" as people have described it?

9 **A.** I don't think -- well, I think there may well
 10 be a time period where people start to think is there
 11 another reason for this and is this from intentional
 12 harm. And the -- the earliest time, I think, for us
 13 probably would have been the triplet pregnancy where we
 14 delivered a babe at 34 weeks, three babies in excellent
 15 condition, and you will know from the papers the
 16 survival rates at this gestation should approach above
 17 95%.

18 So that -- that was -- was certainly
 19 a consideration at that stage.

20 **Q.** So you -- never mind everyone else, you were
 21 saying that you certainly thought about that after the
 22 triplet deaths.

23 **A.** Well, we certainly considered at -- at that
 24 time that -- that, look, this is a very strange
 25 happening now. I think the discussion in the neonatal

43

1 these discussions, but clearly when I went to look at
 2 the evidence to prepare my review I did the OSR on -- on
 3 Mother A, so I was involved in relation to that.

4 **Q.** And, really, Dr McCormack, it comes to this,
 5 although the paediatricians in detail are being asked
 6 questions here about what they did or didn't know, there
 7 is a sense that other people around them are removing
 8 themselves from conversations that they have had or
 9 documentation that they have seen. But you agree with
 10 me, you did attend discussions about their concerns, you
 11 knew that they were worried about the deaths and that
 12 they were unexpected, unexplained and some of the
 13 clinical features?

14 **A.** That's correct. But I would have to say that
 15 at any of the meetings -- the perinatal meetings that
 16 I attended or engaged in any discussion the
 17 understanding was that this was a natural death and --
 18 and it -- it -- it wouldn't have been -- it wouldn't
 19 have really been considered by -- by me that the risk
 20 was -- that the deaths were being caused by -- by harm.

21 **Q.** Dr Lambie told us that in September 2015 she
 22 observed a group of nurses in the neonatal unit trying
 23 to work something out, she wasn't sure what they were
 24 working out, but she said it was clear it was
 25 potentially linking someone to causing deliberate harm

42

1 unit may well have been confined entirely to the
 2 neonatal unit. I'm not devoiding myself from thinking
 3 of the situation. But I -- I know that in discussions
 4 I had with paediatricians there -- there wasn't
 5 a discussion and -- and -- and a discussion to say to
 6 us, "Look, we are concerned here this must be
 7 intentional." That was not something I heard at -- in
 8 any interaction with the paed. What I did think after
 9 the triplets that this was certainly something very
 10 strange.

11 **Q.** You are recorded as saying there that you
 12 think the discussion may well have been confined
 13 entirely to the neonatal unit. These are colleagues
 14 that you have conversations with. Are you saying
 15 Dr Brearey, Consultants aren't talking to you about
 16 concerns that someone else is involved, deliberately
 17 causing harm, their suspicions about this?

18 **A.** Well, I -- I can't talk for Dr Brearey.

19 **Q.** No, I'm talking -- asking you -- I'm not
 20 asking you to talk for him -- that he hasn't said that
 21 to you?

22 **A.** Well, you know, I -- I sat with him right
 23 through whatever number of governance board meetings,
 24 and the paediatric team had an opportunity to highlight
 25 their concerns at that stage and -- and that wasn't the

44

1 case. Anybody who was at that governance board meeting
2 still understood that it was likely that these deaths
3 were -- were from natural causes.

4 **Q.** Let me ask you about paragraph 74 please in
5 your statement:

6 "Requests for postmortem examination were usually
7 made in all deaths but only undertaken with maternal
8 consent ..."

9 But you were only involved with stillbirths as an
10 obstetrician.

11 **A.** That -- that's correct. With the Alder Hey
12 Inquiry and the difficulties with the organ issues at
13 that time it completely changed our ability to undertake
14 post-mortems that had been sent for examinations, and
15 they weren't undertaking without explicit consent from
16 mum. And we were fortunate in relation to a stillbirth
17 that nearly all of our placentas went for examination
18 but the mum had to decide and consent to having the
19 pathological examination of their baby for either
20 a neonatal death or a stillbirth.

21 **Q.** Did you understand that was necessary from
22 a neonatal death that you needed mother's consent or not
23 at that time?

24 **A.** Yes, you definitely needed consent. They had
25 to complete a consent form for organ examination and for

45

1 undertaking a multi-disciplinary review, the thematic
2 review of neonatal mortality, dated February 2016.
3 There's a subsequent one in March. When did you see
4 that, do you know?

5 **A.** The thematic review?

6 **Q.** Yes.

7 **A.** The thematic review I didn't see it until
8 June 16.

9 **Q.** Right. So we asked you whether it had been --
10 at paragraph 82 you answer this I think -- whether it
11 was the intention that the neonatal unit would complete
12 their own review or they would be combined. There was
13 some suggestion that they might be combined, the Head of
14 Midwifery review and Dr Brearey's review, but that
15 didn't happen, did it? His --

16 **A.** I don't -- I don't think there was ever an
17 intention because I don't think there was a discussion
18 prior to either that, "Look, you do this and we do
19 that."

20 We looked at the stillbirths and the neonatal
21 deaths, and they reviewed the years of the neonatal
22 deaths. So the two reports are entirely separate and
23 I think properly supplementary.

24 **Q.** In terms -- you referred earlier to the
25 obstetric review and the learning from it, can we go to

47

1 keeping specimens for teaching. And it was -- it was
2 a very extensive document that mum had to read it and
3 sign.

4 **Q.** So if a mum said she didn't want one, there
5 would be no circumstances where you would say that
6 should happen or not?

7 **A.** Well, I think you would have to -- from my
8 perspective in -- in -- with relation to stillbirths, it
9 may well be that a scan has shown very serious
10 abnormalities and it's clear that these are present with
11 the baby and that a post-mortem may not be necessary.
12 But if there was strong concern of an issue you would
13 try and encourage the mother to consider it, but it
14 was -- it was a difficult conversation quite honestly.
15 They'd just lost the baby and suddenly you were -- you
16 were in a position where you were discussing very
17 serious things with them.

18 So it -- in general it was a fairly immediate thing
19 for mum. They knew straight away, "Yes, I want that,
20 I want more information", or "Oh, I didn't want that to
21 happen." So there wasn't a big persuasion thing, the
22 mums themselves knew, in my experience, fairly
23 immediately, and -- and -- and that's usually what
24 happened.

25 **Q.** Paragraph 83 you refer to Dr Brearey

46

1 INQ0015135, and we see a Lorraine Millward emails many
2 people. Page 1, 2 and then 3 we see the content of the
3 email.

4 **LADY JUSTICE THIRLWALL:** We haven't got it yet.

5 **A.** I think that she was one of our risk staff
6 and --

7 **MS LANGDALE:** She was. And it's 0015 -- here we
8 are go to page 3, if we may, Ms Killingback.

9 **A.** And although the report was received in
10 Women's and Children in December, I think some of the
11 learning hadn't been completed until the end of March
12 because I think we changed the -- just let me find it.

13 **Q.** If you look at the email here -- it's there:

14 "We must ensure a Datix is completed for all
15 neonatal deaths or stillbirths."

16 That went to a lot of people, didn't it, that
17 email?

18 **A.** Yes, because I think one of the stillbirths
19 hadn't been Datixed and it was sent to remind them of
20 the importance of a Datix in relation to a death.

21 **Q.** And what was your understanding of the
22 importance of the Datix? What information -- that can
23 go down now, thank you -- what should it incorporate?

24 **A.** When you complete it?

25 **Q.** Yes. The nurses complete it, do they, or

48

1 doctors or both, who should complete a Datix?

2 **A.** Both -- well, both would complete it and --
3 and you really produce a small synopsis of the event
4 and -- and the risk staff then -- depending on where it
5 came from then obtain more detailed SBAR assessment of
6 exactly what that involved.

7 **Q.** Dr Brearey's thematic review, February 2016,
8 appeared at the Women and Children's Care Governance
9 Board. If we can find, please, INQ0003212, page 5.
10 Page 5, please. Thank you.

11 You're chair of this board, I think, then and we
12 see there the thematic review is referred to higher than
13 expected mortality rate. Cases have been reviewed at
14 NNIRG. Perinatal mortality review and action plans have
15 been made:

16 "An obstetric thematic review did not identify any
17 common themes or identifiers that might be responsible
18 for the rise in mortality in 2015."

19 Your review wasn't even attempting to look at
20 whether any person or individual could be involved in
21 deliberately causing deaths, was it?

22 **A.** No, not at all. Both of these reviews were on
23 the basis of a natural death, and the investigations
24 were based on that. I don't think there was any,
25 these -- these -- these aren't -- aren't, for want of

49

1 being unusual or unexpected?

2 **A.** Well, I think it did. And he had got it as
3 one of his -- top of his -- top of the little list,
4 sudden deaths and -- and the time period, and I think
5 that was -- they would have been two factors I think he
6 was highlighting, and certainly on reading it, I was
7 reading as, well, that is a bit odd.

8 **Q.** You went to two meetings I think -- I think
9 the Inquiry understands they both happened on 30 June --
10 one with the paediatricians in the morning and one with
11 management later, and you deal with these at
12 paragraph 110 of your statement. It was a meeting you
13 were invited to attend at 7.30 on 30 June.

14 **A.** Yes, these two meetings -- there was two
15 meetings. One was at the request of the paediatricians
16 in early morning and the other one was to join them at
17 a board meeting on 30 June.

18 I think the paediatric meeting was -- occurred in
19 response to the deaths of the two triplets.

20 **Q.** Pausing there. The unit and everyone was in
21 shock about that, reeling and devastated, weren't they,
22 nobody expected that, and you say yourself at that point
23 you were thinking someone could be responsible?

24 **A.** Correct. Though, the paediatricians we met
25 them one morning early, so the Baby P died on the 24th

51

1 a better word, a "forensic" review of everything
2 surrounding the death.

3 **Q.** So your evidence is that there was
4 an assumption even behind the thematic review that these
5 were natural deaths just looking for any learning --
6 clinical learning or generally, it wasn't even
7 a question whether forensic scrutiny or suspicion of
8 someone was being factored into the analysis?

9 **A.** Well, I'm not sure about that because
10 Dr Brearey modified his report after three weeks and he
11 did add in some features that would have suggested that
12 it was odd, in other words he did mention that there
13 were sudden deteriorations, and he also mentioned that
14 six out of the nine deaths had occurred at an odd time
15 between 12 midnight and 4 am, and it would be slightly
16 unusual to have your deaths confined -- confined to that
17 time period.

18 But -- so he has included those but hasn't gone as
19 far as saying in the report, to my knowledge on reading
20 it, that it was caused by intentional harm. And this --
21 this report was undertaken on 8 February, so ...

22 **Q.** The time, deaths occurring in the night,
23 you've just picked that up, so was that something --
24 that can go down, thank you -- was that something,
25 looking at that review, that did jump out at you as

50

1 and the meeting with the execs was on the 30th, so
2 I assume this meeting was early on the Monday, the 27th,
3 or early on Tuesday morning, but it was at half 7 in the
4 morning.

5 **Q.** Leave aside the date that may be contentious,
6 but we've all have got the point, you're at this
7 meeting, all of you together, and what happens at the
8 meeting -- what do you say that causes some response?

9 **A.** Well, we -- we had no idea -- well, it was
10 very unusual for the paedes to ask to meet at 7 in the
11 morning. It was very well attended by obstetricians.
12 There was three paediatricians there, Dr Gibbs,
13 Dr Jayaram and Dr Brearey, and some senior neonatal
14 staff of which one was Eirian Powell. And Dr Brearey
15 I think quite early on, the meeting was not long, it
16 couldn't have been anymore than 15/20 minutes but he
17 said there was great concern -- or the there is concern
18 that a nurse was causing intentional harm to babies on
19 the unit.

20 And, like, my remark, it seems I could have
21 expressed myself better and maybe said, "Is this
22 intentional harm causing deaths?" But I did say that,
23 "Are you saying that a nurse on the unit is a murderer?"
24 And he replied, "Yes." And like we were absolutely
25 shocked at this stage, and everybody was taken aback

52

1 from in an obstetric point of view -- obviously the
2 paediatricians were aware of this for some time -- and
3 the meeting really finished very quickly.

4 They also mentioned two other things at the
5 meeting, one, that they were considering downgrading the
6 unit and, two, that they were thinking about external
7 review. And they asked us -- they had a planned meeting
8 with the executive team on the 30th June and would some
9 of the obstetricians like to attend. And the meeting
10 finished. And we were at the back of the room and the
11 paediatricians and nursing staff were at the front and,
12 as we left, they filed out first and we filed out
13 afterwards.

14 I had no idea of the impact on what I'd said to
15 Eirian Powell. I didn't witness any interaction with
16 her and Dr Brearey. And I -- on the way through and out
17 to my clinic I had no contact with anyone. And the
18 first time I knew that there had been any concern with
19 what I had said was when Ian Harvey rang to ask me to
20 apologise seven months later.

21 **Q.** Pausing there --

22 **A.** So --

23 **Q.** -- let's go back a bit, first of all. So you
24 say you said -- are you saying a member of staff is
25 a murderer or something like that? What were your exact

53

1 they said "there was concern". So --

2 **Q.** Eirian Powell will give her evidence about
3 this meeting but, as far as you're concerned you didn't
4 see Eirian Powell you said in the meeting, you didn't
5 see her talking to Dr Brearey, you didn't appear -- you
6 didn't have any feedback about that comment when you
7 were in the meeting from anyone; is that the position?

8 **A.** Correct. Absolutely correct.

9 **Q.** Right. So no one says anything at the time
10 and then months later you get a telephone call from
11 Mr Harvey, so do pick up and tell us again in your own
12 words.

13 **A.** Well, I got a call from Mr Harvey, could
14 I come over to his office, and I wasn't expecting
15 anything. He would have rang me and odd time to
16 facilitate a Level 2 report from a department, and I was
17 expecting something like that.

18 I walked into his office, sat down with him and he
19 said to me, "You are going to have to make an apology to
20 Lucy Letby." Now, I didn't even know who Lucy Letby was
21 at that meeting of the paediatricians. One,
22 Steve Brearey didn't say the name of the person nor
23 whether it was male or female, but I didn't know who she
24 was, and he passed me the report for -- no, he didn't.

25 I asked to see the report because he said it had been

55

1 words?

2 **A.** Well, from what --

3 **Q.** -- as far as you can remember?

4 **A.** -- I remember saying I think I said, "Are you
5 saying a member of staff is a murderer on the unit?"

6 **Q.** So you say -- you're saying, "There's
7 a murderer on the unit", and you say, "We were all
8 surprised with when Dr Brearey said it." You've already
9 told us you were thinking after these deaths of O and P
10 and all that had gone before something had happened,
11 someone is causing harm. That was in your own mind,
12 wasn't it, it can't have been a complete surprise when
13 Dr Brearey said it to you?

14 **A.** Well, don't forget that was only -- that was
15 only two/three days before.

16 **Q.** Yeah, but it was in your mind, these perfectly
17 health triplets, two of them had died unexpectedly and
18 everyone was devastated you didn't know why.

19 **A.** Yes, but I hadn't discussed it with anybody
20 else and I hadn't actually heard the paediatricians
21 standing up or coming across and saying to me, "We also
22 think that. There is great concern on the unit." So it
23 still was a surprise to me to be confronted with the
24 paediatric team, the three senior paediatricians saying,
25 "Look, we have" -- they didn't say "grave concerns",

54

1 documented in the report that I'd called Lucy Letby
2 a murderer. And I said, "That's not the case. It's
3 definitely not the case." I qualified what Dr Brearey
4 had said and asked him, "Are you saying that a nurse on
5 the -- on the unit is a murderer?"

6 **Q.** So you did say a nurse rather than a member of
7 staff or you can't remember which? Before -- I'm not
8 sure these --

9 **A.** I said a nurse. But he said a nurse.

10 **Q.** Right, he said a nurse.

11 **A.** Steve Brearey said, "We are concerned that
12 a nurse is intentionally harming babies on the unit."
13 So I said in response to that, "Are you saying a nurse
14 is a murderer on the unit?" And it had been disclosed
15 in the HR report from Annette Weatherley that I had
16 called -- it had moved then to say I had called her
17 a murderer.

18 I didn't call her a murderer. I didn't know who
19 she was. And I said this to Ian Harvey. I said, "Look
20 Ian, I'm very -- this -- this -- this isn't right. You
21 know, that's down in an official document now. I've got
22 a HR document with that in it and I'm a bit unhappy
23 about that."

24 **Q.** Were you sent that at the time -- the
25 Inquiry's got the grievance procedure documents and the

56

1 findings -- were you sent what Annette Weatherley said
 2 to you at the time or have you had that subsequently
 3 through this Inquiry process?
 4 **A.** I have only had that through the Inquiry
 5 process, but I did get --
 6 **Q.** Right. So at the time you just listened to
 7 Mr Harvey telling you what --
 8 **A.** No, I didn't. I asked him, "Could I see the
 9 report?" And he produced the report and I read the
 10 section that he was talking about and gave it back to
 11 him. So I read a small paragraph where the bit said,
 12 "Jim McCormack had called her a murderer."
 13 So -- and I said, "Well, look, I'm a bit unhappy
 14 with that. I shouldn't really have to apologise."
 15 And --
 16 **Q.** So you weren't allowed to take the report out,
 17 you were just shown the paragraph that referred to you
 18 by Mr Harvey in his office?
 19 **A.** Correct. Correct. I didn't see the report
 20 until you provided it recently.
 21 **Q.** And that was the same page that you saw about
 22 where you were supposed to have said something in what
 23 way you said it; yes?
 24 **A.** Correct.
 25 **Q.** So if we go to INQ0012076, page 1, we see your
 57

1 her a murderer. So I was surprised that she didn't come
 2 back and say, "I want Mr McCormack to actually say." So
 3 my letter that I wrote I was very careful in what I said
 4 that it didn't actually say that because I didn't
 5 actually do it, and so I was -- I was -- I was surprised
 6 that in fact she had accepted the apology and -- and
 7 took it exactly as it was.
 8 **Q.** Did Mr Harvey -- that can come down -- think
 9 it was a reasonable thing that you had to do? Did he
 10 say that to you or what was your sense of what he felt
 11 about it?
 12 **A.** Well, I think he was in the position because
 13 he -- I can't remember what -- I -- I think ... Do you
 14 know in my statement where it's discussed?
 15 **Q.** It's only if you remembered anything in
 16 addition --
 17 **A.** But, I -- he -- he certainly was because he
 18 said to me that -- and I can't remember the words in the
 19 statement but he said to me that the chairman wants --
 20 needs an apology from all those involved to address the
 21 issue and that I hadn't choice because the
 22 paediatricians had already replied. And he said to me,
 23 "Look, do you want to go and add your name to the
 24 paediatricians?"
 25 So I'm sitting down, when I'd finished with
 59

1 apology letter dated 8 March.
 2 **A.** Yes.
 3 **Q.** You say "I appreciate" -- to Lucy:
 4 "I appreciate you have had a very difficult and
 5 stressful time during the course of the investigations
 6 into issues relating to the neonatal unit. I have been
 7 reported to have made an inappropriate comment during
 8 meetings with the Consultants and senior nursing staff
 9 when discussing events related to the neonatal unit
 10 issue. I wanted to apologise if this caused you any
 11 distress."
 12 And you explain there:
 13 "I am only aware recently that first name is Lucy
 14 and I have specifically avoided knowing your identity or
 15 name to try and afford you some anonymity when you
 16 returned to work in the neonatal unit. I have made no
 17 specific derogatory references personally about
 18 yourself."
 19 **A.** Correct.
 20 **Q.** At the time, did you think you should have to
 21 be sending that letter?
 22 **A.** No, I didn't. Not at all. I didn't send
 23 the -- and I was surprised that she accepted it when
 24 I -- when I was writing the letter because I was really
 25 saying nothing. I didn't actually apologise for calling
 58

1 Ian Harvey, I toddled over and Ravi Jayaram was in his
 2 office and so I went in and he smiled at me expecting me
 3 to come in because he knew I probably would come in and
 4 always thought I would be pulled up on that remark. And
 5 he showed me what their letter was and I said, "Well,
 6 look, thanks for that I -- I don't think" -- and
 7 I wasn't really working on the unit and I didn't want to
 8 be included in that group, and so I said, "I'll make
 9 a separate letter."
 10 And so I prepared the separate letter, met
 11 Ian Harvey and said -- and he was actually quite helpful
 12 about some comments and saying, "Don't say that." And
 13 that was the final letter that I sent -- that I gave to
 14 Ian Harvey.
 15 **Q.** So in that process you found Ian helpful --
 16 Ian -- Mr Ian Harvey helpful to you and you thought he
 17 was doing it at the direction the Chair of the board or
 18 you thought it was necessary in any -- in any event?
 19 **A.** Definitely he said to me that it was
 20 Tony Chambers had insisted that an apology letter was
 21 written. He -- he I don't think -- he was helpful to me
 22 in the text of the letter. That's what he was helpful
 23 to me with.
 24 **Q.** So he was helpful with the text but he said
 25 Tony Chambers required that of you?
 60

1 A. Tony Chambers required that an apology be --
2 be provided.

3 Q. Did you have a conversation with Mr Chambers
4 about that?

5 A. No. No, the only thing I asked -- because
6 I was then in a position when he said that four
7 paediatricians had apologised I thought, "Well, I'm not
8 really going to be in a position I can get out of this
9 it's already been documented in the HR report." And
10 I thought it wasn't going to be something that I was
11 going to be unable to avoid.

12 Q. Standing back, and you're retired now
13 Dr McCormack, what do you make of that HR process that
14 you ended up writing that letter, and the paediatricians
15 had as well, to someone who's now convicted of
16 murders --

17 A. Well, I think it's extremely disappointing,
18 extremely disappointing, and I said to Ian Harvey at the
19 time -- and I actually specifically asked Ian that, you
20 know, of all the departments in the hospital to be
21 producing the report and -- and not to have confirmed
22 from a person, "Is that what you said?" Or, "Are there
23 any truths to it?" I -- I couldn't understand it. And
24 I asked Ian could he go back and address that with the
25 HR team because there seemed to be something amiss with

61

1 sent them, and -- look, I think -- I think they're
2 fairly representative. They're only notes, obviously.
3 Nobody's reviewed them and said -- I was only making the
4 point that they're Stephen Cross's notes without someone
5 looking at them and changing them. And my impression
6 was that they -- they -- on my recollection that they
7 fairly represent what was discussed at the meeting.
8 That's what I thought when I read them.

9 And, you know, I had somewhat prepared after the --
10 after the meeting with the paedes that were going to this
11 executive team -- because it was a very senior team,

12 there were six of the Executives there, and I thought it
13 would be an opportunity to discuss the issues and --

14 Q. It's interesting you say that, Dr McCormack,
15 because six of the Executives and, of course, seven
16 paediatricians -- as an Inquiry we see many letters
17 signed by seven paediatricians. In your experience, how
18 rare is it to have that number of people committed to
19 the same intention or documents and writing around
20 an issue, does that happen very often, in your
21 experience?

22 A. Well, you know, I -- I -- at that time I'd
23 stopped most of my senior roles so I wasn't at big board
24 meetings and big meetings, so in the past I might have
25 sat round the board with those.

63

1 me that an investigation had a remark to that extent
2 resulting in what was happening I hadn't got
3 an opportunity to -- to discuss the situation and the
4 sequence with which the remark was made.

5 Q. Dr McCormack, I have only got two or three
6 more questions, are you all right to continue? Is that
7 all right with, my Lady? The time -- I notice the time.

8 A. Yes, I'm all right.

9 LADY JUSTICE THIRLWALL: Yes, thank you very much,
10 Dr McCormack. Yes, please do continue.

11 MS LANGDALE: Another meeting, please, at
12 INQ0003362, page 1, it starts at page 1.

13 This is a meeting on 30 June that you tell us you
14 attended, Dr McCormack, with there Dr Jayaram,
15 Mr Chambers, Mr Harvey, Dr Brearey and Ms Fogarty, and
16 it's understood that the handwritten notes are made by
17 Mr Cross.

18 A. Correct.

19 Q. And this is a meeting where a downgrade of the
20 unit is discussed and also RCPCH review. You make the
21 point in your statement, Mr McCormack that you didn't
22 have the chance to review the minutes or approve them.
23 You saw these notes I think -- was it the first time
24 when we sent them or had you seen them before?

25 A. No, the first time I saw them was when you

62

1 But for everybody in the room there, there was
2 eight Consultants and seven senior members of the
3 exec -- six senior members the executive team, plus
4 the chairman of the board. So it was a -- it was
5 a fairly serious meeting.

6 Q. If we go to page 4, you are discussing the
7 RCPCH instruction or potential instruction and you --
8 look next to your name Jim McCormack:

9 "Do they know about nurse concern?"

10 A. Which page is that?

11 Q. Can you see that?

12 LADY JUSTICE THIRLWALL: It's on page 4.

13 MS LANGDALE: Page 4. It's on the screen at the
14 bottom, in the last few --

15 A. Can you make it a bit bigger?

16 Q. You see the handwriting? Here we are.

17 "Do they know about ..."

18 A. Yes, I do, yeah --

19 Q. So you're raising --

20 A. -- and I remember asking this because I wasn't
21 really that supportive of them doing the external review
22 because of what Ravi and Steve had said about their
23 concern about harm, and I thought that we -- even though
24 I -- it was only very recently I'd thought of it,
25 I thought that this wasn't going to address the

64

1 intentional harm.

2 The expertise of the Royal College of Physicians
3 I understood, having had previous obstetric reviews, it
4 was all about manpower and about your guidelines and
5 about how you address risk. It -- it wasn't going,
6 I didn't think, to give us information that was going to
7 help us address the issue of intentional harm, and
8 that's why I asked them:

9 "Do they know about the nurse concern?"

10 And he said quite clearly, "Yes, the issues have
11 been highlighted and including the nurse issue."

12 **Q.** And then you say -- carry on with what you say
13 then. See the --

14 **A.** I then said at that stage I don't think it's
15 fair to ask the college to do a forensic -- I didn't use
16 the word "forensic", I think he -- Stephen Cross has put
17 that in. But I would have said I don't think it's fair
18 to ask the college to do this review and I meant that in
19 relation to the nurse issue, because I couldn't see how
20 they could address that in another review. And I knew
21 from the two reviews we'd done, albeit they can be
22 criticised for various things, that there was certainly
23 no concern in relation to natural deaths with the two
24 reviews, and I couldn't see the college being able to
25 address that. And I specifically had in mind that this

65

1 **Q.** Blue and white?

2 **A.** Yes. You know they way you get the blue and
3 white tape. His -- his quotation, not mine, blue and
4 white tape round the wards. And in fact to stand up for
5 the police, their investigation when they suddenly
6 arrived they were very accommodating, you wouldn't have
7 known they were there, and entirely unobtrusive.

8 **Q.** But he was saying blue and white tape
9 everywhere, what, that it would be disruptive to the
10 unit, close the unit, be a problem, what was the
11 inference did you take from whatever he was saying?

12 **A.** I took that it would become a crime scene and
13 that there would be blue and white tape all around and
14 that it would be the end of the unit. Like, those were
15 the -- his remarks, and it wasn't so much the content of
16 the remarks but for us to be talking about the need for
17 a police investigation and contact the police to address
18 a specific issue it didn't seem a very supportive remark
19 to address that particular issue of intentional harm,
20 because that had been brought up by both Ravi -- sorry,
21 by both Dr Jayaram and Dr Brearey and, at that time, no
22 one, except myself, had said, "Look, this is something
23 that the Royal College of physicians will not address
24 and it's something that is a police expertise."

25 **Q.** And then you say:

67

1 was something that was in the realms of the police would
2 be able to do a better investigation, and that's what
3 I was -- that's what I was saying at that stage.

4 **LADY JUSTICE THIRLWALL:** Sorry, Dr McCormack, just
5 to be clear, so what appears beneath the yellow, that's
6 all what you were saying?

7 **A.** That's all what I was saying, yes.

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

9 **MS LANGDALE:** And if we go to page 5 at the top of
10 it, that's presumably SPC, Stephen Cross:

11 "Outline and police action."

12 **A.** Yes.

13 **Q.** Can you remember what Mr Cross said about
14 that, about police?

15 **A.** That was the -- that was the surprising thing
16 because -- and everybody spoke forcefully at the
17 meeting, like Steve and Ravi spoke forcefully about
18 their issues, and Stephen Cross made it absolutely clear
19 that it would be the end of the unit, there would be
20 black and white tape up everywhere and gave a very
21 unwelcome tone to the suggestion that the police should
22 be involved?

23 **Q.** When you say black and white tape everywhere,
24 what did you mean by --

25 **A.** Sorry, blue and white.

66

1 "Women around the country are not stupid,
2 choice ..."

3 And then what did you say after that?

4 **A.** Well, that was in relation to the unintended
5 consequences. I'm not -- my recollection of exactly
6 what it was -- but I was saying that, look, police, no
7 police you know if -- if you're talking now, women are
8 very educated as regarding their pregnancies and they
9 will choose their unit depending as they -- as they see,
10 and if there's increasing deaths with no intervention
11 they will move to another unit. If the police are
12 brought in and they've concerns of that they'll also
13 move to another unit.

14 It had no bearing on the need that we required, in
15 my opinion, at that stage if the two Consultant
16 paediatricians had grave concern and I think this is the
17 first time at the meeting that they actually openly
18 declared it that I was aware of, and I just thought that
19 it looked very like, in my interpretation, that the only
20 resolution at that time was police to address that
21 issue.

22 **Q.** That can go down now, please.

23 Then can we go to 0014605, page 31. While we are
24 finding that, Mr McCormack, whilst that was the only
25 time you say you heard them openly say that in those

68

1 terms, and you say earlier that day you used the term
 2 "murderer", that's not to say they weren't raising
 3 concerns for some time that someone would be
 4 deliberately -- could be deliberately harming.
 5 **A.** I would agree with that.
 6 **Q.** Because it's very easy, isn't it, to say the
 7 concerns weren't expressed loudly or clearly enough in
 8 the terms that you raised in the meeting on the 30th,
 9 but the concerns were still there, weren't they, and
 10 still evidenced by the sudden and unexpected deaths
 11 repeatedly that were occurring, and deteriorations?
 12 **A.** Yes, and -- and we've discussed that a couple
 13 of times.
 14 **Q.** Yes. If we go to this page, this is your
 15 interview with the RCPCH I think because it says at the
 16 top "Three midwives, Jim and Sarah." And it looks, and
 17 it's just for clarification for the record:
 18 "Detailed second report. All cases have been OSR.
 19 Went through all the cases together looking at them."
 20 It looks like you're talking about the Head of
 21 Midwifery or someone is that Brigham review that you'd
 22 gone through, stillbirths and neonatal deaths, yes, that
 23 told them that that review had been conducted?
 24 **A.** Yes, I think so.
 25 **Q.** You don't have much recollection of it. Do

69

1 obstetric, gynaecology, paediatric staff, and when there was
 2 an issue on the board, the particular staff that that
 3 related to and their expertise related to would have
 4 clearly discussed that, and that's what I was saying to
 5 you in relation to the governance board and the
 6 paediatric. At no stage did -- was any concerns shared
 7 directly at the board.
 8 Now, I don't know why that was, but, you know, it
 9 may well have been that he considered this the incident
 10 so sensitive in relation to the staff involved that that
 11 wasn't a discussion. You'll have to enquire why that
 12 was. But certainly I got the -- I got the impression --
 13 and don't forget, everybody at the board had no
 14 knowledge still of the talk of intentional harm and
 15 concern in that regard.
 16 So the only people coming to the meeting who would
 17 have access to that information were the head of -- the
 18 nursing head of paediatrics, the lead, Dr Jayaram, or
 19 I think once Dr Brearey came. And, as you said
 20 previously, they were beavering industriously elsewhere
 21 to ensure that the Senior Executives understood there
 22 was an issue with intentional harm. But that wasn't the
 23 nature of their conversations at the governance board.
 24 **Q.** Were you aware of the case of Beverley Allitt
 25 at that time?

71

1 you know if somebody interrogated that a little bit
 2 further, as I have today, about what it represented and
 3 did and did not do?
 4 **A.** My recollection of the meeting was it wasn't
 5 really -- there wasn't any persistent questioning or
 6 confirmation in relation to anything that was said, but
 7 if you hadn't sent me that copy of the written text,
 8 I would have no recollection whatsoever of what was
 9 discussed.
 10 **Q.** So not memorable at all, from your
 11 perspective, in terms of trying to find out what was
 12 happening with --
 13 **A.** No, and that would reflect what I said
 14 previously about the nature of a college review. They
 15 weren't there to investigate deaths. They were there to
 16 undertake a review.
 17 **Q.** Looking at the governance structure that was
 18 in place at the hospital at the time, Dr McCormack, how
 19 do you say concerns about a staff member should have
 20 been reported and addressed through the governance
 21 structure that you had there? The document can come
 22 down, thank you.
 23 **A.** Well, I did discuss that slightly earlier with
 24 you in relation to the members of staff at the
 25 governance board. The governance board had senior

70

1 **A.** Oh, absolutely. I was 23 years a Consultant.
 2 And, you know, that -- that would have been something
 3 that all of us at that time would have been -- would
 4 have been shocked about.
 5 **Q.** So as those cases were repeating themselves,
 6 Baby A, Baby C, Baby D, E, I and then the deaths of the
 7 triplets, O, P, never mind the deteriorations in
 8 between, and there were a number, were you thinking for
 9 yourself, whatever they said "We could have somebody
 10 here intentionally harming or killing these babies?"
 11 Irrespective of what they -- how they articulated their
 12 concerns to you, just the numbers and the patients that
 13 you'd seen who were --
 14 **A.** And, again, we've discussed that previously in
 15 relation to at what stage you arrive and consider, look,
 16 this does look to be something very abnormal, and should
 17 we be considering intentional harm? And I assume there
 18 must be a threshold by which -- by which that -- that
 19 actually happens.
 20 And I have to be honest with you and say I didn't
 21 reach that threshold until June 16 with -- with, as
 22 I have discussed, the triplets and then the subsequent
 23 visit of the paediatrics and then the subsequent visit with
 24 the board, and, you know --
 25 **Q.** Do you think you should have reached that

72

1 earlier -- do you think you should have reached that
2 earlier looking back and listening to what people were
3 saying?

4 **A.** But I -- I think -- you know, I used to do
5 perinatal meetings and there was a chain of events in
6 labour ward and you would have discussed it, and it was
7 very easy when you look back and you say, "Well, why
8 didn't we make that decision?" And -- and I think the
9 same is very valid of this. Like, if you think of there
10 has only been four deaths as a result of
11 Beverley Allitt, and we've 7,500 deliveries a year since
12 that time, and I think that the -- the realisation of
13 intentional harm is something I think very, very
14 difficult to grasp. And, you know, I still -- when
15 I heard -- read John Gibbs's statement and he was
16 ashamed of his -- that they hadn't -- I think any of the
17 clinicians involved have a feeling of shame that in some
18 way that they couldn't actually have prevented that.

19 **Q.** You tell us in reflections that medical
20 examiners and their introduction would assist with this
21 and provide independent scrutiny of deaths not referred
22 to the Coroner, is that your view, that the --

23 **A.** I -- I have no experience of medical
24 examiners. They've only actually been brought in now in
25 the last -- I think they were only appointed '23/'24 but

73

1 wasn't enough awareness of how to contact the police?

2 **A.** I don't think there was enough awareness to
3 contact the police. I'm not sure whether it was
4 self-belief that this isn't happening or -- or what
5 exactly it was, and you'll get the opportunity to ask
6 them. But my point was -- and I have to apologise,
7 I hadn't realised there was a memorandum of
8 understanding already in some existence of contact the
9 police (inaudible) and I hadn't actually realised,
10 because I've nothing to do with the child death overview
11 reviews, I hadn't exactly realised there was contactable
12 police there as well.

13 But I did think that for this sort of scenario,
14 where one of the senior execs to be able to speak to
15 a senior police officer in confidence and say, "Look, we
16 have a genuine concern here in the hospital. Our two
17 paediatricians have grave concern of intentional harm.
18 There is no evidence whatsoever to support that. Look,
19 can I have a chat with you?" And I thought that could
20 have been -- like, even after a meeting I had in a board
21 on 30 June, I thought that was a discussion that should
22 have been available at that time without leaving it to
23 much, much later.

24 **MS LANGDALE:** Thank you, those are all my
25 questions. Thank you, Dr McCormack.

75

1 my suggestion was that this is an office within your own
2 hospital that has expertise about deaths and would
3 easily facilitate this type of discussion. In other
4 words, you could go confidentially and talk to someone
5 and it would give you the ability then to -- to source
6 the place or Coroners or whatever it was, and I just
7 thought that it's a role I would have thought should be
8 emphasised greatly.

9 And -- and even as far as education, if you talk
10 about Beverley Allitt and then Chua, and then Norris,
11 and all these guys, you know I have never seen in my
12 23 years an educational meeting where someone comes in
13 and just reminds us of these things. And, like, Chua
14 was, what, he sentenced the same year and still we're
15 not aware of that. And from the medical examiners they
16 have that great ability now I think maybe as part of an
17 education to raise it, even though I've mentioned
18 extremely rare, and that would be a role I think could
19 easily be highlighted.

20 **Q.** You also say:

21 "I think it is necessary to have established links
22 with the police and Trust Executives to permit
23 discussion at any time to assess the need for police
24 involvement or investigation."

25 Do you think being at that meeting there just

74

1 **A.** Thank you.

2 **MS LANGDALE:** Does my Lady have any questions?

3 **LADY JUSTICE THIRLWALL:** I have no questions, thank
4 you very much. No questions from anyone else.

5 Dr McCormack, thank you very much indeed and for
6 sitting a bit later, that concludes your evidence and
7 you are free to switch off.

8 **A.** Thank you very much, my Lady.

9 **MS LANGDALE:** My Lady, can we resume at 12.05.

10 **LADY JUSTICE THIRLWALL:** Yes, so we will adjourn
11 until five past 12.

12 (11.47 am)

(A short break)

14 (12.06 pm)

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

16 **MR DE LA POER:** My Lady, thank you, our next
17 witness is Dr McGuigan and I wonder if you might step
18 forward, please.

19 **LADY JUSTICE THIRLWALL:** Dr McGuigan, would you
20 like to come up to the desk, please.

21 **DR MICHAEL MCGUIGAN (affirmed)**

22 Thank you, Dr McGuigan, please sit down.

23

24 **Questions by MR DE LA POER**

25 **MR DE LA POER:** Please could you give us your full

76

1 name.
 2 **A.** It's Michael Patrick McGuigan.
 3 **Q.** And, Dr McGuigan, can you confirm, please,
 4 that you provided the Inquiry with a statement dated
 5 30 May 2024?
 6 **A.** That's correct.
 7 **Q.** And are the contents of that statement true to
 8 the best of your knowledge and belief?
 9 **A.** They are.
 10 **Q.** Did you qualify as a doctor in 2002?
 11 **A.** Yes.
 12 **Q.** And you became a member of the RCPCH in 2005;
 13 is that correct?
 14 **A.** That's correct.
 15 **Q.** Since 2004, have you worked exclusively in
 16 paediatrics and neonatology?
 17 **A.** That's correct.
 18 **Q.** Did you become a Consultant in paediatrics in
 19 2012?
 20 **A.** Correct.
 21 **Q.** And did you initially work as a Consultant in
 22 Crewe in paediatrics and neonates?
 23 **A.** That's correct.
 24 **Q.** In June of 2016, did you apply from a job at
 25 the Countess of Chester?

77

1 immediately -- as soon as possible in the half hour/hour
 2 or so after the event, a meeting of the doctors, nursing
 3 staff who were involved in the resuscitation, and
 4 sometimes a cold debrief a few days later to discuss
 5 sort of after the events.
 6 The purposes of those debriefs, in my mind at that
 7 time, were two-fold. The first was to support the staff
 8 who had been involved. For example, a staff member may
 9 leave a resuscitation thinking because I didn't do this
 10 at this time this is why the patient died, an
 11 opportunity for people to raise concerns and potentially
 12 correct things that needed correcting for people. So
 13 immediate staff support. And then also giving staff
 14 an opportunity to share any immediate feedback or
 15 learning from the process of the resuscitation, perhaps
 16 a piece of equipment wasn't as handy as it could have
 17 been or something else would have been helpful, you
 18 know, whether there's any immediate learning from the
 19 resuscitation that's taken place.
 20 **Q.** At the start of your explanation for debriefs,
 21 you said -- and here we're talking about before you got
 22 to the Countess -- that these debriefs would occur when
 23 there was a death but also when there was a collapse
 24 leading to resuscitation which didn't ultimately and
 25 happily end in death. Was that uniformly the case at

79

1 **A.** Yes.
 2 **Q.** And did that job begin on 9 January 2017?
 3 **A.** It did.
 4 **Q.** Finally, just to complete the overview of your
 5 career, in December 2018, did you become the clinical
 6 lead for the paediatric department at the Countess of
 7 Chester?
 8 **A.** I did.
 9 **Q.** And was that in effect taking over from
 10 Dr Jayaram?
 11 **A.** Yes.
 12 **Q.** And did you continue in that position until
 13 December 2023?
 14 **A.** Yes. Yes.
 15 **Q.** So we're going to begin the substance of my
 16 questions, Dr McGuigan, by just dealing with your
 17 understanding of ordinary medical practice in
 18 paediatrics before you arrived at the Countess of
 19 Chester.
 20 Firstly, what was your understanding of the purpose
 21 of debriefs?
 22 **A.** Debriefs were often conducted after there had
 23 been either a difficult resuscitation or an
 24 unexpected -- or resuscitations that had ended in
 25 a death there would usually be a hot debrief, as in

78

1 Crewe or did it depend upon the person who was leading
 2 the resuscitation effort, or were there some other
 3 factors that governed whether a debrief would take
 4 place?
 5 **A.** Yes, I don't there was any policy on it, so it
 6 was always a decision by the person leading the team
 7 based on the severity of the resuscitation. Certainly
 8 if there was a cardiac arrest as part of the
 9 resuscitation I think it would be usual for some kind of
 10 debrief to take place afterwards.
 11 **Q.** And when you got to the Countess of Chester,
 12 did you find that in those early months their approach
 13 to debriefs was the same as you had experienced at Crewe
 14 or was there a difference?
 15 **A.** Yes, I don't think I ever particularly
 16 remembered when I was rotating round as a junior doctor
 17 different hospitals having a different approach to
 18 debriefs or having any formal policy about debriefs.
 19 I think practice was probably fairly similar from place
 20 to place.
 21 I don't remember if there are any debriefs in those
 22 first few months, but I don't remember the practice
 23 being different to where I'd worked previously.
 24 **Q.** When you were in Crewe, did the hospital you
 25 were working at use the Datix system?

80

1 A. They did.

2 Q. And before you got to the Countess, what was
3 your understanding about the circumstances in which
4 a Datix form should be created?

5 A. I think my understanding was that a Datix form
6 was usually being completed when an incident happened
7 where there could be learning so, for example, if
8 a mistake had been made, if a drug error had been made.
9 I don't remember it being routine to Datix, for example,
10 that there had been a collapse or even necessarily that
11 every death would be Datixed at the time.

12 It's really hard thinking back, you know, because
13 it is quite a long time ago, but that would be my
14 recollection was that -- and that's changed a lot in the
15 years since but my recollection at the time was it
16 wouldn't be routine necessarily to Datix a death or
17 a sudden collapse in the way that it would be now.

18 Q. When you got to the Countess of Chester in
19 those early months, did you find that the approach of
20 the paediatric department was the same as that which you
21 had previously experienced in relation to Datix or were
22 there differences?

23 A. I think there were inevitable differences
24 because of the situation that they were in, that they
25 were investigating a number of unexplained deaths and

81

1 not necessarily perceive there was a problem with the
2 care but once there's opportunity to review the care in
3 more detail in the cold light of day that there might be
4 useful learning that comes out of that, so I think it's
5 a good change of practice, and I think it reflected
6 a big change in general in how we've approached these
7 things over the last few years. We didn't have HSSIB
8 investigating neonatal deaths and brain injuries at that
9 time.

10 I don't think we had the perinatal mortality tool
11 at that time, or it had been recently introduced, so
12 there's been a lot of changes in how we approach child
13 death particularly in neonates over the last few years.

14 Q. The sudden unexpected death in infancy and
15 childhood protocol, and here I'm speaking about
16 something the Inquiry has heard quite a lot about,
17 namely the convening of a Joint Agency Response or
18 a multi-agency reaction where local authority and police
19 will be involved very quickly, so that SUDIc process,
20 when you were at Crewe, did you follow that SUDIc
21 process in relation to sudden unexpected deaths on the
22 neonatal unit?

23 A. I've thought a lot about this in preparing for
24 my evidence. I can't think of an example anywhere that
25 I've worked where there's been a sudden unexpected death

83

1 collapses and, therefore, the expectation in how we
2 would respond particularly if there was an unexpected
3 event on the neonatal unit was different by that point.

4 Q. So you think the policy that you were met by
5 had been influenced by the events of the previous
6 months?

7 A. Yes.

8 Q. You mentioned that the procedure has changed
9 since the circumstances you experienced at Crewe. Is it
10 now your understanding that Datixes would always be
11 created in relation to a sudden unexpected collapse that
12 does not end in death but for which there is no
13 immediate or obvious explanation?

14 A. Our practice now would be any significant
15 deterioration in a patient's condition that led to them
16 needing intensive level care of support would be
17 Datixed, and that would be on our children's unit as
18 well, so any child, even if there were no concerns about
19 the care, who needed to go to intensive care at
20 Alder Hey we would Datix that and we would review all
21 those incidents.

22 Q. And do you regard that as an improvement to
23 the system or is it overly burdensome and impractical?

24 A. I think it's an improvement to the system.
25 The problem sometimes can be that if you -- people might

82

1 of an inpatient that's led to a Joint Agency Response.

2 Q. And so that we understand the geography of
3 where you've worked, has that largely been confined to
4 the north-west or is this -- has your career spanned
5 more areas than that?

6 A. That was in London and Bristol as a junior
7 doctor, SHO level, and in the north-west since middle
8 grade Registrar level.

9 Q. And we know that Working Together was
10 published or republished in 2015, and that's the version
11 that we have been looking at closely. Your career since
12 2015, has that been confined to the north-west or --

13 A. Yes.

14 Q. It has been?

15 A. Yes. Yes. And when I thought about it
16 preparing for this evidence, I remember attending
17 training as a Registrar -- a full day of training in
18 managing sudden unexpected death in childhood and it
19 being made clear in that training that if you had an
20 unexpected unexplained death in hospital that the same
21 rules would apply in terms of activating a Joint Agency
22 Response.

23 But I think it probably reflects that sudden
24 unexpected -- well, certainly sudden unexplained death
25 in hospital patients is not a common event, so it's

84

1 probably not something that would be activated very
 2 often. But I can't recall a time when that has been
 3 activated in that situation.
 4 **Q.** And, finally in terms of your experience,
 5 before you got to the Countess of Chester, had you ever
 6 previously encountered a situation in which there was
 7 concern raised about a particular staff member, whether
 8 doing harm deliberately or inadvertently, so where there
 9 was a concern about an individual, I'm not asking you to
 10 name them, but had you encountered that before you got
 11 to the Countess of Chester?

12 **A.** No, I can't recall any -- any.

13 **Q.** So this question is very much a hypothetical
 14 in those circumstances. If there was concern about
 15 a particular individual, what is your view about whether
 16 or not, whether anonymously or by name, that --
 17 a standard governance meeting should be discussing that
 18 issue?

19 I can put that in a different way, if you like,
 20 that is the standard governance structure equipped for
 21 discussing a concern like that about a particular person
 22 or should there be a separate route by which that person
 23 is discussed and the risk is managed?

24 **A.** I think my answer to that would be that within
 25 a governance meeting there's lots of people with

85

1 member is performing in some way. But, yes, I --
 2 I can't see that it would be usual practice for that to
 3 come through a governance board meeting.

4 **Q.** So does it follow from that that if you don't
 5 think that that is the appropriate route, that it is
 6 extremely important that there is a clearly designated
 7 route by which those concerns can be investigated,
 8 monitored and progressed?

9 **A.** Yes.

10 **Q.** And looking back to your time at Crewe, were
 11 you aware of any such route existing at Crewe?

12 **A.** No, I think -- I suspect there may have been
 13 a route but -- and I suspect -- you know, I was
 14 a relatively junior Consultant at the time -- that if
 15 I'd spoken to people in more senior positions that there
 16 would be a route for progressing that but I wasn't
 17 familiar with it.

18 **Q.** So we're just going to move chronology
 19 logically through your experience of the Countess of
 20 Chester and in fact events begin for you before you
 21 arrive in January of 2017. You applied in June of 2016;
 22 is that right?

23 **A.** Correct.

24 **Q.** And the Inquiry has received evidence that
 25 there was a press release by the Countess of Chester in

87

1 different roles. There might be an audit lead there,
 2 there might be -- you know, there might be a variety of
 3 people there and that a sensitive investigation like
 4 that might not be appropriate to be discussed within
 5 a governance meeting setting and might be discussed
 6 separately. If that happened and I was leading that
 7 governance meeting, I certainly would be thinking about
 8 whether in some way it needs to be acknowledged that
 9 this process was going on.

10 But I would be mindful of -- of having a fair
 11 process for the individual concerned and the
 12 confidentiality issues with that against the need for
 13 that to be -- have the oversight of the governance
 14 committee.

15 **Q.** So are you perhaps, and you tell me,
 16 envisaging a hybrid situation where the detail of it
 17 isn't discussed at the governance meeting but the fact
 18 that such an investigation is taking place might be
 19 mentioned and minuted so that at the governance level,
 20 whichever tier that is of the hospital, a track can be
 21 kept of the fact that that is occurring?

22 **A.** Yes, and I guess it depends on what the level
 23 of concern is. You know, I'm trying to think back
 24 whether it's hypothetical or not, there must be
 25 circumstances where there's concerns about how a staff

86

1 early July of 2016 about the downgrading of the unit
 2 and, given that that was a place that you wished to
 3 work, did you become aware of that press release?

4 **A.** Yes, my memory is that it was made between the
 5 job being advertised and my application being completed.

6 **Q.** And was it drawn to your attention by those
 7 that you had applied to, ie the Countess said, "You
 8 should be aware of this", or did you just see it in the
 9 press or --

10 **A.** Not by the Countess but because there was
 11 a change in designation of the unit that was
 12 communicated around all the local hospitals so that we
 13 were aware of that. So I knew it through -- through the
 14 Neonatal Network rather than directly from Chester.

15 After I'd applied for the job, Dr Jayaram then
 16 contacted me to say, "There's been developments here and
 17 I think you need to come and speak to us before you come
 18 to your interview to understand a bits more what's
 19 happening."

20 **Q.** So we'll come to that now. You describe this
 21 as a pre-visit --

22 **A.** Yes.

23 **Q.** -- where you met with Dr Jayaram, and was that
 24 at the Countess?

25 **A.** It would have been, yes.

88

1 Q. And was that meeting such that you just went
2 straight into a room and talked to Dr Jayaram or did you
3 gather any feel for the unit as you walked through?

4 A. Yes, so --

5 Q. How much information did you gain from that
6 first meeting outside of what Dr Jayaram told you?

7 A. Yes, so the usual process of applying for
8 a Consultant -- substantive Consultant job would be that
9 you would meet a number of members of the organisation.
10 One of the nursing leads took me on a tour of the estate
11 and the paediatric and neonatal units, so I spoke to
12 a number of different people as part of my pre-interview
13 visits. But in particular Dr Jayaram had asked me to
14 make an appointment to speak to him because he wanted to
15 give more information on what was happening with the
16 neonatal unit.

17 Q. What was your impression outside of what
18 Dr Jayaram told you in August or July of 2016 of what
19 sort of place it was to work and how it was functioning
20 and how people's morale appeared?

21 A. Yes, the people I met were nice. They seemed
22 to have good relationships with each other. I knew some
23 of the people who worked there who liked the teams that
24 they worked with. Lots of our junior doctors will have
25 come from Crewe who've rotated from Chester in

89

1 A. Yes, that's right. Yes.

2 Q. Now, we're going to come in a moment to what
3 you were told when you were appointed and turned up for
4 your first few weeks of work. But what I would like to
5 just deal with first had, please, is your impression at
6 the very earliest stage of your arrival in January of
7 2017, because I think it wasn't immediately that you
8 were told about more detail of the concerns; is that
9 right?

10 A. I think it was in the first week that
11 I started that Dr Jayaram came to speak to me to give me
12 more detail about what the concerns were and where they
13 were up to at that point.

14 Q. Well, doing the best you can to disentangle
15 things in terms of when you did and didn't know
16 things --

17 A. Yes.

18 Q. -- before you were told about those very
19 serious matters, what was your impression of the
20 department that you walked into fresh?

21 A. It felt very similar to where I'd come from in
22 Crewe. Like I said, the junior doctors rotate around
23 and my understanding of Chester was it was a unit that
24 had a good reputation, that it was good for training,
25 the trainees liked going there, it was a popular place

91

1 a previous and said good things about it and that it was
2 a God place to work. So I -- yeah, I had a good
3 impression of the department, which was partly the
4 reason I decided to continue with my application there.

5 Q. Did anyone other than Dr Jayaram tell you
6 about events of the recent months or anything about why
7 the unit had been downgraded?

8 A. Gosh, I don't remember. I don't remember.

9 Q. Tell us, please, what Dr Jayaram told you in
10 that pre-visit meeting with him.

11 A. I can't remember what I said in my statement.
12 I don't remember --

13 Q. Paragraph 8 if you wish to remind yourself.

14 A. Yeah, what I've said there -- what I remember
15 is that is those facts that there had been a spike in
16 mortality, that there had been a Royal College review
17 commissioned, that they'd downgraded their status of the
18 unit while investigations were taking place, and
19 presumably with an intention of dealing with those
20 issues and getting back up to Level 2 status again.

21 Q. And, as you've told us, you continued with
22 your application following that pre-visit.

23 A. (Nods).

24 Q. Is that because you were comfortable with what
25 you were told?

90

1 to work, that the trainees who went there felt supported
2 by the team they worked with, and it was a good unit to
3 work in, and that's, you know, what I found when
4 I started and started working on the wards and going to
5 handovers.

6 Q. And so does it follow if that that you didn't
7 detect from your interactions with various people before
8 you were told more about the concerns that there was any
9 dysfunctioning within any of the relationships?

10 A. No, I -- I would have met Mr Chambers and
11 Mr Harvey as part of my pre-interview visits. As far as
12 I remember, Mr Harvey was on the appointments panel for
13 my interview. You know, a conversation, 20 minutes,
14 they seemed like nice people and, you know, I -- I had
15 a good impression of the place I was coming to work in.

16 Q. Did either of them tell you anything about
17 what was -- what you now know was going on in the
18 background at the time that you met them?

19 A. I don't remember what we discussed.

20 Q. If you just think -- think back, do you think
21 it would have stood out in your recollection, as it has
22 for Dr Jayaram, that you were given some information
23 about the challenges the hospital was facing at that
24 time?

25 A. I don't remember. Mr Harvey we met in the

92

1 coffee area of the education centre with all the
 2 candidates that were interviewing that day, so certainly
 3 I don't think we would have discussed anything like
 4 that.
 5 Mr Chambers I met on his own. My memory of talking
 6 to him was talking about where things were likely to go
 7 with paediatrics and health in that part of the world
 8 over the next few years, thoughts about how Chester and
 9 Arrows might work more closely together, and I don't
 10 remember discussing the neonatal issue with him.

11 **Q.** Knowing what you do now, do you think that was
 12 something he should have talked to you about even in the
 13 oblique terms that Dr Jayaram had?

14 **A.** I don't know. I obviously walked into a very
 15 difficult position -- situation that I didn't appreciate
 16 I was walking into. It was also an evolving situation.
 17 There was lots of confidential issues in there. I think
 18 I can understand why I was only given limited
 19 information at that point.

20 I think I would have liked to have understood the
 21 difficulty of the relationship between the paediatric
 22 Consultants and the execs at that point, but I think
 23 that had deteriorated a lot more between July/August and
 24 then when I started in January.

25 **Q.** What you tell us in your statement was that
 93

1 and -- and see what the normal relationships would be
 2 like. My experience at Crewe was very good in that both
 3 the Chief Executive and the Medical Director had invited
 4 me to meet them in my first two or three months in the
 5 post and welcomed me and got to know me a little bit.

6 I obviously arrived here and by the third week we
 7 had this very difficult meeting. So I walked into
 8 a very difficult situation.

9 **Q.** Again, we're going to look at the detail of
 10 this, but just dealing with your summary of the
 11 position. At your paragraph 61 -- you don't need it
 12 turn it up unless you want to -- you observe that the
 13 Consultants could have given up. Was it your perception
 14 over the course of those early months that the
 15 Consultants' concerns could have resulted in them simply
 16 stopping raising problems?

17 **A.** They certainly could have done, but I never
 18 saw any intention that they were going to stop until
 19 they were satisfied that the issues they were concerned
 20 about had been addressed.

21 **Q.** In terms of the quality of the care on the
 22 neonatal unit that you observed -- again, you deal with
 23 this in your witness statement -- but just describe for
 24 us in your own words what you thought of that?

25 **A.** Yes. So what I was able to witness working
 95

1 you observed good relationships between the clinicians
 2 and managers at the ward level --

3 **A.** Yes.

4 **Q.** -- in the department, and that you found the
 5 Consultants to be supportive of each other.

6 **A.** Yes.

7 **Q.** You also say that what you discovered upon
 8 arrival was that outside of the department those
 9 relationships were strained.

10 **A.** Yes. So there's various levels of management,
 11 but -- that their relationships with the higher level
 12 management, ie the executive level management, was very
 13 strained at that point.

14 **Q.** And was that something simply that you were
 15 told or, as perhaps we shall see, was that something you
 16 observed for yourself as events unfolded?

17 **A.** I don't remember. I think -- I think it
 18 probably became clear to me at that meeting at the end
 19 of January I attended in the third week of working at
 20 the Countess of Chester.

21 **Q.** And you said that it was very different to
 22 your experience at Crewe in terms of that interaction
 23 between those outside the department at managerial level
 24 and the department.

25 **A.** I guess I hadn't really had time to settle in
 94

1 there was working on the neonatal unit seeing the
 2 policies and practices they had in place, seeing the
 3 expertise of the nurses who were looking after the
 4 patients talking to me about what was happening with the
 5 patients, hearing the other Consultants talking about
 6 patients at handovers and how they were managing the
 7 patients. And, as far as I could see, the care was
 8 excellent quality. I agreed with the clinical decisions
 9 that my Consultant colleagues were making on the
 10 patients, and I didn't -- I felt like I was working in
 11 a place where the doctors and nurses knew what they were
 12 doing and providing a good level of care.

13 **Q.** Just dealing with the governance arrangements
 14 and matters of management and the divisions. Again,
 15 this is something you deal with in your witness
 16 statement, we can turn it up if needed, but what was
 17 your view, having walked in to the situation that you
 18 did, about the divisional structure that the hospital
 19 was operating, in other words the fact that paediatrics
 20 was in Urgent Care whereas obstetrics was in Planned
 21 Care?

22 **A.** Yes. I don't think you see that as much when
 23 you are not in a clinical lead role within a department.
 24 But certainly I was quite surprised at the way it was
 25 divided. And clearly we've heard from Dr McCormack this
 96

1 morning, the paediatricians' and the obstetricians'
2 offices are very close, the neonatal labour ward was
3 close. So there was lots of interaction between the
4 two. But it did concern me that the governance
5 structure and the divisional structures were -- were so
6 separate --

7 **Q.** And --

8 **A.** -- and I hadn't seen that anywhere else I had
9 worked.

10 **Q.** Was it under your clinical lead position that
11 the divisional structure changed to what it is now or
12 did what change before you took over that role?

13 **A.** Yes. So over the year after I started
14 probably in 2018, there was a decision to bring women
15 and children's back together as a single directorate
16 within one division. So we were in the Planned Care
17 division, which included all the surgical services,
18 women and children's became a separate directorate with
19 its own directorate management within that division, and
20 then in the last year we have separated out and become
21 our own women and children's division separate from any
22 of the other divisions in the Trust.

23 **LADY JUSTICE THIRLWALL:** I'm sorry, Mr De La Poer,
24 does that mean you have a seat at the board table, as it
25 were?

97

1 that?

2 **A.** Yes, that was perhaps from listening to the
3 people that I was working with, you know, who perhaps
4 had those risk lead roles at that time and if
5 a significant incident occurs and you want to have an
6 investigation it takes a lot of time to do that
7 investigation. Somebody needs to prepare the timeline,
8 to get the statements, to bring all the information
9 together. Often these things can be 30, 40, 50 pages
10 long, and it takes a lot of time, and without the
11 personnel to be able to do that, you can't have that
12 rigorous analysis of the events, and from what
13 I understood, the amount of support they had from people
14 to do that at governance level wasn't there.

15 And I think we've heard from other people that, and
16 this is what I was aware, that sort of the Consultants
17 were basically finding time to do that outside of their
18 normal working hours to try and process -- and so many
19 significant events had happened in such a short space of
20 time -- trying to process that.

21 **Q.** So where was there a lack? Was it in the
22 paediatric department or was it in the risk department
23 supporting --

24 **A.** Yes, so my understanding was particularly the
25 risk -- midwife risk nurses who would support with that

99

1 **A.** Yes, so that means that the women and
2 children's division is run by a triumvirate of nursing
3 manager, which is the Director of Midwifery, the Medical
4 Manager, which is the Clinical Director for the
5 division, and a divisional manager and that those three
6 people then speak directly to the execs as their
7 immediate managers above them.

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

9 **MR DE LA POER:** And is that a change for the
10 better?

11 **A.** Yes, very -- it very much feels that way. And
12 I think it's easy in any organisation for which
13 predominantly deals with adults, you know, often is
14 starting its morning with 30 patients in A&E corridors,
15 lots of busy wards and trying to keep operating lists
16 going, it's potentially very easy for the needs of the
17 smaller patients to be lost within that, and certainly
18 I think that being in a separate women and children's
19 division again just gives the -- it just gives a bigger
20 voice and easier to make sure that that voice is heard.

21 **Q.** You say in your witness statement that the
22 governance support in place at the time, meaning when
23 you arrived:

24 "... struck me as minimal and insufficient."

25 Please could you just tell us what you mean by

98

1 process were lacking.

2 I think as well within job plans, you know,
3 Dr Brearley was the neonatal lead but also took the
4 responsibility for the neonatal risk. The plan had
5 been, and what ultimately came when the Consultant after
6 me was appointed, was that a second Consultant took on,
7 you know, a PA a week to be the neonatal risk lead and
8 took that role separate from the neonatal lead.

9 So that led us to a place where we had -- and
10 ultimately we've got more midwife nursing risk support
11 from the risk team, but also more time within the
12 Consultant job plans to have the time to look at
13 neonatal risk and assess it properly.

14 **LADY JUSTICE THIRLWALL:** So when you talk about
15 a job plan, that's a sort of -- is it how many hours you
16 spend on what?

17 **A.** Yes. So a job plan, yes, would be how many
18 hours have you got in a week to work.

19 **LADY JUSTICE THIRLWALL:** Yes.

20 **A.** And what do you spend that time doing. If
21 your time is full of clinics and clinical work, but you
22 also need time to do other things like being a clinical
23 lead role or working in neonatal risk, for example.

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

25 **MR DE LA POER:** So now, is this right, there are

100

1 two people effectively doing the job that Dr Brearey was
2 doing during this period?

3 **A.** Yes. Yes. They don't spend their full time
4 doing that, you know, but sort of two people doing -- or
5 the work has been split between two people with one
6 taking a lead perhaps on service development and
7 neonatal standards and that sort of thing and one taking
8 a lead on term admissions, incidents, Datixes, reviewing
9 all of those things to make sure that that's being
10 managed correctly.

11 **Q.** Finally, before we come to what you were told
12 when you arrived and what then transpired, you say that:
13 "Management within the division at the time also
14 struck me as lean."

15 Again, can you just tell us what you mean by that?

16 **A.** Yes. What I mean is that there weren't many
17 managers within the directorate, and managers have
18 an important role in getting things done correctly. And
19 then when we faced challenges, that's when you
20 particularly see that. The challenge they were facing
21 in 2015/2016 was a spike in neonatal deaths and trying
22 to understand what was causing that. In 2020 it was
23 Covid. In 2021 it was our transition to a new
24 electronic patient record. And each time when the
25 situation is stressed when you lack that management

101

1 **Q.** So we come now to the point in your first week
2 when you are told more about what the problems had been.

3 **A.** Yes.

4 **Q.** Just in your own words, what information were
5 you given and by whom?

6 **A.** Yes. So my memory is that in that first week
7 Dr Jayaram wanted to speak to me and explain the
8 situation in that not only had there been a spike in
9 neonatal deaths, but a number of the deaths were
10 unexplained and unexpected, that there were a number of
11 features of those deaths which had raised concern, for
12 example this pattern of recurrent mottling and rashes on
13 the skin which they'd not seen before and that there --
14 that he'd come across some evidence that that
15 potentially might be linked with air embolisms.

16 My memory of how he explained it to me was that
17 they had come to recognise that the unexplained
18 collapses and deaths were all occurring when one member
19 of staff was on shift and that that member of staff had
20 been moved from working days and night shifts to only
21 working on day shifts, at which point the collapses at
22 night had stopped, and they'd only been happening during
23 the daytime and, therefore, they'd reached a concern
24 that between the unexpected nature and the recurrence of
25 this individual associated with them that there might be

103

1 support you particularly feel it.

2 There's been a general sort of expectation in terms
3 of managers, so all units now are expected to have
4 a director of midwifery, which we didn't have before, so
5 that's a senior, you know, midwife who is the nursing
6 lead for our division. We had a Matron for paediatric
7 nursing but we now also have above her a lead nurse for
8 paediatric and neonatal nursing.

9 And, again, I see a huge difference in -- you know,
10 the Matron trying to do that whole job by herself was
11 just overwhelmed, they didn't have the time to do all
12 the things that needed doing with in terms of whether
13 that might be service development or responding to
14 incidents and risks, and both the Director of Midwifery
15 and the Head of Paediatric Nursing would have
16 significant roles in the risk and governance management
17 within the department.

18 **Q.** And just so that we understand which of the
19 people that we are very familiar with you're talking
20 about, when you refer to the Matron, are you talking
21 about the role that Ann Murphy was doing at the time?

22 **A.** Yes. So we still have a Matron, which is the
23 role Ann Murphy was doing at the time, but above her we
24 now have a Head of Paediatric and Neonatal Nursing who
25 has a more senior role.

102

1 somebody deliberately causing patient harm.

2 It was then explained to me that the way the Trust
3 had decided to approach it is they wanted to make sure
4 that there wasn't any systemic problems in how the
5 neonatal department was practising before, you know --
6 I think his words might have even been, "Make sure
7 there's no problems in our own backyard" before sort of
8 looking at that and, therefore, they'd commissioned the
9 Royal College review, and that had led on to an external
10 Casenote Review and that the reports from those two were
11 due back imminently to then sort of work out how we
12 would proceed next with this concern that somebody might
13 have been deliberately harming patients and that that
14 person had been moved out of clinical practice while
15 those investigations were taking place.

16 **Q.** Now, you were interviewed by Facere Melius,
17 the organisation, and what you told them was that you
18 had been a Consultant in Crewe and you couldn't remember
19 a single baby who had suddenly and unexpectedly
20 deteriorated and died, do you recall saying that to
21 them?

22 **A.** Yes. And in 2017 I think I put that in my
23 email as well. I -- I thought that what they were --
24 what Ravi was describing to me in that meeting that
25 first week was very unusual and I could think of babies

104

1 becoming sick maybe sort of having a sudden collapse,
 2 having some resuscitation which they responded to,
 3 continuing to deteriorate, perhaps transferring out to
 4 a Level 3 unit, continuing to deteriorate and dying.

5 But I couldn't think of a time where a baby had
 6 suddenly collapsed and died out of the blue. And they
 7 were describing this happening on a repeated frequent
 8 basis over that year period of time. So it struck me as
 9 very unusual what was being described to me.

10 **Q.** The phrase you use in your witness statement
 11 "extremely concerning". Does that represent your state
 12 of mind at that time?

13 **A.** Very much so, yes.

14 **Q.** Having had this described to you, one
 15 professional to another, did you think this doesn't
 16 sound like a problem, or did you think that the
 17 Consultants might be thinking along the right lines?

18 **A.** Yes. Certainly, you know, with full awareness
 19 of what had happened in Stockport, full awareness of
 20 Beverley Allitt, that combination of repeated sudden
 21 unexpected unexplained collapses and deaths associated
 22 with one member of staff being on duty certainly I was
 23 immediately concerned that that needed to be
 24 appropriately investigated to ensure that somebody
 25 wasn't deliberately harming patients, and perhaps was on

105

1 training as a paediatric trainee and as a paediatric
 2 Consultant. A lot of that would have been relevant to
 3 that specifically, you know, as a paediatric Consultant
 4 that's about being prepared to think the unthinkable,
 5 being prepared to investigate something according to
 6 protocols. You know, for example, a baby presenting
 7 with a bruise, even if everything else seems in order,
 8 that we would still go through the process of
 9 investigating that according to protocols because you
 10 have to be prepared to think the unthinkable and you
 11 can't judge people just by the way they come across to
 12 you. You need -- it's based on making sure things are
 13 investigated appropriately.

14 I can't remember if I had any specific safeguarding
 15 training on if I was concerned a member of staff might
 16 be harming patients. I don't remember. If -- if I had,
 17 it was perhaps in relation to thinking about perhaps
 18 sexual abuse. I think there had been a paediatrician at
 19 that point in the media who had been convicted of sexual
 20 abuse on patients at work.

21 So I must -- I'm sure -- it's hard to recall what
 22 training I had had but certainly I think a lot of the
 23 generic training we'd had about safeguarding was very
 24 applicable to the situation. But I don't know if
 25 I would have been fully clear on the best way to raise

107

1 the understanding that those investigations were in
 2 progress through the Casenote Review and the Royal
 3 College review.

4 **Q.** What was your view, in that first conversation
 5 when all this information was given to you, about
 6 whether the RCPCH were an appropriate body to be
 7 investigating in these circumstances?

8 **A.** Yes, I think it was a lot to take in to be
 9 honest. I don't think I got as far as thinking through
 10 the Terms of Reference and how they had gone about that.

11 **Q.** Was there any discussion between you and
 12 Dr Jayaram in that first conversation about whether the
 13 police should be involved?

14 **A.** I don't remember.

15 **Q.** In that first conversation, did you consider
 16 that what you were being told was a safeguarding issue
 17 or did you think about it in different terms?

18 **A.** I think in the way that I'm usually thinking
 19 about safeguarding issues it -- it felt different and
 20 clearly it was a safeguarding issue. I probably was
 21 thinking patient safety rather than safeguarding.

22 **Q.** Had you had any safeguarding training about
 23 how you might raise concern about a colleague if you
 24 thought they might be causing deliberate harm?

25 **A.** I've certainly had a lot of safeguarding

106

1 concerns in that situation.

2 **Q.** I mean, looking back on it now, with the
 3 benefit of hindsight, you acknowledge that the
 4 principles are equally applicable but your thought was
 5 patient safety, not safeguarding, do you think it would
 6 have been better to think about it as a safeguarding
 7 issue and do you think that's how people should think
 8 about this sort of issue should it ever arise in the
 9 future in those terms, that this is a safeguarding
 10 issue?

11 **A.** Yes. I think when people were making their
 12 decisions about how to manage and investigate the
 13 situation that they are thinking through all of those,
 14 there's lots of things they take into account. And in
 15 some ways patient safety and safeguarding are the same
 16 thing, you're trying to protect children from -- from
 17 harm. I guess patient safety we're often thinking about
 18 non-deliberate harm rather than deliberate harm.

19 Yes, I -- yes, I don't know if safeguarding was the
 20 word that came to mind.

21 **Q.** I suppose one advantage about thinking of it
 22 in that way is that there are trained safeguarders
 23 within the hospital who you can immediately go and tell
 24 who are outside all of the management structures and
 25 whose single remit when you raise that with them is to

108

1 pursue it relentlessly.

2 **A.** Yes, and I think, you know, if there had been
3 an allegation that somebody had, you know, slapped
4 a child or, you know, touched a child inappropriately or
5 anything like that that would be the obvious path to go
6 down. But I can see why perhaps it wasn't the obvious
7 path to go down when people were considering how to
8 investigate this case.

9 **Q.** So you have had your initial briefing in situ
10 from Dr Jayaram?

11 **A.** Yes.

12 **Q.** Was there any more discussion that you had
13 with any of your other colleagues before that meeting on
14 26 January to better understand the situation that you
15 had walked into?

16 **A.** I don't remember. The gap between that
17 conversation, you know, settling into a new place, you
18 know, and all those things and the meeting that happened
19 later that month was so short, I don't remember if I had
20 many more conversations in the meantime.

21 **Q.** There came a point when you and your
22 Consultant colleagues were invited to a meeting which we
23 now know took place on 26 January of 2017.

24 **A.** Yes.

25 **Q.** Why did you go to that meeting?

109

1 don't need to bring Union representation or something
2 like that. That just gave me a flavour that this was
3 not quite the meeting I was expecting.

4 **Q.** Now, for transparency, Dr McGuigan, I showed
5 you an email this morning and I will just tell everybody
6 what the reference is. I do not want it brought up on
7 screen. That's simply because it hasn't been
8 appropriately redacted, not because there is anything
9 sinister about it. INQ0057567. That's for everybody
10 else so that they know what you have seen.

11 That's an email that you were a recipient of which
12 started with Ian Harvey asking for dates for the
13 meeting; is that right?

14 **A.** Yes, that's right.

15 **Q.** Having had a chance to refresh your memory
16 this morning about that, is that the email that you are
17 referring to mentioning, "Not disciplinary, don't bring
18 Union reps"?

19 **A.** I don't think that's the email. I think
20 that's an email that's gone via the paediatric
21 secretaries to liaise with the Consultants about
22 a convenient time for the meeting. My memory is
23 a separate email inviting us to the meeting with
24 a confirmed venue and time.

25 **Q.** Have you been able to find the email that you

111

1 **A.** That's a good question. I believe an email
2 came round saying can we try and find a time when as
3 many of the paediatricians are available, Consultants
4 are available as possible and, therefore, I was included
5 in that email when people were asking about
6 availability, and then I was invited to the meeting.

7 My understanding from having to spoken to
8 Dr Jayaram is that we were waiting for these reports to
9 come back and, therefore, this meeting would be a chance
10 to discuss those reports. So as a Consultant within the
11 department it seemed appropriate to be invited and go
12 along to hear the outcome of the reports on the
13 department.

14 **Q.** Now, as best as you can recollect, what was
15 the terms of the invite that you received to that
16 meeting?

17 **A.** Yes. As best as I can recall, and my earliest
18 written recollections of -- from two years later when
19 I was giving a statement to the police, but the best
20 that I can recall is that the invitation was unusual in
21 that it wasn't saying, you know, "We want to share these
22 reports with you." It was that you were invited to this
23 meeting.

24 My memory was that there were words along the lines
25 of it's not a disciplinary matter at this point and you

110

1 received?

2 **A.** No. I -- my email address is an NHS email
3 address and there was quite limited storage, and
4 I presume at some point it's ended up lost and sort of
5 rather than archived. I looked hard for it in 2019, but
6 I wasn't able to find it at that point.

7 **Q.** Just so that everybody understands, the
8 Inquiry hasn't yet identified that but you've given us
9 your recollection of what was in it.

10 You've told us that you were expecting that at the
11 meeting there would be some discussion about the reports
12 that were pending. In your experience, if you were to
13 go to a meeting to discuss a report, would you expect to
14 see the report ahead of the meeting so that you could
15 read it or would you expect that you would simply
16 receive a copy or be told about it for the first time in
17 the meeting?

18 **A.** Yes, I think the NHS isn't famous for
19 efficient meetings, but, yes, I would expect that
20 the report would be sent out before the meeting, people
21 can read the report and then come to the meeting to
22 discuss it together.

23 **Q.** And did that happen in this case?

24 **A.** No.

25 **Q.** Were you party to any pre-meeting discussion

112

1 between the Consultants about the approach that was
2 going to be taken in the meeting or with any other
3 person who was giving information about what the meeting
4 might contain?

5 **A.** I don't remember a pre-meeting. I remember
6 that because we needed to walk over that most of us
7 walked over together and that in the corridor on the way
8 over that there was a discussion that there was
9 a feeling that the execs were after somebody's scalp and
10 that the plan would be that the Consultants wouldn't be
11 speaking up within that meeting for fear that if they
12 spoke up they might be scapegoated in some way and,
13 therefore, we were going to listen to hear what was
14 being said and that we would then come back and speak
15 together before rather than anybody raising questions
16 within the meeting.

17 **Q.** The Inquiry has received evidence that
18 a person by the name of Dr David Semple may have given
19 some information ahead of the meeting. Were you aware
20 of that at the time?

21 **A.** No.

22 **MR DE LA POER:** So -- my Lady, I'm conscious of the
23 time and I'm also conscious that this is an important
24 part of Dr McGuigan's evidence which perhaps best be
25 heard as apiece. I wonder if now would be a convenient

113

1 to me, but I think at least one the nursing managers was
2 sat on my side the table.

3 **Q.** And what was the atmosphere as you walked in
4 and everybody took their seats?

5 **A.** I don't know if I remember that now.

6 **Q.** You begin your narrative of this meeting by
7 saying that Ian Harvey provided a summary. Can you just
8 give us a flavour, please, of what Ian Harvey was
9 talking about?

10 **A.** So he was giving a summary of the Royal
11 College of Paediatrics Invited Review, which he
12 explained contained 22 recommendations about
13 improvements that could be made to neonatal services and
14 the results of the -- the Hawdon review, the external
15 Casenote Review, which he told us hadn't identified any
16 evidence suggested foul play and that, you know,
17 concluded that the deaths were natural causes.

18 Can I take the last bit back? I can't remember --
19 I don't think he said he concluded the deaths were
20 natural causes, but the feedback from the Hawdon report
21 was that there was -- there was nothing concerning that
22 had been revealed from that external Casenote Review.

23 **Q.** The way you put it in your statement and you
24 do caveat it by saying, "I don't remember his exact
25 words", was:

115

1 moment just to rise and we will come back after lunch to
2 deal with this.

3 **LADY JUSTICE THIRLWALL:** Very well. Dr McGuigan,
4 we are going to rise for a break and would you be back
5 please ready to start at 2 o'clock.

6 **A.** Thank you.

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

8 (12.58 pm)

9 (The luncheon adjournment)

10 (2.00 pm)

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

12 **MR DE LA POER:** My Lady, thank you. Dr McGuigan,
13 we had got to the point in your narrative that you were
14 entering a meeting that had been convened on
15 26 January 2017. And what sort of room did that meeting
16 take place in?

17 **A.** I think it was the boardroom, so a room with
18 a long narrow table and everybody sat round the table.

19 **Q.** And was everybody dispersed throughout the
20 room or was it doctors on one side, managers on the
21 other, how was it arranged?

22 **A.** I was at one end of the long table,
23 Tony Chambers was at the opposite end of that table.
24 A lot of the managers were clustered seated near him,
25 a lot of the paediatricians were clustered seated near

114

1 "The interpretation was there was no evidence that
2 babies had been deliberately harmed."

3 **A.** Yes.

4 **Q.** Does that capture it?

5 **A.** Yes.

6 **Q.** And again doing the best you can, was that
7 delivered in a measured tone from a seated position --

8 **A.** Yes, yes.

9 **Q.** -- or -- nothing that stood out about the
10 style of that presentation to you?

11 **A.** No.

12 **Q.** You tell us that the next event was that
13 a statement by Letby was read out. Was that given any
14 introduction by anybody?

15 **A.** I think it might have been written by Letby's
16 parents, if my recollection is correct. There was some
17 degree of introduction that there had been a grievance
18 procedure and that this letter would summarise, from
19 Lucy Letby's experiences, the suffering that she'd
20 experienced over the preceding months while she'd been
21 under investigation.

22 **Q.** You say in your witness statement of that
23 document the statement was relatively long and very
24 emotive.

25 **A.** (Nods).

116

1 Q. I would like to bring up a document on screen
2 to see if you recognise the statement that was read out,
3 just to help the Inquiry understand exactly what
4 happened at this meeting INQ0012080. Just ignore the
5 highlights on it, that's the form in which we've
6 received it, and take a moment just to familiarise
7 yourself with the content of it.

8 (Pause).

9 It goes on over the page. I mean, you'll have
10 noted that it appears to be addressed -- forgive me, if
11 we could go back -- it appears to be addressed to the
12 doctors, at least inferentially, the highlighted section
13 at the bottom that:

14 "Analysis tables relating to the mortality rates
15 had columns amended by your team."

16 A. (Nods). Yes.

17 Q. If you don't know, you don't know,
18 Dr McGuigan, but does this document ring any bells for
19 you in terms of prompt your memory in terms of what was
20 read out at the meeting?

21 A. I've not seen this document before. But, yes,
22 that -- that's similar to what I recall was it was
23 an explanation of what Lucy Letby had experienced, what
24 she'd found upsetting and how she felt that -- well,
25 presumably the result of her grievance, why she felt

117

1 the job and I've gone to this -- this rather remarkable
2 meeting, so the events still stand out to me.

3 My recollection of what Tony Chambers said was that
4 the conclusion of the process was that the reports had
5 been received, they'd identified that there were areas
6 of neonatal care that needed to be addressed, that
7 they'd not -- that the external Casenote Review hadn't
8 found anything of concern, and that while the
9 Consultants weren't wrong to raise concerns that the way
10 it had been carried out was inappropriate and that he
11 had met with Lucy Letby and her parents, had apologised
12 to them, that Lucy Letby would be returning to work on
13 the neonatal unit and the Consultants would be expected
14 to apologise to her before that happened, that they
15 would be accepting the recommendations of the Royal
16 College review and that that would be published on the
17 Trust website in the next few weeks.

18 Q. And in what tone and from what position in the
19 room did Tony Chambers say that?

20 A. So my recollection is that he was seated at
21 the other end of the boardroom table from where me and
22 the -- what I remember the other paediatricians were sat
23 at that end of the table as well.

24 Q. And the tone?

25 A. The tone was -- my memory of the tone was that

119

1 that she had been treated badly.

2 Q. And so if not that document itself, then
3 a document of a similar tone?

4 A. Yes.

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

6 After the statement or letter was read out, did
7 Tony Chambers speak?

8 A. He did.

9 Q. And you deal with this at paragraphs 18-20 of
10 your witness statement if you want to turn it up, but it
11 may be that you have a recollection sitting there of
12 what he said.

13 So do you want to just walk us through as best you
14 can remember what he said and how he said it.

15 A. Yes, when I prepared my statement I looked
16 back at the written statements I'd made in the past, the
17 earliest of which was 2019, which was obviously a lot
18 closer to events than it is now. I recognise that
19 different people have reported different recollections
20 of what was said in that meeting.

21 I think from my perspective, you know, there's
22 meetings since then that I've been asked about from
23 a year later that I don't remember much about the
24 meetings, but this one was very striking. I'd just
25 arrived in the hospital, you know, I'm three weeks into

118

1 it was a measured tone, that it was serious, stern but
2 not angry or shouting is my recollection.

3 Q. And have you had an opportunity to consider
4 the typed record of that meeting?

5 A. Yes. I -- in 2018, we, in communications with
6 the exec, said we'd never seen minutes of that meeting.
7 I first saw minutes of that meeting I think in May 2019,
8 so about two years afterwards when I was interviewed by
9 the police.

10 Q. So we're just going to bring those records up,
11 INQ0003523, and we'll turn to page 2, please.

12 Firstly, having considered those nearer the time,
13 do you regard this typed record as broadly reflecting
14 what was said at the meeting?

15 A. They're fairly brief, aren't they? In some
16 parts, yes, in terms of who spoke and the board --
17 I didn't recognise some of the things that Dr Jayaram is
18 reported to have said and I disagreed with the
19 recollection of some of the things Mr Chambers said.

20 Q. Well, let's just look at the latter first. In
21 the middle of this page on page 2, at the end of the
22 largest paragraph in the centre:

23 "It is recorded he [that is Tony Chambers] said
24 'Let's be clear that we need to draw a line on the past
25 and it is about how we go forward in the future.'"

120

1 A. (Nods).

2 Q. Is that a fair and accurate summary of what
3 Tony Chambers said, as far as your recollection is
4 concerned?

5 A. No, that -- that differs from my recollection.

6 Q. You used the word "distortion" in your witness
7 statement; is that a fair way of describing it?

8 A. Yes, the word "line" is in there, but the
9 phrasing has changed a lot from what I recall him
10 saying, and that sounds quite reasonable to say you need
11 to draw a line in the past and think about how we go in
12 the future, but that's not at all what I remember him
13 saying.

14 Q. Well, tell us best you can what you remember
15 him saying.

16 A. So my memory is that he -- that he said, "I'm
17 drawing a line under this", and then looked up at us and
18 said, "Do not cross that line."

19 Q. And in what tone did he say that latter part?

20 A. In quite a severe, stern tone.

21 Q. Others have recalled that the table was
22 thumped or struck at some point during Tony Chambers's
23 address to the Consultants, is that a recollection that
24 you have?

25 A. I don't remember that.

121

1 there's -- overall the care looks okay but there's
2 probably some things you could improve and here's some
3 recommendations?

4 But, you know, I wasn't given the chance to read
5 the -- well, ultimately we did get to see the report
6 before it was released, but ...

7 Q. But would you expect a report that contains
8 comments upon the running of a department to be
9 published for the world to see before the people it's
10 commenting upon have had a chance to read it?

11 A. I think this is why the meeting is so
12 shocking, that a report has been received on the
13 neonatal unit and that I'm going to read it when it's
14 published on the Trust website despite being
15 a Consultant in that department. I would expect --
16 I would expect not just to read it but that the people
17 with expertise in the neonates in the hospital would be
18 expected to help the Trust to understand the content of
19 that report before they made decisions about based on
20 it.

21 Q. Thank you, we can take that document down.

22 And so coming out of this meeting, once it had
23 finished, what was your impression of how the situation
24 was being managed by the Executive Directors?

25 A. Yeah, I came out of the meeting very shocked,

123

1 Q. Now, over the particulars of claim I think is
2 the part that you don't recognise in terms of
3 Dr Jayaram. That first sentence:

4 "Dr Jayaram stated that consideration would have to
5 be given to any poor Consultant performance."

6 Do you recall him saying that?

7 A. I -- I don't remember him saying anything
8 along those lines. The only thing I really remember him
9 saying was, "Can we see the report", because it had been
10 made clear at that point the Trust were making the
11 decisions on these reports and that the paediatricians
12 wouldn't be allowed to see them and that the first sight
13 we would have of the Royal College report would be when
14 it was published on the Trust website.

15 Q. And as somebody who had no investment in what
16 had happened before, what did you make of the suggestion
17 that the Royal College report would be published on the
18 website apparently containing criticisms of the
19 paediatric department before any of the Consultants had
20 seen it?

21 A. Well, I really wanted to know and what
22 I wished I'd asked in that meeting was, is that report
23 in front of you to say there are serious failings on the
24 neonatal unit and these explain why you have had so many
25 deaths on the neonatal unit, or does that report say

122

1 expecting that I was going into a meeting where it was
2 going to really get the answers to what the
3 paediatricians had been wanting to be investigated over
4 the last year, and came away with a feeling that there
5 had been a Royal College review that had made
6 recommendations but, from what I heard, hadn't really
7 identified significant failings on the neonatal unit
8 that explained the spike in mortality in a unit that
9 prior to that had a good reputation, had a low mortality
10 rate and in many ways was quite advanced in some of the
11 aspects of patient safety and care that they had in
12 place, and that -- and just felt that an external
13 Casenote Review wasn't the level of investigation that
14 was needed to be able to exclude somebody harming
15 children. So I left thinking that there's no answers
16 there and this hasn't been investigated in the way that
17 it needs to be investigated.

18 Q. What did you make of the expectation that the
19 Consultants would apologise and how that had been
20 handled?

21 A. Well, it was hard because the Consultants'
22 concerns were that somebody may have been harming
23 patients, that they had good reasons to be suspicious
24 that somebody may have been harming patients, and that
25 the person who had fallen under suspicion hadn't

124

1 really -- there hadn't been an investigation sufficient
2 to clear that allegation and, therefore, the idea that
3 they would be expected to apologise to her was
4 ridiculous really to apologise whilst still actively
5 concerned that it hadn't been investigated.

6 **Q.** Now, there was a meeting on 27 March which you
7 didn't attend. But did you send an email in advance of
8 that meeting setting out what your views were?

9 **A.** That's right. There was -- on 27 March,
10 Dr Brearey and Dr Jayaram were meeting with
11 Tony Chambers and Ian Harvey as part of ongoing
12 discussions that the paediatric Consultants were
13 concerned about the level of investigation that had
14 happened. Before they were meeting with the execs, the
15 Consultants were meeting together to have one final
16 discussion about what views they wanted Dr Jayaram and
17 Dr Brearey to say on their behalf at that meeting.

18 I would normally have been at that meeting but
19 there was a gap on the junior doctor rota the night
20 before, so I stepped in to cover the night shift. So
21 reflecting over that day I decided that I wanted to send
22 an email with my thoughts so that they could be heard
23 within that Consultant meeting the following day and,
24 therefore, potentially reflected on to Tony Chambers and
25 Ian Harvey.

125

1 page, please.

2 So we can see your email at the top, and so just
3 talk us through it and why you included what you did.

4 **A.** Yes. So, firstly, what had been happening on
5 the neonatal unit for that period was very unusual.
6 There was a high number of deaths and collapses. They
7 were a number that were unexplained, unexpected and, you
8 know, it needed an answer of what was going on, whether
9 that was poor care or whether that was an infection that
10 was spreading in the unit or whatever it was it needed
11 an answer.

12 I'd read by that point the Royal College review,
13 and while there were recommendations on there I didn't
14 see anything that really explained the high number of
15 deaths that we had seen over that period. And points
16 that had been drawn out and highlighted, you know,
17 including in the media at that point, about shortages of
18 staff, shortages of nurses weren't substantially
19 different from other units -- the staffing wasn't
20 different to other units I had worked in substantially.

21 Some of the -- some of the staffing levels that
22 were being discussed were potentially aspirational
23 targets that a lot of units were looking to sort of
24 whether they could get there over time but weren't at
25 the moment. So I didn't see any significant differences

127

1 **Q.** Just by way of a short digression before we
2 get to that email, you were effectively acting down to
3 cover the junior doctor rota. We've heard a bit about
4 that. Was that something that happened not
5 infrequently?

6 **A.** Yes, there was sort -- there were times when
7 it was better and there was times when it was worse, it
8 depended on exactly what staffing we had on our current
9 Registrar rota. Registrars come from the deanery and
10 they rotate every six months, so you might have gaps
11 sometimes, not gaps other times. If somebody goes off
12 on long-term sick it is not very easy to get cover in.
13 And there weren't and continue not to be very easy
14 access to paediatric locums at that level to be able to
15 cover the gaps. So it wasn't infrequent that
16 a Consultant had to act down to cover a Registrar gap to
17 ensure that care remained safe in the Trust.

18 **Q.** Let's have a look at the email you sent
19 INQ0101093. And if you want to turn up your witness
20 statement, because you devote a substantial portion of
21 your witness statement just to talking about your
22 reasoning. It starts at paragraph 27, and I'm not
23 inviting you to read it out loud, but let's just have
24 a look at the email and you can talk us through what was
25 in your mind and why you framed it as you did. Over the

126

1 in the staffing levels that explained the -- the
2 mortality.

3 And I was -- I'd arrived from another hospital.
4 I'd moved -- I'd started work as a Consultant and I felt
5 I was working with people who were good at their jobs,
6 who had good processes in place, you know, competent
7 nurses, competent doctors. I didn't feel I'd seen
8 an explanation for these unusual unexplained unexpected
9 events, and there was this nagging worry that there was
10 one individual who always was there when these were
11 happening. And, therefore, I felt it hadn't been --
12 I felt it hadn't been investigated properly.

13 **Q.** And that is the very thing that you begin
14 with:

15 "My opinion is that this can never be investigated
16 properly without a police-led investigation."

17 You go on to indicate that you don't think the
18 Coroner is an appropriate alternative to that or an
19 adequate alternative to that.

20 **A.** Yes.

21 **Q.** Is that fundamentally because of the time that
22 that process would take?

23 **A.** Yes, that was the other approach that was
24 being considered was that a number of these deaths still
25 need to go there through the Coroner's process and that

128

1 would be an opportunity to raise concerns and
2 potentially a way to lead to other investigations. But
3 that if you waited for that, by the time you got there
4 you've left even more time without investigations and
5 more time for memories to lapse and for sort of the
6 investigation to become harder.

7 **Q.** You've already told us about your opinion
8 about the RCPCH service review.

9 **A.** Yes.

10 **Q.** Your penultimate paragraph, something you've
11 told us already, but this is you saying it at the time:

12 "In five years at an equally busy Level 2 unit in
13 Crewe I can't remember a single unexplained collapse and
14 I think the events you have described to me are
15 extremely unusual."

16 **A.** (Nods).

17 **Q.** And then, finally, this:

18 "Ultimately you suspect a crime has been committed
19 and I think there is an obligation to report this to the
20 police whether or not your managers agree."

21 Now, "obligation", a very powerful word.
22 Presumably you gave considerable thought to how you were
23 going to frame this for the Consultants because there
24 was going to be no back and forth about what your
25 opinion was. Why did you choose the word "obligation"?

129

1 We've heard that in one Thursday, Friday, Saturday
2 in June 2016 two babies unexpectedly collapsed and died
3 and a third unexpectedly collapsed in a three-day
4 period, and over the following week lots of discussions
5 happened about whether this should go to the police or
6 not. If a police investigation had been launched at
7 that point, you know, those post-mortems potentially
8 hadn't been carried out yet, there might have been more
9 detailed toxicology, infusion bags might still be around
10 that could be -- you know, there was all sorts of
11 potential opportunities, even at that point, to
12 investigate more thoroughly that were missed by a delay
13 in police investigation.

14 **Q.** Two days -- thank you, we can take that
15 down -- in fact I think it was three days, my mistake,
16 after that email, two days after the meeting that you
17 couldn't attend, you tell us in your witness statement
18 that you received contact from a person called
19 Tracy Bullock. Firstly, who was Tracy Bullock to you?

20 **A.** Tracy Bullock was the Chief Executive at
21 Leighton Hospital in Crewe where I'd worked for the
22 previous five years as a Consultant.

23 **Q.** And was she one of the people that you told us
24 about that you had met and had got to know you a little
25 bit when you were working as a Consultant?

131

1 **A.** Well, the other discussion that had been
2 happening over those preceding weeks was about
3 whistle-blowing and whether what the Consultants were
4 considering doing, which was speaking to the police,
5 even though the Trust was saying that this shouldn't go
6 to the police, whether that would be considered
7 whistle-blowing. And what I'm saying there is, you
8 know, I don't think this is whistle-blowing -- I haven't
9 said that word -- I don't think this is whistle-blowing,
10 I think this is you suspect a crime has been committed
11 and you need to inform the police.

12 **Q.** And might have -- get lost in that natural
13 construction but it's need, that was your view at the
14 time?

15 **A.** Yes.

16 **Q.** You've mentioned about the potential
17 disadvantages of just leaving it to the coronial process
18 in terms of delay. Did you, at that time, in March,
19 have concern about the delay that had already been
20 caused and what was it that you thought that delay would
21 affect?

22 **A.** So I -- I've mentioned already that sort of as
23 time passes it gets more difficult to remember events,
24 so the more time that passed the more difficult it was
25 for people to recall what exactly had happened.

130

1 **A.** Yes. Yes, somebody I knew well from working
2 there and had a friendly relationship with.

3 **Q.** And the contact in the first instance,
4 according to your witness statement, was that you
5 received a request to contact her by telephone.

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

7 **Q.** And what initially did you think that
8 conversation might be about?

9 **A.** I had no idea. I really wasn't expecting it
10 was going to be about events at Chester. I really
11 didn't know. My secretary contacted me, we arranged
12 a time, and she called me I think the following day or
13 two days later.

14 **Q.** And when you spoke to Ms Bullock what did she
15 say to you?

16 **A.** What she said to me was that as
17 a Chief Executive working close to Chester Chief
18 Executives spoke to each other about situations they
19 were facing and she'd become aware of the situation in
20 Chester and that she hadn't clicked that I had moved on
21 from Crewe and was now working in Chester but that
22 an email from me had been read out in a meeting in the
23 last few days, and she wanted to contact me really to
24 give me a bit of friendly advice and warning about the
25 situation I was potentially finding myself in.

132

1 Essentially what she was saying is that her
2 understanding of the situation was that there were
3 problems on the neonatal unit, that the Consultant
4 paediatricians were refusing to accept that there were
5 problems in the standard of care on the neonatal unit
6 and instead they were pursuing this other line of
7 inquiry, that there were two particular -- I think she
8 used the word "ringleaders" or certainly two particular
9 leaders of that and things were likely to end very badly
10 for those two, and she was concerned that my reputation
11 potentially could be dragged down along with them if
12 I wasn't very careful in how I was conducting myself.

13 **Q.** Let's see if we can just unpack a little bit
14 of that. The email of yours that had been read out, did
15 you infer that's your email of 26 March?

16 **A.** Yes.

17 **Q.** And the meeting, therefore, must have been the
18 meeting on the 27th --

19 **A.** Yes.

20 **Q.** -- that you couldn't attend. Had you been
21 aware until that point that your email was read out at
22 that meeting? Had anybody told you that they read out?

23 **A.** Yes, I think Dr Brearey had told me that sort
24 of at that meeting he'd said, "Look, here's an email
25 from a Consultant who's just joined our department

133

1 Steve meeting with the execs.

2 **Q.** I understand. And so that meeting at 5.00 pm,
3 Dr Jayaram and Dr Brearey, and who did you understand
4 that they met?

5 **A.** Tony Chambers and Ian Harvey. I'm not sure
6 who else.

7 **Q.** And did Ms Bullock tell you who she'd got her
8 information from and who was it who thought there might
9 be ringleaders and that it might end badly for them and
10 that you're --

11 **A.** My understanding was that her information was
12 from Tony Chambers as a friend and local fellow
13 Chief Executive.

14 **Q.** Chief exec to chief exec?

15 **A.** Yes.

16 **Q.** And what was your reaction to being provided
17 with this information by Ms Bullock?

18 **A.** I -- I think at this point I was already
19 treading very carefully and thinking very carefully
20 through my actions. So I was grateful for the warning
21 in a way but I was already, you know, very aware that
22 I was in a difficult situation.

23 I kept the conversation to myself and just
24 reflected on it, really. But it was really -- it was
25 only later months really that I realised it helped to

135

1 working in a similar hospital down the road and these
2 are his thoughts about the situation here."

3 **Q.** And so who --

4 **A.** Sorry, I was going to say also my
5 understanding that the outcome of that meeting had been
6 that Tony Chambers had agreed that there would be an
7 approach to the police.

8 **Q.** So that's something that was fed back to you
9 by one of your Consultant colleagues?

10 **A.** Presumably by one of my Consultant colleagues,
11 yes.

12 **Q.** After the meeting. Who had you understood was
13 present at that meeting on the 27th? Obviously the
14 Consultants were all invited.

15 **A.** No, it was only -- I think it was only
16 Dr Brearey and Dr Jayaram representing the Consultants
17 for that meeting.

18 **Q.** So why -- why might you have attended, you
19 were giving your apologies effectively?

20 **A.** So there was a meeting at 11 am where the
21 paediatric Consultants were joining together to talk
22 about the situation and what they wanted Ravi and Steve
23 to say on our behalf --

24 **Q.** And then --

25 **A.** -- and then a meeting at 5.00 pm was Ravi and

134

1 understand the thinking at that time, that certainly
2 Tony Chambers appeared to be seeing it that the
3 paediatricians were looking for a better excuse than
4 saying your department is not doing very well and were
5 refusing to accept that there was a problem in their
6 department.

7 **Q.** And did Ms Bullock indicate to you who the two
8 ringleaders were supposed to be?

9 **A.** No. But I think it was obvious that it would
10 be Dr Brearey and Dr Jayaram.

11 **Q.** And were they acting as ringleaders, as far as
12 you were concerned?

13 **A.** No, not at all. No. And I think you've heard
14 that from other people here that the concerns that were
15 being expressed were the concerns of the whole
16 paediatric Consultant body.

17 **Q.** Just a few more matters to deal with by way of
18 your overall reflections. You say in your statement
19 that you are struck looking back at how difficult it was
20 for the entire Consultant body of seven paediatricians
21 to have their voice heard in an organisation.

22 **A.** (Nods).

23 **Q.** Would you like just to tell us why you wrote
24 that and what it was about the situation that you now
25 see looking back?

136

1 **A.** I think in the NHS we're aware there's a lot
2 of people who work -- some of them are in more powerful
3 positions -- or power and some less positions of power.
4 There's lots of people who are in NHS organisations
5 might have concerns and be trying to speak up and the
6 Freedom to Speak Up process is trying to make sure that
7 when people have concerns that they are able to have
8 their voice heard.

9 You'd have thought that it would be relatively easy
10 for a Consultant to speak up within an organisation
11 because they're people who have a relative amount of
12 power within an organisation. You'd have thought that
13 when all of the Consultants within a particular
14 specialty are trying to say something that that would be
15 relatively easy to have that voice heard, but that's not
16 how it appeared to me looking back at the experience
17 that happened over that period.

18 **Q.** And from your perspective, are you able to
19 identify why you think that was?

20 **A.** No. And I think coming in, having not been
21 a part of it, it was very difficult to understand the
22 timelines and what had happened at different points, and
23 there's a lot that I would like to understand from this
24 Inquiry myself.

25 **Q.** Turning to your concluding remarks and just
137

1 at a board meeting that thought it would be helpful to
2 get my opinion on, she would contact me.

3 I think those roles have moved on now so that now
4 it's a mandatory expectation that all units will have
5 a neonatal safety champion and a maternity safety
6 champion, and that the lady who took on that children's
7 champion role ultimately took on all those roles, and we
8 now have both a non-executive and an executive who has
9 those champion roles within sort of patient safety and
10 children's and neonates and maternity.

11 And I think in an organisation where it's a big
12 organisation, there's lots of things happening, there's
13 lots of people involved, you know, that -- that link
14 between the execs, non-exec's and the paediatricians and
15 neonatologists I think is very helpful.

16 **Q.** Data. You comment upon the relative
17 usefulness of data and in particular how data when it is
18 of a historical character is perhaps less useful to
19 day-to-day care than real-time data.

20 Do you see a role for real-time data in terms of
21 day-to-day paediatric care and improving your service?

22 **A.** Like I said in my statement, I think because
23 the numbers are small often changes are just the natural
24 variation and statistical distribution. So I don't know
25 if I do, and the time it takes often to get the data
139

1 some observations that you make there generally. You
2 identify the role of the children's champion as been
3 an important one. Just tell us about the children's
4 champion when that came about and why that might be
5 generally an appropriate role?

6 **A.** Yes, the children's champion was
7 a recommendation from the Royal College report. I don't
8 think I'd heard of a children's champion before I read
9 that report, I think it was a relatively new
10 recommendation by the Royal College. The idea of
11 a children's champion was somebody sitting on the board
12 who took a particular role in championing children's
13 issues when they were being discussed at board level.

14 I'm not sure what we got in place the first year or
15 so was quite right, but sort of once we got to
16 a position where we got it right, we had a non-executive
17 director who took a lead in thinking about children's --
18 within the hospital. And when I was clinical lead, she
19 would contact me on a regular basis. I was free to
20 speak to her at any time if there was anything I felt
21 that I was stuck on that I needed to sort of get some
22 escalation on. If I'd not spoken to her for a while she
23 would contact me and say, "Can I catch up with you? And
24 let's just touch base on what's happening with
25 paediatric services." Or she if came across something
138

1 back it's probably missed the opportunities to intervene
2 would be my opinion.

3 **Q.** But when things start to go wrong, so not
4 necessarily business as usual but where things start to
5 go wrong, might data in real time have a role to play
6 there?

7 **A.** Yes, I think in general data is really helpful
8 and there would be lots of data we would want to look at
9 in a neonatal unit to help understand that the care
10 we're providing is good, not just mortality rates but
11 all sorts of outcomes which we get now benchmarked
12 against some of the units.

13 **Q.** And, finally, just an insight that you had
14 into the CCTV question, should it be on neonatal wards?

15 **A.** Yes.

16 **Q.** You present both sides of the argument for it.
17 But I don't know that we've heard this necessarily from
18 any other person, certainly not very many other people.
19 The way in which CCTV might be presented as a good
20 thing, do you want to just help us with that?

21 **A.** Yes, I think you probably heard already the
22 sort of concerns the staff have of having CCTV cameras
23 on them all the time, the privacy concerns in a unit
24 where women would be breast feeding and these types of
25 things, and expressing, and how you balance that. But
140

1 often on the -- most of the time on the children's ward,
2 certainly in the district general hospital, most of the
3 time any small children in hospital their parent or one
4 of their family members will be with them at all times.

5 And the neonatal is quite different to that because
6 the babies are in for such a long time it's quite common
7 that most babies there will be quite frequent times
8 where they're just on the unit being looked on the staff
9 without their parents there, and I think that's quite
10 difficult for parents. We try and make our unit as
11 welcoming as possible. We now have beds next to the cot
12 spaces so the parents can stay. They're open 24/7
13 access. We have a siblings' room so that if there's
14 a toddler sibling it doesn't obstruct the parent in
15 spending time on the neonatal unit.

16 But the idea of video links has been quite popular,
17 regardless of the safety thing, that being able to check
18 in and look at your baby at any point while they're on
19 the neonatal unit seems a good thing, and I would have
20 thought a thing that most parents would welcome.

21 **MR DE LA POER:** Dr McGuigan, thank you for
22 answering my questions.

23 My Lady, those are all the questions that I have
24 for Dr McGuigan and there aren't any Rule 10 questions?

25 **LADY JUSTICE THIRLWALL:** Thank you very much.

141

1 **Q.** And what is your current role, Dr Jameson?

2 **A.** I'm a Consultant anaesthetist at the Countess
3 of Chester Hospital.

4 **Q.** Thank you.

5 Turning to your role on the Medical Staff Committee
6 at the Countess of Chester, you were chair of the
7 Medical Staff Committee from approximately 2011 to 2019,
8 and I think it's correct that that's an elected and
9 unpaid post?

10 **A.** That's correct.

11 **Q.** And who is it that elects -- who elects the
12 chair of the Medical Staff Committee?

13 **A.** So you put yourself forward or you're
14 nominated and seconded, and then there's an election for
15 that post by the -- all members -- all permanent members
16 of the medical staff within the Countess of Chester
17 Hospital.

18 **Q.** And I think it's the case that, certainly
19 since your appointment as a Consultant in 1996, there
20 has been a Medical Staff Committee at the hospital.

21 **A.** That's correct.

22 **Q.** Turning to the purpose and role of the
23 committee, you address this in your statement and it is
24 at paragraph 15, and you say it's threefold. It
25 represents the interests of medical staff, it provides

143

1 Indeed, Dr McGuigan. Thank you very much indeed for
2 coming to give us your evidence, it has been very
3 helpful and you are free to go.

4 **A.** Thank you.

5 **MR DE LA POER:** My Lady, with your leave I will now
6 hand over to Ms Browne.

7 **LADY JUSTICE THIRLWALL:** Very well.

8 Can the witness be sworn.

9 **DR PAUL JAMESON (sworn)**

10 **LADY JUSTICE THIRLWALL:** Do sit down, Dr Jameson.

11 **Questions by MS BROWN**

12 **MS BROWN:** Could you please state your full name.

13 **A.** Dr Paul Morpeth Jameson.

14 **Q.** And you've provided a statement to the Inquiry
15 dated 31 May 2024. Is that true to the best of your
16 knowledge and belief?

17 **A.** Yes, it is.

18 **Q.** Dr Jameson, you graduated from the University
19 of Liverpool Medical School in 1986 and are a fellow of
20 the Royal College of Anaesthetists. You have a clinical
21 fellowship in paediatric critical care from the
22 University of Toronto and you were appointed as
23 a Consultant anaesthetist at the Countess of Chester in
24 1996; is that correct?

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

142

1 a forum where mutual concerns can be discussed between
2 colleagues and the MSC enables communication between
3 medical staff and the Trust management.

4 **A.** Yes.

5 **Q.** If I can just turn to what's tab 6, my Lady,
6 in your bundle and it is INQ0098143. These are the
7 terms of reference for the Medical Staff Committee.
8 They're not dated, Dr Jameson, but we know from other
9 documents that they were in fact drafted by Mr Butcher
10 the ophthalmic surgeon who was the secretary to the
11 Medical Staff Committee from approximately 2010 to 2020,
12 and they were drafted in 2017.

13 Do you recall approving these Terms of Reference?

14 **A.** Yes.

15 **Q.** And is it fair to say that although they were
16 formalised in 2017, and I think based on a BMA document,
17 they reflected what had already been the case, they
18 weren't a -- they weren't a departure from what the
19 Medical Staff Committee had --

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

21 **Q.** And just going to this document, then. We see
22 there under the heading "Membership" that the membership
23 consists of all Consultant medical staff, all permanent
24 staff and associate specialist doctors and appropriate
25 representation of junior doctors is determined by the

144

1 committee. What did that mean in practice,
2 representation of the junior doctors?

3 **A.** We asked for junior doctors to -- for
4 a representative of the junior doctors. In fairness,
5 I don't think we ever had any junior doctors attend.

6 **Q.** Thank you. And then going down, we see
7 standing invitations are normally issued to the
8 Chief Executive. So for most of the period we'll be
9 talking about that was Tony Chambers, the Chairman of
10 the Trust board, so Sir Duncan Nichol and any Clinical
11 Director, and then we see beneath that the words:

12 "The Chief Executive, Chairman of the Trust board
13 and Medical Director [of course, Ian Harvey] may be
14 asked to retire from the meeting of the discussion of
15 items where it is felt their presence would not be
16 appropriate."

17 So it seems there, Dr Jameson, it was engaged that
18 there might be occasion on which those individuals might
19 attend but equally there might be an occasion where they
20 would be asked to leave the meeting?

21 **A.** That's correct.

22 **Q.** And prior to the events we're looking at, 2016
23 onwards, were there any instances that you can recall
24 where as a matter of course the Chairman, the chief exec
25 or the Medical Director would attend these meetings?

145

1 with the senior management regarding the wishes of the
2 Medical Staff Committee. And later on you define
3 "senior management" as being the Chair -- being the
4 Medical Director, the chief exec and the Chair of the
5 hospital board.

6 **A.** Correct.

7 **Q.** And if we could just go to, my Lady, tab 7 in
8 your bundle that's INQ0017868. This is the corporate
9 directors group and it's a meeting on 27 January, and we
10 will see there that it was attended by, amongst others,
11 Mr Chambers, Mr Harvey, Mrs Kelly, Mrs Hodgkinson and
12 your name appears in the centre of the page, chair of
13 the medical staffing committee Mr Jameson.

14 And if we go over to page 5 of that document, we
15 see there that an example of you acting in your role as
16 spokesperson. What was being discussed was the
17 paediatrics business case.

18 And if we go to the bottom of the page we can see
19 that what was being discussed was a business case to
20 appoint two Consultants. And we see about 10 lines up
21 from the bottom your initials:

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

25 So we see you there, would you accept, acting as

147

1 **A.** The Medical Director would fairly regularly
2 attend.

3 **Q.** So that's Mr Harvey?

4 **A.** Yes, often because he would want to address
5 the Medical Staff Committee about particular issues.
6 I don't remember Mr Chambers attending any of our
7 meetings.

8 **Q.** Thank you. And looking at meetings, just
9 going down towards the bottom of that document, we see
10 the committee should meet on an average of once every
11 six weeks but as a minimum four times a year.

12 And then if we can go over the page, to page 2, we
13 see there the chairman -- at the top of the page:

14 "The chairman must arrange an extraordinary meeting
15 if more than four members request it in writing."

16 And then below that in the centre of the page:

17 "The chairman of the committee is to be the
18 spokesperson for medical staff in the Trust."

19 And would you agree with that characterisation of
20 your role as chairman and as spokesperson?

21 **A.** Correct.

22 **Q.** Turning back to your statement, Dr Jameson,
23 you expand a little on the role in paragraph 20 of your
24 statement and you say that, in addition to the role of
25 spokesperson, you saw your role as one of interfacing

146

1 a spokesperson for your paediatric colleagues and quite
2 forcefully supporting their business case?

3 **A.** Yes, that's right. Do you want me to expand
4 on that?

5 **Q.** No, it's just to make the point --

6 **A.** Thank you.

7 **Q.** -- that was the role you took within those
8 sort of meetings.

9 **A.** Yes.

10 **Q.** Yes. Sorry, Mr Jameson, if there is something
11 you think is pertinent to say regarding that that goes
12 to the event that we are looking at.

13 **A.** The only point I would make is that because
14 I worked fairly regularly and closely with the
15 paediatricians in my role as being one of the paediatric
16 anaesthetists at the Countess of Chester Hospital, so
17 I was regularly on the ward, I think I had quite a clear
18 understanding of their workload dealing with the sick
19 and injured child and their dedication to that service,
20 and so really felt they needed help and support in the
21 expansion of their department.

22 **Q.** Thank you very much.

23 And going back then to paragraph 21 of your
24 statement, you say there that:

25 "Historically the Chair of the Medical Staff

148

1 Committee had a place on the Hospital Board and that
2 was ... the case with the previous management
3 structure ..."

4 When did that change? When did the Medical Staff
5 Committee no longer have a place on the board?

6 **A.** From memory, I can't remember exactly when but
7 it must have been after that meeting that you've shown
8 the minutes there?

9 **Q.** I think that wasn't a board meeting that
10 was -- that was a meeting which you were invited to.

11 **A.** Right. Historically, I'd always been invited
12 to the -- to the hospital board meeting. Then I think
13 probably around 2015/16, I noticed I wasn't being
14 invited, so I asked the -- the Chief Executive's
15 secretary if she could send me the date of the next
16 meeting and I turned up to the next meeting and then was
17 asked to leave that meeting because it was felt that the
18 Chair of the Medical Staff Committee didn't have a role
19 on that meeting. And from then on I didn't attend
20 hospital board meetings as I was uninvited.

21 **Q.** And did you raise an objection to that, that
22 you were no longer able to attend those meetings?

23 **A.** So, I brought it up with Mr Harvey, the
24 Medical Director, and his explanation was that it was
25 felt that the medical staff were like any other staff

149

1 **A.** No. I think it was just a restructuring of
2 their management structure within the hospital. I think
3 maybe they felt they were needed to be a leaner
4 management board to make decision-making and
5 communication easier. But I never got a clear
6 explanation about why it occurred. I didn't know if it
7 was a national directive, a regional directive or just
8 a local directive.

9 **Q.** And I think you said date, the best you could
10 do, was that approximately 2015?

11 **A.** Around that time, just because you sent me the
12 minutes of that previous meeting that you brought up,
13 and I think that was one of the last meetings I'd have
14 been at.

15 **Q.** Well, that was a meeting, the one we've just
16 looked at, the corporate directors group, that was
17 27 January 2016.

18 **A.** Well, it must have been around 2016 then.

19 **Q.** If I could just turn to the topic of
20 safeguarding now, Dr Jameson and you address this in
21 paragraph 63 of your statement, and you say there that
22 you've undergone regular safeguarding training
23 throughout. Does that relate to regular safeguarding
24 training throughout your time at the hospital?

25 **A.** Yes, because of my role as a paediatric

151

1 group and, therefore, shouldn't have a place on the
2 hospital board ahead of any other staff group, and that
3 was the thinking and reasoning behind it.

4 **Q.** And it was -- did you understand that to be
5 Mr Harvey's position or as his own personal view or
6 something that had been decided on collectively?

7 **A.** I think he was transmitting a collective view,
8 as far as I was aware.

9 **Q.** And did you feel that that decision
10 represented a change where staff views were not given so
11 much importance?

12 **A.** It made it very difficult to be chair of the
13 Medical Staff Committee because it took away that
14 interface I had with the senior management teams,
15 I didn't know them as well, I didn't speak to them
16 regularly in that environment, I didn't know what was
17 going on within those management and, therefore, the
18 role almost became impossible because my only interface
19 with senior medical staff was through the meetings with
20 the Medical Director. So I was aware I would get his --
21 his view that was to be transmitted to me and so I felt
22 it was an issue.

23 **Q.** And just looking at the timing of this, was
24 there any event that you understood provoked the
25 decision to not allow you to attend board meetings?

150

1 anaesthetist I have to undergo Level 3 safeguarding
2 training and keep that up to date. So I have done
3 throughout my career.

4 **Q.** And -- so presumably you would be familiar
5 with the Working Together to safeguard children
6 guidance?

7 **A.** So I'm familiar with it but it's a while since
8 I've undergone that training because it's three-yearly.

9 **Q.** I'm not going to go through it in detail but
10 just in terms of the key principle that safeguarding
11 children is everyone's responsibility and that each
12 professional and organisation should play their full
13 part, you would be familiar with that as a principle?

14 **A.** Absolutely.

15 **Q.** And at paragraph 64 you say there in relation
16 to that:

17 "... if any person, either a member of staff or
18 anybody involved in harming a child or baby in
19 hospital ... I would know to inform the safeguarding
20 officer and that this [would] be clearly documented as
21 per safeguarding training."

22 And, Dr Jameson, just to check, that would be your
23 understanding now but was that your understanding in the
24 period from 2015 onwards as well?

25 **A.** Yes, it would.

152

1 Q. And were you aware of who the designated
2 doctor for safeguarding was in 2015 to 2017?

3 A. I would have been at the time because it would
4 have been -- we sort of had a safeguarding intranet
5 page, so if I had a safeguarding issue my first port of
6 call would be the -- if it was a paediatric patient
7 would be the paediatric team on-call and then they would
8 highlight it through their safeguarding process.

9 Q. And what level of concern would trigger
10 reporting to a safeguarding officer?

11 A. So from my point of view as an anaesthetist,
12 it might be that we might see some physical harm to
13 a child that we would then highlight, or within
14 a history we might highlight it, and within the -- the
15 admission notes of every patient there is -- the Trust
16 does have a safeguarding box, so the admitting team
17 should have considered safeguarding.

18 Q. And in fact the designated doctor for
19 safeguarding at the time was Dr Mittal. Does that ring
20 a bell?

21 A. It does, yes.

22 Q. And if we can go back now to paragraph 22 of
23 your statement. You say in there -- that paragraph that
24 you were first approached or you believe you were first
25 approached by the paediatricians around the end of

153

1 A. No.

2 Q. But presumably that would be something, if it
3 was a rumour, that would be the subject of
4 a conversation if someone was being removed. Was there
5 speculation?

6 A. To my memory, no. I mean, the neonatal unit
7 was very much a very small part of the hospital and
8 unless you were directly involved in the neonatal unit,
9 you probably wouldn't know what was going on. So in all
10 honesty, I cannot remember hearing the specifics
11 about -- or remembering that rumour this far away from
12 it, but obviously remembering that Dr Jayaram contacted
13 me February -- January, February, March 2017.

14 Q. And prior to that, prior to the contact from
15 the paediatricians, were you aware already of the
16 increased mortality rates?

17 A. No.

18 Q. Dr Tighe can't remember precisely but he
19 thinks he might recollect speaking to you in early 2016,
20 some informal discussions about mortality rates. Is
21 that a conversation that you can recall?

22 A. I can't remember. I know that we did discuss
23 it in 2017 because the paediatricians had approached me
24 because of their concerns regarding grievance procedures
25 that were being brought against them.

155

1 January/early February 2017.

2 If we could just go to look at that date, first of
3 all to tab 2, and the document number is INQ0012995,
4 page 1.

5 **LADY JUSTICE THIRLWALL:** Ms Brown just while that's
6 being looked up, may I just check that the transcript is
7 still working for everyone. Plenty of nods around the
8 room. I think it's just mine. I can manage, I just
9 wanted to make sure we weren't all in the same position.

10 **MS BROWN:** And this is an interview or the copy of
11 a record of an interview that you gave in July 2020 to
12 Facere Melius, and you say in the middle of the page:

13 "I was approached I think -- it was sort
14 of February/March of '17 by a number of the
15 paediatricians who were basically in crisis. They --
16 and that was the first I heard really anything about the
17 neonatal concerns. There had been the odd sort of
18 rumour within the hospital."

19 Just stopping there. What was the rumour that you
20 had heard prior to them approaching you?

21 A. So I think all I'd heard -- at that point,
22 I may have heard that a member of staff was -- had been
23 excluded from the neonatal unit but no more than that.

24 Q. Did the rumour extend to why that member of
25 staff had been removed from the unit?

154

1 Q. Just going back to the document there. You
2 say you were approached by a number of paediatricians.
3 Who were the paediatricians that first approached you?

4 A. I was first approached by Dr Jayaram and then
5 Dr Jayaram asked if I could meet within -- in his
6 office, and I spoke, from memory, with Dr Jayaram and
7 Dr Brearey.

8 Q. And if we see as well in that paragraph, the
9 passage we're looking at, you say that they were feeling
10 bullied and harassed and what they were trying to do was
11 raise patient safety.

12 A. Correct.

13 Q. And if we could go over to page 2, just trying
14 to date this. Your evidence is that, doing the best you
15 can, it was approximately February. I just want to see
16 if it may have been slightly earlier.

17 We see there towards the bottom paragraph:

18 "They came to me when the Royal College of
19 Paediatrics Child Health report came in and they were --
20 you know, they were only allowed access it to a brief
21 period of time and then when they were given a redacted
22 report."

23 Now, we know that they were -- Dr Brearey and
24 Dr Jayaram were allowed access to it for a brief period
25 in November. Does that help you at all? It's

156

1 a slightly confusing --

2 **A.** Yes, no, I think they came to me actually very
3 specifically after -- in -- after their meeting that was
4 discussed slightly earlier about being asked to write
5 a letter of apology, and that's when they first came to
6 me in my role as the chair of the medical staff. But at
7 that point, they did -- then gave me a narrative saying
8 that earlier they had been -- these were the issues that
9 they were -- they were, in their words, probably
10 battling with and they brought up the fact that they'd
11 only been asked -- allowed to see briefly a redacted
12 Royal College report earlier.

13 **Q.** So the redacted report was in February, and in
14 terms of asking to write a letter of apology, that would
15 bring it closer to December. We're going to look at
16 a document that talks about the letter of apology.
17 But -- so at the very -- the end of 2015, beginning of
18 2016, would that be?

19 **A.** No, that was much later than that that I first
20 heard of. It was certainly 2017.

21 **Q.** Sorry, 2017, sorry, my error. But it was
22 between January -- between December and February?

23 **A.** Probably, yes, to the best of my recollection.

24 **Q.** And, Dr Jameson, was an explanation offered to
25 you as to why they had waited until January,

157

1 dying that had been communicated to you that that was
2 from all of the department, and you were aware, at this
3 stage, that the issue related to a particular nurse; is
4 that correct?

5 **A.** Correct.

6 **Q.** And they were communicating as well that they
7 were frustrated by the response of senior management?

8 **A.** I think they were not only frustrated, I think
9 they were quite fearful about their jobs and so their
10 frustration was -- and fear was huge.

11 **Q.** And, Dr Jameson, in your role as spokesman who
12 has then been approached by the paediatricians, why did
13 you not go to Ian Harvey or Tony Chambers at that point
14 on their behalf and say, "This matter must be reported
15 to the police"?

16 **A.** I did go to Ian Harvey and the first thing
17 I expressed to him was that this was a whole department
18 that I knew, respected. I knew they were not only
19 thought of as good paediatricians and it was a strong
20 department but because of some of the work I'd done with
21 the -- regionally with paediatrics I knew it was a very
22 well-respected department regionally, and that their
23 concerns should be really treated with the utmost
24 importance.

25 **Q.** And you say in your statement that you

159

1 February 2017 to come to you? We know, of course, their
2 concerns arose much earlier.

3 **A.** I feel at that point their concerns were that
4 Lucy Letby had been removed from the unit and then there
5 was a suggestion at that point that they were to
6 apologise to her and that she was to be allowed back on
7 the unit. And from their point of view, I think when
8 they were pressing for a full investigation that they
9 felt that Ms Letby was excluded from the unit patients
10 weren't at risk, but I think they were very fearful at
11 that point that she might be reintroduced to the ward
12 and what on earth could they do and, therefore, they
13 looked for the support of the Medical Staff Committee.

14 **Q.** And if we can look at paragraph 24 of your
15 statement, you list then what their concerns were, which
16 I think you've highlighted, but they were concerned
17 about the increased morbidity and mortality of the
18 neonatal unit, so the number of deaths and collapses on
19 the neonatal unit, they were frustrated about how this
20 was being handled by the senior management and, going
21 down, serious concerns regarding patient safety and that
22 these were concerns of the whole department.

23 **A.** Exactly.

24 **Q.** So at that stage, at the latest February 2017,
25 there were specific concerns about the rates of babies

158

1 championed their cause by saying that they should be
2 listened to. But did you say specifically to Mr Harvey
3 or any other senior executive that the police should be
4 approached at this point and that you as a spokesman
5 were making that point to him?

6 **A.** I think I used the words that this was
7 a safeguarding issue and that, you know, if the
8 paediatricians are asking to go to the police, then the
9 senior managers should go to police?

10 **Q.** And just looking at safeguarding, we know that
11 at this stage whilst Letby was off the ward there
12 weren't any restrictions on her registration at this
13 stage.

14 We've looked at the fact that the paediatricians
15 were coming to you with serious issues of patient
16 safety. When you heard of their concerns, did you
17 enquire as to whether they had informed the safeguarding
18 officer?

19 **A.** I have no memory of doing that. But they were
20 very clear to me that they were pursuing all avenues.

21 **Q.** Sorry, who was saying they were pursuing all
22 avenues?

23 **A.** This was -- this would be Dr Jayaram and
24 Dr Brearey, and they were very clearly stating to me
25 that they wanted to go to the police but had been told

160

1 that they should not at present.

2 **Q.** And what did you do actively to support them
3 by going to the police, did you consider going to the
4 police yourself?

5 **A.** I felt that I should very clearly go to the
6 senior execs and say is all due process being followed?
7 Because the details of actually what had gone on, I knew
8 very little of the actual details other than knowing
9 that I knew and trusted the opinion of my paediatric
10 colleagues.

11 **Q.** And did you consider that you needed to make
12 a safeguarding report?

13 **A.** I didn't. I probably regret not doing that
14 but I felt that because this was 2017, and I'd been told
15 that due process and investigation was being followed,
16 I regret that.

17 **Q.** And if we can go to paragraph 34 of your
18 statement where you set out the actions you took. You
19 say that you recall meeting with the Medical Director
20 Mr Ian Harvey and you felt your role was to stress that
21 the paediatric department were highly regarded, and you
22 say:

23 "I had at least one or maybe two meetings with
24 Mr Ian Harvey within his office. These were non-minuted
25 meetings ..."

161

1 minuted?

2 **A.** In retrospect I should have done that.

3 **Q.** And you say at paragraph 37 that:

4 "... Mr Harvey did not want any external
5 involvement by other members of the Medical Staff
6 Committee ... he very clearly stated the matter was in
7 hand."

8 What reassurance did he give you that the matter
9 was in hand?

10 **A.** He just very clearly stated that there was
11 a full investigation going on. He didn't mention to me
12 the Royal College reports but he made it clear that he
13 was in charge of governance and that this was not
14 something for the Medical Staff Committee to get
15 involved with.

16 **Q.** And did you think he was right about that or
17 did you think it was a matter for the Medical Staff
18 Committee?

19 **A.** I think we should have been more vocal in
20 stating that the police should have been called earlier.

21 **Q.** And you then say that you also met -- so these
22 are meetings with Mr Harvey, but you also met with
23 Sir Duncan Nichol. And what took place in those
24 meetings and when did they occur?

25 **A.** So they occurred in the months after when I'd

163

1 Why did you not take minutes of these meetings,
2 given the severity of the matters that were being
3 discussed?

4 **A.** I suppose that our meetings had always been
5 relatively informal meetings within his office and what
6 I was trying to do was make it clear to him that I had
7 faith and belief in my paediatric colleagues and the
8 points they were making, and I was hopeful that that
9 would -- would stimulate him to reconsider the process
10 that he and his team were going through.

11 **Q.** You say there that Mr Harvey:

12 "... made it clear to me that these issues were not
13 a matter for the Medical Staff Committee to get involved
14 [in] ..."

15 What was your response to that?

16 **A.** I -- at the time I felt that the way we could
17 help support the paediatricians was just to reassure
18 them and make it clear that in effect we -- we had their
19 back, that if they were threatened with losing their
20 jobs that we would -- as a Medical Staff Committee we
21 would support them.

22 **Q.** Did you not consider this was a meeting that
23 you should minute a clear statement by you on their
24 behalf that the police should be contacted and if the
25 executive didn't do that that was something you wanted

162

1 first become aware, and at that point I think the police
2 had been called, so it was round the time that the
3 police were involved.

4 **Q.** So February, when the paediatricians first
5 approach you, the police weren't contacted for a few
6 months after that. Given the police in these months
7 were not being contacted, did you consider going to
8 Sir Duncan Nichol when Mr Harvey was clearly not taking
9 action at that point to contact the police?

10 **A.** I think I spoke with Sir Duncan Nichol and
11 explained that I had concerns and that my concerns were
12 one and the same as the paediatricians and that he was
13 fully informed of that.

14 **Q.** So that's quite significant, Dr Jameson. Your
15 recollection, is it, that you went to Sir Duncan Nichol
16 before the police had been contacted to say that in your
17 role you felt the police should be contacted?

18 **A.** I'm not certain of the exact timings when
19 Sir Duncan Nicol and I started a dialogue. It was
20 around about the time that the police were called, so
21 I couldn't honestly say when -- when I had that first
22 meeting.

23 **Q.** But do you recollect or not saying to
24 Duncan Nichol the police need to be called in this
25 matter?

164

1 A. No, I don't recollect saying that to him.
 2 Q. And going down to paragraph 41, you say there:
 3 "Primarily my meetings were just to try and support
 4 them to act as a sounding board ... [and] to try and
 5 facilitate meetings with ... Duncan Nichol ..."
 6 Do you feel on reflection, Dr Jameson, that in fact
 7 the Medical Staff Committee should have done something
 8 more than being acting as a sounding board?
 9 A. So what I'm referring to there is a period of
 10 time after the police had been called and when we were
 11 trying to support the paediatricians while they were
 12 navigating gauge this very difficult time when the
 13 relationships between the senior managers and themselves
 14 had totally broken down.
 15 Q. And you address then the very specific issue
 16 that you've mentioned before, the fact that the
 17 paediatricians were only permitted to review a redacted
 18 report, and you say your response to that was one of
 19 disbelief. Can you just expand on that briefly?
 20 A. Yes. My feeling is that the experts in the
 21 running of the neonatal unit were the paediatricians and
 22 that if a report had been asked for it should have been
 23 shared with them immediately in an open, transparent,
 24 inclusive way, where team working is at the heart of
 25 running a safe unit. And I -- I genuinely could not
 165

1 compared to the previous Chief Executive ... Medical
 2 Director ..."
 3 How would you characterise the management style of
 4 Tony Chambers and how did it differ?
 5 A. The previous Chief Executive and Medical
 6 Director were very opening and welcoming of -- of
 7 medical opinion and being questioned. Certainly I felt
 8 that I almost didn't have a relationship with
 9 Mr Chambers after I had been asked to leave a sort of
 10 management board meeting. And my meetings with
 11 Ian Harvey, though we had them regularly, were always
 12 quite superficial.
 13 Q. And if I could turn you to -- my Lady, it's
 14 tab 3 in your bundle and document INQ0103247. This is
 15 the statement of Jeremy Butcher. He's the ophthalmic
 16 surgeon who is the secretary to the Medical Staff
 17 Committee, and if we could turn to page 2 and
 18 paragraph 11. He says there:
 19 "Paul Jameson, the chair of the MSC, told me that
 20 he no longer sat on the board of the trust. He also
 21 told me that Tony Chambers had said that he considered
 22 the Consultants as no more important than any other
 23 staff group such as porters."
 24 Is that something you recall saying?
 25 A. I can't recall wording it in such a specific
 167

1 believe what I learnt of this in early 2017 that they
 2 wouldn't have been sharing that report from its -- from
 3 its very first time it was available so that they could
 4 learn from it.
 5 Q. And you say there:
 6 "I think he stated to me [that's referring to
 7 Mr Harvey] that ... it was handled appropriately though
 8 this meeting was not minuted ... [it] is only my memory
 9 of the meeting."
 10 When Mr Harvey gave these responses that it was
 11 handled appropriately, what -- what response did you
 12 make to that, given your disbelief at what had been
 13 going on?
 14 A. I think at that point my relationships with
 15 Mr Harvey were the communication was quite short and
 16 brusque. I don't think he was really interested in my
 17 view as chair of the Medical Staff Committee, so it
 18 was -- it was as simple as that.
 19 Q. And if I could turn now to the general
 20 management style of the Trust, which is something you
 21 address at paragraph 45 in your statements, and you say
 22 that:
 23 "My observations regarding the management style of
 24 Mr Tony Chambers and Mr Ian Harvey, is that there was
 25 certainly a marked change in the management style
 166

1 way, but certainly Mr Harvey had said it to me that one
 2 of the reasons that we weren't -- we weren't -- the
 3 chair of the Medical Staff Committee wasn't required on
 4 the board because we were just like any other staff
 5 group and no more important.
 6 Q. And just following that theme, if we could
 7 turn now to INQ0012995 and page 5 of that document.
 8 This again is the interview you had in 2020 about
 9 events, and you say, looking towards three quarters of
 10 the way done that page:
 11 "Certainly the impression I got about Tony Chambers
 12 is very clearly that senior medical staff were not that
 13 high up on his priority in running the Trust."
 14 Can I just stop there. Is that -- where you say
 15 senior medical staff, are you referring specifically to
 16 the paediatricians or are you referring to Consultants
 17 more generally?
 18 A. I think Consultants more generally.
 19 Q. "... and he sort of ..."
 20 And you go on:
 21 "... and he sort of openly made that clear and he
 22 wanted -- you know, his view, maybe rightly or wrongly,
 23 you know, senior medical staff are just like any other
 24 medical staff."
 25 Again, is there anything you can say to expand upon
 168

1 that view in terms of how Tony Chambers viewed senior
2 medical staff?

3 **A.** Not specifically, other than saying that when
4 I felt he didn't value the chair of the medical staff
5 within involvement with the board but also, as we've
6 heard earlier, the conversation with the paediatricians
7 when they were very clearly told what to do.

8 **Q.** And what are you basing your opinion upon
9 there, Dr Jameson?

10 **A.** My own personal view.

11 **Q.** And your own personal experiences?

12 **A.** Yes.

13 **Q.** And any experience in particular?

14 **A.** No, other than the -- that -- that issue where
15 I did turn up at a board meeting where I expected to
16 have a place and then be politely but firmly ushered out
17 of the room.

18 **Q.** And going back to your statement -- that
19 document can come down now, thank you -- at
20 paragraph 48. You say:

21 "When I discussed the paediatricians concern with
22 Mr Ian Harvey, he certainly gave me the impression that
23 he felt they were a difficult department to interact
24 with."

25 How did he give that impression and what was it

169

1 "The committee understands that the police
2 investigation to premature baby deaths is ongoing."

3 And you told the committee that:

4 "... would continue to offer our support to our
5 paediatrician colleagues."

6 And that was the stance of the committee at that
7 stage?

8 **A.** Correct.

9 **Q.** And going over, tab 9 in the bundle, my Lady,
10 and document INQ0004485.

11 This is a meeting, so seven months later, in
12 June 2018. Larger numbers here. You sitting at the
13 chair, Mr Butcher the secretary, and approximately 31
14 others.

15 And if we go over to page 3, we see there under
16 "Any Other Business" that you told the committee that
17 the paediatricians were feeling marginalised, stressed
18 and isolated, and that there may -- that they may "have
19 an extraordinary MSC meeting to demonstrate support for
20 our colleagues". And you urged good attendance.

21 If we can go then to -- it's one tab on in the
22 bundle, INQ0083556, this is a chain of emails where you
23 were discussing that meeting.

24 And if we can go to page 3 of that email chain,
25 which is the first in time, you wrote to

171

1 that he was saying to you?

2 **A.** I don't think he said anything directly but it
3 was just his overall body language and he made it clear
4 he didn't want to discuss their issues with me.

5 **Q.** Thank you. If we could just look now at a few
6 of the minutes of the Medical Staff Committee, so if we
7 could go first to tab 8, which is, my Lady, tab 8 in
8 your bundle, and that is INQ0004451.

9 This is the Medical Staff Committee meeting on
10 1 November 2017, so about nine months after you first --
11 the paediatricians came to you.

12 And we see that you were sitting as the chair,
13 Mr Butcher the secretary, and there were six others
14 present. That seems like a small number. Was that
15 characteristic of the meetings, the numbers that would
16 turn up at a meeting?

17 **A.** Unfortunately it was, it wouldn't be quorate
18 at that number, and there was a disengagement with the
19 Medical Staff Committee over this period of time.

20 **Q.** Was that related in any way to the fact that
21 the Medical Staff Committee didn't have a seat on the
22 board, in your view?

23 **A.** I couldn't answer that.

24 **Q.** Going over to page 2 of that document, you say
25 there the -- at the top of the page:

170

1 Detective Inspector Hughes, you introduced your, and you
2 say in that email that the paediatricians have
3 approached you as the chair to ask if you can call an
4 extraordinary meeting, and you go on to say:

5 "The meeting will not discuss the issues related to
6 the investigation. It will be limited to the breakdown
7 in Trust, communication and relationship between
8 paediatric medical staff and senior management and their
9 concerns."

10 Just pausing there. Was that how you saw the issue
11 there, a breakdown in communication and relationships?

12 **A.** At that point it was because the investigation
13 was now ongoing but it had moved on to that breakdown in
14 trust between one group of Consultant staff and the
15 senior managers.

16 **Q.** And you wanted essentially the police to say
17 whether they felt it was appropriate to have that
18 meeting. And I think we can see if we go to page 2 of
19 that document, which is the email in response, that
20 Mr Detective Inspector Hughes responds and said that he
21 is aware of the breakdown in relationship between
22 doctors -- some of the doctors within your organisation
23 of the Trust and that he is happy for the meeting to
24 continue. And he says with some foresight:

25 "I'm quite sure that at the conclusion of this

172

1 investigation a public Inquiry could well be
2 commissioned and I am certain most of these concerns
3 will be raised in that format."

4 And then if we can go on to page 1, we see, just to
5 follow the trail, that you forwarded that email to
6 Sir Duncan Nichol and made clear that the police were
7 happy for the MSC to call an extraordinary, meeting and
8 you add your view that you also feel that a public
9 Inquiry is inevitable.

10 And if we can go -- and this is -- we are almost at
11 the end of the documents now, Dr Jameson -- to the
12 minutes of that extraordinary meeting, which is
13 INQ0098147 and tab 11 of the bundle. There are actually
14 two meetings that are referred to there, there's
15 a pre-meeting on 11 September 2018 and that was attended
16 by Sir Duncan Nichol, Dr Gilby, so that's the new
17 Medical Director, Mr Harvey having retired by now,
18 yourself and Mr Butcher.

19 Why was there felt to be a need for a pre-meeting?

20 **A.** At the time, because there was such -- this
21 huge breakdown in trust between a group of Consultants
22 and the senior managers, that one of our -- one of the
23 concerns of the Medical Staff Committee -- because
24 I didn't really hear about the issues on the neonatal
25 unit until 2017, one of my concerns was could there be

173

1 know, the court case hadn't gone ahead but we were
2 discussing -- you know, hugely delicate and upsetting
3 for the family and we didn't want that The Families to
4 be hurt any more than they'd already been hurt.

5 **Q.** Thank you. And we see there then it goes on
6 to the minutes of the meeting of 19 September, and we
7 see huge numbers attending. I think if one counts it up
8 it is over 100.

9 And turning over the page to page 2 of that
10 document, you gave a statement on the purpose of that
11 meeting emphasising the confidentiality and read out
12 a statement from Detective Inspector Hughes stating that
13 there should be no discussion about anything that would
14 prejudice the investigation.

15 And you made the point about the minutes that you
16 would review them for accuracy but they wouldn't be
17 circulated, or I think they would be accessible for
18 those who attended. And you told the committee then
19 that you'd invited Sir Duncan Nichol, Dr Susan Gilby to
20 the meeting.

21 Mr Butcher's views were he felt their presence
22 might inhibit discussion. Was that something you agreed
23 with?

24 **A.** No, I didn't. I felt at this point that
25 Dr Susan Gilby was new to the Trust and new as a Medical

175

1 other departments where there was a similar breakdown in
2 trust between -- and, therefore, we needed to explore
3 this. Also we felt that there would be highly likely
4 that from the secondary meeting that the Medical Staff
5 Committee might ask for a vote of no confidence in
6 Mr Chambers.

7 **Q.** And we'll come -- that didn't happen in fact,
8 we'll come to that, but that was -- so was the risk of
9 vote of no confidence that you felt -- you, therefore,
10 felt the need to have the pre-meeting, were you alerting
11 Sir Duncan Nicol and Dr Gilby to that vote at that
12 point?

13 **A.** Yes.

14 **Q.** And we see then -- sorry, you also say there
15 that the minutes will not be circulated by email to
16 ensure confidentiality. What was the particular
17 confidentiality issue that you were concerned about?

18 **A.** I think we were very much concerned at this
19 point about The Families of the bereaved that -- you
20 know, it was -- we were still all the medical staff --
21 and I did want to say earlier that contact with the
22 present medical staff -- that all the medical staff in
23 the Countess of Chester were very much aware of the --
24 the absolute pain and loss that all these families had
25 gone through, and so we felt it was important that, you

174

1 Director, and I knew her view on the way this had been
2 handled previously was very different from the previous
3 Medical Director's and --

4 **Q.** What -- just expand on what you mean by that,
5 very different?

6 **A.** Well, within a week of her being appointed,
7 she was very clear that she couldn't believe that the
8 paediatricians hadn't been treated in a more trusted and
9 collaborative and open, transparent way.

10 **Q.** And we see there in the middle of the page
11 Sir Duncan Nichol told the committee he was there to
12 listen, and he told the committee that Tony Chambers had
13 decided to stand aside as CEO, and that Susan Gilby
14 would be acting CEO. Was that the first time you and --
15 not only you but all those 101 doctors attending, was
16 that the first time they were informed that
17 Tony Chambers had decided to stand down?

18 **A.** Yes.

19 **Q.** Were you aware of it prior to this meeting?

20 **A.** I think I might have been made aware of it,
21 I don't know, half an hour before the meeting.

22 **Q.** And what happened then was there was
23 a presentation by Dr Gibbs, and in that presentation
24 some slides were shown, and these minutes in fact
25 reproduce what was on those slides, and he sets out

176

1 the -- Dr Gibbs set out the history.

2 Did he talk -- can you recall, did he talk through
3 the events or how did that take place in practice?

4 **A.** I cannot specifically remember his
5 presentation but it was very much a narrative timeline
6 of the events.

7 **Q.** And we see that reflected in fact in the notes
8 here, which in turn reflect the PowerPoint slides. He
9 talks -- I'm just going to pick out one or two --
10 June 2015 the serious incident meeting held after the
11 three deaths.

12 Going down then, July 2016, the Consultant
13 paediatrician demanding action from the police. That's
14 following the death of Child O and Child P.

15 Then September 2016, the RCPCH review. And then
16 coming right down after various other events to meeting
17 with a QC and then contacting the Child Death Overview
18 Panel.

19 And in May 2017 the Deputy Chief Constable
20 informing the Chief Executive, who at that point would
21 have been Tony Chambers, that the police investigation
22 would take place, and that history was set out to you?

23 **A.** Yes.

24 **Q.** And were you already well aware of this
25 history at this point?

177

1 concerns. At the end of that they also -- there's
2 reference to repeated misleading statements concerns
3 regarding what has been said to parents. That was
4 another concern that was discussed, was it?

5 **A.** That was the first time that I'd heard of
6 that, though in my -- one of my meetings with Mr Harvey
7 he was very clear that the Medical Staff Committee
8 shouldn't get involved was because he was in discussions
9 with families and, therefore, there was a patient
10 confidentiality and sensitivity that would be around the
11 discussions I had between February and May of 2017.

12 **Q.** And as far as you can recall, Dr Jameson,
13 these concerns, which we're obviously just viewing as
14 a list here, was there a lot of discussion of these
15 amongst the 101 doctors that were present or did
16 Dr Gibbs in effect run through a list, insofar as you
17 can recall?

18 **A.** At the time there was quiet shock displayed by
19 the whole meeting, but we were very clearly going to
20 allow all the paediatricians to say what they felt was
21 important?

22 **Q.** And I think if we go over the page, to page 4,
23 we'll see that some notes have been made, a summary of
24 what the paediatricians said. So we have -- and I'm
25 just going to pick out a very brief line from each of

179

1 **A.** No. That was really the first time in detail
2 that I understood the timeline.

3 **Q.** And then we see the concerns set out. And
4 then just very briefly, the lack of action of patient
5 regarding serious patient safety concerns, only two
6 paediatricians had -- briefly saw the redacted RCPCH
7 report. Did you understand that to be Brearey and
8 Jayaram? Dr Brearey and Dr Jayaram.

9 **A.** Correct.

10 **Q.** And then the fact that the executive decided
11 deaths and collapses were explicable but the
12 paediatricians disagreed, was that expanded upon in the
13 meeting?

14 **A.** I think later in the meeting, when other
15 paediatricians presented, there was more information.
16 But I was the same as almost everybody else in that
17 meeting, it was utter disbelief that this had occurred.

18 **MS BROWN:** My Lady, I'm conscious of the time,
19 I have probably about another five minutes. I don't
20 know if you permit to carry on to the end.

21 **LADY JUSTICE THIRLWALL:** Yes. Dr Jameson, are you
22 all right to continue for another five minutes?

23 **A.** Yes, thank you.

24 **LADY JUSTICE THIRLWALL:** Thank you. Let's do that.

25 **MS BROWN:** So just dealing then -- the other

178

1 those -- Dr Saladi referred to the fact that the
2 Consultants were concerned about deaths being unexpected
3 and unexplained, and that these were not then
4 investigated appropriately by the Executives.

5 Dr ZA talked about the relationship with the
6 executive board had broken down to the extent that
7 current patient safety was jeopardised. And Dr ZA also
8 had concerns that there was victimisation of two
9 Consultants.

10 Can you assist -- one assumes that is Dr Brearey
11 and Dr Jayaram, are you able to assist if that's who was
12 being referred to?

13 **A.** Yes.

14 **Q.** And, again, a reference there to concerns that
15 the grieving families had been misled over the cause of
16 their child's death.

17 Dr Jayaram spoke as well. He was attempting to
18 obtain some minutes of board meetings. He refers to
19 board documents that could not be specified in this
20 forum.

21 Do you know what he was referring to then?

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

23 **Q.** And he -- also going over the page, this is
24 page 6 -- suggested things said in the Speak Out Safely
25 forum had been used against the paediatricians. Were

180

1 you involved Dr Jameson in the Speak Out Safely?
 2 **A.** No, I wasn't.
 3 **Q.** Dr Brearey then spoke. He was concerned about
 4 press statements being inaccurate or misleading, and he
 5 picks out in particular a comment by Mr Harvey -- this
 6 is halfway down -- comments by Mr Harvey that there were
 7 only two infants for whom the cause of death was
 8 uncertain, and Dr Brearey said that was inaccurate.
 9 And Dr Brearey also referred to a May 2018
 10 interview with the Chester Chronicle where Tony Chambers
 11 is reported to have said:
 12 "There were just a few niggles that our clinicians
 13 said, 'Look, we have got 90% the answers but there are
 14 still bits that we need to in a sense be clear we have
 15 not missed anything'.
 16 And Dr Brearey felt that didn't reflect accurately
 17 the paediatricians' concerns.
 18 And then, finally, Dr Holt, and this maybe gives us
 19 some idea of what had been intended by the meeting and
 20 what in fact occurred. She highlighted the purpose of
 21 the meeting had changed in the light of the events. Was
 22 the purpose of the meeting, Dr Jameson, to have a vote
 23 of no confidence on Tony Chambers?
 24 **A.** The purpose of the meeting was to clearly
 25 allow the paediatricians to voice their concerns and the
 181

1 bottom, you say that:
 2 "The main aim of the meeting was to facilitate the
 3 paediatricians ... expressions of their experience."
 4 And that you -- consideration for a further
 5 extraordinary meeting.
 6 Was there a further extraordinary meeting?
 7 **A.** No, we didn't have a further extraordinary
 8 meeting after that. But the other conclusion that
 9 I said on the page before when we specifically asked
 10 whether any other departments felt bullied,
 11 marginalised, threatened or treated in the same way as
 12 paediatrics it was important that we raise that question
 13 in this forum.
 14 **Q.** And as a result of that, you didn't feel the
 15 need to go forward to another extraordinary meeting to
 16 look at another department?
 17 **A.** Yeah, yes.
 18 **Q.** And just on page 9, then, the final page of
 19 these minutes, you thank -- well, first of all
 20 Sir Duncan Nichol thanks Susan Gilby and you, and said
 21 the non-executive directors would look at the culture of
 22 speaking out. Then you thanked colleagues for attending
 23 in such numbers and you said the previous senior
 24 management had not wanted the meeting to happen.
 25 What's that a reference to and who's that
 183

1 way they had been treated, and then following on from
 2 that if the Medical Staff Committee had felt that this
 3 complete breakdown in trust between one whole department
 4 and Consultant group would suggest we have a vote of no
 5 confidence in the Chief Executive, then we would have
 6 taken that forward, if that had been the view of the
 7 Medical Staff Committee.
 8 **Q.** And that would explain in part the numbers of
 9 those attending at this meeting.
 10 **A.** Absolutely.
 11 **Q.** Then going on, there was a discussion, as one
 12 might expect, following the paediatricians. And just so
 13 that I'm correct in this, the minutes would imply each
 14 paediatrician took the floor for a moment and set out
 15 their particular concerns; is that correct?
 16 **A.** Yes.
 17 **Q.** And we see on page 8, "RJ", so that's
 18 a reference, one assumes to, Dr Jayaram:
 19 "... said that he had been told at the beginning of
 20 the process that the idea of intentional harm would be
 21 a convenient possibility."
 22 What did you understand he was referring to there?
 23 **A.** I think you would have to ask Dr Jayaram, so
 24 I don't know what he's referring to there.
 25 **Q.** And then the conclusion there, we see at the
 182

1 a reference to by senior management?
 2 **A.** That was in reference to the meetings I had
 3 with Mr Harvey where he very clearly stated that he felt
 4 the -- this issue was not one at that time that was to
 5 be discussed by the Medical Staff Committee as in when
 6 I was having the discussions with him in early 2017.
 7 **Q.** And just with that, so 2017, when the matters
 8 came to you as chair of the Medical Staff Committee,
 9 this meeting 2018, was it the opposition of Mr Harvey to
 10 this meeting that meant that the forum that the MSC
 11 created for discussion of this meeting wasn't used it
 12 appears until September 2018?
 13 **A.** I think we didn't use it before that point
 14 because there was the period of time where we were
 15 waiting for the police involvement. And after the
 16 police involvement, there was a hope that there could be
 17 a reconciliation in that we hoped that the senior
 18 managers would understand that the paediatricians were
 19 the ones who were speaking out and needed to be
 20 supportive, and certainly that's what Sir Duncan was
 21 trying to -- trying to take forward, but that failed
 22 really at every turn.
 23 **Q.** And there is just one final matter on the
 24 documents. You've been shown I think a letter dated
 25 1 December that was sent by Ms Weatherley to Letby, and
 184

1 I think your evidence is that that wasn't a document you
2 saw at the time.

3 **A.** Correct.

4 **Q.** And this relates to the grievance, and in that
5 letter -- so although you clearly didn't see the letter
6 but what Ms Weatherley concluded was that the -- Letby's
7 removal from the unit was orchestrated by the
8 Consultants with no hard evidence to support this
9 action, their behaviours and comments fell short of what
10 was expected by the Trust.

11 Was that a conclusion that you were aware of at any
12 time?

13 **A.** No.

14 **Q.** And also in that letter, Ms Weatherley talks
15 about the fact that apologies would be required from
16 named Consultants who had made unsubstantiated comments
17 and refers specifically to Mr McCormack, Dr Brearley
18 Dr Jayaram and Dr V. The question there is, were you
19 aware of the comments these doctors had made which
20 prompted the recommendation for an apology?

21 **A.** No.

22 **Q.** And, finally, Dr Jameson, if I could just
23 return to your statement for your reflections that you
24 set out at paragraph 71, you say:

25 "It is my view, on reflection, that as soon as the
185

1 involved, I wished I'd been more forceful in saying to
2 the senior management that, "You must go to the police."

3 **MS BROWN:** Thank you very much, Dr Jameson. There
4 are no Rule 10 questions, my Lady.

5 **LADY JUSTICE THIRLWALL:** Thank you, Ms Brown.

6 Dr Jameson, thank you very much indeed. Often
7 a barrister says five minutes they mean 15. I suspect
8 you probably guessed that.

9 **A.** Yes.

10 **LADY JUSTICE THIRLWALL:** So thank you for being
11 patient with that, and you're free to go. So we will
12 take a break until five past 4.

13 (3.48 pm)

(A short break)

15 (4.05 pm)

16 **LADY JUSTICE THIRLWALL:** Ms Langdale.

17 **MS LANGDALE:** My Lady, may I call Dr Tighe.

18 **LADY JUSTICE THIRLWALL:** If you would like to come
19 and take the affirmation.

20 **DR SEAN TIGHE (affirmed)**

21 **Questions by MS LANGDALE**

22 **MS LANGDALE:** Dr Tighe, you have provided the
23 Inquiry with two statements, the first dated
24 18 June 2024 and a short statement of clarification
25 4 September 2024.

187

1 paediatricians raised any concerns regarding the
2 increased mortality within the neonatal unit by any
3 member of the department, that these should have been
4 immediately passed on to the Local Authority Designated
5 Officer and the police".

6 Dr Jameson, whose responsibility do you consider it
7 was to contact the local authority and specifically to
8 contact the police?

9 **A.** I think the paediatricians informed senior
10 management of their concerns and, therefore, senior
11 management, probably jointly with the paediatricians.
12 In a -- in a healthy Trust one would hope that that
13 trust and respect for both would mean that they would
14 both draw that conclusion. It's easy with retrospect to
15 say that, but fundamentally at one and the same time
16 they should have been going to the local authority and
17 police.

18 **Q.** And when you were aware of the patient safety
19 concerns that had reached you, and the concerns that the
20 management weren't reacting to respond to that, did you
21 feel on reflection that that was also part of your
22 responsibility to go to the police?

23 **A.** I felt at the time because Lucy Letby was
24 excluded from the unit and, therefore, the unit wasn't
25 at risk. But, in retrospect, I think like all those
186

1 Can you confirm the contents of true and accurate,
2 as far as you are concerned?

3 **A.** Yes.

4 **Q.** You were a Consultant anaesthetist at the
5 Countess of Chester Hospital from August 1993 to
6 April 2021; is that right?

7 **A.** Correct.

8 **Q.** You're retired now.

9 **A.** Yes.

10 **Q.** And you were, while you were at the Countess
11 of Chester, chair of the BMA local negotiating
12 committee; is that right?

13 **A.** Yes.

14 **Q.** Can you tell us what that roll entailed and
15 what more about the BMA?

16 **A.** Yes. Well, the BMA is the main Union of --
17 representative Union of all doctors and I was an elected
18 chair of that and, as such, was the Union representative
19 for the doctors employed by the Trust, and my role was
20 mainly in negotiating terms and conditions with the
21 executive dealing with complaints and concerns of
22 colleagues with regard to application of those terms and
23 conditions and in disputes with management.

24 In that role, I enjoyed an excellent relationship
25 with the executive through quarterly meetings that we
188

1 had, called the Local Negotiating Committee Meetings,
2 and we generally came to very satisfactory mutually
3 advantageous decisions.

4 **Q.** When you say -- through the period 2015 to
5 2016 and 2017, were you having those LNC meetings then
6 with the Executives?

7 **A.** Yes, we would have had around that time.

8 **Q.** And so when you say you enjoyed excellent
9 relationships, can you tell us which executive officers
10 you enjoyed such relationships with?

11 **A.** Sorry, I'm having difficulty hearing you.

12 **Q.** Which executive officers did you enjoy such
13 good relationships with in 2015 to 2016?

14 **A.** Okay, so the Medical Director.

15 **Q.** Was that Mr Harvey?

16 **A.** Ian Harvey, the Chief Executive -- several
17 Chief Executives in fact over my 10-year tenure, and the
18 representatives of the Human Resources department. Also
19 on the committee was Dr Jameson, the chair of the
20 Medical Staff Committee, who you just heard from, and
21 there was always a BMA representative from -- employed
22 by the British Medical Association in attendance as
23 well.

24 **Q.** You tell us in your first statement, Dr Tighe,
25 about an informal meeting with Mr Harvey, the Medical
189

1 and he handed me one of them to read. I can't remember
2 whether he actually let me take that away or not but
3 I assume he must have --

4 **Q.** Was it redacted?

5 **A.** -- because I refer to it later. Very
6 significantly redacted. I mean, about 50% of it was
7 blacked out. And I did not see the Jane Hawdon report
8 but he told me that that had not raised any concerns.
9 And, therefore, the purpose of the meeting was in order
10 to consider the reinstatement of Ms Letby back on to the
11 unit as she -- he also told me that she had been removed
12 from -- from a clinical role for some months by that
13 time and had raised a grievance procedure which had been
14 upheld, and the result of that was that she was -- they
15 were hoping that she would be reinstated, and that all
16 I had to do was literally sit there and be a witness.

17 I think he was actually doing that in order to be
18 seen to be protecting in some way the interests of the
19 paediatricians. An independent party, if you like, to
20 observe the proceedings.

21 **Q.** So to be helpful for the paediatricians. Was
22 the request from Mr Harvey that you should be there to
23 be helpful and supportive of them or when you say
24 protecting?

25 **A.** I can't remember exactly what it was but I got
191

1 Director, in his office in early January 2017 where he
2 asked or requested that you attend a meeting on
3 26 January between the CEO, himself, other board
4 directors, senior nurses and the paediatricians as
5 a witness. Can you tell us about that conversation and
6 what Mr Harvey was asking you?

7 **A.** The informal conversation --

8 **Q.** Yes.

9 **A.** -- before the meeting?

10 **Q.** Yes.

11 **A.** Yes, he asked me to come and see him and -- to
12 discuss me attending as a witness to a meeting that was
13 to take place between the paediatricians and the Medical
14 Director and himself. And this was really the first
15 time that I'd heard any detail at all about the problems
16 on the neonatal unit.

17 The Medical Director appraised me of his view of
18 the current situation, assured me that he had undertaken
19 an independent analysis that had not -- that had not
20 registered any firm evidence that harm was being done
21 and that it was much more likely to be a statistical
22 aberration or related to poor clinical performance.

23 He told me that, as a result of the concerns
24 expressed by the Consultant paediatricians, two
25 independent reports had been commissioned by the Trust
190

1 the impression that I was there as an independent
2 observer.

3 **Q.** You say in that paragraph 5 he gave you:
4 "... a detailed explanation about the concerns
5 expressed by the paediatricians, including a description
6 of his personal analysis of a series of unexpected
7 deaths on the NNU ..."

8 Did you understand that Mr Harvey had done
9 a personal analysis of the unexpected deaths?

10 **A.** That was my impression, yes.

11 **Q.** What did he say to you about that, his own
12 analysis? I see what you say about the RCPCH and
13 Jane Hawdon's but about his own analysis?

14 **A.** Well, I couldn't really -- I didn't really say
15 anything about it. I had no -- nothing to go on. He
16 wasn't actually showing me the data.

17 **Q.** But you understood that he'd done something
18 himself to reassure him --

19 **A.** I understood that he'd done something himself,
20 he was the Medical Director, and with the very limited
21 or zero knowledge I had at the time I had to take his
22 word for this.

23 **Q.** You say here:

24 "The MD also raised concerns about the professional
25 behaviour of some of the paediatricians ..."
192

1 What were those concerns about their professional
2 behaviour that he raised in that first meeting with you?

3 **A.** There was also an issue over alleged --
4 alleged negative remarks that Ms Letby had accused some
5 of the Consultant paediatricians of making and that if
6 those allegations were to be upheld those would be
7 considered professional misconduct.

8 It has to be said, however, that the paediatricians
9 vigorously denied every making --

10 **Q.** I'll go it that in a moment. Sorry, to
11 interrupt, Dr Tighe, but just dealing --

12 **A.** But that's what it was about. And also it was
13 also that one of the -- some of the relatives had
14 threatened to refer some or one of the paediatricians to
15 the General Medical Council.

16 **Q.** So that was my next question, was it
17 Mr Harvey, because that's his evidence to the Inquiry,
18 that it was Letby and her father who'd raised the
19 possibility of reporting the Consultants to the GMC; is
20 that what he was saying to you or that he was --

21 **A.** No, I got the impression that it was one of
22 the parents -- the parents of the -- of the children
23 that had threatened GMC action. I wasn't aware that
24 Ms Letby or her father had threatened to do so, although
25 I might be not remembering that correctly. It might

193

1 **Q.** -- when you were there?

2 **A.** Only afterwards when I spoke to the
3 paediatricians informally.

4 **Q.** We see at the beginning:

5 "Mr Harvey reported that running in parallel to the
6 above reviews was the HR process relating to the
7 grievance."

8 What did you understand or did he say about the
9 grievance process, can you remember?

10 **A.** Well, it was the first time I'd heard that --
11 no -- that there was a grievance. Mr Harvey might have
12 mentioned it in the informal meeting in his office
13 beforehand that a grievance -- no, he had mentioned it,
14 there was a grievance procedure had been enacted and as
15 a result that grievance procedure had concluded that she
16 was to come back to work.

17 **Q.** And if you see at page 2, paragraph 3, it's
18 recorded Mrs Rees read out Lucy's statement to the
19 meeting. Do you remember that, a statement being read
20 out?

21 **A.** Yes, I do.

22 **Q.** What did you make of that in this meeting?

23 **A.** Well, I thought it was completely
24 inappropriate. We had been told that the meeting was to
25 explore the reports -- the contents of the reports and

195

1 well have been the other way round, as you say. I don't
2 know.

3 But all I remember was there was the -- the
4 potential for GMC referral was mentioned and that
5 frightened me on behalf of my paediatric colleagues,
6 because the potential -- the actual GMC referral is
7 an absolutely disastrous thing to happen to any
8 clinician because you are guilty until proved innocent
9 in effect, and they would be automatically suspended
10 from clinical practice until the GMC had made their
11 decision. So it's a very, very major thing to happen
12 and, as my evidence shows, a lot of my actions
13 subsequently were to prevent that happening.

14 **Q.** At what cost would you say you would prevent
15 that happening?

16 **A.** By encouraging my paediatric colleagues to do
17 the right thing but to also be seen as co-operative and
18 understanding of the executive point of view.

19 **Q.** If we go to the meeting itself, the reference
20 is INQ0003523 and it starts at page 1. This is the
21 meeting that you bore witness to. Did you say anything
22 in the meeting?

23 **A.** I have seen this, yes.

24 **Q.** Did you say anything in the meeting --

25 **A.** No, nothing.

194

1 to explore the possibility of Ms Letby returning to
2 work, not to hear a 20-minute melodramatic dissertation
3 from Ms Letby herself.

4 **Q.** We know -- I think it's -- that can -- it's
5 been on the screen earlier -- we know that there was
6 reference in that letter to suggestions of various names
7 that she had been called. Do you remember that?

8 **A.** Yes.

9 **Q.** And what did the Consultants say in response
10 to that?

11 **A.** Well, they completely denied that they had
12 said anything derogatory.

13 **Q.** Can you remember which one said anything
14 specifically or not really, they just all said they
15 hadn't?

16 **A.** I think it was Dr Jayaram, and they followed
17 that up and also to say, "Can we please have details of
18 exactly what these derogatory remarks were?" And that
19 was no comment was made.

20 **Q.** In the statement -- and, again, I don't need
21 to call it up -- but the statement that was read out
22 said:

23 "Members of your team have been heard to publicly
24 make comments such as angel of death, murderer on the
25 unit, cold and calculated."

196

1 So that's what was said to the Consultants.
 2 **A.** That I think is what Ms Letby was referring
 3 to.
 4 **Q.** Yes.
 5 **A.** But the way it was presented to us was that it
 6 was directly the Consultants that had said that not
 7 members of their team. The Consultants recognised that
 8 members of their team may possibly have said that.
 9 **Q.** What do you think the tone of that meeting
 10 was? How would you describe it?
 11 **A.** Well, it was -- it was pretty shocking really.
 12 The -- first of all, it was extremely one-sided.
 13 The paediatricians hardly had any opportunity to say
 14 anything, and in fact hardly did say anything. The tone
 15 started off with the Medical Director being fairly
 16 placatory but just describing factually his -- his own
 17 and the board's interpretation of the two reports,
 18 concluding that there were no concerns, other than
 19 perhaps organisational issues and staffing issues, and
 20 it was followed up by the Chief Executive, whose tone
 21 was dictatorial, somewhat regimental, demanding that the
 22 board had made their decision, that this was final, and
 23 that the paediatricians were to draw a line under the
 24 whole thing, and were to accept Miss Letby back to work
 25 and were to apologise to her for the derogatory remarks
 197

1 professionally managed, he noted emotions were running
 2 high at the time. Things have been said and done that
 3 were below the values and standards of the Trust. He
 4 added that an action would be developed from the outcome
 5 of the grievance".
 6 What did you understand to be the Speak Out Safely
 7 process and did you know if that had been used or not?
 8 **A.** Sorry, could you repeat that question again
 9 I'm having terrible trouble hearing you because of the
 10 echo in here.
 11 **Q.** There is an echo. Me too.
 12 **A.** And I've got bad hearing.
 13 **Q.** Mr Chambers stated that the Speak Out Safely
 14 process had been professionally managed. Do you know
 15 what he meant by that and do you know if that process
 16 had been used?
 17 **A.** No, I don't know what he meant by that.
 18 I think he was referring to freedom to speak out, the
 19 policy that the government were pushing at the time and
 20 following previous Inquiries. But it was -- I got -- it
 21 was almost a passing remark.
 22 **Q.** You tell us in paragraph 12 of your statement,
 23 if you would like it go to it, you -- the document can
 24 come down now, thank you, Ms Killingback -- you met with
 25 Dr Jayaram on the morning of 29 January 2017 in his
 199

1 that they had -- that had been alleged they had made.
 2 **Q.** Given that was the tone, did you think to
 3 speak up about this at the time in the meeting or say
 4 anything --
 5 **A.** No --
 6 **Q.** -- and if not, why not?
 7 **A.** -- I didn't think this was my role. I was
 8 being specifically asked to sit there and be a witness
 9 and say nothing.
 10 **Q.** In the earlier meeting that you'd had with
 11 Mr Harvey or --
 12 **A.** Yes, yes.
 13 **Q.** Did the paediatricians expect you to be there?
 14 **A.** I expected some paediatricians to be there
 15 I didn't expect all of them -- I think all of them all
 16 of the Consultant paediatricians were there. I'm not
 17 sure. But I knew they were going to be some
 18 paediatricians there. That was the whole point of the
 19 meeting.
 20 **LADY JUSTICE THIRLWALL:** But did they know you were
 21 going to be there?
 22 **A.** I'm not sure. Ma'am, I'm not sure.
 23 **MS LANGDALE:** At the top of the page on the screen,
 24 we see Mr Chambers stated that:
 25 "The Speak Out Safely process had been
 198

1 office. What did you discuss with him then? The
 2 meeting, of course, had been on the 26th, what was your
 3 conversation with him about?
 4 **A.** Right. I think actually this was probably
 5 a typo or error here. I think it's probably the 27th,
 6 the morning after, which was a Friday --
 7 **Q.** Right.
 8 **A.** -- the 29th was a Sunday. I doubt I -- he or
 9 I would be there unless we were on-call together.
 10 **Q.** So it was the Friday looking at your
 11 subsequent letter.
 12 **A.** So the content of the meeting, yes. Well,
 13 I was -- after the -- after the actual meeting on the
 14 26th I met, after, in the corridor with Dr Jayaram and
 15 Dr Brearey to express my surprise and shock as to what
 16 we had both just witnessed and my deep concern for them
 17 and the position they were in and this particular
 18 conflict with the Trust, and this request to apologise
 19 for something that they firmly confirm that they had
 20 nothing -- that they had firmly denied, and so I had
 21 said to them, "Look, there's nothing to be lost by
 22 making a reserved apology for perceived hurt and it is
 23 not going to do any harm and you -- and it still leaves
 24 you complete freedom to proceed in any direction you
 25 want to go." But I said, "As your Union representative,
 200

1 I'm extremely disturbed by the -- by the pressure you
 2 are being put under", and by the -- what I saw as
 3 a direct threats to them that if they didn't do as they
 4 were told by the Chief Executive there were going to be
 5 consequences. I think he even said, "There will be
 6 consequences." I thought this was completely
 7 inappropriate and realised that my position as a witness
 8 was no longer as such. I was now their
 9 Union representative because there was potential that
 10 their jobs were at stake. And that's very much where my
 11 role was in defending their terms and conditions and
 12 defending them should there be any threat to their
 13 employment as a result of what I thought they were
 14 doing, which was very much the right thing.

15 So I had had that meeting with them. But I said,
 16 you know, "If it's a matter of -- the other issue here
 17 is that the Trust want to let Ms Letby back to work.
 18 What do you think about that?" And they said "Under no
 19 circumstances. That is completely impossible. That is
 20 our bottom line and we cannot have that."

21 So I said, "Well, I'll help. I will do whatever
 22 I can to make sure that happens." So I said, "To take
 23 the heat off, let's think about writing this apology so
 24 we can proceed with the more important issues."

25 So I then --

201

1 reported to the GMC you said that's just the worse
 2 thing, you wanted to avoid that if you could.

3 **A.** Yes, yes. It would be -- when, in my view, my
 4 Consultant colleagues had done absolutely nothing wrong
 5 and in fact quite the opposite, were proceeding in an
 6 extraordinarily professional and courageous manner
 7 I thought that would be disastrous because the GMC only
 8 has one way of doing things and that is suspicion and
 9 that's it.

10 You know, there's nothing -- that's what happens.
 11 Overnight you are suspended and then of course the
 12 paediatricians would have no ability to proceed with
 13 their case.

14 **Q.** You then went home that weekend and
 15 I understand from your evidence read the RCPCH report,
 16 did you? Or you tell us. What did you look at?

17 **A.** Yes, well, I then -- I was very disturbed by
 18 a) the meeting itself, b) the subsequent meeting with
 19 Dr Jayaram in his office where he went into further
 20 detail and don't forget I knew very little about this
 21 until Dr Jayaram sat me down and told me what had been
 22 going on.

23 So I then went home and did some research and, yes,
 24 my research was extremely disturbing and I wrote the
 25 letter that you have that you no doubt are about to

203

1 **Q.** Sorry, just to --

2 **A.** -- met with Ravi the following morning.
 3 Sorry.

4 **Q.** I was just going to say you met him that
 5 following morning, but can I just ask you about what you
 6 said about the threats.

7 Dr ZA -- there is a cipher list if you want to see
 8 who that is, I can't give you the name of that doctor --
 9 in her written evidence says she remembers someone
 10 saying:

11 "Senior management in the Trust were keen for
 12 someone to stick their head above the parapet and get
 13 blamed and they could get their head knocked off."

14 And she referred to the fact it may have been you
 15 saying that. You don't remember saying that --

16 **A.** Yes.

17 **Q.** -- but this threat of the GMC, did you discuss
 18 that with the doctors?

19 **A.** No, I didn't. Not -- well, I did discuss it
 20 the following morning with Dr Jayaram. I did raise that
 21 issue that I was aware that there were threats of GMC
 22 referral and that I was very concerned about that.

23 **Q.** So you did on the 27th discuss that threat of
 24 referral and you said a moment ago that was the worst
 25 thing that you -- when you were describing being

202

1 refer to.

2 **Q.** I am. Let me put that on the screen so you
 3 can tell us. INQ0003489, page 1 and 2. That's your
 4 letter of 29 January 2017. Please tell us what you are
 5 setting out there at paragraph 2.

6 **A.** So I start off by saying, you know, you've got
 7 to recognise that the Trust are doing something, they
 8 have come to a conclusion, the board has come to
 9 a conclusion. But that if you think they are wrong
 10 having now read the reports -- which of course they
 11 hadn't seen, they hadn't seen the case report at all and
 12 they hadn't seen the unredacted report -- and having
 13 seen that and considered them as impartially as you can,
 14 you cannot draw a line under this because there is by
 15 definition a significant risk that serious crimes have
 16 been committed and therefore could be committed again if
 17 not in this Trust then in another.

18 There was talk of Ms Letby being moved to Alder Hey
 19 so I was actually concerned that if that were to occur
 20 we still had a major responsibility to prevent that
 21 happening.

22 So -- but I gave them the alternative on
 23 paragraph 3, which is: however, if after reading the
 24 reports you agree the Trust has done everything they
 25 possibly can then of course you can take the accused

204

1 person back and draw a line under as you have been
2 asked.

3 **Q.** You say in paragraph 1:

4 "I have done some background reading and there are
5 disturbing similarities with the Beverley Allitt case
6 and others."

7 So you were aware of that case.

8 **A.** I was aware of that case, yes. I read it up
9 and there were others in the United States of
10 professional staff murdering patients, murdering their
11 own patients.

12 **Q.** If we go to page 2 of this letter, you set out
13 there assurance for all the deaths or as many as
14 possible, at 2, have been subjected to detailed forensic
15 pathology and toxicology, including all remaining
16 infusions, blood samples, et cetera, and you set out
17 what's needed to allay concerns.

18 At paragraph 262 you believe a full forensic
19 examination must take place:

20 "This has not been adequately carried out and this
21 can probably only be done properly by the Coroner and
22 the police."

23 Yes?

24 **A.** Yes. I was concerned that although I wasn't
25 aware of the full details, I was highly suspicious that
205

1 out on every autopsy. But it was obvious that they had
2 not tested for unusual drugs, otherwise they would have
3 an answer.

4 **Q.** That can go down now, please. Then if we can
5 have instead INQ0003159. This is a two-page letter from
6 Mr Chambers, the Chief Executive, to Dr Jayaram and
7 setting out there at paragraph 3:

8 "I confirm that a copy of the report was shared
9 with the Coroner on 20 January following which a meeting
10 with Mr Rheinberg, the Trust Medical Director and
11 Director of Corporate and Legal Services was held at the
12 Countess on 8 February to ensure the Coroner was fully
13 briefed on all matters."

14 The Inquiry is investigating, Dr Tighe, what
15 information the Coroner was provided with and I know you
16 are not apprised with the details of that and indeed
17 you didn't provide information yourself to the Coroner.
18 But we see here on 16 February that it's confirmed by
19 Mr Chambers that the paediatricians' letter of --:

20 "Dr Jayaram's letter of 10 February has been shared
21 with the RCPCH College Review team and Dr Hawdon for
22 comment in view of the fact you are not satisfied with
23 the findings of those reports."

24 If we go to page 2 of this document stating:

25 "In summary there has been a thorough
207

1 the Royal College report had not been properly briefed
2 about the concerns of the paediatricians, had been
3 briefed by the Trust executive and therefore there was
4 a biased briefing, if you like, and that was my only
5 explanation as to why they had not addressed the issue
6 that we were all -- we were all so concerned about.

7 All that was in the college, redacted college
8 report that I saw was criticism of -- of the neonatal
9 unit, organisational aspects. But it turns out that
10 they did look into those issues and it was in part of
11 the redacted part, but at that time we hadn't seen it.

12 So my concern -- and similarly with the Casenote
13 Review for the pathologist, I was concerned that she had
14 not been properly briefed either.

15 **Q.** Is this Dr Hawdon?

16 **A.** The Hawdon Report.

17 **Q.** She's not a pathologist but that review?

18 **A.** So I was -- I was thinking to myself how, both
19 in the interests of Ms Letby and anybody and the -- and
20 the Trust the only way out of this was to have
21 a detailed forensic investigation and a detailed
22 forensic investigation includes detailed toxicology.

23 I note that the Shipman Inquiry recommended, one of
24 the recommendations -- I think it was 263 or
25 something -- recommended that full toxicology is carried
206

1 internal/external review into the unexpected increase in
2 mortality levels for newborn babies on our neonatal unit
3 for 2015 and 2016 compared to previous years."

4 And setting that out. You are told, that can go
5 down now, thank you, you are told by Dr Jayaram that the
6 Coroner has been informed or given that information and
7 we see your response at INQ0006079, page 3.

8 This is from you, is it? Dr Tighe, you see the
9 email?

10 **A.** Yes.

11 **Q.** Yes:

12 "I am slightly surprised and pleased that the Trust
13 has so rapidly escalated your concerns verbatim to the
14 Coroner and to the authors the two recent reports."

15 And you set that out. What did you think was
16 happening at this point when the Coroner had been given
17 information from Mr Chambers?

18 **A.** Well, I thought that the Coroner had been
19 given the letter that the Consultant paediatricians had
20 sent to the Chief Executive saying that they still had
21 major concerns that had not been answered and that they
22 wanted him to open a full forensic inquiry as I had
23 advised them to do.

24 I -- I was pleased that that had happened because
25 I had confidence in the Coroner and the Coroner's
208

1 service. I felt that the Coroner -- it was so obvious
2 to me that what was happening was of major -- at least
3 demanded forensic, further forensic detailed
4 investigation that the Coroner would also see that and
5 would take action and if necessary would then refer to
6 the police. It seemed to me that that was the process
7 that we should go through.

8 I was however, well, not aware that the Coroner,
9 I'm not sure if it's at this time or later, the Coroner
10 had actually been extremely dismissive and had said that
11 it was not in his jurisdiction.

12 **Q.** Well, we haven't heard evidence about that.
13 We will I'm sure in due course, Dr Tighe.

14 That can come down.

15 You say the Coroner could then have considered
16 referral to the police. Did you at any point with the
17 paediatricians discuss they might go directly to the
18 police if they had these concerns or indeed you might go
19 directly to the police, one of you, someone?

20 **A.** Well, yes, that was part of the conversation
21 I had with Dr Jayaram on the morning, after the meeting
22 on the morning of Friday the 27th.

23 We did discuss that and my feeling was that we
24 should go to the Coroner first. I had confidence in the
25 Coroner that was, it turns out, misplaced. But I felt

209

1 about when a police investigation -- so I thought it was
2 appropriate that due consideration should be taken about
3 how that was to be done.

4 **Q.** Indeed you tell us you reflected back in 2020
5 and you probably can now, about the position Mr Chambers
6 and Mr Harvey found themselves in. How do you view
7 that?

8 **A.** Yes. Could you be more specific about what
9 you are asking me? Sorry.

10 **Q.** Yes. You made a further comment in 2020
11 I think about feeling -- who was more responsible or who
12 was finding was under pressure to suggest -- let me find
13 the exact --

14 **A.** Is this the comment where I had expressed some
15 sympathy with the Chief Executive?

16 **Q.** That's right, yes.

17 **A.** Yes. Okay. Yes. That's a bit semantic
18 really. But do you want me to go into detail about it?

19 **Q.** I just want to know what you think. Whether
20 it was then or now, what do you think?

21 **A.** Right. So I put myself in the
22 Chief Executive's position if I was sitting in the
23 boardroom with -- surrounded by other non-medically
24 qualified executives and whom the only medically
25 qualified person in the room was the Medical Director

211

1 it was the Coroner first and the police after if the

2 Trust could not be convinced to do that themselves.

3 I felt the natural approach here was to encourage
4 the Trust to go through the proper channels and do it
5 themselves as soon as possible, bearing in mind please
6 that our bottom line was already met. Ms Letby was no
7 longer working on the unit.

8 It was by this time apparent that she was never
9 going to go back to the unit under any circumstances.
10 So we had time. As far as I was concerned at this
11 point, the point of the letter you just showed me after
12 the Coroner had been informed by the executive, that
13 actually we had -- we had plenty of time. There was no
14 urgency to contact the police. Our bottom line is our
15 patients were safe and Ms Letby was no longer on the
16 unit and wasn't going back there.

17 So in a sense, I had some sympathy with the Trust
18 in wanting to see due process and in particular not
19 wanting the media circus to get involved and upset
20 The Families who, by this stage, knew nothing --

21 **Q.** And I think --

22 **A.** -- and they had been extremely -- and there
23 was no process in place. They had discussed it, but
24 they hadn't formulated a policy as to how they were
25 going -- and what they were going to inform the parents

210

1 and the Medical Director was telling you, the
2 Chief Executive, that there was nothing to be worried
3 about and that the paediatricians were making a huge
4 fuss over nothing, what would I do as a non-medically
5 qualified Chief Executive who had himself appointed the
6 Medical Director to that job?

7 Would it not be seen as a lack of confidence in the
8 Medical Director not to accept his -- his professional
9 medical opinion and so I had some sympathy for the Chief
10 Executive in the position that he found himself in
11 during this whole process which was in effect, I hate to
12 say it, but in effect being driven by the Medical
13 Director.

14 **Q.** Why do you say being driven by the Medical
15 Director?

16 **A.** If the Medical Director had taken due
17 consideration of his Consultant paediatrician
18 colleagues, the experts in neonatology that he had
19 available to him, and involved them from the start in
20 a thorough external, independent investigation which
21 they lead because they are the experts and which they
22 subsequently interpret, then I think this whole thing
23 would have gone in a very different way.

24 **Q.** You tell us at paragraph 19 about the culture
25 and atmosphere at the hospital and if you go to your

212

1 statement, you say:

2 "In general, relationships between clinicians and
3 managers, nurses, midwives and managers and between
4 medical professionals between June 2015 and June 2016
5 were quite good at COCH in my opinion. However, there
6 was an element of distrust between consultant
7 paediatricians, senior nurses and senior managers as
8 a result of the allegations made by the former."

9 And you refer then to:

10 "... professional rivalry as most Board members
11 were from the nursing profession."

12 Can you expand upon that, please?

13 **A.** Yes. This is supposition. It's just struck
14 me again that if I was in -- if I was sitting on the
15 board as an Executive Director or whatever that the
16 board were -- all the professional people on the board
17 other than the Medical Director were from the nursing
18 profession.

19 The -- some -- most of them were no longer in
20 practice but, nevertheless, their backgrounds was
21 from -- were from the nursing profession. The only
22 medically qualified person on the board was the medical.
23 There were other non-executive directors who were -- who
24 were not to do with -- who were not medically or nursing
25 colleagues, as far as I was aware, I may be wrong on

213

1 say:

2 "In my view, she should have been removed as soon
3 as the paediatricians made their concerns known in late
4 2015, early 2016."

5 What concerns are you relating -- referring to
6 there?

7 **A.** Well, by February 2016 there had been several
8 more unexplained deaths and there had been -- and
9 Dr Brearey had raised this formally with the executive.
10 I think you should have records of those meetings.

11 **Q.** Sure. So you don't -- my question then, you
12 don't know specifically when they were raised. They
13 weren't raised with you in February 2016 or earlier --

14 **A.** No.

15 **Q.** -- this is your understanding of the
16 chronology?

17 **A.** That is my understanding indeed. And so
18 I felt that, with hindsight and the knowledge I have as
19 a result of this Inquiry, that there was a very strong
20 case to suspend Ms Letby in February and certainly
21 March 2016 after that meeting.

22 **Q.** In terms of reflections in your statements on
23 page 9, 22(d), you say:

24 "It was clearly inappropriate for the MD to mount
25 his own internal investigation and to analyse this

215

1 that, but as far as I'm aware.

2 So the nursing profession and their views of the
3 nursing profession were overwhelming on the executive
4 board.

5 The accused was from the nursing profession. Would
6 it not, therefore, be natural for the nurses to defend
7 their own and perhaps perfectly understandably on the
8 basis that this situation -- this accusation was so
9 utterly unbelievable and so extraordinarily rare that
10 surely it cannot possibly happen here and that we must
11 be wrong -- the paediatricians must be wrong, and that
12 they must be victimising this poor nurse.

13 And if I'm sitting there as an executive,
14 non-medically qualified, at the board and I'm being told
15 all this I think I might actually accept it.

16 **Q.** You say:

17 "I think that this obviously did, these
18 relationships, very negatively affect the quality of
19 care on the NNU as Ms Letby was allowed to continue to
20 murder babies after major concerns were raised
21 in February 2016."

22 What do you say were the major concerns being
23 raised in 2016?

24 **A.** Well --

25 **Q.** Later on you say -- just to be clear, you then

214

1 himself, with no input from his own paediatric experts,
2 or from any of the expert researchers employed by the
3 Trust."

4 Are you referring there at 22(d) to that piece of
5 work that the MD was telling you he'd done in that
6 preliminary meeting before you attended --

7 **A.** I'm sorry, reflections -- could you give me
8 the reference again.

9 **Q.** It is paragraph 22 of your statement and then
10 it is d on the next page?

11 **A.** Yes.

12 **Q.** On the next page?

13 **A.** C?

14 **Q.** D. See are where you say:

15 "... clearly inappropriate for the MD to mount his
16 own internal investigation and to analyse this
17 himself ..."

18 Can you find that, Dr Tighe?

19 **A.** It's all about the Coroner I'm looking at.
20 I'm looking -- which --

21 **Q.** That's paragraph c go to the one below
22 paragraph --

23 **A.** Para d. Right. It's my hearing again, sorry.

24 Yes. So the Medical Director's first response was
25 to analyse the staffing data himself and cross-reference

216

1 that with the deaths and serious clinical incidents.
 2 I'm not sure if he did do serious clinical incidents but
 3 it was certainly the deaths and --
 4 **Q.** Do you think it was the deaths?
 5 **A.** -- if I remember, Ms Letby was alleged to be
 6 present at every single one of them and that this was
 7 one of the main reasons that my Consultant colleagues,
 8 paediatric colleagues, had raised concerns. And he did
 9 this himself and he mounted his own investigation. He
 10 didn't have any input from his own paediatric experts on
 11 site, or indeed -- we actually had a very
 12 well-established research department at the Countess of
 13 Chester Hospital with some internationally renowned
 14 research experts who would have known an awful lot about
 15 research methodology and particularly statistical
 16 analysis, and he didn't do that, he did it himself.
 17 **Q.** Do you know that? I mean, Mr Harvey can give
 18 evidence himself about that, but he may well have
 19 employed assistance from others in the Trust. Do you
 20 know he didn't or --
 21 **A.** No, I don't know if he didn't --
 22 **Q.** No, okay, so we can ask him about that.
 23 **A.** -- but the -- it subsequently came to my
 24 attention that the -- that the quality of that report
 25 was not particularly good and did not justify the

217

1 conclusions that he came to, ie that there were
 2 perfectly reasonable explanations for these deaths and,
 3 and unexplained incidents.
 4 **MS LANGDALE:** Thank you, Dr Tighe, I have no
 5 further questions. Does my Lady?
 6 **LADY JUSTICE THIRLWALL:** No, thank you very much
 7 indeed, Dr Tighe. I'm sorry about the echo --
 8 **A.** It's all right.
 9 **LADY JUSTICE THIRLWALL:** -- it is maddening.
 10 **A.** It is all right, I need to get a hearing aide.
 11 **LADY JUSTICE THIRLWALL:** But thank you very much
 12 for your help. You are free to go.
 13 So, Ms Langdale, tomorrow morning.
 14 **MS LANGDALE:** Tomorrow at 10 o'clock.
 15 **LADY JUSTICE THIRLWALL:** I will adjourn until 10
 16 o'clock tomorrow.
 17 **(4.49 pm)**
 18 **(The Inquiry adjourned until 10.00 am,**
 19 **on Wednesday 9 October 2024)**
 20
 21
 22
 23
 24
 25

218

INDEX

1		
2		
3	DR JIM McCORMACK (affirmed)	1
4	Questions by MS LANGDALE	1
5	DR MICHAEL MCGUIGAN (affirmed)	76
6	Questions by MR DE LA POER	76
7	DR PAUL JAMESON (sworn)	142
8	Questions by MS BROWN	142
9	DR SEAN TIGHE (affirmed)	187
10	Questions by MS LANGDALE	187
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		

219

LADY JUSTICE THIRLWALL: [37] 1/3 1/6 1/9 2/2 8/3 48/4 62/9 64/12 66/4 66/8 76/3 76/10 76/15 76/19 97/23 98/8 100/14 100/19 100/24 114/3 114/7 114/11 141/25 142/7 142/10 154/5 178/21 178/24 187/5 187/10 187/16 187/18 198/20 218/6 218/9 218/11 218/15 MR DE LA POER: [8] 76/16 76/25 98/9 100/25 113/22 114/12 141/21 142/5 MS BROWN: [5] 142/12 154/10 178/18 178/25 187/3 MS LANGDALE: [16] 1/4 1/12 2/3 8/6 48/7 62/11 64/13 66/9 75/24 76/2 76/9 187/17 187/22 198/23 218/4 218/14	11 [2] 167/18 173/13 11 am [1] 134/20 11 September 2018 [1] 173/15 11.47 [1] 76/12 110 [1] 51/12 12 [6] 2/25 40/25 41/2 50/15 76/11 199/22 12 days [1] 5/4 12.05 [1] 76/9 12.06 pm [1] 76/14 12.58 pm [1] 114/8 15 [2] 143/24 187/7 15/20 minutes [1] 52/16 15/20 people [1] 7/5 16 [4] 4/5 47/8 72/21 149/13 16 February [1] 207/18 18 [1] 40/10 18 June 2024 [1] 187/24 18 weeks [1] 29/14 19 [1] 212/24 19 September [1] 175/6 1982 [1] 1/15 1986 [1] 142/19 1987 [1] 1/18 1993 [1] 188/5 1996 [2] 142/24 143/19 1997 [1] 1/16 1999 [1] 1/20	2016 [27] 9/8 23/14 47/2 49/7 77/24 87/21 88/1 89/18 101/21 131/2 145/22 151/17 151/18 155/19 157/18 177/12 177/15 189/5 189/13 208/3 213/4 214/21 214/23 215/4 215/7 215/13 215/21 2017 [28] 78/2 87/21 91/7 104/22 109/23 114/15 144/12 144/16 153/2 154/1 155/13 155/23 157/20 157/21 158/1 158/24 161/14 166/1 170/10 173/25 177/19 179/11 184/6 184/7 189/5 190/1 199/25 204/4 2018 [8] 78/5 97/14 120/5 171/12 173/15 181/9 184/9 184/12 2019 [4] 112/5 118/17 120/7 143/7 2020 [6] 101/22 144/11 154/11 168/8 211/4 211/10 2021 [2] 101/23 188/6 2023 [1] 78/13 2024 [7] 1/1 1/22 77/5 142/15 187/24 187/25 218/19 21 [1] 148/23 22 [5] 115/12 153/22 215/23 216/4 216/9 22 October [1] 21/10 23 years [4] 3/3 9/24 72/1 74/12 24 [1] 158/14 24 June 2015 [1] 4/20 24/7 [1] 141/12 24th [1] 51/25 26 January [3] 109/14 109/23 190/3 26 January 2017 [1] 114/15 26 March [1] 133/15 262 [1] 205/18 263 [1] 206/24 26th [2] 200/2 200/14 27 [1] 126/22 27 January [2] 147/9 151/17 27 March [2] 125/6 125/9 27th [6] 52/2 133/18 134/13 200/5 202/23 209/22 29 January 2017 [2] 199/25 204/4 29th [1] 200/8	3 3.48 pm [1] 187/13 30 [2] 98/14 99/9 30 June [6] 36/20 51/9 51/13 51/17 62/13 75/21 30 May 2024 [1] 77/5 30 weeks [1] 29/6 30th [2] 52/1 69/8 30th June [1] 53/8 31 [2] 68/23 171/13 31 May 2024 [1] 142/15 33 [1] 9/2 34 [1] 161/17 34 weeks [3] 38/8 38/10 43/14 37 [1] 163/3	4 4 am [1] 50/15 4 September 2024 [1] 187/25 4.05 pm [1] 187/15 4.49 pm [1] 218/17 40 [1] 99/9 41 [1] 165/2 45 [1] 166/21 47 [5] 21/10 21/10 21/13 21/14 21/16 48 [1] 169/20	5 5.00 pm [2] 134/25 135/2 50 [1] 191/6 50 pages [1] 99/9 51 [1] 10/25 52 [2] 13/20 13/20 54 [1] 26/20 55 [1] 27/16	6 61 [1] 95/11 63 [1] 151/21 64 [1] 152/15 69 [2] 16/12 41/12	7 7 June 2024 [1] 1/22 7,500 [1] 73/11 7.30 [1] 51/13 71 [1] 185/24 74 [1] 45/4	8 8 February [2] 50/21 207/12 8 March [1] 58/1 8 October 2024 [1] 1/1 82 [1] 47/10 83 [1] 46/25	9 9 January 2017 [1] 78/2 9 October 2024 [1] 218/19 9.59 am [1] 1/2 90 [1] 181/13 95 [1] 43/17
' 17 [1] 154/14 ' 23 [1] 73/25 ' 23/24 [1] 73/25 ' 24 [1] 73/25 ' Let's [1] 120/24 ' Look [1] 181/13	1982 [1] 1/15 1986 [1] 142/19 1987 [1] 1/18 1993 [1] 188/5 1996 [2] 142/24 143/19 1997 [1] 1/16 1999 [1] 1/20	2 2 August [1] 27/12 2 July [2] 27/10 27/13 2 o'clock [1] 114/5 2.00 pm [1] 114/10 20 [2] 118/9 146/23 20 January [1] 207/9 20 minutes [1] 92/13 2002 [1] 77/10 2004 [1] 77/15 2005 [1] 77/12 2010 [2] 11/10 144/11 2011 [1] 143/7 2012 [1] 77/19 2015 [29] 3/3 4/20 4/21 9/8 11/9 11/22 12/21 15/6 38/22 38/24 39/10 40/5 41/1 42/21 43/5 43/6 49/18 84/10 84/12 151/10 152/24 153/2 157/17 177/10 189/4 189/13 208/3 213/4 215/4 2015/16 [1] 149/13 2015/2016 [1] 101/21	2 2 am [1] 50/15 2 September 2024 [1] 187/25 2.05 pm [1] 187/15 2.49 pm [1] 218/17 20 [1] 99/9 21 [1] 165/2 25 [1] 166/21 27 [5] 21/10 21/10 21/13 21/14 21/16 28 [1] 169/20	3 3.00 pm [2] 134/25 135/2 30 [1] 191/6 30 pages [1] 99/9 31 [1] 10/25 32 [2] 13/20 13/20 34 [1] 26/20 35 [1] 27/16	4 4 [1] 95/11 4 [1] 151/21 4 [1] 152/15 4 [2] 16/12 41/12	5 5 June 2024 [1] 1/22 5,500 [1] 73/11 5.30 [1] 51/13 51 [1] 185/24 54 [1] 45/4	6 6 February [2] 50/21 207/12 6 March [1] 58/1 6 October 2024 [1] 1/1 62 [1] 47/10 63 [1] 46/25	7 7 January 2017 [1] 78/2 7 October 2024 [1] 218/19 7.59 am [1] 1/2 70 [1] 181/13 75 [1] 43/17	
0 0003294 [1] 4/14 0003294/1 [1] 4/14 0004235 [1] 15/9 0004249 [1] 21/8 0014605 [1] 68/23 0015 [1] 48/7	1 1 December [1] 184/25 1 November 2017 [1] 170/10 10 [3] 141/24 187/4 218/15 10 February [1] 207/20 10 lines [1] 147/20 10 o'clock [1] 218/14 10-year [1] 189/17 10.00 [1] 218/18 100 [1] 175/8 101 [2] 176/15 179/15	2 2 am [1] 50/15 2 September 2024 [1] 187/25 2.05 pm [1] 187/15 2.49 pm [1] 218/17 20 [1] 99/9 21 [1] 165/2 25 [1] 166/21 27 [5] 21/10 21/10 21/13 21/14 21/16 28 [1] 169/20	3 3.00 pm [2] 134/25 135/2 30 [1] 191/6 30 pages [1] 99/9 31 [1] 10/25 32 [2] 13/20 13/20 34 [1] 26/20 35 [1] 27/16	4 4 [1] 95/11 4 [1] 151/21 4 [1] 152/15 4 [2] 16/12 41/12	5 5 June 2024 [1] 1/22 5,500 [1] 73/11 5.30 [1] 51/13 51 [1] 185/24 54 [1] 45/4	6 6 February [2] 50/21 207/12 6 March [1] 58/1 6 October 2024 [1] 1/1 62 [1] 47/10 63 [1] 46/25	7 7 January 2017 [1] 78/2 7 October 2024 [1] 218/19 7.59 am [1] 1/2 70 [1] 181/13 75 [1] 43/17		

A	128/19	against [4] 86/12 140/12 155/25 180/25	ally [1] 205/17	137/11	
accusation [1] 214/8	adequately [1] 205/20	age [2] 35/1 35/2	allegation [2] 109/3 125/2	anaesthetist [5] 142/23 143/2 152/1 153/11 188/4	
accused [3] 193/4 204/25 214/5	adjourn [2] 76/10 218/15	agency [4] 83/17 83/18 84/1 84/21	allegations [2] 193/6 213/8	anaesthetists [2] 142/20 148/16	
acknowledge [1] 108/3	adjourned [1] 218/18	ago [3] 8/11 81/13 202/24	alleged [4] 193/3 193/4 198/1 217/5	analyse [4] 14/9 215/25 216/16 216/25	
acknowledged [1] 86/8	adjournment [1] 114/9	agree [10] 10/23 23/3 26/7 35/19 38/21 42/9 69/5 129/20 146/19 204/24	Allitt [5] 71/24 73/11 74/10 105/20 205/5	analysis [10] 22/21 50/8 99/12 117/14 190/19 192/6 192/9 192/12 192/13 217/16	
across [4] 54/21 103/14 107/11 138/25	administration [1] 10/8	agreed [4] 40/14 96/8 134/6 175/22	allocated [3] 5/9 5/11 22/7	angel [1] 196/24	
act [2] 126/16 165/4	admission [1] 153/15	ah [1] 1/7	allow [4] 5/3 150/25 179/20 181/25	angry [1] 120/2	
acting [6] 126/2 136/11 147/15 147/25 165/8 176/14	admissions [1] 101/8	ahead [4] 112/14 113/19 150/2 175/1	allowed [9] 11/2 13/1 57/16 122/12 156/20 156/24 157/11 158/6 214/19	Ann [2] 102/21 102/23	
action [9] 49/14 66/11 164/9 177/13 178/4 185/9 193/23 199/4 209/5	admitting [1] 153/16	aide [2] 6/2 218/10	almost [6] 147/22 150/18 167/8 173/10 178/16 199/21	Ann Murphy [2] 102/21 102/23	
actions [4] 17/8 135/20 161/18 194/12	adults [1] 98/13	aide memoire [1] 6/2	along [5] 105/17 110/12 110/24 122/8 133/11	Annette [2] 56/15 57/1	
activated [2] 85/1 85/3	advance [3] 5/2 5/7 125/7	aim [2] 4/24 183/2	already [16] 54/8 59/22 61/9 75/8 129/7 129/11 130/19 130/22 135/18 135/21 140/21 144/17 155/15 175/4 177/24 210/6	Annette Weatherley [2] 56/15 57/1	
activating [1] 84/21	advanced [1] 124/10	air [1] 103/15	announced [1] 36/4	announced [1] 36/4	
actively [2] 125/4 161/2	advantage [1] 108/21	albeit [1] 65/21	announcement [2] 35/25 36/13	annual [1] 7/3	
activity [1] 5/3	advantageous [1] 189/3	Alder [4] 5/16 45/11 82/20 204/18	announced [1] 36/4	anonymity [1] 58/15	
actual [7] 3/12 9/16 22/2 31/3 161/8 194/6 200/13	advertised [1] 88/5	Alder Hey [4] 5/16 45/11 82/20 204/18	announced [2] 35/25 36/13	anonymously [1] 85/16	
actually [36] 7/2 17/20 19/4 21/1 23/8 27/8 30/16 31/6 34/3 35/8 35/12 37/1 54/20 58/25 59/2 59/4 59/5 60/11 61/19 68/17 72/19 73/18 73/24 75/9 157/2 161/7 173/13 191/2 191/17 192/16 200/4 204/19 209/10 210/13 214/15 217/11	advice [1] 132/24	alerting [1] 174/10	announced [2] 35/25 36/13	another [18] 27/13 33/7 39/2 39/13 39/25 43/11 62/11 65/20 68/11 68/13 105/15 128/3 178/19 178/22 179/4 183/15 183/16 204/17	
acute [1] 28/14	advised [1] 208/23	all [125] 2/4 2/6 2/8 3/11 5/13 5/22 6/9 6/15 6/17 6/18 7/1 7/8 7/9 8/1 8/2 9/24 10/13 10/16 10/17 13/10 13/24 17/4 17/15 18/5 19/16 20/2 22/6 25/16 28/7 36/10 37/11 38/14 40/20 40/21 45/7 45/17 48/14 49/22 52/6 52/7 53/23 54/7 54/10 58/22 59/20 61/20 62/6 62/7 62/8 65/4 66/6 66/7 67/13 69/18 69/19 70/10 72/3 74/11 75/24 82/20 88/12 93/1 97/17 99/8 101/9 102/3 102/11 103/18 106/5 108/13 108/24 109/18 121/12 131/10 134/14 136/13 137/13 139/4 139/7 140/11 140/23 141/4 141/23 143/15 143/15 144/23 144/23 154/3 154/9 154/21 155/9 156/25 159/2 160/20 160/21 161/6 174/20 174/22 174/24 176/15 178/22 179/20 183/19 186/25 188/17 190/15 191/15 194/3 196/14 197/12 198/15 198/15 198/15 204/11 205/13 205/15 206/6 206/6 206/7 207/13 213/16 214/15 216/19 218/8 218/10	affected [2] 36/12 37/11	also [47] 2/20 3/4 4/8 5/15 6/8 17/22 37/17 41/19 50/13 53/4 54/21 62/20 68/12 74/20 79/13 79/23 93/16 94/7 100/3 100/11 100/22 101/13 102/7 113/23 134/4 163/21 163/22 167/20 169/5 173/8 174/3 174/14 179/1 180/7 180/23 181/9 185/14 186/21 189/18 191/11 192/24 193/3 193/12 193/13 194/17 196/17 209/4	ans [1] 33/2
add [3] 50/11 59/23 173/8	affect [2] 130/21 214/18	affirmation [1] 187/19	answered [2] 30/16 208/21	answered [2] 30/16 208/21	
added [2] 17/22 199/4	affirmed [6] 1/8 76/21 187/20 219/3 219/5 219/9	afford [1] 58/15	ans [1] 33/2	answer [6] 47/10 85/24 127/8 127/11 170/23 207/3	
addition [3] 6/7 59/16 146/24	after [56] 8/4 8/5 8/17 18/3 18/7 20/20 24/17 28/21 28/24 30/18 38/15 38/20 41/16 43/21 44/8 50/10 54/9 63/9 63/10 68/3 75/20 78/22 79/2 79/5 88/15 96/3 97/13 100/5 113/9 114/1 118/6 131/16 131/16 134/12 149/7 157/3 157/3 163/25 164/6 165/10 167/9 170/10 177/10 177/16 183/8 184/15 200/6 200/13 200/13 200/14 204/23 209/21 210/1 210/11 214/20 215/21	affirming [1] 174/10	answer [6] 47/10 85/24 127/8 127/11 170/23 207/3	answered [2] 30/16 208/21	
address [24] 24/19 25/19 25/20 25/24 38/5 59/20 61/24 64/25 65/5 65/7 65/20 65/25 67/17 67/19 67/23 68/20 112/2 112/3 121/23 143/23 146/4 151/20 165/15 166/21	afterwards [5] 16/20 53/13 80/10 120/8 195/2	all [125] 2/4 2/6 2/8 3/11 5/13 5/22 6/9 6/15 6/17 6/18 7/1 7/8 7/9 8/1 8/2 9/24 10/13 10/16 10/17 13/10 13/24 17/4 17/15 18/5 19/16 20/2 22/6 25/16 28/7 36/10 37/11 38/14 40/20 40/21 45/7 45/17 48/14 49/22 52/6 52/7 53/23 54/7 54/10 58/22 59/20 61/20 62/6 62/7 62/8 65/4 66/6 66/7 67/13 69/18 69/19 70/10 72/3 74/11 75/24 82/20 88/12 93/1 97/17 99/8 101/9 102/3 102/11 103/18 106/5 108/13 108/24 109/18 121/12 131/10 134/14 136/13 137/13 139/4 139/7 140/11 140/23 141/4 141/23 143/15 143/15 144/23 144/23 154/3 154/9 154/21 155/9 156/25 159/2 160/20 160/21 161/6 174/20 174/22 174/24 176/15 178/22 179/20 183/19 186/25 188/17 190/15 191/15 194/3 196/14 197/12 198/15 198/15 198/15 204/11 205/13 205/15 206/6 206/6 206/7 207/13 213/16 214/15 216/19 218/8 218/10	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
addressed [9] 31/2 31/25 32/19 70/20 95/20 117/10 117/11 119/6 206/5	again [23] 19/10 20/21 24/15 31/22 55/11 72/14 90/20 95/9 95/22 96/14 98/19 101/15 102/9 116/6 168/8 168/25 180/14 196/20 199/8 204/16 213/14 216/8 216/23	albeit [1] 65/21	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
addressing [1] 24/11	adequate [2] 36/23	allegation [2] 109/3 125/2	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
adequate [2] 36/23		allegations [2] 193/6 213/8	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		alleged [4] 193/3 193/4 198/1 217/5	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		Allitt [5] 71/24 73/11 74/10 105/20 205/5	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		allocated [3] 5/9 5/11 22/7	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		allow [4] 5/3 150/25 179/20 181/25	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		allowed [9] 11/2 13/1 57/16 122/12 156/20 156/24 157/11 158/6 214/19	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		almost [6] 147/22 150/18 167/8 173/10 178/16 199/21	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		along [5] 105/17 110/12 110/24 122/8 133/11	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		already [16] 54/8 59/22 61/9 75/8 129/7 129/11 130/19 130/22 135/18 135/21 140/21 144/17 155/15 175/4 177/24 210/6	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		also [47] 2/20 3/4 4/8 5/15 6/8 17/22 37/17 41/19 50/13 53/4 54/21 62/20 68/12 74/20 79/13 79/23 93/16 94/7 100/3 100/11 100/22 101/13 102/7 113/23 134/4 163/21 163/22 167/20 169/5 173/8 174/3 174/14 179/1 180/7 180/23 181/9 185/14 186/21 189/18 191/11 192/24 193/3 193/12 193/13 194/17 196/17 209/4	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		alternative [3] 128/18 128/19 204/22	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		although [6] 42/5 48/9 144/15 185/5 193/24 205/24	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		always [12] 9/7 22/5 34/21 38/6 60/4 80/6 82/10 128/10 149/11 162/4 167/11 189/21	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		am [13] 1/2 2/14 8/13 18/20 19/12 50/15 58/13 76/12 134/20 173/2 204/2 208/12 218/18	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		amended [1] 117/15	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		amiss [1] 61/25	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		amongst [2] 147/10 179/15	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	
		amount [2] 99/13	ans [1] 33/2	answers [4] 33/8 124/2 124/15 181/13	

A	appeared [4] 49/8 89/20 136/2 137/16	33/24 34/25 35/6 38/2 38/18 38/18 38/20 42/5 42/7 43/6 44/6 44/11 44/13 44/14 46/10 47/22 48/8 52/23 53/24 54/4 55/19 56/4 56/11 56/13 61/22 62/6 62/16 64/6 64/16 68/1 68/7 68/11 68/23 75/24 76/7 77/7 77/9 80/21 86/15 96/23 97/2 100/25 102/3 102/19 102/20 103/2 107/12 108/4 108/13 108/15 108/22 108/24 110/3 110/4 111/16 114/4 122/23 129/14 134/2 136/19 137/2 137/4 137/7 137/14 137/18 139/23 139/23 141/6 141/23 142/3 142/19 144/6 145/7 148/12 160/8 163/22 168/15 168/16 168/23 169/8 173/10 173/13 173/14 178/21 180/11 181/13 187/4 188/2 194/8 201/2 203/11 203/25 204/4 204/7 204/9 205/4 207/16 207/22 208/4 208/5 211/9 212/21 215/5 216/4 216/14 218/12	articulated [1] 72/11 as [243] ashamed [1] 73/16 aside [3] 19/2 52/5 176/13 ask [19] 13/17 14/1 14/3 15/7 16/9 18/8 30/1 30/2 45/4 52/10 53/19 65/15 65/18 75/5 172/3 174/5 182/23 202/5 217/22 asked [30] 12/16 18/6 42/5 47/9 53/7 55/25 56/4 57/8 61/5 61/19 61/24 65/8 89/13 118/22 122/22 145/3 145/14 145/20 149/14 149/17 156/5 157/4 157/11 165/22 167/9 183/9 190/2 190/11 198/8 205/2 asking [17] 1/10 2/14 18/20 20/11 30/8 30/9 33/5 44/19 44/20 64/20 85/9 110/5 111/12 157/14 160/8 190/6 211/9 aspects [2] 124/11 206/9 aspirational [1] 127/22 assertion [1] 35/18 assess [3] 38/2 74/23 100/13 assessment [2] 4/20 49/5 assessor [1] 41/5 assigned [1] 28/3 assist [3] 73/20 180/10 180/11 assistance [1] 217/19 Assistant [1] 3/10 associate [3] 3/1 3/6 144/24 associated [2] 103/25 105/21 Association [1] 189/22 assume [5] 4/20 27/4 52/2 72/17 191/3 assumes [2] 180/10 182/18 assuming [1] 37/24 assumption [1] 50/4 assurance [1] 205/13 assured [1] 190/18 at [401] atmosphere [2] 115/3 212/25 attached [1] 28/25 attempting [3] 25/3 49/19 180/17 attend [19] 5/3 6/19	6/24 7/4 41/14 42/10 51/13 53/9 125/7 131/17 133/20 145/5 145/19 145/25 146/2 149/19 149/22 150/25 190/2 attendance [4] 7/2 7/5 171/20 189/22 attended [10] 4/25 42/16 52/11 62/14 94/19 134/18 147/10 173/15 175/18 216/6 attending [8] 14/24 84/16 146/6 175/7 176/15 182/9 183/22 190/12 attention [2] 88/6 217/24 attributes [1] 3/21 audit [1] 86/1 August [4] 27/12 89/18 93/23 188/5 August 1993 [1] 188/5 authority [4] 83/18 186/4 186/7 186/16 authors [1] 208/14 automatically [1] 194/9 autopsy [1] 207/1 availability [1] 110/6 available [10] 7/1 7/9 7/10 39/17 40/3 75/22 110/3 110/4 166/3 212/19 avenues [2] 160/20 160/22 average [2] 7/4 146/10 avoid [2] 61/11 203/2 avoided [1] 58/14 awaiting [2] 7/17 28/14 awaiting pm [2] 7/17 28/14 aware [43] 8/8 30/4 30/11 30/17 36/4 40/23 53/2 58/13 68/18 71/24 74/15 87/11 88/3 88/8 88/13 99/16 113/19 132/19 133/21 135/21 137/1 150/8 150/20 153/1 155/15 159/2 164/1 172/21 174/23 176/19 176/20 177/24 185/11 185/19 186/18 193/23 202/21 205/7 205/8 205/25 209/8 213/25 214/1 awareness [4] 75/1 75/2 105/18 105/19 away [6] 14/2 46/19 124/4 150/13 155/11
----------	--	---	--	--

A	210/16 211/4	beds [1] 141/11	bells [1] 117/18	blue [7] 66/25 67/1
away... [1] 191/2	background [2]	been [251]	below [3] 146/16	67/2 67/3 67/8 67/13
awful [1] 217/14	92/18 205/4	before [52] 2/1 3/14	199/3 216/21	105/6
B	backgrounds [1]	8/4 12/9 15/6 31/1	benchmarked [1]	BMA [5] 144/16
	213/20	31/5 31/11 37/12	140/11	188/11 188/15 188/16
babe [1] 43/14	backyard [1] 104/7	39/16 39/16 54/10	beneath [2] 66/5	189/21
babies [24] 13/14	bad [1] 199/12	54/15 56/7 62/24	145/11	board [67] 4/6 11/4
18/8 21/20 24/17 25/4	badly [3] 118/1 133/9	78/18 79/21 81/2 85/5	benefit [3] 16/17	12/3 12/20 12/21 13/5
26/15 34/20 36/12	135/9	85/10 87/20 88/17	16/18 108/3	13/15 13/18 13/22
38/2 40/11 41/15 43/1	bags [1] 131/9	91/18 92/7 97/12	bereaved [1] 174/19	21/6 36/20 44/23 45/1
43/14 52/18 56/12	balance [1] 140/25	101/11 102/4 103/13	best [14] 77/8 91/14	49/9 49/11 51/17
72/10 104/25 116/2	barrister [1] 187/7	104/5 104/7 109/13	107/25 110/14 110/17	60/17 63/23 63/25
131/2 141/6 141/7	base [1] 138/24	112/20 113/15 117/21	110/19 113/24 116/6	64/4 70/25 70/25 71/2
158/25 208/2 214/20	based [5] 49/24 80/7	119/14 122/16 122/19	118/13 121/14 142/15	71/5 71/7 71/13 71/23
baby [49] 7/7 7/12	107/12 123/19 144/16	123/6 123/9 123/19	151/9 156/14 157/23	72/24 75/20 87/3
7/15 8/10 8/17 10/2	basically [2] 99/17	125/14 125/20 126/1	better [9] 11/6 50/1	97/24 120/16 138/11
15/9 17/4 17/18 18/2	154/15	138/8 147/23 164/16	52/21 66/2 98/10	138/13 139/1 145/10
20/19 21/2 21/3 21/4	basing [1] 169/8	165/16 176/21 183/9	108/6 109/14 126/7	145/12 147/5 149/1
21/21 21/25 22/2 25/1	basis [5] 14/12 49/23	184/13 190/9 216/6	136/3	149/5 149/9 149/12
26/21 27/20 28/24	105/8 138/19 214/8	beforehand [1]	between [37] 9/6	149/20 150/2 150/25
29/3 29/13 30/16	battling [1] 157/10	195/13	9/10 9/13 10/5 18/22	151/4 165/4 165/8
30/20 31/21 32/18	be [307]	begin [5] 78/2 78/15	50/15 72/8 88/4 93/21	167/10 167/20 168/4
34/11 34/13 34/14	bearing [2] 68/14	87/20 115/6 128/13	93/23 94/1 94/23 97/3	169/5 169/15 170/22
35/6 35/8 35/11 35/18	210/5	beginning [3] 157/17	101/5 103/24 106/11	180/6 180/18 180/19
39/10 40/12 45/19	beavering [1] 71/20	182/19 195/4	109/16 113/1 139/14	190/3 197/22 204/8
46/11 46/15 51/25	became [5] 1/17	begins [1] 26/22	144/1 144/2 157/22	213/10 213/15 213/16
72/6 72/6 72/6 104/19	77/12 94/18 97/18	behalf [5] 125/17	157/22 165/13 172/7	213/16 213/22 214/4
105/5 107/6 141/18	150/18	134/23 159/14 162/24	172/14 172/21 173/21	214/14
152/18 171/2	because [98] 5/2 6/4	194/5	174/2 179/11 182/3	board's [1] 197/17
Baby A [4] 7/12 7/15	6/18 6/19 7/10 8/17	behaviour [2] 192/25	190/3 190/13 213/2	boardroom [3]
15/9 72/6	10/12 11/9 13/3 15/23	193/2	213/3 213/4 213/6	114/17 119/21 211/23
Baby A's [1] 8/17	16/24 21/2 24/17	behaviours [1] 185/9	between December	body [4] 106/6
Baby C [12] 20/19	26/16 27/17 28/5	behind [3] 14/4 50/4	[1] 157/22	136/16 136/20 170/3
21/2 21/3 21/4 26/21	29/15 29/18 30/18	150/3	between June 2015	bond [1] 38/17
27/20 28/24 30/16	33/15 34/7 35/18 39/9	being [71] 8/25 18/4	[1] 213/4	bore [1] 194/21
30/20 31/21 32/18	40/23 43/1 47/17	18/5 19/1 20/8 32/22	Beverley [5] 71/24	born [1] 17/4
72/6	48/12 48/18 50/9	33/25 40/19 42/5	73/11 74/10 105/20	both [15] 49/1 49/2
Baby C's [1] 35/11	55/25 58/24 59/4	42/20 50/8 51/1 65/24	205/5	49/2 49/22 51/9 67/20
baby cots [1] 39/10	59/12 59/17 59/21	74/25 80/23 81/6 81/9	Beverley Allitt [5]	67/21 95/2 102/14
Baby D [3] 22/2 25/1	60/3 61/5 61/25 63/11	84/19 88/5 88/5 98/18	71/24 73/11 74/10	139/8 140/16 186/13
72/6	63/15 64/20 64/22	100/22 101/9 105/9	105/20 205/5	186/14 200/16 206/18
Baby I wasn't [1]	65/19 66/16 67/20	105/22 106/16 107/4	biased [1] 206/4	bottom [10] 64/14
40/12	69/6 69/15 75/10 79/9	107/5 113/14 123/14	big [5] 46/21 63/23	117/13 146/9 147/18
Baby P [1] 51/25	81/12 81/24 88/10	123/24 127/22 128/24	63/24 83/6 139/11	147/21 156/17 183/1
baby's [1] 34/9	89/14 90/24 91/7	135/16 136/15 138/13	bigger [3] 25/21	201/20 210/6 210/14
back [56] 4/18 7/16	107/9 111/7 111/8	141/8 141/17 147/3	64/15 98/19	bowel [1] 28/14
15/9 19/10 19/19	113/6 122/9 124/21	147/3 147/16 147/19	biopsy [1] 29/18	box [6] 13/25 22/11
24/14 26/19 27/24	126/20 128/21 129/23	148/15 149/13 154/6	birth [1] 29/6	22/22 23/11 23/15
28/1 29/10 29/15	137/11 139/22 141/5	155/4 155/25 157/4	births [1] 5/11	153/16
31/20 53/10 53/23	146/4 148/13 149/17	158/20 161/6 161/15	bit [16] 10/7 51/7	box 7 [1] 13/25
57/10 59/2 61/12	150/13 150/18 151/11	162/2 164/7 165/8	53/23 56/22 57/11	boxes [3] 22/9 22/17
61/24 73/2 73/7 81/12	151/25 152/8 153/3	167/7 176/6 180/2	57/13 64/15 70/1 76/6	22/25
86/23 87/10 90/20	155/23 155/24 159/20	180/12 181/4 187/10	95/5 115/18 126/3	boys [1] 37/21
92/20 97/15 104/11	161/7 161/14 168/4	190/20 195/19 197/15	131/25 132/24 133/13	brain [1] 83/8
108/2 110/9 113/14	172/12 173/20 173/23	198/8 201/2 202/25	211/17	break [4] 76/13 114/4
114/1 114/4 115/18	179/8 184/14 186/23	204/18 212/12 212/14	bits [5] 32/13 32/14	187/12 187/14
117/11 118/16 129/24	191/5 193/17 194/6	214/14 214/22	32/15 88/18 181/14	breakdown [7] 172/6
134/8 136/19 136/25	194/8 199/9 201/9	Belfast [1] 11/5	black [2] 66/20 66/23	172/11 172/13 172/21
137/16 140/1 146/22	203/7 204/14 208/24	belief [4] 75/4 77/8	blacked [1] 191/7	173/21 174/1 182/3
148/23 153/22 156/1	212/21	142/16 162/7	blamed [1] 202/13	breaking [1] 147/23
158/6 162/19 169/18	become [8] 67/12	believe [5] 110/1	blood [2] 29/24	Brearey [46] 5/8 5/21
191/10 195/16 197/24	77/18 78/5 88/3 97/20	153/24 166/1 176/7	205/16	6/8 6/24 8/1 8/14 9/14
201/17 205/1 210/9	129/6 132/19 164/1	205/18	blowing [4] 130/3	13/11 16/5 18/25
	becoming [1] 105/1	bell [1] 153/20	130/7 130/8 130/9	27/24 44/15 44/18

B	burnout [1] 147/24	158/14 161/17 165/19	45/1 56/2 56/3 71/24	cetera [2] 11/18
Brearey... [33] 46/25	business [5] 140/4	168/14 168/25 169/19	79/25 109/8 112/23	205/16
50/10 52/13 52/14	147/17 147/19 148/2	171/21 171/24 172/3	143/18 144/17 147/17	chain [3] 73/5 171/22
53/16 54/8 54/13 55/5	171/16	172/18 173/4 173/10	147/19 148/2 149/2	171/24
55/22 56/3 56/11	busy [2] 98/15	177/2 179/12 179/17	175/1 203/13 204/11	chair [23] 4/5 49/11
62/15 67/21 71/19	129/12	180/10 188/1 188/14	205/5 205/7 205/8	60/17 143/6 143/12
101/1 125/10 125/17	but [245]	189/9 190/5 195/9	215/20	147/3 147/4 147/12
133/23 134/16 135/3	Butcher [5] 144/9	196/4 196/13 196/17	Casenote [7] 104/10	148/25 149/18 150/12
136/10 156/7 156/23	167/15 170/13 171/13	199/23 201/22 201/24	106/2 115/15 115/22	157/6 166/17 167/19
160/24 178/7 178/8	173/18	202/5 204/3 204/13	119/7 124/13 206/12	168/3 169/4 170/12
180/10 181/3 181/8	Butcher's [1] 175/21	204/25 204/25 205/21	cases [9] 14/12 16/8	171/13 172/3 184/8
181/9 181/16 200/15	C	207/4 207/4 208/4	19/13 19/20 40/10	188/11 188/18 189/19
215/9	C's [1] 35/11	209/14 211/5 213/12	49/13 69/18 69/19	chaired [1] 18/13
Brearey's [2] 47/14	calculated [1] 196/25	216/18 217/17 217/22	72/5	chairman [9] 59/19
49/7	calendar [1] 5/4	can't [27] 2/17 8/11	catch [1] 138/23	64/4 145/9 145/12
Brearey [2] 100/3	call [15] 1/4 9/12	14/15 31/3 34/3 44/18	categories [2] 21/19	145/24 146/13 146/14
185/17	9/16 9/20 10/9 55/10	54/12 56/7 59/13	22/5	146/17 146/20
breast [1] 140/24	55/13 56/18 153/6	59/18 83/24 85/2	categorisation [1]	challenge [1] 101/20
bridging [1] 8/24	153/7 172/3 173/7	85/12 87/2 90/11	21/25	challenges [2] 92/23
brief [8] 6/1 6/2 31/19	187/17 196/21 200/9	99/11 107/11 107/14	categorise [1] 23/4	101/19
31/19 120/15 156/20	called [14] 26/1 56/1	115/18 129/13 149/6	category [2] 21/21	challenging [3] 35/5
156/24 179/25	56/16 56/16 57/12	155/18 155/22 167/25	23/7	35/16 35/18
briefed [4] 206/1	131/18 132/12 163/20	191/1 191/25 202/8	causation [2] 24/11	Chambers [42] 60/20
206/3 206/14 207/13	164/2 164/20 164/24	candidates [1] 93/2	25/3	60/25 61/1 61/3 62/15
briefing [2] 109/9	165/10 189/1 196/7	cannot [5] 155/10	cause [12] 21/1	92/10 93/5 114/23
206/4	calling [1] 58/25	177/4 201/20 204/14	25/24 26/5 26/14	118/7 119/3 119/19
briefly [4] 157/11	came [21] 10/3 49/5	214/10	29/17 32/19 32/19	120/19 120/23 121/3
165/19 178/4 178/6	71/19 91/11 100/5	capture [1] 116/4	34/24 35/12 160/1	125/11 125/24 134/6
Brigham [6] 23/25	108/20 109/21 110/2	cardiac [1] 80/8	180/15 181/7	135/5 135/12 136/2
24/3 24/7 24/10 38/23	123/25 124/4 138/4	care [62] 7/7 9/9	caused [7] 19/22	145/9 146/6 147/11
69/21	138/25 156/18 156/19	11/20 11/20 12/1 12/2	22/3 30/10 42/20	159/13 166/24 167/4
Brigham's [3] 24/14	157/2 157/5 170/11	13/18 14/8 15/14	50/20 58/10 130/20	167/9 167/21 168/11
25/18 40/8	184/8 189/2 217/23	16/20 16/23 16/24	causes [6] 13/14	169/1 174/6 176/12
bring [7] 97/14 99/8	218/1	17/2 17/2 17/4 17/5	29/20 45/3 52/8	176/17 177/21 181/10
111/1 111/17 117/1	cameras [1] 140/22	17/9 17/11 17/18 18/1	115/17 115/20	181/23 198/24 199/13
120/10 157/15	can [133] 1/5 1/12	18/2 18/18 21/5 21/9	causing [10] 13/6	207/6 207/19 208/17
Bristol [1] 84/6	1/22 3/6 4/11 4/17 8/6	24/16 25/1 25/19 26/9	42/25 44/17 49/21	211/5
British [1] 189/22	9/2 10/7 11/5 12/19	26/12 26/12 26/13	52/18 52/22 54/11	Chambers's [1]
broadly [1] 120/13	14/16 15/7 15/8 15/21	26/14 26/18 28/22	101/22 104/1 106/24	121/22
broken [2] 165/14	16/1 16/21 17/14 21/8	31/17 37/17 39/2	caveat [1] 115/24	champion [9] 138/2
180/6	22/25 23/7 23/12	40/15 40/18 49/8	CCTV [3] 140/14	138/4 138/6 138/8
brought [8] 67/20	22/25 23/7 23/12	82/16 82/19 82/19	140/19 140/22	138/11 139/5 139/6
68/12 73/24 111/6	23/14 24/8 25/17	83/2 83/2 95/21 96/7	centre [4] 93/1	139/7 139/9
149/23 151/12 155/25	26/21 26/25 28/9	96/12 96/20 96/21	120/22 146/16 147/12	championed [1]
157/10	30/25 36/14 40/5	97/16 119/6 123/1	CEO [3] 176/13	160/1
BROWN [4] 142/11	40/21 41/12 47/25	124/11 126/17 127/9	176/14 190/3	championing [1]
154/5 187/5 219/8	48/22 49/9 50/24 54/3	133/5 139/19 139/21	certain [9] 8/13 9/25	138/12
Browne [1] 142/6	59/8 61/8 64/11 64/15	140/9 142/21 214/19	19/12 20/14 20/14	chance [5] 62/22
bruise [1] 107/7	65/21 66/13 68/22	career [4] 78/5 84/4	31/4 33/10 164/18	110/9 111/15 123/4
brusque [1] 166/16	68/23 70/21 75/19	84/11 152/3	173/2	123/10
build [1] 38/19	76/9 77/3 82/25 85/19	careful [2] 59/3	certainly [41] 1/6	change [9] 29/20
building [2] 10/12	86/20 87/7 91/14	133/12	8/22 14/1 32/17 34/7	83/5 83/6 88/11 97/12
10/15	93/18 96/16 99/9	carefully [2] 135/19	36/23 36/24 40/15	98/9 149/4 150/10
bullied [2] 156/10	101/15 108/23 109/6	135/19	43/18 43/21 43/23	166/25
183/10	110/2 110/14 110/17	carried [4] 119/10	44/9 51/6 59/17 65/22	changed [12] 11/10
Bullock [7] 131/19	110/20 112/21 115/7	131/8 205/20 206/25	71/12 80/7 84/24 86/7	11/13 11/14 11/18
131/19 131/20 132/14	115/18 116/6 118/5	carry [3] 2/1 65/12	93/2 95/17 96/24	12/15 45/13 48/12
135/7 135/17 136/7	118/14 121/14 122/9	178/20	98/17 105/18 105/22	81/14 82/8 97/11
bundle [7] 144/6	123/21 126/24 127/2	carrying [1] 37/21	106/25 107/22 133/8	121/9 181/21
147/8 167/14 170/8	128/15 131/14 133/13	case [36] 8/15 8/23	136/1 140/18 141/2	changes [4] 12/5
171/9 171/22 173/13	138/23 141/12 142/8	13/3 14/2 14/10 14/11	143/18 157/20 166/25	12/10 83/12 139/23
burdensome [1]	144/1 144/5 145/23	17/24 18/15 18/15	167/7 168/1 168/11	changing [1] 63/5
82/23	146/12 147/18 153/22	19/20 23/15 23/25	169/22 184/20 215/20	channels [1] 210/4
	154/8 155/21 156/15	25/1 28/5 35/11 39/24	217/3	character [1] 139/18

C	6/14 11/2 11/16 13/17 21/5 21/9 49/8 82/17 97/15 97/18 97/21 98/2 98/18 138/2 138/3 138/6 138/8 138/11 138/12 138/17 139/6 139/10 141/1	190/22 191/12 194/10 217/1 217/2 clinician [1] 194/8 clinicians [4] 73/17 94/1 181/12 213/2 clinics [2] 5/5 100/21 close [7] 10/13 10/15 37/21 67/10 97/2 97/3 132/17 closely [3] 84/11 93/9 148/14 closer [2] 118/18 157/15 clustered [2] 114/24 114/25 co [1] 194/17 co-operative [1] 194/17 COCH [1] 213/5 coffee [1] 93/1 cold [3] 79/4 83/3 196/25 collaborative [1] 176/9 collapse [7] 30/11 79/23 81/10 81/17 82/11 105/1 129/13 collapsed [4] 10/2 105/6 131/2 131/3 collapses [7] 82/1 103/18 103/21 105/21 127/6 158/18 178/11 colleague [1] 106/23 colleagues [21] 44/13 96/9 109/13 109/22 134/9 134/10 144/2 148/1 161/10 162/7 171/5 171/20 183/22 188/22 194/5 194/16 203/4 212/18 213/25 217/7 217/8 collective [1] 150/7 collectively [1] 150/6 college [27] 1/17 1/19 65/2 65/15 65/18 65/24 67/23 70/14 90/16 104/9 106/3 115/11 119/16 122/13 122/17 124/5 127/12 138/7 138/10 142/20 156/18 157/12 163/12 206/1 206/7 206/7 207/21 columns [1] 117/15 combination [1] 105/20 combined [2] 47/12 47/13 come [40] 8/6 14/16 24/7 24/23 28/9 55/14 59/1 59/8 60/3 60/3 70/21 76/20 87/3 88/17 88/17 88/20 89/25 91/2 91/21	101/11 103/1 103/14 103/17 107/11 110/9 112/21 113/14 114/1 126/9 158/1 169/19 174/7 174/8 187/18 190/11 195/16 199/24 204/8 204/8 209/14 comes [3] 42/4 74/12 83/4 comfortable [1] 90/24 coming [9] 36/1 54/21 71/16 92/15 123/22 137/20 142/2 160/15 177/16 commend [1] 2/9 comment [13] 10/25 16/25 17/3 24/3 26/17 55/6 58/7 139/16 181/5 196/19 207/22 211/10 211/14 commented [2] 18/4 18/5 commenting [2] 16/24 123/10 comments [9] 18/14 28/13 60/12 123/8 181/6 185/9 185/16 185/19 196/24 commercial [1] 33/4 commissioned [4] 90/17 104/8 173/2 190/25 committed [5] 63/18 129/18 130/10 204/16 204/16 committee [52] 15/22 86/14 143/5 143/7 143/12 143/20 143/23 144/7 144/11 144/19 145/1 146/5 146/10 146/17 147/2 147/13 149/1 149/5 149/18 150/13 158/13 162/13 162/20 163/6 163/14 163/18 165/7 166/17 167/17 168/3 170/6 170/9 170/19 170/21 171/1 171/3 171/6 171/16 173/23 174/5 175/18 176/11 176/12 179/7 182/2 182/7 184/5 184/8 188/12 189/1 189/19 189/20 common [3] 49/17 84/25 141/6 communicated [2] 88/12 159/1 communicating [1] 159/6 communication [9] 9/13 18/21 36/24 37/8 144/2 151/5 166/15	172/7 172/11 communications [3] 36/3 36/21 120/5 compared [2] 167/1 208/3 compelling [1] 2/6 competent [2] 128/6 128/7 complaints [1] 188/21 complete [11] 5/12 45/25 47/11 48/24 48/25 49/1 49/2 54/12 78/4 182/3 200/24 completed [6] 14/7 22/10 48/11 48/14 81/6 88/5 completely [7] 15/25 39/25 45/13 195/23 196/11 201/6 201/19 compulsory [1] 7/1 computer [1] 16/4 conceived [1] 37/23 concern [39] 9/18 13/13 16/4 16/8 19/21 20/22 23/20 39/15 46/12 52/17 52/17 53/18 54/22 55/1 64/9 64/23 65/9 65/23 68/16 71/15 75/16 75/17 85/7 85/9 85/14 85/21 86/23 97/4 103/11 103/23 104/12 106/23 119/8 130/19 153/9 169/21 179/4 200/16 206/12 concerned [31] 1/24 10/19 20/19 27/14 37/7 39/14 39/21 44/6 55/3 56/11 86/11 95/19 105/23 107/15 121/4 125/5 125/13 133/10 136/12 158/16 174/17 174/18 180/2 181/3 188/2 202/22 204/19 205/24 206/6 206/13 210/10 concerning [2] 105/11 115/21 concerns [90] 6/16 10/4 10/24 12/4 15/13 18/23 18/24 19/24 20/11 32/6 33/12 37/12 38/5 42/10 44/16 44/25 54/25 68/12 69/3 69/7 69/9 70/19 71/6 72/12 79/11 82/18 86/25 87/7 91/8 91/12 92/8 95/15 108/1 119/9 124/22 129/1 136/14 136/15 137/5 137/7 140/22 140/23 144/1 154/17 155/24 158/2
----------	---	--	---	---

C				
<p>concerns... [44] 158/3 158/15 158/21 158/22 158/25 159/23 160/16 164/11 164/11 172/9 173/2 173/23 173/25 178/3 178/5 179/1 179/2 179/13 180/8 180/14 181/17 181/25 182/15 186/1 186/10 186/19 186/19 188/21 190/23 191/8 192/4 192/24 193/1 197/18 205/17 206/2 208/13 208/21 209/18 214/20 214/22 215/3 215/5 217/8</p> <p>concluded [4] 115/17 115/19 185/6 195/15</p> <p>concludes [1] 76/6</p> <p>concluding [2] 137/25 197/18</p> <p>conclusion [8] 119/4 172/25 182/25 183/8 185/11 186/14 204/8 204/9</p> <p>conclusions [1] 218/1</p> <p>condition [3] 29/19 43/15 82/15</p> <p>conditions [3] 188/20 188/23 201/11</p> <p>conducted [4] 40/5 40/16 69/23 78/22</p> <p>conducting [1] 133/12</p> <p>conferred [1] 1/19</p> <p>confidence [8] 75/15 174/5 174/9 181/23 182/5 208/25 209/24 212/7</p> <p>confidential [1] 93/17</p> <p>confidentiality [5] 86/12 174/16 174/17 175/11 179/10</p> <p>confidentially [1] 74/4</p> <p>confined [7] 26/11 44/1 44/12 50/16 50/16 84/3 84/12</p> <p>confirm [7] 1/22 16/1 23/12 77/3 188/1 200/19 207/8</p> <p>confirmation [1] 70/6</p> <p>confirmed [4] 5/8 61/21 111/24 207/18</p> <p>conflict [1] 200/18</p> <p>confronted [1] 54/23</p> <p>confusing [1] 157/1</p> <p>conscious [4] 13/3 113/22 113/23 178/18</p> <p>consent [6] 45/8</p>	<p>45/15 45/18 45/22 45/24 45/25</p> <p>consequences [3] 68/5 201/5 201/6</p> <p>consider [11] 21/1 46/13 72/15 106/15 120/3 161/3 161/11 162/22 164/7 186/6 191/10</p> <p>considerable [1] 129/22</p> <p>consideration [5] 43/19 122/4 183/4 211/2 212/17</p> <p>considered [18] 3/14 14/23 26/4 32/21 32/23 38/7 38/11 42/19 43/23 71/9 120/12 128/24 130/6 153/17 167/21 193/7 204/13 209/15</p> <p>considering [4] 53/5 72/17 109/7 130/4</p> <p>consistency [2] 22/4 22/4</p> <p>consistent [1] 34/10</p> <p>consists [1] 144/23</p> <p>Constable [1] 177/19</p> <p>construction [1] 130/13</p> <p>consultant [56] 3/3 3/9 3/12 7/9 9/10 9/12 9/17 9/20 9/23 10/8 68/15 72/1 77/18 77/21 87/14 89/8 89/8 96/9 100/5 100/6 100/12 104/18 107/2 107/3 109/22 110/10 122/5 123/15 125/23 126/16 128/4 131/22 131/25 133/3 133/25 134/9 134/10 136/16 136/20 137/10 142/23 143/2 143/19 144/23 172/14 177/12 182/4 188/4 190/24 193/5 198/16 203/4 208/19 212/17 213/6 217/7</p> <p>Consultants [45] 5/16 7/3 8/2 30/21 36/9 44/15 58/8 64/2 93/22 94/5 95/13 96/5 99/16 105/17 110/3 111/21 113/1 113/10 119/9 119/13 121/23 122/19 124/19 125/12 125/15 129/23 130/3 134/14 134/16 134/21 137/13 147/20 167/22 168/16 168/18 173/21 180/2 180/9 185/8 185/16 193/19 196/9 197/1 197/6 197/7</p> <p>Consultants' [2]</p>	<p>95/15 124/21</p> <p>contact [19] 11/24 53/17 67/17 75/1 75/3 75/8 131/18 132/3 132/5 132/23 138/19 138/23 139/2 155/14 164/9 174/21 186/7 186/8 210/14</p> <p>contactable [1] 75/11</p> <p>contacted [8] 88/16 132/11 155/12 162/24 164/5 164/7 164/16 164/17</p> <p>contacting [1] 177/17</p> <p>contain [1] 113/4</p> <p>contained [1] 115/12</p> <p>containing [1] 122/18</p> <p>contains [1] 123/7</p> <p>content [5] 48/2 67/15 117/7 123/18 200/12</p> <p>contentious [1] 52/5</p> <p>contents [3] 77/7 188/1 195/25</p> <p>context [1] 4/22</p> <p>continue [10] 21/24 62/6 62/10 78/12 90/4 126/13 171/4 172/24 178/22 214/19</p> <p>continued [1] 90/21</p> <p>continuing [2] 105/3 105/4</p> <p>contract [5] 3/9 3/13 3/14 3/15 3/21</p> <p>contrast [1] 15/7</p> <p>contributed [1] 24/21</p> <p>convened [1] 114/14</p> <p>convenient [3] 111/22 113/25 182/21</p> <p>convening [1] 83/17</p> <p>conversation [20] 9/19 20/9 32/12 37/1 46/14 61/3 92/13 106/4 106/12 106/15 109/17 132/8 135/23 155/4 155/21 169/6 190/5 190/7 200/3 209/20</p> <p>conversations [8] 10/9 10/10 18/22 42/8 43/7 44/14 71/23 109/20</p> <p>convicted [2] 61/15 107/19</p> <p>convinced [2] 11/8 210/2</p> <p>coping [1] 2/10</p> <p>copy [4] 70/7 112/16 154/10 207/8</p> <p>Coroner [22] 73/22 128/18 205/21 207/9</p>	<p>207/12 207/15 207/17 208/6 208/14 208/16 208/18 208/25 209/1 209/4 209/8 209/9 209/15 209/24 209/25 210/1 210/12 216/19</p> <p>Coroner's [2] 128/25 208/25</p> <p>Coroners [1] 74/6</p> <p>coronial [1] 130/17</p> <p>corporate [3] 147/8 151/16 207/11</p> <p>correct [41] 7/22 24/13 29/9 42/14 45/11 51/24 55/8 55/8 57/19 57/19 57/24 58/19 62/18 77/6 77/13 77/14 77/17 77/20 77/23 79/12 87/23 116/16 132/6 142/24 142/25 143/8 143/10 143/21 144/20 145/21 146/21 147/6 156/12 159/4 159/5 171/8 178/9 182/13 182/15 185/3 188/7</p> <p>correcting [1] 79/12</p> <p>correction [1] 41/22</p> <p>correctly [3] 101/10 101/18 193/25</p> <p>corridor [3] 10/9 113/7 200/14</p> <p>corridors [1] 98/14</p> <p>cost [2] 11/12 194/14</p> <p>cot [1] 141/11</p> <p>cots [3] 39/10 39/17 40/3</p> <p>could [76] 2/1 6/25 7/18 7/19 10/21 13/24 16/11 16/19 17/11 21/12 24/21 26/13 32/24 34/20 37/16 39/25 49/20 51/23 52/20 55/13 57/8 61/24 65/20 69/4 72/9 74/4 74/18 75/19 76/25 79/16 81/7 95/13 95/15 95/17 96/7 98/25 104/25 112/14 115/13 117/11 123/2 125/22 127/24 131/10 133/11 142/12 147/7 149/15 151/9 151/19 154/2 156/5 156/13 158/12 162/16 165/25 166/3 166/19 167/13 167/17 168/6 170/5 170/7 173/1 173/25 180/19 184/16 185/22 199/8 202/13 203/2 204/16 209/15 210/2 211/8 216/7</p> <p>couldn't [15] 28/19 40/1 52/16 61/23</p>	<p>65/19 65/24 73/18 104/18 105/5 131/17 133/20 164/21 170/23 176/7 192/14</p> <p>Council [1] 193/15</p> <p>Countess [26] 39/4 77/25 78/6 78/18 79/22 80/11 81/2 81/18 85/5 85/11 87/19 87/25 88/7 88/10 88/24 94/20 142/23 143/2 143/6 143/16 148/16 174/23 188/5 188/10 207/12 217/12</p> <p>country [1] 68/1</p> <p>counts [1] 175/7</p> <p>couple [1] 69/12</p> <p>courageous [1] 203/6</p> <p>course [13] 2/2 18/19 58/5 63/15 95/14 145/13 145/24 158/1 200/2 203/11 204/10 204/25 209/13</p> <p>court [1] 175/1</p> <p>cover [5] 125/20 126/3 126/12 126/15 126/16</p> <p>covering [1] 6/20</p> <p>Covid [1] 101/23</p> <p>created [4] 26/2 81/4 82/11 184/11</p> <p>Crewe [16] 77/22 80/1 80/13 80/24 82/9 83/20 87/10 87/11 89/25 91/22 94/22 95/2 104/18 129/13 131/21 132/21</p> <p>crime [3] 67/12 129/18 130/10</p> <p>crimes [1] 204/15</p> <p>criminal [1] 30/6</p> <p>crisis [1] 154/15</p> <p>critical [1] 142/21</p> <p>criticised [1] 65/22</p> <p>criticism [1] 206/8</p> <p>criticisms [1] 122/18</p> <p>cross [7] 62/17 65/16 66/10 66/13 66/18 121/18 216/25</p> <p>Cross's [1] 63/4</p> <p>cross-reference [1] 216/25</p> <p>CTG [1] 25/17</p> <p>culture [2] 183/21 212/24</p> <p>curiosity [1] 18/7</p> <p>curious [2] 19/10 20/19</p> <p>current [4] 126/8 143/1 180/7 190/18</p>

D	49/23 50/2 75/10 78/25 79/23 79/25 81/11 81/16 82/12 83/13 83/14 83/25 84/18 84/20 84/24 177/14 177/17 180/16 181/7 196/24	deep [1] 200/16 defend [1] 214/6 defending [2] 201/11 201/12 defer [2] 33/3 33/7 define [1] 147/2 definitely [5] 13/8 21/23 45/24 56/3 60/19 definition [1] 204/15 degree [3] 1/16 32/17 116/17 delay [4] 130/18 130/19 130/20 131/12 deliberate [5] 32/24 42/25 106/24 108/18 108/18 deliberately [9] 44/16 49/21 69/4 69/4 85/8 104/1 104/13 105/25 116/2 delicate [1] 175/2 deliver [2] 39/8 39/9 delivered [5] 18/3 24/17 38/9 43/14 116/7 deliveries [1] 73/11 delivering [1] 39/15 delivery [6] 17/1 17/7 26/15 29/4 30/18 39/3 demanded [1] 209/3 demanding [2] 177/13 197/21 demonstrate [1] 171/19 denied [3] 193/9 196/11 200/20 department [35] 55/16 78/6 81/20 90/3 91/20 94/4 94/8 94/23 94/24 96/23 99/22 99/22 102/17 104/5 110/11 110/13 122/19 123/8 123/15 133/25 136/4 136/6 148/21 158/22 159/2 159/17 159/20 159/22 161/21 169/23 182/3 183/16 186/3 189/18 217/12 departments [4] 11/19 61/20 174/1 183/10 departure [1] 144/18 depend [1] 80/1 depended [1] 126/8 depending [2] 49/4 68/9 depends [1] 86/22 Deputy [1] 177/19 Deputy Chief [1] 177/19 derogatory [4] 58/17 196/12 196/18 197/25 describe [4] 23/1	88/20 95/23 197/10 described [8] 8/8 9/22 22/5 28/22 43/8 105/9 105/14 129/14 describing [5] 104/24 105/7 121/7 197/16 202/25 description [2] 23/1 192/5 designated [4] 87/6 153/1 153/18 186/4 designation [1] 88/11 desk [1] 76/20 despite [1] 123/14 detail [11] 42/5 83/3 86/16 91/8 91/12 95/9 152/9 178/1 190/15 203/20 211/18 detailed [9] 49/5 69/18 131/9 192/4 205/14 206/21 206/21 206/22 209/3 details [6] 14/1 161/7 161/8 196/17 205/25 207/16 detect [1] 92/7 Detective [3] 172/1 172/20 175/12 Detective Inspector [1] 172/1 Detective Inspector Hughes [1] 175/12 deteriorate [2] 105/3 105/4 deteriorated [2] 93/23 104/20 deterioration [1] 82/15 deteriorations [3] 50/13 69/11 72/7 determined [1] 144/25 devastated [2] 51/21 54/18 developed [1] 199/4 development [2] 101/6 102/13 developments [1] 88/16 devoiding [1] 44/2 devote [1] 126/20 dialogue [1] 164/19 dictatorial [1] 197/21 did [165] 1/15 6/23 6/25 10/22 13/4 13/21 16/10 16/15 20/21 27/22 27/25 28/16 34/1 34/4 39/1 39/3 40/17 40/20 41/14 42/2 42/6 42/10 44/8 45/21 47/3 47/15 49/16 50/11 50/12 50/25 51/2 52/22 56/6	57/5 58/20 59/8 59/9 61/3 66/24 67/11 68/3 70/3 70/3 70/23 71/6 75/13 77/10 77/18 77/21 77/24 78/2 78/3 78/5 78/8 78/12 80/1 80/12 80/24 81/1 81/19 83/20 88/3 88/8 89/2 89/5 90/5 91/15 92/16 96/18 97/4 97/12 105/15 105/16 106/15 106/17 109/25 112/23 114/15 118/6 118/8 119/19 121/19 122/16 123/5 124/18 125/7 126/25 127/3 129/25 130/18 132/7 132/14 133/14 135/3 135/7 136/7 145/1 149/4 149/4 149/21 150/4 150/9 154/24 155/22 157/7 159/12 159/16 160/2 160/16 161/2 161/3 161/11 162/1 162/22 163/4 163/8 163/16 163/17 163/24 164/7 166/11 167/4 169/15 169/25 174/21 177/2 177/2 177/3 178/7 179/15 182/22 186/20 189/12 191/7 192/8 192/11 194/21 194/24 195/8 195/8 195/22 196/9 197/14 198/2 198/13 198/20 199/6 199/7 200/1 202/17 202/19 202/20 202/23 203/16 203/16 203/23 206/10 208/15 209/16 209/23 214/17 217/2 217/8 217/16 217/25 didn't [86] 17/2 20/23 21/1 26/9 30/7 42/6 46/4 46/20 47/7 47/15 48/16 53/15 54/18 54/25 55/3 55/4 55/5 55/6 55/20 55/22 55/23 55/24 56/18 56/18 57/8 57/19 58/22 58/22 58/25 59/1 59/4 59/4 60/7 62/21 65/6 65/15 67/18 72/20 73/8 79/9 79/24 83/7 91/15 92/6 93/15 96/10 102/4 102/11 120/17 125/7 127/13 127/25 128/7 132/11 149/18 149/19 150/15 150/15 150/16 151/6 161/13 162/25 163/11 167/8 169/4 170/4 170/21 173/24 174/7 175/3 175/24
----------	--	--	--	--

D	211/25 212/1 212/6 212/8 212/13 212/15 212/16 213/15 213/17 Director's [2] 176/3 216/24 directorate [8] 6/14 11/15 11/17 12/8 97/15 97/18 97/19 101/17 directorates [1] 11/19 directors [6] 123/24 147/9 151/16 183/21 190/4 213/23 disadvantages [1] 130/17 disagreed [2] 120/18 178/12 disappointing [2] 61/17 61/18 disastrous [2] 194/7 203/7 disbelief [4] 37/20 165/19 166/12 178/17 disciplinary [4] 15/11 47/1 110/25 111/17 disclosed [1] 56/14 discovered [2] 36/25 94/7 discuss [27] 29/3 29/5 29/7 29/23 31/16 31/18 32/2 32/22 33/8 38/5 62/3 63/13 70/23 79/4 110/10 112/13 112/22 155/22 170/4 172/5 190/12 200/1 202/17 202/19 202/23 209/17 209/23 discussed [44] 15/15 17/24 19/5 19/14 19/18 19/25 20/4 27/19 27/20 30/13 30/19 30/21 31/4 31/13 32/2 33/11 41/17 54/19 59/14 62/20 63/7 69/12 70/9 71/4 72/14 72/22 73/6 85/23 86/4 86/5 86/17 92/19 93/3 127/22 138/13 144/1 147/16 147/19 157/4 162/3 169/21 179/4 184/5 210/23 discussing [13] 10/20 30/3 30/22 36/6 36/21 46/16 58/9 64/6 85/17 85/21 93/10 171/23 175/2 discussion [33] 7/13 13/2 13/4 18/11 31/15 32/17 33/14 33/14 34/7 36/18 42/16 43/25 44/5 44/5 44/12 47/17 71/11 74/3	74/23 75/21 106/11 109/12 112/11 112/25 113/8 125/16 130/1 145/14 175/13 175/22 179/14 182/11 184/11 discussions [15] 8/12 9/9 11/3 41/14 41/21 42/1 42/10 43/7 44/3 125/12 131/4 155/20 179/8 179/11 184/6 disease [1] 20/20 disengagement [1] 170/18 disentangle [1] 91/14 dismissive [1] 209/10 dispersed [1] 114/19 displayed [1] 179/18 disputes [1] 188/23 disruptive [1] 67/9 dissertation [1] 196/2 distension [1] 28/14 distortion [1] 121/6 distress [1] 58/11 distribution [1] 139/24 district [1] 141/2 distrust [1] 213/6 disturbed [2] 201/1 203/17 disturbing [2] 203/24 205/5 divided [1] 96/25 division [11] 11/2 14/10 97/16 97/17 97/19 97/21 98/2 98/5 98/19 101/13 102/6 divisional [5] 12/1 96/18 97/5 97/11 98/5 divisions [2] 96/14 97/22 do [115] 1/25 2/18 2/20 3/23 4/2 11/5 11/13 14/19 16/9 18/9 19/24 21/11 21/22 22/4 23/22 23/22 29/24 32/12 34/22 36/20 47/4 47/18 47/18 48/25 52/8 55/11 59/5 59/9 59/13 59/23 61/13 62/10 64/9 64/17 64/18 65/9 65/15 65/18 66/2 69/25 70/3 70/19 72/25 73/1 73/4 74/25 75/10 79/9 82/22 92/20 93/11 93/11 99/6 99/11 99/14 99/17 100/20 100/22 102/10 102/11 104/20 108/5 108/7 111/6 115/24 118/13 120/13	121/18 122/6 139/20 139/25 140/20 142/10 144/13 148/3 151/10 156/10 158/12 161/2 162/6 162/25 164/23 165/6 169/7 178/24 180/21 186/6 191/16 193/24 194/16 195/19 195/21 196/7 197/9 199/14 199/15 200/23 201/3 201/18 201/21 208/23 210/2 210/4 211/6 211/18 211/20 212/4 212/14 213/24 214/22 217/2 217/4 217/16 217/17 217/19 doctor [10] 8/14 24/5 77/10 80/16 84/7 125/19 126/3 153/2 153/18 202/8 doctors [27] 6/17 8/19 30/21 32/5 41/14 49/1 79/2 89/24 91/22 96/11 114/20 117/12 128/7 144/24 144/25 145/2 145/3 145/4 145/5 172/22 172/22 176/15 179/15 185/19 188/17 188/19 202/18 document [33] 6/7 15/8 26/22 27/6 28/9 46/2 56/21 56/22 70/21 116/23 117/1 117/18 117/21 118/2 118/3 123/21 144/16 144/21 146/9 147/14 154/3 156/1 157/16 167/14 168/7 169/19 170/24 171/10 172/19 175/10 185/1 199/23 207/24 documentation [2] 15/10 42/9 documented [3] 56/1 61/9 152/20 documents [7] 22/1 56/25 63/19 144/9 173/11 180/19 184/24 does [19] 26/25 37/22 63/20 72/16 76/2 82/12 87/4 92/6 97/24 105/11 116/4 117/18 122/25 151/23 153/16 153/19 153/21 156/25 218/5 doesn't [7] 6/23 14/2 22/3 25/23 34/23 105/15 141/14 doing [24] 43/5 60/17 64/21 85/8 91/14 96/12 100/20 101/1 101/2 101/4 101/4 102/12 102/21 102/23 116/6 130/4 136/4	156/14 160/19 161/13 191/17 201/14 203/8 204/7 don't [105] 2/21 6/4 7/5 12/3 12/14 19/7 19/20 22/6 22/17 28/8 30/1 31/14 31/14 32/2 32/7 32/7 32/10 32/13 32/14 32/15 33/3 34/21 35/1 37/1 39/22 39/22 41/10 41/11 43/9 47/16 47/16 47/17 49/24 54/14 60/6 60/12 60/21 65/14 65/17 69/25 71/8 71/13 75/2 80/5 80/15 80/21 80/22 81/9 83/10 87/4 90/8 90/8 90/12 92/19 92/25 93/3 93/9 93/14 94/17 95/11 96/22 101/3 106/9 106/14 107/16 107/24 108/19 109/16 109/19 111/1 111/17 111/19 113/5 115/5 115/19 115/24 117/17 117/17 118/23 121/25 122/2 122/7 128/17 130/8 130/9 138/7 139/24 140/17 145/5 146/6 165/1 166/16 170/2 176/21 178/19 180/22 182/24 194/1 196/20 199/17 202/15 203/20 215/11 215/12 217/21 done [27] 8/3 8/5 16/13 26/11 33/11 33/25 40/19 40/20 65/21 95/17 101/18 152/2 159/20 163/2 165/7 168/10 190/20 192/8 192/17 192/19 199/2 203/4 204/24 205/4 205/21 211/3 216/5 doppler [1] 34/12 doubt [3] 18/12 200/8 203/25 down [45] 8/6 14/16 17/14 17/24 20/12 23/7 24/8 28/9 36/8 40/21 48/23 50/24 55/18 56/21 59/8 59/25 68/22 70/22 76/22 109/6 109/7 118/5 123/21 126/2 126/16 131/15 133/11 134/1 142/10 145/6 146/9 158/21 165/2 165/14 169/19 176/17 177/12 177/16 180/6 181/6 199/24 203/21 207/4 208/5 209/14
----------	--	--	--	--

D	181/22 182/18 182/23 185/17 185/18 185/18 185/22 186/6 187/3 187/6 187/17 187/20 187/22 189/19 189/24 193/11 196/16 199/25 200/14 200/15 202/7 202/20 203/19 203/21 206/15 207/6 207/14 207/20 207/21 208/5 208/8 209/13 209/21 215/9 216/18 218/4 218/7 219/3 219/5 219/7 219/9	110/8 120/17 122/3 122/4 125/10 125/16 134/16 135/3 136/10 155/12 156/4 156/5 156/6 156/24 160/23 178/8 180/11 180/17 182/18 182/23 185/18 196/16 199/25 200/14 202/20 203/19 203/21 207/6 208/5 209/21	due [8] 18/19 104/11 161/6 161/15 209/13 210/18 211/2 212/16 Duncan [15] 145/10 163/23 164/8 164/10 164/15 164/19 164/24 165/5 173/6 173/16 174/11 175/19 176/11 183/20 184/20 Duncan Nichol [1] 164/24 during [9] 17/9 21/3 25/16 58/5 58/7 101/2 103/22 121/22 212/11 duty [1] 105/22 dying [2] 105/4 159/1 dysfunctioning [1] 92/9	Eirian Powell [4] 52/14 53/15 55/2 55/4 either [6] 45/19 47/18 78/23 92/16 152/17 206/14 elderly [1] 34/20 elected [2] 143/8 188/17 election [1] 143/14 elective [1] 10/4 electronic [1] 101/24 elects [2] 143/11 143/11 element [5] 15/14 16/23 25/19 31/17 213/6 elements [1] 31/19 else [12] 2/22 11/12 43/20 44/16 54/20 76/4 79/17 97/8 107/7 111/10 135/6 178/16 elsewhere [3] 15/18 39/20 71/20 email [33] 48/3 48/13 48/17 104/23 110/1 110/5 111/5 111/11 111/16 111/19 111/20 111/23 111/25 112/2 112/2 125/7 125/22 126/2 126/18 126/24 127/2 131/16 132/22 133/14 133/15 133/21 133/24 171/24 172/2 172/19 173/5 174/15 208/9 emails [2] 48/1 171/22 embolisms [1] 103/15 emotions [1] 199/1 emotive [1] 116/24 empathised [1] 32/18 emphasised [1] 74/8 emphasising [1] 175/11 employed [5] 3/10 188/19 189/21 216/2 217/19 employment [1] 201/13 enables [1] 144/2 enacted [1] 195/14 encountered [2] 85/6 85/10 encourage [3] 39/20 46/13 210/3 encouraging [1] 194/16 end [18] 48/11 66/19 67/14 79/25 82/12 94/18 114/22 114/23 119/21 119/23 120/21 133/9 135/9 153/25
downgrade [2] 36/5 62/19 downgraded [2] 90/7 90/17 downgrading [2] 53/5 88/1 downstairs [1] 10/18 DP [1] 23/17 Dr [213] 1/5 1/8 1/9 1/12 1/21 2/12 5/8 5/21 6/8 6/23 6/24 8/1 8/14 9/14 13/11 13/12 13/25 16/5 16/21 18/25 20/18 21/24 23/25 24/3 24/14 24/24 25/18 26/19 27/15 27/24 27/25 28/8 30/3 31/8 32/5 33/16 33/22 33/23 35/5 35/17 40/8 41/10 42/4 42/21 44/15 44/18 46/25 47/14 49/7 50/10 52/12 52/13 52/13 52/14 53/16 54/8 54/13 55/5 56/3 61/13 62/5 62/10 62/14 62/14 62/15 63/14 66/4 67/21 67/21 70/18 71/18 71/19 75/25 76/5 76/17 76/19 76/21 76/22 77/3 78/10 78/16 88/15 88/23 89/2 89/6 89/13 89/18 90/5 90/9 91/11 92/22 93/13 96/25 100/3 101/1 103/7 106/12 109/10 110/8 111/4 113/18 113/24 114/3 114/12 117/18 120/17 122/3 122/4 125/10 125/10 125/16 125/17 133/23 134/16 134/16 135/3 135/3 136/10 136/10 141/21 141/24 142/1 142/9 142/10 142/13 142/18 143/1 144/8 145/17 146/22 151/20 152/22 153/19 155/12 155/18 156/4 156/5 156/6 156/7 156/23 156/24 157/24 159/11 160/23 160/24 164/14 165/6 169/9 173/11 173/16 174/11 175/19 175/25 176/23 177/1 178/8 178/8 178/21 179/12 179/16 180/1 180/5 180/7 180/10 180/11 180/17 181/1 181/3 181/8 181/9 181/16 181/18	181/22 182/18 182/23 185/17 185/18 185/18 185/22 186/6 187/3 187/6 187/17 187/20 187/22 189/19 189/24 193/11 196/16 199/25 200/14 200/15 202/7 202/20 203/19 203/21 206/15 207/6 207/14 207/20 207/21 208/5 208/8 209/13 209/21 215/9 216/18 218/4 218/7 219/3 219/5 219/7 219/9 Dr Brearey [42] 5/8 5/21 6/8 6/24 8/1 8/14 9/14 13/11 16/5 18/25 27/24 44/15 44/18 46/25 50/10 52/13 52/14 53/16 54/8 54/13 55/5 56/3 67/21 71/19 101/1 125/10 125/17 133/23 134/16 135/3 136/10 156/7 156/23 160/24 178/8 180/10 181/3 181/8 181/9 181/16 200/15 215/9 Dr Brearey's [2] 47/14 49/7 Dr Brearley [2] 100/3 185/17 Dr Brigham [2] 23/25 24/3 Dr Brigham's [2] 24/14 25/18 Dr David Semple [1] 113/18 Dr Davies [1] 27/25 Dr Gibbs [9] 20/18 31/8 33/16 33/22 33/23 52/12 176/23 177/1 179/16 Dr Gilby [2] 173/16 174/11 Dr Hawdon [2] 206/15 207/21 Dr Holt [1] 181/18 Dr Jameson [23] 142/10 142/18 143/1 144/8 145/17 146/22 151/20 152/22 157/24 159/11 164/14 165/6 169/9 173/11 178/21 179/12 181/1 181/22 185/22 186/6 187/3 187/6 189/19 Dr Jayaram [50] 13/12 52/13 62/14 67/21 71/18 78/10 88/15 88/23 89/2 89/6 89/13 89/18 90/5 90/9 91/11 92/22 93/13 103/7 106/12 109/10	Dr Jayaram's [1] 207/20 DR JIM McCORMACK [2] 1/8 219/3 Dr Lambie [1] 42/21 Dr McCormack [29] 1/5 1/9 1/12 1/21 2/12 6/23 13/25 16/21 21/24 24/24 26/19 27/15 28/8 30/3 32/5 35/5 35/17 41/10 42/4 61/13 62/5 62/10 62/14 63/14 66/4 70/18 75/25 76/5 96/25 Dr McGuigan [12] 76/17 76/19 76/22 77/3 78/16 111/4 114/3 114/12 117/18 141/21 141/24 142/1 Dr McGuigan's [1] 113/24 DR MICHAEL MCGUIGAN [2] 76/21 219/5 Dr Mittal [1] 153/19 Dr Saladi [1] 180/1 Dr Sarah [1] 40/8 Dr Susan [2] 175/19 175/25 Dr Tighe [11] 155/18 187/17 187/22 189/24 193/11 207/14 208/8 209/13 216/18 218/4 218/7 Dr V [1] 185/18 Dr ZA [3] 180/5 180/7 202/7 drafted [2] 144/9 144/12 dragged [1] 133/11 draw [6] 120/24 121/11 186/14 197/23 204/14 205/1 drawing [1] 121/17 drawn [2] 88/6 127/16 drive [1] 6/14 driven [3] 11/12 212/12 212/14 drops [1] 2/17 drug [1] 81/8 drugs [1] 207/2	each [14] 5/4 5/10 6/16 9/24 10/10 10/13 19/13 89/22 94/5 101/24 132/18 152/11 179/25 182/13 earlier [18] 18/25 41/22 47/24 69/1 70/23 73/1 73/2 156/16 157/4 157/8 157/12 158/2 163/20 169/6 174/21 196/5 198/10 215/13 earliest [4] 43/12 91/6 110/17 118/17 early [15] 51/16 51/25 52/2 52/3 52/15 80/12 81/19 88/1 95/14 154/1 155/19 166/1 184/6 190/1 215/4 earth [1] 158/12 easier [2] 98/20 151/5 easily [2] 74/3 74/19 easy [9] 69/6 73/7 98/12 98/16 126/12 126/13 137/9 137/15 186/14 echo [3] 199/10 199/11 218/7 educated [1] 68/8 education [3] 74/9 74/17 93/1 educational [1] 74/12 effect [7] 16/19 78/9 162/18 179/16 194/9 212/11 212/12 effectively [4] 20/21 101/1 126/2 134/19 efficient [1] 112/19 effort [1] 80/2 eight [2] 40/25 64/2 Eirian [4] 52/14 53/15 55/2 55/4	

E	84/25 116/12 148/12 150/24 events [28] 2/11 5/13 5/25 7/14 28/20 30/18 43/2 58/9 73/5 79/5 82/5 87/20 90/6 94/16 99/12 99/19 118/18 119/2 128/9 129/14 130/23 132/10 145/22 168/9 177/3 177/6 177/16 181/21 ever [8] 15/1 32/23 39/3 47/16 80/15 85/5 108/8 145/5 every [9] 37/19 81/11 126/10 146/10 153/15 184/22 193/9 207/1 217/6 everybody [11] 52/25 64/1 66/16 71/13 111/5 111/9 112/7 114/18 114/19 115/4 178/16 everyone [4] 43/20 51/20 54/18 154/7 everyone's [1] 152/11 everything [3] 50/1 107/7 204/24 everywhere [3] 66/20 66/23 67/9 evidence [32] 2/7 2/13 13/10 13/11 16/14 20/24 27/8 30/5 42/2 50/3 55/2 75/18 76/6 83/24 84/16 87/24 103/14 113/17 113/24 115/16 116/1 142/2 156/14 185/1 185/8 190/20 193/17 194/12 202/9 203/15 209/12 217/18 evidenced [1] 69/10 evolving [1] 93/16 exact [6] 3/8 8/12 53/25 115/24 164/18 211/13 exactly [14] 6/3 13/8 49/6 59/7 68/5 75/5 75/11 117/3 126/8 130/25 149/6 158/23 191/25 196/18 examination [6] 29/19 45/6 45/17 45/19 45/25 205/19 examinations [1] 45/14 examine [1] 34/24 examiners [3] 73/20 73/24 74/15 examining [1] 25/2 example [10] 12/19 23/7 79/8 81/7 81/9 83/24 100/23 103/12	107/6 147/15 excellent [10] 9/22 15/10 15/11 15/12 17/18 18/21 43/14 96/8 188/24 189/8 except [1] 67/22 exception [1] 5/23 exclude [1] 124/14 excluded [3] 154/23 158/9 186/24 exclusively [1] 77/15 excuse [1] 136/3 exec [6] 64/3 120/6 135/14 135/14 145/24 147/4 execs [10] 52/1 75/14 93/22 98/6 113/9 125/14 135/1 139/14 139/14 161/6 executive [44] 53/8 63/11 64/3 94/12 95/3 123/24 131/20 132/17 135/13 138/16 139/8 139/8 145/8 145/12 160/3 162/25 167/1 167/5 177/20 178/10 180/6 182/5 183/21 188/21 188/25 189/9 189/12 189/16 194/18 197/20 201/4 206/3 207/6 208/20 210/12 211/15 212/2 212/5 212/10 213/15 213/23 214/3 214/13 215/9 Executive's [2] 149/14 211/22 executives [10] 13/13 63/12 63/15 71/21 74/22 132/18 180/4 189/6 189/17 211/24 exercise [1] 7/11 existed [1] 18/21 existence [1] 75/8 existing [1] 87/11 expand [7] 11/5 146/23 148/3 165/19 168/25 176/4 213/12 expanded [1] 178/12 expansion [1] 148/21 expect [9] 112/13 112/15 112/19 123/7 123/15 123/16 182/12 198/13 198/15 expectation [5] 7/7 82/1 102/2 124/18 139/4 expectations [1] 3/18 expected [13] 6/6 36/23 37/15 41/1 49/13 51/22 102/3 119/13 123/18 125/3 169/15 185/10 198/14	expecting [7] 55/14 55/17 60/2 111/3 112/10 124/1 132/9 experience [15] 3/3 9/5 34/16 46/22 63/17 63/21 73/23 85/4 87/19 94/22 95/2 112/12 137/16 169/13 183/3 experienced [5] 80/13 81/21 82/9 116/20 117/23 experiences [3] 2/6 116/19 169/11 expert [1] 216/2 expertise [13] 8/25 14/11 14/18 26/17 30/24 32/15 33/7 65/2 67/24 71/3 74/2 96/3 123/17 experts [7] 33/3 165/20 212/18 212/21 216/1 217/10 217/14 explain [8] 15/21 20/16 20/17 29/3 58/12 103/7 122/24 182/8 explained [7] 103/16 104/2 115/12 124/8 127/14 128/1 164/11 explanation [9] 79/20 82/13 117/23 128/8 149/24 151/6 157/24 192/4 206/5 explanations [1] 218/2 explicable [1] 178/11 explicit [1] 45/15 explore [3] 174/2 195/25 196/1 express [3] 35/4 37/20 200/15 expressed [7] 52/21 69/7 136/15 159/17 190/24 192/5 211/14 expressing [2] 2/7 140/25 expressions [1] 183/3 extend [1] 154/24 extensive [1] 46/2 extent [3] 36/22 62/1 180/6 external [17] 14/9 14/13 14/21 14/23 14/25 15/17 41/5 53/6 64/21 104/9 115/14 115/22 119/7 124/12 163/4 208/1 212/20 extraordinarily [2] 203/6 214/9 extraordinary [9] 146/14 171/19 172/4 173/7 173/12 183/5	183/6 183/7 183/15 extremely [12] 19/6 61/17 61/18 74/18 87/6 105/11 129/15 197/12 201/1 203/24 209/10 210/22
			F	
			faced [1] 101/19 Facere [2] 104/16 154/12 Facere Melius [2] 104/16 154/12 facilitate [4] 55/16 74/3 165/5 183/2 facing [3] 92/23 101/20 132/19 fact [37] 4/19 12/2 16/13 23/25 24/14 26/1 27/7 34/22 38/10 40/17 40/19 59/6 67/4 86/17 86/21 87/20 96/19 131/15 144/9 153/18 157/10 160/14 165/6 165/16 170/20 174/7 176/24 177/7 178/10 180/1 181/20 185/15 189/17 197/14 202/14 203/5 207/22 factored [1] 50/8 factors [2] 51/5 80/3 facts [1] 90/15 factually [1] 197/16 failed [1] 184/21 failings [2] 122/23 124/7 failure [2] 19/15 30/11 fair [6] 65/15 65/17 86/10 121/2 121/7 144/15 fairly [10] 46/18 46/22 63/2 63/7 64/5 80/19 120/15 146/1 148/14 197/15 fairness [1] 145/4 faith [1] 162/7 fallen [1] 124/25 falls [1] 24/13 false [1] 26/3 familiar [7] 3/12 11/11 87/17 102/19 152/4 152/7 152/13 familiarise [1] 117/6 families [6] 174/19 174/24 175/3 179/9 180/15 210/20 family [3] 2/5 141/4 175/3 famous [1] 112/18 far [20] 1/23 14/2 20/18 27/14 50/19 54/3 55/3 74/9 92/11 96/7 106/9 121/3	

F	few [14] 13/23 64/14 79/4 80/22 83/7 83/13 91/4 93/8 119/17 132/23 136/17 164/5 170/5 181/12	floor [3] 10/16 10/16 182/14	free [5] 76/7 138/19 142/3 187/11 218/12	168/18 189/2
far... [8] 136/11 150/8 155/11 179/12 188/2 210/10 213/25 214/1	filed [2] 53/12 53/12	focus [1] 16/22	freedom [3] 137/6 199/18 200/24	generic [1] 107/23
fashion [1] 34/22	final [5] 60/13 125/15 183/18 184/23 197/22	focused [3] 11/3 40/14 40/18	frequent [3] 38/3 105/7 141/7	genuine [1] 75/16
father [2] 193/18 193/24	finally [8] 35/23 78/4 85/4 101/11 129/17 140/13 181/18 185/22	Fogarty [1] 62/15	freely [3] 29/13 38/1 39/7	genuinely [1] 165/25
fear [2] 113/11 159/10	financial [2] 11/14 12/9	fold [1] 79/7	fresh [1] 91/20	geography [1] 84/2
fearful [2] 158/10 159/9	find [15] 14/6 32/11 33/5 33/17 36/25 48/12 49/9 70/11 80/12 81/19 110/2 111/25 112/6 211/12 216/18	follow [4] 83/20 87/4 92/6 173/5	Friday [4] 131/1 200/6 200/10 209/22	George [1] 34/4
feature [1] 20/2	finding [6] 13/25 33/25 68/24 99/17 132/25 211/12	following [15] 2/11 5/20 90/22 125/23 131/4 132/12 168/6 177/14 182/1 182/12 199/20 202/2 202/5 202/20 207/9	friend [1] 135/12	George Kokai [1] 34/4
features [5] 19/13 20/10 42/13 50/11 103/11	findings [2] 57/1 207/23	forceful [1] 187/1	friendly [2] 132/2 132/24	gestation [1] 43/16
February [21] 47/2 49/7 50/21 154/1 154/14 155/13 155/13 156/15 157/13 157/22 158/1 158/24 164/4 179/11 207/12 207/18 207/20 214/21 215/7 215/13 215/20	finished [4] 53/3 53/10 59/25 123/23	forcefully [3] 66/16 66/17 148/2	frightened [1] 194/5	gestures [1] 2/23
February 2016 [1] 49/7	firm [1] 190/20	forensic [11] 50/1 50/7 65/15 65/16 205/14 205/18 206/21 206/22 208/22 209/3 209/3	front [2] 53/11 122/23	get [27] 33/8 33/24 40/3 55/10 57/5 61/8 67/2 75/5 99/8 123/5 124/2 126/2 126/12 127/24 130/12 138/21 139/2 139/25 140/11 150/20 162/13 163/14 179/8 202/12 202/13 210/19 218/10
February 2017 [2] 158/1 158/24	firmly [3] 169/16 200/19 200/20	forensically [2] 7/19 25/2	frustrated [3] 158/19 159/7 159/8	gets [1] 130/23
fed [1] 134/8	first [59] 13/24 53/12 53/18 53/23 58/13 62/23 62/25 68/17 79/7 80/22 89/6 91/4 91/5 91/10 95/4 103/1 103/6 104/25 106/4 106/12 106/15 112/16 120/7 120/20 122/3 122/12 132/3 138/14 153/5 153/24 153/24 154/2 154/16 156/3 156/4 157/5 157/19 159/16 164/1 164/4 164/21 166/3 170/7 170/10 171/25 176/14 176/16 178/1 179/5 183/19 187/23 189/24 190/14 193/2 195/10 197/12 209/24 210/1 216/24	foresight [1] 172/24	frustration [1] 159/10	getting [2] 90/20 101/18
feedback [3] 55/6 79/14 115/20	format [1] 173/3	forget [4] 6/4 54/14 71/13 203/20	full [16] 37/15 40/1 76/25 84/17 100/21 101/3 105/18 105/19 142/12 152/12 158/8 163/11 205/18 205/25 206/25 208/22	Gibbs [12] 10/18 20/18 31/5 31/8 31/15 33/16 33/22 33/23 52/12 176/23 177/1 179/16
feeding [2] 21/20 140/24	formally [2] 10/25 215/9	forgive [1] 117/10	fully [3] 107/25 164/13 207/12	Gibbs's [1] 73/15
feel [9] 89/3 102/1 128/7 150/9 158/3 165/6 173/8 183/14 186/21	former [1] 213/8	forgotten [1] 3/8	functioning [1] 89/19	Gilby [6] 173/16 174/11 175/19 175/25 176/13 183/20
feeling [9] 19/21 73/17 113/9 124/4 156/9 165/20 171/17 209/23 211/11	formalised [1] 144/16	form [6] 22/9 26/20 45/25 81/4 81/5 117/5	fundamentally [2] 128/21 186/15	give [18] 1/12 4/22 12/19 41/8 55/2 65/6 74/5 76/25 89/15 91/11 115/8 132/24 142/2 163/8 169/25 202/8 216/7 217/17
feels [1] 98/11	formally [2] 10/25 215/9	formal [1] 80/18	further [11] 1/15 3/2 28/2 70/2 183/4 183/6 183/7 203/19 209/3 211/10 218/5	given [21] 20/24 88/2 92/22 93/18 95/13 103/5 106/5 112/8 113/18 116/13 122/5 123/4 150/10 156/21 162/2 164/6 166/12 198/2 208/6 208/16 208/19
fell [2] 14/14 185/9	format [1] 173/3	formalised [1] 144/16	future [5] 30/23 31/23 108/9 120/25 121/12	gives [3] 98/19 98/19 181/18
fellow [3] 1/19 135/12 142/19	formulated [1] 210/24	forth [1] 129/24	G	giving [5] 79/13 110/19 113/3 115/10 134/19
fellowship [1] 142/21	formally [2] 10/25 215/9	fortunate [2] 10/12 45/16	gain [1] 89/5	GMC [9] 193/19 193/23 194/4 194/6 194/10 202/17 202/21 203/1 203/7
felt [49] 3/22 36/8 38/14 59/10 91/21 92/1 96/10 106/19 117/24 117/25 124/12 128/4 128/11 128/12 138/20 145/15 147/22 148/20 149/17 149/25 150/21 151/3 158/9 161/5 161/14 161/20 162/16 164/17 167/7 169/4 169/23 172/17 173/19 174/3 174/9 174/10 174/25 175/21 175/24 179/20 181/16 182/2 183/10 184/3 186/23 209/1 209/25 210/3 215/18	formally [2] 10/25 215/9	forum [5] 144/1 180/20 180/25 183/13 184/10	gap [3] 109/16 125/19 126/16	go [101] 4/18 7/16 9/2 13/24 17/14 19/10 19/23 21/4 21/8 21/13 23/14 24/8 26/21 26/23 31/20 33/5 39/23 40/2 40/6 40/10 47/25 48/8 48/23 50/24 53/23 57/25 59/23 61/24 64/6 66/9 68/22 68/23 69/14
female [1] 55/23	firstly [5] 4/6 78/20 120/12 127/4 131/19	forward [7] 14/6 76/18 120/25 143/13 182/6 183/15 184/21	gaps [3] 126/10 126/11 126/15	
	five [9] 6/9 21/19 76/11 129/12 131/22 178/19 178/22 187/7 187/12	forwarded [1] 173/5	gather [1] 89/3	
	five minutes [3] 178/19 178/22 187/7	foul [1] 115/16	gauge [1] 165/12	
	five past [2] 76/11 187/12	found [8] 2/5 60/15 92/3 94/4 117/24 119/8 211/6 212/10	gave [12] 57/10 60/13 66/20 111/2 129/22 154/11 157/7 166/10 169/22 175/10 192/3 204/22	
	five top [1] 21/19	four [8] 5/5 6/9 11/22 41/2 61/6 73/10 146/11 146/15	general [9] 34/19 46/18 83/6 102/2 140/7 141/2 166/19 193/15 213/2	
	five years [2] 129/12 131/22	four years [1] 11/22	General Medical Council [1] 193/15	
	flavour [2] 111/2 115/8	frame [2] 28/5 129/23	generalisation [1] 35/20	
		framed [1] 126/25	generally [6] 50/6 138/1 138/5 168/17	
		frank [1] 20/8		

G	83/5 89/22 90/1 90/2 91/24 91/24 92/2 92/15 94/1 95/2 96/12 110/1 124/9 124/23 128/5 128/6 140/10 140/19 141/19 159/19 171/20 189/13 213/5 217/25 Gosh [1] 90/8 got [43] 5/21 11/23 17/17 18/10 19/5 22/24 26/16 38/9 48/4 51/2 52/6 55/13 56/21 56/25 62/2 62/5 71/12 71/12 79/21 80/11 81/2 81/18 85/5 85/10 95/5 100/10 100/18 106/9 114/13 129/3 131/24 135/7 138/14 138/15 138/16 151/5 168/11 181/13 191/25 193/21 199/12 199/20 204/6 governance [32] 4/6 12/20 12/21 13/5 13/15 13/18 19/2 21/6 44/23 45/1 49/8 70/17 70/20 70/25 70/25 71/5 71/23 85/17 85/20 85/25 86/5 86/7 86/13 86/17 86/19 87/3 96/13 97/4 98/22 99/14 102/16 163/13 governed [1] 80/3 government [1] 199/19 grade [1] 84/8 grading [1] 22/2 graduated [1] 142/18 grasp [1] 73/14 grateful [1] 135/20 grave [3] 54/25 68/16 75/17 great [4] 39/11 52/17 54/22 74/16 greatly [1] 74/8 grievance [13] 56/25 116/17 117/25 155/24 185/4 191/13 195/7 195/9 195/11 195/13 195/14 195/15 199/5 grieving [1] 180/15 ground [1] 10/15 group [14] 21/9 34/22 42/22 43/3 60/8 147/9 150/1 150/2 151/16 167/23 168/5 172/14 173/21 182/4 groups [1] 18/22 growing [1] 38/2 growth [4] 29/4 29/13 29/17 34/13 guess [3] 86/22 94/25 108/17	guessed [1] 187/8 guidance [1] 152/6 guidelines [1] 65/4 guilty [1] 194/8 guys [1] 74/11 gyaeny [2] 12/23 71/1 gynaecologist [1] 12/2 gynaecology [3] 3/4 11/17 13/22 Gynecologists [1] 1/18	H had [374] hadn't [33] 16/13 26/16 48/11 48/19 54/19 54/20 59/21 62/2 70/7 73/16 75/7 75/9 75/11 94/25 97/8 115/15 119/7 124/6 124/25 125/1 125/5 128/11 128/12 131/8 132/20 175/1 176/8 196/15 204/11 204/11 204/12 206/11 210/24 half [3] 52/3 79/1 176/21 halfway [1] 181/6 hand [4] 2/18 142/6 163/7 163/9 handed [1] 191/1 handled [5] 124/20 158/20 166/7 166/11 176/2 handovers [2] 92/5 96/6 handwriting [1] 64/16 handwritten [1] 62/16 handy [1] 79/16 happen [11] 31/22 46/6 46/21 47/15 63/20 112/23 174/7 183/24 194/7 194/11 214/10 happened [24] 5/18 10/2 17/2 18/9 33/2 46/24 51/9 54/10 81/6 86/6 99/19 105/19 109/18 117/4 119/14 122/16 125/14 126/4 130/25 131/5 137/17 137/22 176/22 208/24 happening [20] 6/4 43/25 62/2 70/12 75/4 88/19 89/15 96/4 103/22 105/7 127/4 128/11 130/2 138/24 139/12 194/13 194/15 204/21 208/16 209/2 happens [4] 52/7	72/19 201/22 203/10 happily [1] 79/25 happy [2] 172/23 173/7 harassed [1] 156/10 hard [5] 81/12 107/21 112/5 124/21 185/8 harder [1] 129/6 hardly [2] 197/13 197/14 harm [34] 13/13 19/22 21/16 21/21 22/3 22/3 22/22 42/20 42/25 43/12 44/17 50/20 52/18 52/22 54/11 64/23 65/1 65/7 67/19 71/14 71/22 72/17 73/13 75/17 85/8 104/1 106/24 108/17 108/18 108/18 153/12 182/20 190/20 200/23 harmed [1] 116/2 harming [10] 56/12 69/4 72/10 104/13 105/25 107/16 124/14 124/22 124/24 152/18 Harvey [61] 27/8 53/19 55/11 55/13 56/19 57/7 57/18 59/8 60/1 60/11 60/14 60/16 61/18 62/15 92/11 92/12 92/25 111/12 115/7 115/8 125/11 125/25 135/5 145/13 146/3 147/11 149/23 159/13 159/16 160/2 161/20 161/24 162/11 163/4 163/22 164/8 166/7 166/10 166/15 166/24 167/11 168/1 169/22 173/17 179/6 181/5 181/6 184/3 184/9 189/15 189/16 189/25 190/6 191/22 192/8 193/17 195/5 195/11 198/11 211/6 217/17 Harvey's [1] 150/5 has [44] 9/7 12/15 12/16 17/18 17/18 18/8 22/11 31/9 46/9 50/18 65/16 73/10 74/2 82/8 83/16 84/3 84/4 84/12 84/14 85/2 87/24 92/21 101/5 102/25 113/17 121/9 123/12 129/18 130/10 139/8 141/16 142/2 143/20 159/12 179/3 193/8 203/8 204/8 204/24 205/20 207/20 207/25 208/6 208/13 hasn't [5] 44/20	50/18 111/7 112/8 124/16 hate [1] 212/11 have [369] haven't [6] 5/21 19/5 27/14 48/4 130/8 209/12 having [24] 3/1 35/23 39/11 45/18 65/3 80/17 80/18 86/10 96/17 105/1 105/2 105/14 110/7 111/15 120/12 137/20 140/22 173/17 184/6 189/5 189/11 199/9 204/10 204/12 Hawdon [6] 115/14 115/20 191/7 206/15 206/16 207/21 Hawdon's [1] 192/13 he [169] 1/5 5/12 8/3 9/17 9/19 16/6 16/9 19/3 20/21 20/23 31/9 31/12 44/20 50/10 50/12 50/13 50/18 51/2 51/5 52/16 52/24 55/15 55/18 55/24 55/24 55/25 56/9 56/10 57/9 57/10 59/9 59/10 59/12 59/13 59/17 59/17 59/17 59/19 59/22 60/2 60/3 60/5 60/11 60/16 60/19 60/21 60/21 60/21 60/22 60/24 60/24 61/6 61/24 65/10 65/16 67/8 67/11 71/9 73/15 74/14 89/14 93/12 103/16 115/10 115/11 115/15 115/19 115/19 118/8 118/12 118/14 118/14 119/10 119/20 120/23 121/16 121/16 121/19 146/4 150/7 155/18 155/19 162/10 163/6 163/8 163/10 163/11 163/12 163/12 163/16 164/12 166/6 166/16 167/18 167/20 167/20 167/21 168/19 168/21 168/21 169/4 169/22 169/23 169/25 170/1 170/2 170/3 170/4 172/20 172/23 172/24 175/21 176/11 176/12 176/25 177/2 177/2 177/8 179/7 179/8 180/17 180/18 180/21 180/23 181/3 181/4 182/19 182/22 184/3 184/3 190/1 190/11 190/18 190/23 191/1 191/2 191/3
----------	---	---	--	--	---

H	21/3 24/3 28/21 29/5 29/10 29/14 29/23 31/1 31/23 32/1 32/20 36/7 36/9 36/14 38/4 38/5 38/6 38/14 38/14 38/15 39/5 39/9 39/14 39/20 40/1 40/2 53/16 55/2 55/5 56/16 56/18 57/12 59/1 102/7 102/23 117/25 119/11 119/14 125/3 132/5 133/1 135/7 135/11 138/20 138/22 158/6 160/12 176/1 176/6 193/18 193/24 197/25 202/9	his [51] 5/24 30/21 47/15 50/10 51/3 51/3 55/14 55/18 57/18 60/1 67/3 67/3 67/15 73/16 93/5 104/6 115/24 134/2 149/24 150/5 150/20 150/21 156/5 161/24 162/5 162/10 168/13 168/22 170/3 177/4 190/1 190/17 192/6 192/11 192/13 192/21 193/17 195/12 197/16 197/16 199/25 203/19 209/11 212/8 212/8 212/17 215/25 216/1 216/15 217/9 217/10 historical [1] 139/18 Historically [2] 148/25 149/11 history [4] 153/14 177/1 177/22 177/25 hits [1] 147/23 Hodkinson [1] 147/11 Holt [1] 181/18 home [2] 203/14 203/23 honest [3] 32/23 72/20 106/9 honestly [4] 19/6 31/25 46/14 164/21 honesty [1] 155/10 hope [2] 184/16 186/12 hoped [1] 184/17 hopeful [1] 162/8 hoping [1] 191/15 hospital [45] 5/16 6/13 9/6 36/2 36/4 39/2 39/3 39/13 39/23 61/20 70/18 74/2 75/16 80/24 84/20 84/25 86/20 92/23 96/18 108/23 118/25 123/17 128/3 131/21 134/1 138/18 141/2 141/3 143/3 143/17 143/20 147/5 148/16 149/1 149/12 149/20 150/2 151/2 151/24 152/19 154/18 155/7 188/5 212/25 217/13 hospitals [2] 80/17 88/12 hot [1] 78/25 hour [3] 79/1 79/1 176/21 hour/hour [1] 79/1 hours [3] 99/18 100/15 100/18 how [59] 10/24 14/6 21/2 29/3 30/10 32/10 32/11 36/4 36/7 63/17	65/5 65/19 70/18 72/11 75/1 82/1 83/6 83/12 86/25 89/5 89/19 89/20 93/8 96/6 100/15 100/17 103/16 104/4 104/11 106/10 106/23 108/7 108/12 109/7 114/21 117/24 118/14 120/25 121/11 123/23 124/19 129/22 133/12 136/19 137/16 139/17 140/25 158/19 167/3 167/4 169/1 169/25 172/10 177/3 197/10 206/18 210/24 211/3 211/6 however [4] 193/8 204/23 209/8 213/5 HR [6] 56/15 56/22 61/9 61/13 61/25 195/6 HSSIB [1] 83/7 huge [6] 38/13 102/9 159/10 173/21 175/7 212/3 hugely [1] 175/2 Hughes [3] 172/1 172/20 175/12 Human [1] 189/18 Human Resources [1] 189/18 hurt [3] 175/4 175/4 200/22 hybrid [1] 86/16 hypothetical [2] 85/13 86/24 hypoxia [1] 25/16	I can't [20] 8/11 14/15 31/3 34/3 44/18 59/13 59/18 83/24 85/2 85/12 87/2 90/11 107/14 129/13 149/6 155/22 167/25 191/1 191/25 202/8 I cannot [2] 155/10 177/4 I catch [1] 138/23 I certainly [3] 32/17 36/23 86/7 I chaired [1] 18/13 I come [1] 55/14 I confirm [1] 207/8 I could [9] 2/1 52/20 96/7 104/25 151/19 156/5 166/19 167/13 185/22 I couldn't [8] 28/19 40/1 61/23 65/19 65/24 105/5 164/21 170/23 I decided [2] 90/4 125/21 I did [16] 1/15 16/10 16/15 41/14 42/2 44/8 52/22 57/5 75/13 78/8 159/16 169/15 174/21 191/7 202/19 202/20 I didn't [34] 21/1 30/7 46/20 47/7 53/15 55/20 55/23 56/18 56/18 57/19 58/22 58/25 59/4 60/7 65/6 65/15 72/20 79/9 93/15 96/10 120/17 127/13 127/25 128/7 149/19 150/15 150/15 150/16 151/6 161/13 173/24 192/14 198/7 198/15 I disagreed [1] 120/18 I discussed [1] 169/21 I do [5] 36/20 111/6 139/25 195/21 212/4 I don't [68] 2/21 7/5 12/3 12/14 19/20 22/6 28/8 31/14 31/14 37/1 41/11 43/9 47/16 47/16 47/17 49/24 60/6 60/21 65/14 65/17 71/8 75/2 80/15 80/21 80/22 81/9 83/10 90/8 90/8 90/12 92/19 92/25 93/3 93/9 93/14 94/17 96/22 106/9 106/14 107/16 107/24 108/19 109/16 109/19 111/19 113/5 115/5 115/19 115/24 118/23 121/25 122/7
----------	--	---	--	--

I	I heard [4] 44/7 73/15 124/6 154/16	30/13 57/9 57/11 63/8 138/8 205/8	40/24 43/9 43/12 43/25 47/10 47/23 48/5 48/10 48/18 49/11 51/2 51/4 51/5 51/8 51/8 51/18 52/15 54/4 59/12 59/13 61/17 62/23 63/1 63/1 65/16 68/16 69/15 71/19 73/4 73/8 73/12 73/13 73/16 74/16 74/18 74/21 80/9 80/19 81/5 81/23 82/24 83/4 83/5 84/23 85/24 87/12 88/17 91/7 91/10 93/17 93/20 93/22 94/17 94/17 98/12 98/18 99/15 100/2 104/6 104/22 106/8 106/18 107/18 107/22 108/11 109/2 111/19 112/18 114/17 115/1 116/15 118/21 120/7 122/1 129/14 129/19 130/10 131/15 132/12 133/7 133/23 134/15 135/18 136/9 136/13 137/1 137/20 138/9 139/3 139/11 139/15 139/22 140/7 140/21 141/9 143/8 143/18 144/16 148/17 149/9 149/12 150/7 151/1 151/2 151/9 151/13 154/8 154/13 154/21 157/2 158/7 158/10 158/16 159/8 159/8 160/6 163/19 164/1 164/10 166/6 166/14 168/18 172/18 174/18 175/7 175/17 176/20 178/14 179/22 182/23 184/13 184/24 185/1 186/9 186/25 191/17 196/4 196/16 197/2 198/15 199/18 200/4 200/5 201/5 206/24 211/11 212/22 214/15 214/17 215/10	95/7 I want [5] 14/3 21/15 32/11 46/20 59/2 I wanted [4] 2/7 29/23 58/10 125/21 I was [103] 3/9 3/22 5/15 10/19 12/16 13/2 13/9 23/25 24/23 30/14 30/17 31/6 31/18 35/16 35/17 36/19 41/20 41/25 42/3 51/6 55/16 58/23 58/24 58/24 59/1 59/3 59/5 59/5 59/5 61/6 61/10 63/3 66/3 66/3 66/7 68/6 68/18 71/4 72/1 80/16 86/6 87/13 92/15 93/16 93/18 95/25 96/10 96/24 99/3 99/16 105/22 107/15 110/4 110/6 110/19 111/3 114/22 120/8 124/1 128/3 128/5 132/25 133/12 134/4 135/18 135/20 135/21 135/22 138/18 138/19 138/21 148/17 149/20 150/8 150/20 154/13 156/4 162/6 162/8 178/16 184/6 188/17 192/1 198/7 200/13 201/8 202/4 202/21 202/22 203/17 204/19 205/8 205/24 205/25 206/13 206/18 208/24 209/8 210/10 211/22 213/14 213/14 213/25 I wasn't [12] 55/14 60/7 63/23 64/20 87/16 112/6 123/4 133/12 149/13 181/2 193/23 205/24 I went [2] 42/1 60/2 I will [9] 2/13 2/18 2/19 19/23 21/4 111/5 142/5 201/21 218/15 I wished [2] 122/22 187/1 I wonder [2] 76/17 113/25 I worked [1] 148/14 I would [40] 5/5 6/12 9/22 10/9 10/23 17/24 19/12 26/7 34/15 37/25 38/3 38/4 38/20 38/20 39/7 39/15 40/1 41/16 42/14 60/4 65/17 69/5 70/8 74/7 86/10 91/4 92/10 93/20 107/25 117/1 123/15 123/16 125/18 137/23 141/19 148/13 150/20 152/19 153/3
I don't... [16] 130/8 130/9 138/7 139/24 140/17 145/5 146/6 166/16 170/2 176/21 178/19 182/24 194/1 196/20 199/17 217/21	I honestly [1] 31/25 I imagine [1] 12/15 I interpreted [1] 27/5 I just [13] 2/4 16/21 19/23 27/15 32/1 68/18 74/6 154/6 154/8 156/15 168/14 202/5 211/19 I kept [1] 135/23 I knew [17] 29/17 34/10 34/11 34/12 34/13 53/18 65/20 88/13 89/22 159/18 159/18 159/21 161/7 161/9 176/1 198/17 203/20 I know [5] 27/7 35/13 44/3 155/22 207/15 I learnt [1] 166/1 I left [1] 124/15 I looked [2] 112/5 118/15 I made [1] 41/22 I may [11] 2/14 3/20 13/18 13/23 15/25 19/23 21/4 31/4 41/11 154/22 213/25 I mean [6] 30/22 101/16 108/2 117/9 155/6 217/17 I meant [1] 65/18 I mentioned [1] 41/5 I met [3] 89/21 93/5 200/14 I might [6] 18/11 33/3 63/24 176/20 193/25 214/15 I must [1] 107/21 I need [3] 2/22 41/10 218/10 I needed [2] 31/20 138/21 I never [4] 13/15 32/23 95/17 151/5 I note [1] 206/23 I notice [1] 62/7 I noticed [1] 149/13 I obviously [5] 20/23 30/10 30/17 93/14 95/6 I point [1] 16/11 I prepared [3] 5/22 60/10 118/15 I presume [1] 112/4 I presumed [1] 34/9 I probably [3] 60/3 106/20 161/13 I put [2] 104/22 211/21 I qualified [2] 1/14 56/3 I read [8] 2/4 27/5	I realised [2] 16/14 135/25 I really [4] 122/8 122/21 132/9 132/10 I recall [2] 117/22 121/9 I recognise [1] 118/18 I refer [1] 191/5 I regret [1] 161/16 I remember [11] 54/4 64/20 84/16 90/14 92/12 113/5 115/5 119/22 121/12 194/3 217/5 I said [20] 16/12 54/4 56/2 56/13 56/19 56/19 57/13 59/3 60/5 60/8 61/18 70/13 90/11 91/22 139/22 183/9 200/25 201/15 201/21 201/22 I sat [1] 44/22 I saw [6] 29/10 34/8 34/15 62/25 201/2 206/8 I say [1] 39/19 I see [3] 57/8 102/9 192/12 I sent [1] 60/13 I should [3] 3/2 161/5 163/2 I shouldn't [1] 57/14 I showed [1] 111/4 I specifically [1] 65/25 I spoke [5] 31/5 89/11 156/6 164/10 195/2 I start [1] 204/6 I started [6] 16/14 91/11 92/4 93/24 97/13 164/19 I stepped [1] 125/20 I still [1] 73/14 I suppose [2] 108/21 162/4 I suspect [3] 87/12 87/13 187/7 I take [3] 9/14 41/12 115/18 I tell [1] 17/21 I then [3] 65/14 201/25 203/23 I think [177] 2/22 3/20 5/23 8/23 11/14 11/22 12/7 12/14 12/18 16/10 22/9 23/8 23/11 24/13 27/17 27/20 27/21 28/5 28/6 33/9 34/4 34/6 38/17 39/6 39/6 40/14 40/24		

<p>I</p> <p>I would... [1] 200/9</p> <p>I wouldn't [11] 17/3 17/3 18/3 18/4 20/8 31/16 31/16 32/19 32/20 33/14 39/14</p> <p>I wrote [2] 59/3 203/24</p> <p>I'd [32] 23/10 23/10 53/14 56/1 59/25 63/22 64/24 80/23 87/15 88/15 91/21 118/16 118/24 122/22 127/12 128/3 128/4 128/4 128/7 131/21 138/8 138/22 149/11 151/13 154/21 159/20 161/14 163/25 179/5 187/1 190/15 195/10</p> <p>I'd called [1] 56/1</p> <p>I'll [3] 60/8 193/10 201/21</p> <p>I'm [76] 8/24 11/8 13/25 16/11 18/19 18/20 20/11 20/12 20/14 20/14 20/17 25/20 26/7 27/17 30/1 30/2 33/4 33/10 35/5 35/7 35/10 37/24 44/2 44/19 44/19 50/9 56/7 56/20 56/22 57/13 59/25 61/7 62/8 68/5 75/3 83/15 85/9 86/23 97/23 106/18 107/21 113/22 113/23 118/25 121/16 123/13 126/22 130/7 135/5 138/14 143/2 152/7 152/9 164/18 165/9 172/25 177/9 178/18 179/24 182/13 189/11 198/16 198/22 198/22 199/9 201/1 209/9 209/13 214/1 214/13 214/14 216/7 216/19 216/20 217/2 218/7</p> <p>I've [16] 3/8 40/17 41/25 56/21 74/17 75/10 83/23 83/25 90/14 106/25 117/21 118/22 119/1 130/22 152/8 199/12</p> <p>I've thought [1] 83/23</p> <p>Ian [27] 53/19 56/19 56/20 60/1 60/11 60/14 60/15 60/16 60/16 61/18 61/19 61/24 111/12 115/7 115/8 125/11 125/25 135/5 145/13 159/13 159/16 161/20 161/24 166/24 167/11 169/22</p>	<p>189/16</p> <p>Ian Harvey [17] 53/19 56/19 60/1 60/11 60/14 61/18 111/12 115/7 115/8 125/11 125/25 135/5 145/13 159/13 159/16 167/11 189/16</p> <p>idea [9] 41/8 52/9 53/14 125/2 132/9 138/10 141/16 181/19 182/20</p> <p>identified [5] 40/10 112/8 115/15 119/5 124/7</p> <p>identifiers [1] 49/17</p> <p>identify [3] 49/16 137/19 138/2</p> <p>identity [1] 58/14</p> <p>ie [3] 88/7 94/12 218/1</p> <p>if [195] 2/14 2/17 2/20 2/22 2/23 4/18 4/19 5/18 7/12 7/16 7/16 9/3 9/17 10/1 12/6 12/13 13/9 13/9 13/18 13/23 15/8 17/1 19/23 21/4 22/17 22/22 23/14 26/21 26/23 30/24 31/10 31/24 31/24 32/4 32/5 33/22 34/25 35/5 35/14 37/12 39/21 41/11 41/18 46/4 46/12 48/8 48/13 49/9 57/25 58/10 59/15 64/6 66/9 68/7 68/7 68/10 68/11 68/15 69/14 70/1 70/7 73/9 74/9 76/17 80/8 80/21 81/7 81/8 82/2 82/18 82/25 84/19 85/14 85/19 86/6 87/4 87/14 90/13 92/6 92/20 96/16 99/4 100/20 106/23 107/7 107/14 107/15 107/16 107/16 107/24 108/19 109/2 109/19 112/12 113/11 113/25 115/5 116/16 117/2 117/10 117/17 118/2 118/10 126/11 126/19 129/3 131/6 133/11 133/13 138/20 138/22 138/25 139/25 141/13 144/5 146/12 146/15 147/7 147/14 147/18 148/10 149/15 151/6 151/19 152/17 153/5 153/6 153/22 154/2 155/2 155/4 156/5 156/8 156/13 156/16 158/14 160/7 161/17 162/19 162/24</p>	<p>165/22 166/19 167/13 167/17 168/6 170/5 170/6 171/15 171/21 171/24 172/3 172/18 173/4 173/10 175/7 178/20 179/22 180/11 182/2 182/6 185/22 187/18 191/19 193/5 194/19 195/17 198/6 199/7 199/15 199/23 201/3 201/16 202/7 203/2 204/9 204/16 204/19 204/23 205/12 206/4 207/4 207/24 209/5 209/9 209/18 210/1 211/22 212/16 212/25 213/14 213/14 214/13 217/2 217/5 217/21</p> <p>ignore [1] 117/4</p> <p>ill [1] 21/2</p> <p>imagine [1] 12/15</p> <p>immaturity [1] 34/8</p> <p>immediate [6] 46/18 79/13 79/14 79/18 82/13 98/7</p> <p>immediately [7] 46/23 79/1 91/7 105/23 108/23 165/23 186/4</p> <p>imminently [1] 104/11</p> <p>impact [3] 14/3 26/9 53/14</p> <p>impacted [1] 36/16</p> <p>impartially [1] 204/13</p> <p>imply [1] 182/13</p> <p>importance [4] 48/20 48/22 150/11 159/24</p> <p>important [12] 3/5 29/14 87/6 101/18 113/23 138/3 167/22 168/5 174/25 179/21 183/12 201/24</p> <p>impossible [2] 150/18 201/19</p> <p>impractical [1] 82/23</p> <p>impression [14] 63/5 71/12 89/17 90/3 91/5 91/19 92/15 123/23 168/11 169/22 169/25 192/1 192/10 193/21</p> <p>improve [1] 123/2</p> <p>improvement [2] 82/22 82/24</p> <p>improvements [1] 115/13</p> <p>improving [1] 139/21</p> <p>inaccurate [2] 181/4 181/8</p> <p>inadvertently [1] 85/8</p> <p>inappropriate [7] 22/15 58/7 119/10</p>	<p>195/24 201/7 215/24 216/15</p> <p>inappropriately [1] 109/4</p> <p>inaudible [2] 34/12 75/9</p> <p>incident [9] 27/1 27/2 27/19 28/4 28/10 71/9 81/6 99/5 177/10</p> <p>incidents [10] 21/11 21/14 21/16 21/16 82/21 101/8 102/14 217/1 217/2 218/3</p> <p>include [2] 13/21 14/21</p> <p>included [7] 25/4 40/12 50/18 60/8 97/17 110/4 127/3</p> <p>includes [3] 11/16 27/3 206/22</p> <p>including [4] 65/11 127/17 192/5 205/15</p> <p>inclusive [1] 165/24</p> <p>incorporate [1] 48/23</p> <p>increase [1] 208/1</p> <p>increased [3] 155/16 158/17 186/2</p> <p>increasing [3] 14/20 40/23 68/10</p> <p>indeed [18] 1/25 2/12 4/10 4/15 15/4 36/16 37/5 37/25 76/5 142/1 142/1 187/6 207/16 209/18 211/4 215/17 217/11 218/7</p> <p>independent [6] 73/21 190/19 190/25 191/19 192/1 212/20</p> <p>indicate [2] 128/17 136/7</p> <p>indictment [2] 25/4 41/16</p> <p>individual [6] 49/20 85/9 85/15 86/11 103/25 128/10</p> <p>individuals [3] 12/18 12/22 145/18</p> <p>industriously [1] 71/20</p> <p>inevitable [2] 81/23 173/9</p> <p>inexplicable [1] 34/22</p> <p>infancy [1] 83/14</p> <p>infants [1] 181/7</p> <p>infection [1] 127/9</p> <p>infer [1] 133/15</p> <p>inference [1] 67/11</p> <p>inferentially [1] 117/12</p> <p>influenced [1] 82/5</p> <p>inform [3] 130/11 152/19 210/25</p> <p>informal [8] 10/10</p>	<p>18/10 18/22 155/20 162/5 189/25 190/7 195/12</p> <p>informally [2] 10/24 195/3</p> <p>information [22] 37/16 46/20 48/22 65/6 71/17 89/5 89/15 92/22 93/19 99/8 103/4 106/5 113/3 113/19 135/8 135/11 135/17 178/15 207/15 207/17 208/6 208/17</p> <p>informed [7] 36/10 160/17 164/13 176/16 186/9 208/6 210/12</p> <p>informing [1] 177/20</p> <p>infrequent [1] 126/15</p> <p>infrequently [1] 126/5</p> <p>infusion [1] 131/9</p> <p>infusions [1] 205/16</p> <p>inhibit [1] 175/22</p> <p>initial [1] 109/9</p> <p>initially [2] 77/21 132/7</p> <p>initials [1] 147/21</p> <p>injured [1] 148/19</p> <p>injuries [1] 83/8</p> <p>innocent [1] 194/8</p> <p>inpatient [1] 84/1</p> <p>input [4] 15/3 27/22 216/1 217/10</p> <p>INQ [1] 4/13</p> <p>INQ0003159 [1] 207/5</p> <p>INQ0003212 [1] 49/9</p> <p>INQ0003222 [1] 40/6</p> <p>INQ0003229 [1] 26/22</p> <p>INQ0003362 [1] 62/12</p> <p>INQ0003489 [1] 204/3</p> <p>INQ0003523 [2] 120/11 194/20</p> <p>INQ0004235 [1] 13/24</p> <p>INQ0004293 [1] 23/15</p> <p>INQ0004451 [1] 170/8</p> <p>INQ0004485 [1] 171/10</p> <p>INQ0006079 [1] 208/7</p> <p>INQ0012076 [1] 57/25</p> <p>INQ0012080 [1] 117/4</p> <p>INQ0012995 [2] 154/3 168/7</p> <p>INQ0015135 [1] 48/1</p> <p>INQ0017868 [1]</p>
--	--	--	--	--

I	191/18 206/19 interface [2] 150/14 150/18 interfacing [1] 146/25 internal [3] 208/1 215/25 216/16 internal/external [1] 208/1 internationally [1] 217/13 interpret [1] 212/22 interpretation [4] 35/13 68/19 116/1 197/17 interpreted [2] 22/1 27/5 interrogated [1] 70/1 interrupt [1] 193/11 intervene [1] 140/1 intervention [1] 68/10 interview [9] 69/15 88/18 89/12 92/11 92/13 154/10 154/11 168/8 181/10 interviewed [2] 104/16 120/8 interviewing [1] 93/2 into [22] 8/24 27/22 36/1 38/7 50/8 55/18 58/6 89/2 91/20 93/14 93/16 95/7 108/14 109/15 109/17 118/25 124/1 140/14 203/19 206/10 208/1 211/18 intranet [3] 6/13 6/18 153/4 intrapartum [1] 25/15 intrauterine [1] 29/4 introduced [3] 3/15 83/11 172/1 introduction [4] 3/9 73/20 116/14 116/17 investigate [8] 14/14 15/18 33/24 70/15 107/5 108/12 109/8 131/12 investigated [10] 87/7 105/24 107/13 124/3 124/16 124/17 125/5 128/12 128/15 180/4 investigating [7] 28/10 32/11 81/25 83/8 106/7 107/9 207/14 investigation [40] 14/7 14/13 36/1 36/6 36/8 36/11 62/1 66/2 67/5 67/17 74/24 86/3 86/18 99/6 99/7 116/21 124/13 125/1	125/13 128/16 129/6 131/6 131/13 158/8 161/15 163/11 171/2 172/6 172/12 173/1 175/14 177/21 206/21 206/22 209/4 211/1 212/20 215/25 216/16 217/9 investigations [8] 40/16 49/23 58/5 90/18 104/15 106/1 129/2 129/4 investment [1] 122/15 invitation [2] 15/18 110/20 invitations [1] 145/7 invite [3] 6/25 6/25 110/15 invited [14] 4/18 5/17 51/13 95/3 109/22 110/6 110/11 110/22 115/11 134/14 149/10 149/11 149/14 175/19 inviting [3] 5/15 111/23 126/23 involved [31] 3/13 6/19 7/6 36/1 38/22 41/20 41/25 42/3 44/16 45/9 49/6 49/20 59/20 66/22 71/10 73/17 79/3 79/8 83/19 106/13 139/13 152/18 155/8 162/13 163/15 164/3 179/8 181/1 187/1 210/19 212/19 involvement [5] 74/24 163/5 169/5 184/15 184/16 Irrespective [1] 72/11 is [272] isn't [9] 8/21 17/20 34/18 37/10 56/20 69/6 75/4 86/17 112/18 isolated [1] 171/18 issue [35] 10/19 14/18 31/3 46/12 58/10 59/21 63/20 65/7 65/11 65/19 67/18 67/19 68/21 71/2 71/22 85/18 93/10 106/16 106/20 108/7 108/8 108/10 150/22 153/5 159/3 160/7 165/15 169/14 172/10 174/17 184/4 193/3 201/16 202/21 206/5 issued [2] 16/3 145/7 issues [34] 11/3 14/8 15/13 16/23 17/10 18/18 25/21 25/22	25/24 29/6 32/1 38/5 45/12 58/6 63/13 65/10 66/18 86/12 90/20 93/17 95/19 106/19 138/13 146/5 157/8 160/15 162/12 170/4 172/5 173/24 197/19 197/19 201/24 206/10 it [587] it's [83] 2/23 7/16 8/11 16/12 17/19 19/5 19/19 21/13 22/13 22/14 27/10 27/11 30/3 30/24 32/6 32/14 32/14 32/25 34/18 35/14 36/24 38/17 46/10 48/7 48/13 56/2 59/14 59/15 61/9 61/17 62/16 63/14 64/12 64/13 65/14 65/17 67/24 69/6 69/17 74/7 77/2 81/12 82/24 83/4 84/25 86/24 98/12 98/16 107/12 107/21 110/25 112/4 123/9 123/13 130/13 139/4 139/11 140/1 141/6 143/8 143/18 143/24 147/9 148/5 152/7 152/8 154/8 156/25 167/13 171/21 186/14 194/11 195/17 196/4 196/4 200/5 201/16 207/18 209/9 213/13 216/19 216/23 218/8 item [1] 16/12 items [2] 6/15 145/15 its [4] 97/19 98/14 166/2 166/3 itself [3] 118/2 194/19 203/18	154/1 155/13 157/22 157/25 190/1 190/3 199/25 204/4 207/9 January 2016 [1] 23/14 January 2017 [1] 190/1 January/early February 2017 [1] 154/1 Jayaram [52] 13/12 52/13 60/1 62/14 67/21 71/18 78/10 88/15 88/23 89/2 89/6 89/13 89/18 90/5 90/9 91/11 92/22 93/13 103/7 106/12 109/10 110/8 120/17 122/3 122/4 125/10 125/16 134/16 135/3 136/10 155/12 156/4 156/5 156/6 156/24 160/23 178/8 178/8 180/11 180/17 182/18 182/23 185/18 196/16 199/25 200/14 202/20 203/19 203/21 207/6 208/5 209/21 Jayaram's [1] 207/20 jeopardised [1] 180/7 Jeremy [1] 167/15 JIM [5] 1/8 57/12 64/8 69/16 219/3 Jim McCormack [1] 64/8 Jo [1] 27/25 Jo Davies [1] 27/25 job [16] 3/23 4/3 4/3 77/24 78/2 88/5 88/15 89/8 100/2 100/12 100/15 100/17 101/1 102/10 119/1 212/6 jobs [4] 128/5 159/9 162/20 201/10 John [4] 10/18 31/5 31/15 73/15 John Gibbs [3] 10/18 31/5 31/15 John Gibbs's [1] 73/15 join [1] 51/16 joined [1] 133/25 joining [1] 134/21 Joint [3] 83/17 84/1 84/21 jointly [2] 41/17 186/11 judge [1] 107/11 July [7] 27/10 27/13 88/1 89/18 93/23 154/11 177/12 July 2016 [1] 177/12 July/August [1]
----------	--	--	---	---

J	177/9 178/4 178/25 179/13 179/25 181/12 182/12 183/18 184/7 184/23 185/22 189/20 193/11 196/14 197/16 200/16 202/1 202/4 202/5 203/1 210/11 211/19 213/13 214/25 justify [1] 217/25	127/16 128/6 130/8 131/7 131/10 131/24 132/11 135/21 139/13 139/24 140/17 144/8 150/15 150/16 151/6 152/19 155/9 155/22 156/20 156/23 158/1 160/7 160/10 168/22 168/23 174/20 175/1 175/2 176/21 178/20 180/21 182/24 194/2 196/4 196/5 198/20 199/7 199/14 199/15 199/17 201/16 203/10 204/6 207/15 211/19 215/12 217/17 217/20 217/21 know took [1] 109/23 knowing [4] 7/19 58/14 93/11 161/8 knowledge [8] 3/20 4/2 50/19 71/14 77/8 142/16 192/21 215/18 known [5] 36/17 37/12 67/7 215/3 217/14 Kokai [1] 34/4	135/25 147/2 157/19 171/11 178/14 191/5 209/9 214/25 latest [1] 158/24 latter [2] 120/20 121/19 launched [1] 131/6 lawyer [1] 33/4 layout [1] 10/7 lead [26] 4/8 12/23 12/23 12/24 12/25 13/4 16/6 41/20 71/18 78/6 86/1 96/23 97/10 99/4 100/3 100/7 100/8 100/23 101/6 101/8 102/6 102/7 129/2 138/17 138/18 212/21 leaders [1] 133/9 leading [4] 79/24 80/1 80/6 86/6 leads [1] 89/10 lean [1] 101/14 leaner [1] 151/3 learn [2] 7/18 166/4 learning [23] 6/5 6/10 6/11 6/15 6/16 7/10 7/16 7/25 14/21 24/9 24/25 25/13 25/14 25/18 34/3 47/25 48/11 50/5 50/6 79/15 79/18 81/7 83/4 learnt [1] 166/1 least [4] 115/1 117/12 161/23 209/2 leave [7] 7/3 52/5 79/9 142/5 145/20 149/17 167/9 leaves [1] 200/23 leaving [3] 19/2 75/22 130/17 led [5] 82/15 84/1 100/9 104/9 128/16 left [3] 53/12 124/15 129/4 Legal [1] 207/11 Leighton [1] 131/21 less [3] 34/6 137/3 139/18 let [10] 13/17 15/4 21/4 36/8 45/4 48/12 191/2 201/17 204/2 211/12 let's [9] 7/15 53/23 120/20 126/18 126/23 133/13 138/24 178/24 201/23 Letby [28] 55/20 55/20 56/1 116/13 117/23 119/11 119/12 158/4 158/9 160/11 184/25 186/23 191/10 193/4 193/18 193/24 196/1 196/3 197/2	197/24 201/17 204/18 206/19 210/6 210/15 214/19 215/20 217/5 Letby's [3] 116/15 116/19 185/6 letter [32] 6/8 7/23 58/1 58/21 58/24 59/3 60/5 60/9 60/10 60/13 60/20 60/22 61/14 116/18 118/6 157/5 157/14 157/16 184/24 185/5 185/5 185/14 196/6 200/11 203/25 204/4 205/12 207/5 207/19 207/20 208/19 210/11 letters [1] 63/16 level [23] 11/4 20/16 55/16 82/16 84/7 84/8 86/19 86/22 90/20 94/2 94/11 94/12 94/23 96/12 99/14 105/4 124/13 125/13 126/14 129/12 138/13 152/1 153/9 Level 2 [2] 90/20 129/12 Level 3 [1] 152/1 levels [4] 94/10 127/21 128/1 208/2 liaise [1] 111/21 lie [1] 17/21 light [2] 83/3 181/21 like [53] 4/12 8/11 12/17 12/22 13/11 19/19 22/16 23/3 23/12 25/13 34/9 37/3 38/15 40/2 52/20 52/24 53/9 53/25 55/17 66/17 67/14 68/19 69/20 73/9 74/13 75/20 76/20 85/19 85/21 86/3 91/4 91/22 92/14 93/3 95/2 96/10 100/22 105/16 109/5 111/2 117/1 136/23 137/23 139/22 149/25 168/4 168/23 170/14 186/25 187/18 191/19 199/23 206/4 like-minded [2] 12/17 12/22 liked [3] 89/23 91/25 93/20 likely [10] 28/14 29/15 31/22 34/5 35/6 45/2 93/6 133/9 174/3 190/21 limited [4] 93/18 112/3 172/6 192/20 line [14] 8/9 120/24 121/8 121/11 121/17 121/18 133/6 179/25 197/23 201/20 204/14
	K keen [1] 202/11 keep [2] 98/15 152/2 keeping [3] 24/9 25/2 46/1 Kelly [1] 147/11 kept [2] 86/21 135/23 key [2] 19/13 152/10 kill [1] 30/16 killing [1] 72/10 Killingback [4] 8/7 15/8 48/8 199/24 kind [1] 80/9 knew [26] 9/24 29/17 32/4 34/10 34/11 34/12 34/13 42/11 46/19 46/22 53/18 60/3 65/20 88/13 89/22 96/11 132/1 159/18 159/18 159/21 161/7 161/9 176/1 198/17 203/20 210/20 knocked [1] 202/13 know [148] 7/5 8/17 11/13 12/15 13/2 13/12 16/18 17/2 17/17 19/25 20/18 22/2 23/22 24/23 27/7 28/9 28/23 30/14 32/7 32/7 32/10 32/12 32/13 32/14 35/13 37/10 39/16 40/11 41/11 42/6 43/15 44/3 44/22 47/4 54/18 55/20 55/23 56/18 56/21 59/14 61/20 63/9 63/22 64/9 64/17 65/9 67/2 68/7 70/1 71/8 71/8 72/2 72/24 73/4 73/14 74/11 79/18 81/12 84/9 86/2 86/23 87/13 91/15 92/3 92/13 92/14 92/17 93/14 95/5 98/13 99/3 100/2 100/7 101/4 102/5 102/9 104/5 105/18 107/3 107/6 107/24 108/19 109/2 109/3 109/4 109/17 109/18 109/23 110/21 111/10 115/5 115/16 117/17 117/17 118/21 118/25 122/21 123/4 127/8	L La [5] 76/15 76/24 97/23 114/11 219/6 labour [9] 6/21 9/11 9/17 9/18 10/2 10/14 38/7 73/6 97/2 lack [4] 99/21 101/25 178/4 212/7 lacking [1] 100/1 lady [21] 1/4 8/5 62/7 76/2 76/8 76/9 76/16 113/22 114/12 139/6 141/23 142/5 144/5 147/7 167/13 170/7 171/9 178/18 187/4 187/17 218/5 Lambie [1] 42/21 Langdale [10] 1/3 1/10 1/11 12/11 20/8 187/16 187/21 218/13 219/4 219/10 language [1] 170/3 lapse [1] 129/5 largely [2] 40/14 84/3 Larger [1] 171/12 largest [1] 120/22 last [10] 6/12 64/14 73/25 83/7 83/13 97/20 115/18 124/4 132/23 151/13 late [1] 215/3 later [22] 19/23 21/4 24/24 35/17 51/11 53/20 55/10 75/23 76/6 79/4 109/19 110/18 118/23 132/13	197/24 201/17 204/18 206/19 210/6 210/15 214/19 215/20 217/5 Letby's [3] 116/15 116/19 185/6 letter [32] 6/8 7/23 58/1 58/21 58/24 59/3 60/5 60/9 60/10 60/13 60/20 60/22 61/14 116/18 118/6 157/5 157/14 157/16 184/24 185/5 185/5 185/14 196/6 200/11 203/25 204/4 205/12 207/5 207/19 207/20 208/19 210/11 letters [1] 63/16 level [23] 11/4 20/16 55/16 82/16 84/7 84/8 86/19 86/22 90/20 94/2 94/11 94/12 94/23 96/12 99/14 105/4 124/13 125/13 126/14 129/12 138/13 152/1 153/9 Level 2 [2] 90/20 129/12 Level 3 [1] 152/1 levels [4] 94/10 127/21 128/1 208/2 liaise [1] 111/21 lie [1] 17/21 light [2] 83/3 181/21 like [53] 4/12 8/11 12/17 12/22 13/11 19/19 22/16 23/3 23/12 25/13 34/9 37/3 38/15 40/2 52/20 52/24 53/9 53/25 55/17 66/17 67/14 68/19 69/20 73/9 74/13 75/20 76/20 85/19 85/21 86/3 91/4 91/22 92/14 93/3 95/2 96/10 100/22 105/16 109/5 111/2 117/1 136/23 137/23 139/22 149/25 168/4 168/23 170/14 186/25 187/18 191/19 199/23 206/4 like-minded [2] 12/17 12/22 liked [3] 89/23 91/25 93/20 likely [10] 28/14 29/15 31/22 34/5 35/6 45/2 93/6 133/9 174/3 190/21 limited [4] 93/18 112/3 172/6 192/20 line [14] 8/9 120/24 121/8 121/11 121/17 121/18 133/6 179/25 197/23 201/20 204/14	

L	112/5 118/15 121/17 141/8 151/16 154/6 158/13 160/14 looking [32] 13/10 17/10 18/17 23/25 34/19 38/20 50/5 50/25 63/5 69/19 70/17 73/2 84/11 87/10 96/3 104/8 108/2 127/23 136/3 136/19 136/25 137/16 145/22 146/8 148/12 150/23 156/9 160/10 168/9 200/10 216/19 216/20 looks [4] 27/10 69/16 69/20 123/1 Lorraine [1] 48/1 losing [1] 162/19 loss [2] 2/8 174/24 lost [5] 46/15 98/17 112/4 130/12 200/21 lot [24] 7/18 24/9 48/16 81/14 83/12 83/16 83/23 93/23 99/6 99/10 106/8 106/25 107/2 107/22 114/24 114/25 118/17 121/9 127/23 137/1 137/23 179/14 194/12 217/14 lots [11] 85/25 89/24 93/17 97/3 98/15 108/14 131/4 137/4 139/12 139/13 140/8 loud [1] 126/23 loudly [1] 69/7 low [1] 124/9 Lucy [11] 55/20 55/20 56/1 58/3 58/13 116/19 117/23 119/11 119/12 158/4 186/23 Lucy Letby [8] 55/20 55/20 56/1 117/23 119/11 119/12 158/4 186/23 Lucy Letby's [1] 116/19 Lucy's [1] 195/18 lunch [1] 114/1 luncheon [1] 114/9 lungs [1] 34/9	173/6 175/15 176/20 179/23 185/16 185/19 194/10 196/19 197/22 198/1 211/10 213/8 215/3 main [3] 183/2 188/16 217/7 mainly [1] 188/20 major [6] 194/11 204/20 208/21 209/2 214/20 214/22 make [35] 3/12 6/12 18/14 21/12 26/9 28/2 31/20 33/18 55/19 60/8 61/13 62/20 64/15 73/8 89/14 98/20 101/9 104/3 104/6 122/16 124/18 137/6 138/1 141/10 148/5 148/13 151/4 154/9 161/11 162/6 162/18 166/12 195/22 196/24 201/22 making [14] 12/16 14/8 63/3 96/9 107/12 108/11 122/10 151/4 160/5 162/8 193/5 193/9 200/22 212/3 male [1] 55/23 manage [2] 108/12 154/8 managed [5] 85/23 101/10 123/24 199/1 199/14 management [39] 11/3 11/25 15/24 16/9 26/20 51/11 94/10 94/12 94/12 96/14 97/19 101/13 101/25 102/16 108/24 144/3 147/1 147/3 149/2 150/14 150/17 151/2 151/4 158/20 159/7 166/20 166/23 166/25 167/3 167/10 172/8 183/24 184/1 186/10 186/11 186/20 187/2 188/23 202/11 managements [1] 15/12 manager [5] 11/17 17/22 98/3 98/4 98/5 managerial [1] 94/23 managers [17] 94/2 98/7 101/17 101/17 102/3 114/20 114/24 115/1 129/20 160/9 165/13 172/15 173/22 184/18 213/3 213/3 213/7 managing [4] 9/11 39/11 84/18 96/6 mandatory [1] 139/4 manner [1] 203/6	manpower [1] 65/4 many [12] 48/1 63/16 99/18 100/15 100/17 101/16 109/20 110/3 122/24 124/10 140/18 205/13 March [11] 4/21 47/3 48/11 58/1 125/6 125/9 130/18 133/15 154/14 155/13 215/21 March 2016 [1] 215/21 March 2017 [1] 155/13 marginalised [2] 171/17 183/11 marked [1] 166/25 material [1] 6/15 maternal [1] 45/7 maternity [2] 139/5 139/10 Matron [4] 102/6 102/10 102/20 102/22 matter [16] 10/4 18/6 22/16 30/23 34/1 34/2 110/25 145/24 159/14 162/13 163/6 163/8 163/17 164/25 184/23 201/16 matters [7] 18/16 91/19 96/14 136/17 162/2 184/7 207/13 may [51] 1/4 2/3 2/14 3/20 3/22 6/19 6/20 13/18 13/23 15/25 18/24 19/23 21/4 23/5 31/4 32/10 36/3 37/3 39/24 41/11 43/9 44/1 44/12 46/9 46/11 48/8 52/5 71/9 77/5 79/8 87/12 113/18 118/11 120/7 124/22 124/24 142/15 145/13 154/6 154/22 156/16 171/18 171/18 177/19 179/11 181/9 187/17 197/8 202/14 213/25 217/18 maybe [7] 52/21 74/16 105/1 151/3 161/23 168/22 181/18 McCormack [37] 1/5 1/8 1/9 1/12 1/21 2/12 6/23 13/25 16/21 21/24 24/24 26/19 27/15 28/8 30/3 32/5 35/5 35/17 41/10 42/4 57/12 59/2 61/13 62/5 62/10 62/14 62/21 63/14 64/8 66/4 68/24 70/18 75/25 76/5 96/25 185/17 219/3 McGuigan [15] 76/17 76/19 76/21 76/22 77/2 77/3 78/16 111/4	114/3 114/12 117/18 141/21 141/24 142/1 219/5 McGuigan's [1] 113/24 McQueen [1] 1/7 MD [5] 1/16 192/24 215/24 216/5 216/15 me [118] 2/17 8/25 10/7 10/17 12/6 13/17 16/16 18/25 19/4 20/5 21/4 26/25 29/14 34/14 35/19 39/11 42/10 42/19 45/4 48/12 53/19 54/21 54/23 55/15 55/19 55/24 59/18 59/19 59/22 60/2 60/2 60/5 60/19 60/21 60/23 62/1 70/7 86/15 88/16 89/10 89/13 91/11 91/11 94/18 95/4 95/5 95/5 96/4 97/4 98/24 100/6 101/14 103/7 103/16 104/2 104/24 105/8 105/9 111/2 115/1 117/10 119/2 119/21 129/14 132/11 132/12 132/16 132/22 132/23 132/24 133/23 137/16 138/19 138/23 139/2 148/3 149/15 150/21 151/11 155/13 155/23 156/18 157/2 157/6 157/7 160/20 160/24 162/12 163/11 166/6 167/19 167/21 168/1 169/22 170/4 190/11 190/12 190/17 190/18 190/23 191/1 191/2 191/8 191/11 192/16 194/5 199/11 203/21 203/21 204/2 209/2 209/6 210/11 211/9 211/12 211/18 213/14 216/7 mean [17] 27/12 30/22 34/23 66/24 97/24 98/25 101/15 101/16 108/2 117/9 145/1 155/6 176/4 186/13 187/7 191/6 217/17 meaning [1] 98/22 means [1] 98/1 meant [7] 6/1 6/2 7/8 65/18 184/10 199/15 199/17 meantime [1] 109/20 measured [2] 116/7 120/1 media [3] 107/19 127/17 210/19 medical [106] 3/1 3/6
----------	---	---	---	---

<p>M</p> <p>medical... [104] 3/10 8/18 12/1 15/13 22/7 22/13 22/18 22/19 27/4 73/19 73/23 74/15 78/17 95/3 98/3 142/19 143/5 143/7 143/12 143/16 143/20 143/25 144/3 144/7 144/11 144/19 144/23 145/13 145/25 146/1 146/5 146/18 147/2 147/4 147/13 148/25 149/4 149/18 149/24 149/25 150/13 150/19 150/20 157/6 158/13 161/19 162/13 162/20 163/5 163/14 163/17 165/7 166/17 167/1 167/5 167/7 167/16 168/3 168/12 168/15 168/23 168/24 169/2 169/4 170/6 170/9 170/19 170/21 172/8 173/17 173/23 174/4 174/20 174/22 174/22 175/25 176/3 179/7 182/2 182/7 184/5 184/8 189/14 189/20 189/22 189/25 190/13 190/17 192/20 193/15 197/15 207/10 211/25 212/1 212/6 212/8 212/9 212/12 212/14 212/16 213/4 213/17 213/22 216/24</p> <p>medically [6] 211/23 211/24 212/4 213/22 213/24 214/14</p> <p>medicine [1] 1/14</p> <p>meet [5] 52/10 89/9 95/4 146/10 156/5</p> <p>meeting [236]</p> <p>meetings [57] 4/9 4/11 4/13 4/17 4/23 5/1 5/7 5/10 5/24 6/5 13/23 14/21 15/1 15/3 18/12 30/19 42/15 42/15 44/23 51/8 51/14 51/15 58/8 63/24 63/24 73/5 112/19 118/22 118/24 145/25 146/7 146/8 148/8 149/20 149/22 150/19 150/25 151/13 161/23 161/25 162/1 162/4 162/5 163/22 163/24 165/3 165/5 167/10 170/15 173/14 179/6 180/18 184/2 188/25 189/1 189/5 215/10</p> <p>Melius [2] 104/16</p>	<p>154/12</p> <p>melodramatic [1] 196/2</p> <p>member [17] 1/17 53/24 54/5 56/6 70/19 77/12 79/8 85/7 87/1 103/18 103/19 105/22 107/15 152/17 154/22 154/24 186/3</p> <p>members [16] 5/3 6/9 8/18 64/2 64/3 70/24 89/9 141/4 143/15 143/15 146/15 163/5 196/23 197/7 197/8 213/10</p> <p>membership [2] 144/22 144/22</p> <p>memoire [1] 6/2</p> <p>memorable [1] 70/10</p> <p>memorandum [1] 75/7</p> <p>memories [1] 129/5</p> <p>memory [15] 88/4 93/5 103/6 103/16 110/24 111/15 111/22 117/19 119/25 121/16 149/6 155/6 156/6 160/19 166/8</p> <p>mention [3] 15/17 50/12 163/11</p> <p>mentioned [14] 20/7 20/17 41/5 50/13 53/4 74/17 82/8 86/19 130/16 130/22 165/16 194/4 195/12 195/13</p> <p>mentioning [1] 111/17</p> <p>met [19] 51/24 60/10 82/4 88/23 89/21 92/10 92/18 92/25 93/5 119/11 131/24 135/4 163/21 163/22 199/24 200/14 202/2 202/4 210/6</p> <p>method [1] 30/15</p> <p>methodology [1] 217/15</p> <p>MICHAEL [3] 76/21 77/2 219/5</p> <p>Michael Patrick [1] 77/2</p> <p>middle [4] 84/7 120/21 154/12 176/10</p> <p>midnight [1] 50/15</p> <p>midwife [3] 99/25 100/10 102/5</p> <p>midwifery [16] 12/3 12/24 15/12 17/23 18/1 18/17 18/18 24/15 26/12 40/18 43/6 47/14 69/21 98/3 102/4 102/14</p> <p>midwives [2] 69/16 213/3</p>	<p>might [62] 11/2 13/6 18/11 24/12 33/3 33/8 40/4 47/13 49/17 63/24 76/17 82/25 83/3 86/1 86/2 86/2 86/4 86/5 86/18 93/9 102/13 103/15 103/25 104/6 104/12 105/17 106/23 106/24 107/15 113/4 113/12 116/15 126/10 130/12 131/8 131/9 132/8 134/18 135/8 135/9 137/5 138/4 140/5 140/19 145/18 145/18 145/19 153/12 153/12 153/14 155/19 158/11 174/5 175/22 176/20 182/12 193/25 193/25 195/11 209/17 209/18 214/15</p> <p>Millward [1] 48/1</p> <p>mind [11] 30/14 43/20 54/11 54/16 65/25 72/7 79/6 105/12 108/20 126/25 210/5</p> <p>minded [2] 12/17 12/22</p> <p>mindful [1] 86/10</p> <p>mine [2] 67/3 154/8</p> <p>minimal [1] 98/24</p> <p>minimum [1] 146/11</p> <p>minute [2] 162/23 196/2</p> <p>minuted [4] 86/19 161/24 163/1 166/8</p> <p>minutes [22] 21/5 21/9 52/16 62/22 92/13 120/6 120/7 149/8 151/12 162/1 170/6 173/12 174/15 175/6 175/15 176/24 178/19 178/22 180/18 182/13 183/19 187/7</p> <p>misconduct [1] 193/7</p> <p>misinterpretation [1] 25/17</p> <p>misleading [2] 179/2 181/4</p> <p>misled [1] 180/15</p> <p>misplaced [1] 209/25</p> <p>Miss [1] 197/24</p> <p>Miss Letby [1] 197/24</p> <p>missed [3] 131/12 140/1 181/15</p> <p>missing [1] 24/20</p> <p>mistake [2] 81/8 131/15</p> <p>Mittal [1] 153/19</p> <p>mode [1] 30/15</p> <p>moderate [3] 21/16 21/21 22/22</p>	<p>modified [1] 50/10</p> <p>moment [10] 19/8 21/24 24/8 91/2 114/1 117/6 127/25 182/14 193/10 202/24</p> <p>Monday [1] 52/2</p> <p>monitored [1] 87/8</p> <p>month [1] 109/19</p> <p>months [19] 3/11 53/20 55/10 80/12 80/22 81/19 82/6 90/6 95/4 95/14 116/20 126/10 135/25 163/25 164/6 164/6 170/10 171/11 191/12</p> <p>morale [1] 89/20</p> <p>morbidity [4] 4/9 4/12 18/23 158/17</p> <p>more [51] 10/25 11/2 15/6 35/6 35/20 46/20 49/5 62/6 83/3 84/5 87/15 88/18 89/15 91/8 91/12 92/8 93/9 93/23 100/10 100/11 102/25 103/2 109/12 109/20 129/4 129/5 130/23 130/24 130/24 131/8 131/12 136/17 137/2 146/15 154/23 163/19 165/8 167/22 168/5 168/17 168/18 175/4 176/8 178/15 187/1 188/15 190/21 201/24 211/8 211/11 215/8</p> <p>morning [20] 1/4 39/16 51/10 51/16 51/25 52/3 52/4 52/11 97/1 98/14 111/5 111/16 199/25 200/6 202/2 202/5 202/20 209/21 209/22 218/13</p> <p>Morpeth [1] 142/13</p> <p>mortality [22] 4/9 4/13 5/6 6/4 15/15 18/23 47/2 49/13 49/14 49/18 83/10 90/16 117/14 124/8 124/9 128/2 140/10 155/16 155/20 158/17 186/2 208/2</p> <p>mortem [4] 34/8 34/15 35/11 46/11</p> <p>mortems [2] 45/14 131/7</p> <p>most [12] 5/11 34/5 63/23 113/6 141/1 141/2 141/7 141/20 145/8 173/2 213/10 213/19</p> <p>mother [26] 17/9 28/21 28/24 29/2 29/10 30/22 31/5 31/11 31/18 31/20</p>	<p>32/18 33/15 33/20 33/23 34/17 35/23 36/6 37/18 37/19 37/25 38/13 38/20 38/25 39/7 42/3 46/13</p> <p>Mother A [2] 17/9 42/3</p> <p>Mother C [14] 28/21 28/24 29/2 29/10 30/22 31/5 31/11 31/18 31/20 32/18 33/15 33/23 35/23 36/6</p> <p>mother's [1] 45/22</p> <p>mothers [2] 2/1 38/18</p> <p>mothers' [1] 2/5</p> <p>motivated [1] 12/9</p> <p>mottling [1] 103/12</p> <p>mount [2] 215/24 216/15</p> <p>mounted [1] 217/9</p> <p>move [6] 2/22 39/12 41/11 68/11 68/13 87/18</p> <p>moved [8] 56/16 103/20 104/14 128/4 132/20 139/3 172/13 204/18</p> <p>moving [2] 2/5 3/14</p> <p>Mr [81] 27/8 55/11 55/13 57/7 57/18 59/2 59/8 60/16 61/3 62/15 62/15 62/17 62/21 66/13 68/24 76/15 76/24 92/10 92/11 92/12 92/25 93/5 97/23 114/11 120/19 144/9 146/3 146/6 147/11 147/11 147/13 148/10 149/23 150/5 160/2 161/20 161/24 162/11 163/4 163/22 164/8 166/7 166/10 166/15 166/24 166/24 167/9 168/1 169/22 170/13 171/13 172/20 173/17 173/18 174/6 175/21 179/6 181/5 181/6 184/3 184/9 185/17 189/15 189/25 190/6 191/22 192/8 193/17 195/5 195/11 198/11 198/24 199/13 207/6 207/10 207/19 208/17 211/5 211/6 217/17 219/6</p> <p>Mr Butcher [4] 144/9 170/13 171/13 173/18</p> <p>Mr Butcher's [1] 175/21</p> <p>Mr Chambers [15] 61/3 62/15 92/10 93/5 120/19 146/6 147/11</p>
--	---	--	---	---

M	187/5	13/10 16/11 18/14	58/15 59/23 64/8 77/1	26/17 31/17 32/1
Mr Chambers... [8]	Ms Browne [1] 142/6	27/21 30/7 30/14	85/10 85/16 113/18	32/16 38/23 40/6
167/9 174/6 198/24	Ms Bullock [4]	31/19 32/4 34/7 34/16	142/12 147/12 202/8	41/18 42/22 43/25
199/13 207/6 207/19	132/14 135/7 135/17	36/18 39/15 42/2 46/7	named [2] 41/15	44/2 44/13 45/20
208/17 211/5	136/7	46/22 50/19 52/20	185/16	45/22 47/2 47/11
Mr Cross [2] 62/17	Ms Fogarty [1] 62/15	53/17 59/3 59/14 62/7	namely [1] 83/17	47/20 47/21 48/15
66/13	Ms Killingback [4]	63/5 63/6 63/23 68/5	names [1] 196/6	52/13 58/6 58/9 58/16
Mr De La Poer [5]	8/7 15/8 48/8 199/24	68/15 68/19 70/4 74/1	narrative [4] 114/13	69/22 82/3 83/8 83/22
76/15 76/24 97/23	Ms Langdale [8] 1/3	74/11 75/6 75/24 76/2	115/6 157/7 177/5	88/14 89/11 89/16
114/11 219/6	1/10 1/11 187/16	76/8 76/9 76/16 78/15	narrow [1] 114/18	93/10 95/22 96/1 97/2
Mr Detective	187/21 218/13 219/4	79/6 81/5 81/13 81/15	natally [1] 17/12	100/3 100/4 100/7
Inspector Hughes	219/10	83/24 85/24 88/4 88/5	national [1] 151/7	100/8 100/13 100/23
[1] 172/20	Ms Letby [15] 158/9	89/12 90/4 90/11	natural [13] 6/6	101/7 101/21 102/8
Mr Harvey [39] 27/8	191/10 193/4 193/24	91/23 92/11 92/13	20/20 42/17 45/3	102/24 103/9 104/5
55/11 55/13 57/7	196/1 196/3 197/2	93/5 95/2 95/4 96/9	49/23 50/5 65/23	115/13 119/6 119/13
57/18 59/8 62/15	201/17 204/18 206/19	99/24 103/6 103/16	115/17 115/20 130/12	122/24 122/25 123/13
92/11 92/12 92/25	210/6 210/15 214/19	104/22 110/7 110/17	139/23 210/3 214/6	124/7 127/5 133/3
146/3 147/11 149/23	215/20 217/5	110/24 111/22 112/2	naturally [1] 37/23	133/5 139/5 140/9
160/2 162/11 163/4	Ms Weatherley [3]	113/22 114/12 115/2	nature [4] 19/14	140/14 141/5 141/15
163/22 164/8 166/7	184/25 185/6 185/14	116/16 118/15 118/21	70/14 71/23 103/24	141/19 154/17 154/23
166/10 166/15 168/1	MSC [5] 144/2	119/3 119/20 119/25	navigating [1] 165/12	155/6 155/8 158/18
173/17 179/6 181/5	167/19 171/19 173/7	120/2 121/5 121/16	near [2] 114/24	158/19 165/21 173/24
181/6 184/3 184/9	184/10	125/22 128/15 131/15	114/25	186/2 190/16 206/8
189/15 189/25 190/6	much [36] 2/11 7/10	132/11 133/10 134/4	nearer [1] 120/12	208/2
191/22 192/8 193/17	24/25 30/25 32/13	134/10 135/11 135/20	nearby [1] 45/17	neonate [1] 8/20
195/5 195/11 198/11	62/9 67/15 69/25	139/2 139/22 140/2	necessarily [6] 22/13	neonates [8] 11/16
211/6 217/17	75/23 75/23 76/4 76/5	141/22 141/23 142/5	81/10 81/16 83/1	12/8 21/17 25/25
Mr Harvey's [1]	76/8 85/13 89/5 96/22	144/5 147/7 148/15	140/4 140/17	77/22 83/13 123/17
150/5	98/11 105/13 118/23	150/18 151/25 152/3	necessary [7] 9/10	139/10
Mr Ian Harvey [5]	141/25 142/1 148/22	153/5 153/11 155/6	31/7 45/21 46/11	neonatologist [1]
60/16 161/20 161/24	150/11 155/7 157/19	157/6 157/21 157/23	60/18 74/21 209/5	17/13
166/24 169/22	158/2 174/18 174/23	161/9 162/7 164/11	need [30] 2/22 23/17	neonatologists [4]
Mr Jameson [2]	177/5 187/3 187/6	165/3 165/20 166/8	28/8 33/4 34/24 35/20	16/2 17/5 24/18
147/13 148/10	190/21 201/10 201/14	166/14 166/16 166/23	41/5 41/10 41/11	139/15
Mr McCormack [4]	218/6 218/11	167/10 167/13 169/10	67/16 68/14 74/23	neonatology [6] 8/25
59/2 62/21 68/24	multi [3] 15/11 47/1	170/7 171/9 173/25	86/12 88/17 95/11	13/22 26/2 30/25
185/17	83/18	178/18 179/6 179/6	100/22 107/12 111/1	77/16 212/18
Mr Rheinberg [1]	multi-disciplinary [1]	185/25 187/4 187/17	120/24 121/10 128/25	network [2] 33/12
207/10	15/11	188/19 189/17 192/10	130/11 130/13 164/24	88/14
Mr Tony Chambers	mum [6] 36/24 45/16	193/16 194/5 194/12	173/19 174/10 181/14	never [11] 13/15
[1] 166/24	45/18 46/2 46/4 46/19	194/12 194/16 198/7	183/15 196/20 218/10	20/19 32/23 43/20
Mrs [4] 1/7 147/11	mums [2] 29/24	200/15 200/16 201/7	needed [25] 31/16	72/7 74/11 95/17
147/11 195/18	46/22	201/10 203/3 203/3	31/20 39/10 40/16	120/6 128/15 151/5
Mrs Hodgkinson [1]	murder [1] 214/20	203/24 206/4 206/12	40/20 45/22 45/24	210/8
147/11	murderer [13] 52/23	209/23 213/5 215/2	79/12 82/19 96/16	nevertheless [1]
Mrs Kelly [1] 147/11	53/25 54/5 54/7 56/2	215/11 215/17 216/23	102/12 105/23 113/6	213/20
Mrs McQueen [1] 1/7	56/5 56/14 56/17	217/7 217/23 218/5	119/6 124/14 127/8	new [9] 3/9 3/14 3/21
Mrs Rees [1] 195/18	56/18 57/12 59/1 69/2	my Lady [19] 1/4 8/5	127/10 138/21 147/23	101/23 109/17 138/9
Ms [42] 1/3 1/10 1/11	196/24	62/7 76/2 76/8 76/9	148/20 151/3 161/11	173/16 175/25 175/25
8/7 12/11 15/8 20/8	murdering [2] 205/10	76/16 113/22 114/12	174/2 184/19 205/17	newborn [1] 208/2
48/8 62/15 132/14	205/10	142/5 144/5 147/7	needing [1] 82/16	next [14] 10/14 29/16
135/7 135/17 136/7	murders [1] 61/16	167/13 170/7 171/9	needs [6] 28/2 59/20	64/8 76/16 93/8
142/6 142/11 154/5	Murphy [2] 102/21	178/18 187/4 187/17	86/8 98/16 99/7	104/12 116/12 119/17
158/9 184/25 185/6	102/23	218/5	124/17	141/11 149/15 149/16
185/14 187/5 187/16	must [16] 44/6 48/14	myself [11] 5/21	negative [1] 193/4	193/16 216/10 216/12
187/21 191/10 193/4	72/18 86/24 107/21	34/15 44/2 52/21	negatively [1] 214/18	NHS [4] 112/2 112/18
193/24 196/1 196/3	133/17 146/14 149/7	67/22 132/25 133/12	negotiating [3]	137/1 137/4
197/2 199/24 201/17	151/18 159/14 187/2	135/23 137/24 206/18	188/11 188/20 189/1	nice [2] 89/21 92/14
204/18 206/19 210/6	191/3 205/19 214/10	211/21	neonatal [92] 6/20	Nichol [12] 145/10
210/15 214/19 215/20	214/11 214/12	N	9/20 9/22 10/14 10/16	163/23 164/8 164/10
217/5 218/13 219/4	mutual [1] 144/1	nagging [1] 128/9	13/6 15/14 15/24 16/1	164/15 164/24 165/5
219/8 219/10	mutually [1] 189/2	name [14] 26/23	16/20 18/5 21/5 21/10	173/6 173/16 175/19
Ms Brown [2] 154/5	my [158] 1/4 2/7 2/7	28/10 55/22 58/13	21/13 25/11 25/16	176/11 183/20
	3/15 5/10 8/5 13/9		26/3 26/10 26/14	Nicol [2] 164/19

N	138/16 139/8 139/14 161/24 183/21 211/23 212/4 213/23 214/14 non-deliberate [1] 108/18 non-execs [1] 139/14 non-executive [3] 139/8 183/21 213/23 non-medically [2] 211/23 214/14 non-minuted [1] 161/24 none [2] 22/3 22/19 nor [1] 55/22 normal [2] 95/1 99/18 normally [3] 38/2 125/18 145/7 Norris [1] 74/10 north [3] 84/4 84/7 84/12 north-west [3] 84/4 84/7 84/12 not [191] 2/21 6/18 6/19 7/18 8/24 11/8 13/8 14/1 15/5 15/25 16/11 16/25 17/1 17/15 17/16 17/16 20/12 21/13 21/15 21/23 22/7 22/13 24/2 24/11 25/2 25/10 26/5 26/6 26/7 29/7 29/12 29/21 30/1 30/2 30/24 32/12 32/14 33/1 33/4 34/1 34/18 35/4 35/7 35/9 35/14 37/23 39/16 39/20 39/22 40/15 41/20 41/25 44/2 44/7 44/19 45/22 46/6 46/11 49/16 49/22 50/9 52/15 56/2 56/3 56/7 58/22 61/7 61/21 67/3 67/23 68/1 68/5 69/2 70/3 70/10 73/21 74/15 75/3 82/12 83/1 84/25 85/1 85/9 85/16 86/4 86/24 88/10 96/23 103/8 103/13 108/5 110/25 111/3 111/6 111/8 111/17 117/21 118/2 119/7 120/2 121/12 121/18 123/16 126/4 126/11 126/12 126/13 126/22 129/20 131/6 135/5 136/4 136/13 137/15 137/20 138/14 138/22 140/3 140/10 140/18 144/8 145/15 150/10 150/25 152/9 159/8 159/13 159/18 161/1 161/13 162/1 162/12 162/22 163/4 163/13 164/7 164/8	164/18 164/23 165/25 166/8 168/12 169/3 172/5 174/15 176/15 180/3 180/19 181/15 183/24 184/4 190/19 190/19 191/2 191/7 191/8 193/25 196/2 196/14 197/6 198/6 198/6 198/16 198/22 198/22 199/7 200/23 202/19 204/17 205/20 206/1 206/5 206/14 206/17 207/2 207/16 207/22 208/21 209/8 209/9 209/11 210/2 210/18 212/7 212/8 213/24 213/24 214/6 217/2 217/25 217/25 note [2] 6/8 206/23 noted [2] 117/10 199/1 notes [11] 16/16 16/17 24/9 28/25 62/16 62/23 63/2 63/4 153/15 177/7 179/23 nothing [16] 24/12 26/14 58/25 75/10 115/21 116/9 192/15 194/25 198/9 200/20 200/21 203/4 203/10 210/20 212/2 212/4 notice [1] 62/7 noticed [1] 149/13 November [5] 38/22 38/24 43/6 156/25 170/10 November 2015 [2] 38/22 43/6 now [77] 2/15 8/6 8/11 9/24 12/6 12/15 12/21 13/18 14/16 17/14 18/21 19/4 24/24 28/19 40/21 43/25 48/23 55/20 56/21 61/12 61/15 68/7 68/22 71/8 73/24 74/16 81/17 82/10 82/14 88/20 91/2 92/17 93/11 97/11 100/25 102/3 102/7 102/24 103/1 104/16 108/2 109/23 110/14 111/4 113/25 115/5 118/18 122/1 125/6 129/21 132/21 136/24 139/3 139/3 139/8 140/11 141/11 142/5 151/20 152/23 153/22 156/23 166/19 168/7 169/19 170/5 172/13 173/11 173/17 188/8 199/24 201/8 204/10 207/4 208/5 211/5 211/20	number [21] 4/13 21/13 43/1 44/23 63/18 72/8 81/25 89/9 89/12 103/9 103/10 127/6 127/7 127/14 128/24 154/3 154/14 156/2 158/18 170/14 170/18 numbers [7] 72/12 139/23 170/15 171/12 175/7 182/8 183/23 nurse [17] 12/25 52/18 52/23 56/4 56/6 56/9 56/9 56/10 56/12 56/13 64/9 65/9 65/11 65/19 102/7 159/3 214/12 nurses [12] 42/22 43/3 48/25 96/3 96/11 99/25 127/18 128/7 190/4 213/3 213/7 214/6 nursing [21] 27/3 53/11 58/8 71/18 79/2 89/10 98/2 100/10 102/5 102/7 102/8 102/15 102/24 115/1 213/11 213/17 213/21 213/24 214/2 214/3 214/5 O o'clock [3] 114/5 218/14 218/16 objection [1] 149/21 obligation [3] 129/19 129/21 129/25 oblique [1] 93/13 observations [2] 138/1 166/23 observe [2] 95/12 191/20 observed [4] 42/22 94/1 94/16 95/22 observer [1] 192/2 obstetric [21] 9/6 9/10 10/17 14/14 16/8 16/17 18/2 25/7 25/8 25/10 25/12 25/21 25/21 26/2 26/12 26/13 47/25 49/16 53/1 65/3 71/1 obstetrician [7] 4/8 9/1 9/17 17/6 32/22 33/2 45/10 obstetricians [4] 1/18 1/19 52/11 53/9 obstetricians' [1] 97/1 obstetrics [9] 3/4 9/21 12/23 13/21 17/8 18/16 40/15 41/19 96/20 obstruct [1] 141/14	obtain [2] 49/5 180/18 obvious [7] 37/10 82/13 109/5 109/6 136/9 207/1 209/1 obviously [14] 6/20 12/6 20/23 30/10 30/17 53/1 63/2 93/14 95/6 118/17 134/13 155/12 179/13 214/17 occasion [2] 145/18 145/19 occur [3] 79/22 163/24 204/19 occurred [8] 9/10 15/25 50/14 51/18 151/6 163/25 178/17 181/20 occurring [4] 50/22 69/11 86/21 103/18 occurs [2] 38/17 99/5 October [3] 1/1 21/10 218/19 odd [5] 50/12 50/14 51/7 55/15 154/17 off [8] 8/19 76/7 126/11 160/11 197/15 201/23 202/13 204/6 offer [1] 171/4 offered [1] 157/24 office [12] 55/14 55/18 57/18 60/2 74/1 156/6 161/24 162/5 190/1 195/12 200/1 203/19 officer [6] 28/11 75/15 152/20 153/10 160/18 186/5 officer Debbie Peacock [1] 28/11 officers [2] 189/9 189/12 offices [5] 10/8 10/15 10/16 10/17 97/2 official [1] 56/21 often [12] 39/12 63/20 78/22 85/2 98/13 99/9 108/17 139/23 139/25 141/1 146/4 187/6 Oh [2] 46/20 72/1 okay [7] 2/18 5/1 21/7 123/1 189/14 211/17 217/22 old [2] 34/20 34/24 on [279] on-call [5] 9/12 9/16 9/20 153/7 200/9 once [8] 3/14 17/4 38/8 71/19 83/2 123/22 138/15 146/10 one [92] 3/5 4/11 6/6 8/19 10/18 14/2 14/10 14/22 16/2 16/4 16/15
----------	--	--	--	--

<p>O</p> <p>one... [81] 18/11 23/8 25/15 25/15 27/5 27/12 27/19 33/5 35/4 46/4 47/3 48/5 48/18 51/3 51/10 51/10 51/15 51/16 51/25 52/14 53/5 55/9 55/21 67/22 75/14 89/10 97/16 101/5 101/7 103/18 105/14 105/22 108/21 114/20 114/22 115/1 118/24 125/15 128/10 131/1 131/23 134/9 134/10 138/3 141/3 146/25 148/15 151/13 151/15 161/23 164/12 165/18 168/1 171/21 172/14 173/22 173/22 173/25 175/7 177/9 179/6 180/10 182/3 182/11 182/18 184/4 184/23 186/12 186/15 191/1 193/13 193/14 193/21 196/13 197/12 203/8 206/23 209/19 216/21 217/6 217/7</p> <p>one-sided [1] 197/12</p> <p>ones [2] 5/21 184/19</p> <p>ongoing [3] 125/11 171/2 172/13</p> <p>only [57] 12/18 14/25 15/5 16/14 18/15 27/6 27/19 35/4 35/10 36/18 36/22 39/15 39/15 45/7 45/9 54/14 54/15 57/4 58/13 59/15 61/5 62/5 63/2 63/3 64/24 68/19 68/24 71/16 73/10 73/24 73/25 93/18 103/8 103/20 103/22 122/8 134/15 134/15 135/25 148/13 150/18 156/20 157/11 159/8 159/18 165/17 166/8 176/15 178/5 181/7 195/2 203/7 205/21 206/4 206/20 211/24 213/21</p> <p>onset [1] 26/8</p> <p>onwards [2] 145/23 152/24</p> <p>open [6] 7/13 32/23 141/12 165/23 176/9 208/22</p> <p>opening [1] 167/6</p> <p>openly [3] 68/17 68/25 168/21</p> <p>operating [2] 96/19 98/15</p> <p>operative [1] 194/17</p>	<p>ophthalmic [2] 144/10 167/15</p> <p>opinion [11] 68/15 128/15 129/7 129/25 139/2 140/2 161/9 167/7 169/8 212/9 213/5</p> <p>opportunities [2] 131/11 140/1</p> <p>opportunity [13] 10/9 23/11 38/4 44/24 62/3 63/13 75/5 79/11 79/14 83/2 120/3 129/1 197/13</p> <p>opposed [1] 8/25</p> <p>opposite [3] 39/6 114/23 203/5</p> <p>opposition [1] 184/9</p> <p>or [202] 4/3 6/8 6/9 6/9 6/20 7/2 7/24 8/4 10/3 10/10 10/18 11/12 15/6 15/17 15/17 17/2 19/9 19/9 19/21 22/24 24/11 24/16 24/20 25/1 25/2 25/18 26/4 26/14 26/17 27/13 29/7 30/21 32/12 33/6 33/7 34/1 34/21 35/2 38/5 39/3 39/5 39/16 39/16 40/25 42/6 42/8 42/16 43/6 43/7 45/20 45/22 46/6 46/20 47/12 48/15 48/25 49/1 49/17 49/20 50/6 50/7 51/1 52/3 52/17 53/25 54/21 55/23 56/7 57/2 58/14 59/10 60/17 61/22 62/5 62/22 62/24 63/19 64/7 69/7 69/21 70/5 71/18 72/10 74/6 74/6 74/24 75/4 75/4 78/23 78/24 79/2 79/14 79/17 80/1 80/2 80/14 80/18 81/10 81/16 81/21 82/13 82/23 83/11 83/17 84/4 84/10 84/12 85/8 85/16 85/16 85/22 86/24 88/8 88/9 89/2 89/18 90/6 94/15 95/4 97/11 99/22 100/23 101/4 102/13 105/16 106/17 109/4 109/4 111/1 112/15 112/16 113/2 114/20 116/9 118/6 120/2 121/22 122/25 127/9 127/10 128/18 129/20 131/5 132/12 133/8 137/3 138/14 138/25 141/3 143/13 145/25 150/5 150/5 151/7 152/17 152/18</p>	<p>153/13 153/24 154/10 155/11 159/13 160/3 161/23 163/16 164/23 168/16 168/22 175/17 177/3 177/9 179/15 181/4 183/11 190/2 190/22 191/2 191/23 192/21 193/14 193/20 193/24 195/8 196/14 198/3 198/11 199/7 200/5 200/8 203/16 205/13 206/24 208/6 209/9 209/18 211/11 211/20 213/15 213/24 215/13 216/2 217/11 217/20</p> <p>orchestrated [1] 185/7</p> <p>order [3] 107/7 191/9 191/17</p> <p>ordinary [1] 78/17</p> <p>organ [2] 45/12 45/25</p> <p>organisation [11] 4/23 89/9 98/12 104/17 136/21 137/10 137/12 139/11 139/12 152/12 172/22</p> <p>organisational [2] 197/19 206/9</p> <p>organisations [1] 137/4</p> <p>organised [1] 5/1</p> <p>OSR [7] 14/7 16/9 16/10 24/3 27/25 42/2 69/18</p> <p>other [66] 8/1 8/22 9/24 10/11 10/13 13/10 27/4 27/7 29/24 32/5 33/3 42/7 50/12 51/16 53/4 74/3 80/2 89/22 90/5 94/5 96/5 96/19 97/22 99/15 100/22 109/13 113/2 114/21 119/21 119/22 126/11 127/19 127/20 128/23 129/2 130/1 132/18 133/6 136/14 140/18 140/18 144/8 149/25 150/2 160/3 161/8 163/5 167/22 168/4 168/23 169/3 169/14 171/16 174/1 177/16 178/14 178/25 183/8 183/10 190/3 194/1 197/18 201/16 211/23 213/17 213/23</p> <p>others [9] 10/19 36/16 121/21 147/10 170/13 171/14 205/6 205/9 217/19</p> <p>otherwise [1] 207/2</p> <p>our [44] 10/12 10/14 10/19 11/17 12/1 12/2</p>	<p>12/8 14/25 15/1 15/3 26/8 26/9 31/22 34/2 38/25 39/12 45/13 45/17 48/5 75/16 76/16 82/14 82/17 89/24 97/21 101/23 102/6 104/7 126/8 133/25 134/23 141/10 146/6 162/4 171/4 171/4 171/20 173/22 181/12 201/20 208/2 210/6 210/14 210/14</p> <p>ourselves [1] 10/5</p> <p>out [79] 2/23 7/24 8/1 11/7 14/6 16/11 32/11 33/17 34/1 42/23 42/24 50/14 50/25 53/12 53/12 53/16 57/16 61/8 70/11 83/4 92/21 97/20 104/11 104/14 105/3 105/6 112/20 116/9 116/13 117/2 117/20 118/6 119/2 119/10 123/22 123/25 125/8 126/23 127/16 131/8 132/22 133/14 133/21 133/22 161/18 169/16 175/11 176/25 177/1 177/9 177/22 178/3 179/25 180/24 181/1 181/5 182/14 183/22 184/19 185/24 191/7 195/18 195/20 196/21 198/25 199/6 199/13 199/18 204/5 205/12 205/16 205/20 206/9 206/20 207/1 207/7 208/4 208/15 209/25</p> <p>outcome [6] 17/11 24/16 34/17 110/12 134/5 199/4</p> <p>outcomes [1] 140/11</p> <p>Outline [1] 66/11</p> <p>outset [1] 39/22</p> <p>outside [7] 14/10 89/6 89/17 94/8 94/23 99/17 108/24</p> <p>over [42] 31/20 38/19 55/14 60/1 78/9 83/7 83/13 93/8 95/14 97/12 97/13 105/8 113/6 113/7 113/8 116/20 117/9 122/1 124/3 125/21 126/25 127/15 127/24 130/2 131/4 137/17 142/6 146/12 147/14 156/13 170/19 170/24 171/9 171/15 175/8 175/9 179/22 180/15 180/23 189/17 193/3 212/4</p> <p>overall [3] 123/1 136/18 170/3</p>	<p>overlaps [1] 33/6</p> <p>overly [1] 82/23</p> <p>Overnight [1] 203/11</p> <p>oversight [1] 86/13</p> <p>overspeak [1] 2/21</p> <p>overview [3] 75/10 78/4 177/17</p> <p>overwhelmed [1] 102/11</p> <p>overwhelming [1] 214/3</p> <p>own [26] 11/17 12/8 14/25 47/12 54/11 55/11 74/1 93/5 95/24 97/19 97/21 103/4 104/7 150/5 169/10 169/11 192/11 192/13 197/16 205/11 214/7 215/25 216/1 216/16 217/9 217/10</p> <hr/> <p>P</p> <p>PA [1] 100/7</p> <p>paediatric [42] 5/14 44/24 51/18 54/24 71/1 71/6 78/6 81/20 89/11 93/21 99/22 102/6 102/8 102/15 102/24 107/1 107/1 107/3 111/20 122/19 125/12 126/14 134/21 136/16 138/25 139/21 142/21 147/22 148/1 148/15 151/25 153/6 153/7 161/9 161/21 162/7 172/8 194/5 194/16 216/1 217/8 217/10</p> <p>paediatrician [7] 12/24 20/13 107/18 171/5 177/13 182/14 212/17</p> <p>paediatricians [97] 8/23 11/24 16/18 17/5 19/17 20/9 33/10 42/5 44/4 51/10 51/15 51/24 52/12 53/2 53/11 54/20 54/24 55/21 59/22 59/24 61/7 61/14 63/16 63/17 68/16 75/17 110/3 114/25 119/22 122/11 124/3 133/4 136/3 136/20 139/14 148/15 153/25 154/15 155/15 155/23 156/2 156/3 159/12 159/19 160/8 160/14 162/17 164/4 164/12 165/11 165/17 165/21 168/16 169/6 169/21 170/11 171/17 172/2 176/8 178/6 178/12 178/15 179/20 179/24 180/25</p>
---	--	---	---	--

P				
<p>paediatricians... [32] 181/25 182/12 183/3 184/18 186/1 186/9 186/11 190/4 190/13 190/24 191/19 191/21 192/5 192/25 193/5 193/8 193/14 195/3 197/13 197/23 198/13 198/14 198/16 198/18 203/12 206/2 208/19 209/17 212/3 213/7 214/11 215/3</p> <p>paediatricians' [3] 97/1 181/17 207/19</p> <p>paediatrics [15] 12/25 13/21 41/3 71/18 77/16 77/18 77/22 78/18 93/7 96/19 115/11 147/17 156/19 159/21 183/12</p> <p>paeds [5] 11/16 44/8 52/10 63/10 72/23</p> <p>page [78] 4/14 4/15 4/18 7/16 13/24 15/9 16/12 21/10 21/11 23/15 26/22 26/23 26/24 40/6 40/8 40/10 48/2 48/8 49/9 49/10 57/21 57/25 62/12 62/12 64/6 64/10 64/12 64/13 66/9 68/23 69/14 117/9 120/11 120/21 120/21 127/1 146/12 146/12 146/13 146/16 147/12 147/14 147/18 153/5 154/4 154/12 156/13 167/17 168/7 168/10 170/24 170/25 171/15 171/24 172/18 173/4 175/9 175/9 176/10 179/22 179/22 180/23 180/24 182/17 183/9 183/18 183/18 194/20 195/17 198/23 204/3 205/12 207/5 207/24 208/7 215/23 216/10 216/12</p> <p>page 1 [13] 4/14 4/18 26/22 40/6 40/8 48/2 57/25 62/12 62/12 154/4 173/4 194/20 204/3</p> <p>page 2 [18] 4/15 7/16 13/24 21/10 23/15 26/23 40/10 120/11 120/21 146/12 156/13 167/17 170/24 172/18 175/9 195/17 205/12 207/24</p> <p>page 3 [6] 15/9 26/24 48/8 171/15 171/24</p>	<p>208/7</p> <p>page 31 [1] 68/23</p> <p>page 4 [4] 64/6 64/12 64/13 179/22</p> <p>page 5 [5] 49/9 49/10 66/9 147/14 168/7</p> <p>page 6 [1] 180/24</p> <p>page 8 [1] 182/17</p> <p>page 9 [2] 183/18 215/23</p> <p>pages [2] 25/18 99/9</p> <p>pain [1] 174/24</p> <p>panel [9] 26/24 27/2 27/3 27/18 27/20 28/4 28/10 92/12 177/18</p> <p>paper [2] 16/3 36/9</p> <p>papers [1] 43/15</p> <p>Para [1] 216/23</p> <p>Para d [1] 216/23</p> <p>paragraph [49] 2/25 4/5 9/2 10/25 13/20 14/5 26/20 27/16 41/12 45/4 46/25 47/10 51/12 57/11 57/17 90/13 95/11 120/22 126/22 129/10 143/24 146/23 148/23 151/21 152/15 153/22 153/23 156/8 156/17 158/14 161/17 163/3 165/2 166/21 167/18 169/20 185/24 192/3 195/17 199/22 204/5 204/23 205/3 205/18 207/7 212/24 216/9 216/21 216/22</p> <p>paragraph 1 [1] 205/3</p> <p>paragraph 11 [1] 167/18</p> <p>paragraph 110 [1] 51/12</p> <p>paragraph 12 [2] 2/25 199/22</p> <p>paragraph 15 [1] 143/24</p> <p>paragraph 16 [1] 4/5</p> <p>paragraph 19 [1] 212/24</p> <p>paragraph 2 [1] 204/5</p> <p>paragraph 20 [1] 146/23</p> <p>paragraph 21 [1] 148/23</p> <p>paragraph 22 [2] 153/22 216/9</p> <p>paragraph 24 [1] 158/14</p> <p>paragraph 262 [1] 205/18</p> <p>paragraph 27 [1] 126/22</p> <p>paragraph 3 [3]</p>	<p>195/17 204/23 207/7</p> <p>paragraph 33 [1] 9/2</p> <p>paragraph 34 [1] 161/17</p> <p>paragraph 37 [1] 163/3</p> <p>paragraph 41 [1] 165/2</p> <p>paragraph 45 [1] 166/21</p> <p>paragraph 48 [1] 169/20</p> <p>paragraph 5 [1] 192/3</p> <p>paragraph 51 [1] 10/25</p> <p>paragraph 52 [1] 13/20</p> <p>paragraph 54 [1] 26/20</p> <p>paragraph 55 [1] 27/16</p> <p>paragraph 61 [1] 95/11</p> <p>paragraph 63 [1] 151/21</p> <p>paragraph 64 [1] 152/15</p> <p>paragraph 69 [1] 41/12</p> <p>paragraph 7 [1] 14/5</p> <p>paragraph 71 [1] 185/24</p> <p>paragraph 74 [1] 45/4</p> <p>Paragraph 8 [1] 90/13</p> <p>paragraph 82 [1] 47/10</p> <p>Paragraph 83 [1] 46/25</p> <p>paragraphs [1] 118/9</p> <p>paragraphs 18-20 [1] 118/9</p> <p>parallel [1] 195/5</p> <p>parapet [1] 202/12</p> <p>pardon [1] 39/11</p> <p>parent [3] 32/9 141/3 141/14</p> <p>parents [12] 36/11 37/11 116/16 119/11 141/9 141/10 141/12 141/20 179/3 193/22 193/22 210/25</p> <p>part [21] 15/23 18/11 36/21 38/13 74/16 80/8 89/12 92/11 93/7 113/24 121/19 122/2 125/11 137/21 152/13 155/7 182/8 186/21 206/10 206/11 209/20</p> <p>particular [34] 5/19 6/17 7/23 7/25 10/19 14/2 14/17 18/17 24/5</p>	<p>24/19 25/14 25/19 25/22 27/5 27/7 67/19 71/2 85/7 85/15 85/21 89/13 133/7 133/8 137/13 138/12 139/17 146/5 159/3 169/13 174/16 181/5 182/15 200/17 210/18</p> <p>particularly [10] 8/12 34/25 80/15 82/2 83/13 99/24 101/20 102/1 217/15 217/25</p> <p>particulars [1] 122/1</p> <p>partly [1] 90/3</p> <p>parts [1] 120/16</p> <p>party [2] 112/25 191/19</p> <p>passage [1] 156/9</p> <p>passed [3] 55/24 130/24 186/4</p> <p>passes [1] 130/23</p> <p>passing [2] 10/10 199/21</p> <p>past [6] 63/24 76/11 118/16 120/24 121/11 187/12</p> <p>path [2] 109/5 109/7</p> <p>pathological [2] 33/19 45/19</p> <p>pathologist [5] 15/2 33/19 35/14 206/13 206/17</p> <p>pathology [6] 5/16 5/18 15/17 33/18 34/4 205/15</p> <p>patient [21] 18/8 79/10 101/24 104/1 106/21 108/5 108/15 108/17 124/11 139/9 153/6 153/15 156/11 158/21 160/15 178/4 178/5 179/9 180/7 186/18 187/11</p> <p>patient's [1] 82/15</p> <p>patients [22] 9/18 34/19 36/10 72/12 84/25 96/4 96/5 96/6 96/7 96/10 98/14 98/17 104/13 105/25 107/16 107/20 124/23 124/24 158/9 205/10 205/11 210/15</p> <p>Patrick [1] 77/2</p> <p>pattern [1] 103/12</p> <p>PAUL [4] 142/9 142/13 167/19 219/7</p> <p>Pause [1] 117/8</p> <p>pausing [6] 6/22 17/16 35/16 51/20 53/21 172/10</p> <p>Peacock [1] 28/11</p> <p>peculiarity [1] 20/15</p> <p>pending [1] 112/12</p> <p>penultimate [1]</p>	<p>129/10</p> <p>people [54] 6/25 6/25 7/5 18/13 27/4 27/6 34/21 42/7 43/8 43/10 48/2 48/16 63/18 71/16 73/2 79/11 79/12 82/25 85/25 86/3 87/15 89/12 89/21 89/23 92/7 92/14 98/6 99/3 99/13 99/15 101/1 101/4 101/5 102/19 107/11 108/7 108/11 109/7 110/5 112/20 118/19 123/9 123/16 128/5 130/25 131/23 136/14 137/2 137/4 137/7 137/11 139/13 140/18 213/16</p> <p>people's [1] 89/20</p> <p>per [3] 31/2 41/2 152/21</p> <p>per se [1] 31/2</p> <p>perceive [1] 83/1</p> <p>perceived [1] 200/22</p> <p>perception [1] 95/13</p> <p>perfectly [4] 25/23 54/16 214/7 218/2</p> <p>performance [2] 122/5 190/22</p> <p>performing [1] 87/1</p> <p>perhaps [15] 79/15 86/15 94/15 99/2 99/3 101/6 105/3 105/25 107/17 107/17 109/6 113/24 139/18 197/19 214/7</p> <p>perinatal [20] 4/8 4/12 4/22 5/6 5/24 6/4 15/1 15/15 18/12 18/23 19/14 19/18 30/12 30/19 31/14 34/5 42/15 49/14 73/5 83/10</p> <p>period [20] 4/20 36/12 38/16 43/10 50/17 51/4 101/2 105/8 127/5 127/15 131/4 137/17 145/8 152/24 156/21 156/24 165/9 170/19 184/14 189/4</p> <p>permanent [2] 143/15 144/23</p> <p>permit [2] 74/22 178/20</p> <p>permitted [1] 165/17</p> <p>perpetrator [1] 30/10</p> <p>persistent [1] 70/5</p> <p>person [22] 3/23 3/25 4/1 14/25 22/13 49/20 55/22 61/22 80/1 80/6 85/21 85/22 104/14 113/3 113/18</p>

P	208/24	politely [1] 169/16	112/25 113/5 173/15	66/10 90/19 117/25
person... [7] 124/25	plenty [2] 154/7	poor [4] 122/5 127/9	173/19 174/10	129/22 134/10 152/4
131/18 140/18 152/17	210/13	190/22 214/12		155/2
205/1 211/25 213/22	plus [1] 64/3	popular [2] 91/25	pre-interview [2]	presume [1] 112/4
personal [5] 150/5	pm [10] 7/17 28/14	141/16	89/12 92/11	presumed [1] 34/9
169/10 169/11 192/6	76/14 114/8 114/10	port [1] 153/5	pre-meeting [2]	preterm [1] 29/4
192/9	134/25 135/2 187/13	porters [1] 167/23	112/25 174/10	pretty [4] 2/15 31/13
personally [1] 58/17	187/15 218/17	portion [1] 126/20	pre-visit [2] 90/10	37/24 197/11
personnel [1] 99/11	PNM [1] 41/18	position [19] 46/16	90/22	prevent [3] 194/13
perspective [7] 34/7	Poer [5] 76/15 76/24	55/7 59/12 61/6 61/8	preceded [1] 40/13	194/14 204/20
38/25 38/25 46/8	97/23 114/11 219/6	78/12 93/15 95/11	130/2	prevented [1] 73/18
70/11 118/21 137/18	point [73] 3/2 3/5	97/10 116/7 119/18	precise [1] 15/12	previous [14] 11/1
persuasion [1] 46/21	6/12 7/18 12/16 15/19	138/16 150/5 154/9	precisely [1] 155/18	40/24 65/3 82/5 90/1
pertinent [1] 148/11	16/11 18/2 27/11 29/8	200/17 201/7 211/5	predominantly [1]	131/22 149/2 151/12
phrase [1] 105/10	32/25 32/25 39/1	211/22 212/10	98/13	167/1 167/5 176/2
phrasing [1] 121/9	39/21 51/22 52/6 53/1	positions [3] 87/15	pregnancies [3]	183/23 199/20 208/3
physical [1] 153/12	62/21 63/4 75/6 82/3	137/3 137/3	30/23 39/12 68/8	previously [7] 70/14
physicians [2] 65/2	91/13 93/19 93/22	positively [1] 28/23	pregnancy [15]	71/20 72/14 80/23
67/23	94/13 103/1 103/21	possibility [3] 182/21	17/10 21/3 28/21	81/21 85/6 176/2
pick [3] 55/11 177/9	107/19 109/21 110/25	193/19 196/1	29/11 29/12 31/23	Primarily [1] 165/3
179/25	112/4 112/6 114/13	possible [8] 13/14	36/7 36/15 38/1 38/8	principle [5] 14/12
picked [1] 50/23	121/22 122/10 127/12	32/19 37/22 79/1	38/11 38/12 38/14	15/22 34/19 152/10
picks [1] 181/5	127/17 131/7 131/11	110/4 141/11 205/14	40/3 43/13	152/13
piece [2] 79/16 216/4	133/21 135/18 141/18	210/5	pregnant [1] 37/20	principles [1] 108/4
pile [1] 22/24	147/23 147/24 148/5	possibly [3] 197/8	prejudice [1] 175/14	prior [9] 5/17 12/12
PJ [1] 147/22	148/13 153/11 154/21	204/25 214/10	preliminary [1] 216/6	47/18 124/9 145/22
placatory [1] 197/16	157/7 158/3 158/5	post [12] 3/16 17/1	premature [5] 35/6	154/20 155/14 155/14
place [38] 5/25 38/19	158/7 158/11 159/13	17/12 34/8 34/15	35/9 35/19 38/7 171/2	176/19
39/4 70/18 74/6 79/19	160/4 160/5 164/1	35/11 45/14 46/11	prematurity [2] 34/10	priority [1] 168/13
80/4 80/10 80/19	164/9 166/14 172/12	95/5 131/7 143/9	35/2	privacy [1] 140/23
80/20 86/18 88/2	174/12 174/19 175/15	143/15	preparation [1] 13/10	probably [24] 39/6
89/19 90/2 90/18	175/24 177/20 177/25	post-mortem [2]	prepare [3] 37/16	43/13 60/3 80/19
91/25 92/15 96/2	184/13 194/18 198/18	34/8 34/15	42/2 99/7	84/23 85/1 94/18
96/11 98/22 100/9	208/16 209/16 210/11	post-mortems [2]	prepared [11] 5/12	97/14 106/20 123/2
104/15 109/17 109/23	210/11	45/14 131/7	5/20 5/22 16/7 17/25	140/1 140/21 149/13
114/16 124/12 128/6	points [5] 6/10 7/25	post-natally [1]	60/10 63/9 107/4	155/9 157/9 157/23
138/14 149/1 149/5	127/15 137/22 162/8	17/12	107/5 107/10 118/15	161/13 178/19 186/11
150/1 163/23 169/16	police [71] 66/1	postgraduate [1]	preparing [2] 83/23	187/8 200/4 200/5
177/3 177/22 190/13	66/11 66/14 66/21	1/16	84/16	205/21 211/5
205/19 210/23	67/5 67/17 67/17	postmortem [1] 45/6	presence [2] 145/15	problem [6] 29/16
placenta [3] 29/19	67/24 68/6 68/7 68/11	potential [6] 64/7	175/21	67/10 82/25 83/1
29/20 29/21	68/20 74/22 74/23	130/16 131/11 194/4	present [13] 17/1	105/16 136/5
placental [1] 29/18	75/1 75/3 75/9 75/12	194/6 201/9	17/13 27/8 30/12	problems [8] 21/20
placentas [1] 45/17	75/15 83/18 106/13	potentially [10] 42/25	41/17 46/10 134/13	95/16 103/2 104/4
plan [4] 100/4 100/15	110/19 120/9 128/16	79/11 98/16 103/15	140/16 161/1 170/14	104/7 133/3 133/5
100/17 113/10	129/20 130/4 130/6	125/24 127/22 129/2	174/22 179/15 217/6	190/15
planned [6] 11/20	130/11 131/5 131/6	131/7 132/25 133/11	presentation [6] 5/13	procedure [6] 56/25
12/1 12/2 53/7 96/20	131/13 134/7 159/15	Powell [4] 52/14	5/19 116/10 176/23	82/8 116/18 191/13
97/16	160/3 160/8 160/9	53/15 55/2 55/4	176/23 177/5	195/14 195/15
plans [4] 31/23 49/14	160/25 161/3 161/4	power [3] 137/3	presentations [1]	procedures [1]
100/2 100/12	162/24 163/20 164/1	137/3 137/12	6/16	155/24
play [3] 115/16 140/5	164/3 164/5 164/6	powerful [2] 129/21	presented [5] 5/12	proceed [4] 104/12
152/12	164/9 164/16 164/17	137/2	30/6 140/19 178/15	200/24 201/24 203/12
please [27] 1/13 9/2	164/20 164/24 165/10	PowerPoint [2] 5/13	197/5	proceeding [1] 203/5
21/8 45/4 49/9 49/10	171/1 172/16 173/6	177/8	presenting [2] 8/15	proceedings [1]
62/10 62/11 68/22	177/13 177/21 184/15	practice [12] 24/2	107/6	191/20
76/18 76/20 76/22	184/16 186/5 186/8	78/17 80/19 80/22	press [7] 36/13 36/22	process [38] 18/20
76/25 77/3 90/9 91/5	186/17 186/22 187/2	82/14 83/5 87/2	37/1 87/25 88/3 88/9	19/3 20/20 23/4 57/3
98/25 114/5 115/8	205/22 209/6 209/16	104/14 145/1 177/3	181/4	57/5 60/15 61/13
120/11 127/1 142/12	209/18 209/19 210/1	194/10 213/20	pressing [1] 158/8	79/15 83/19 83/21
196/17 204/4 207/4	210/14 211/1	practices [1] 96/2	pressure [2] 201/1	86/9 86/11 89/7 99/18
210/5 213/12	policies [1] 96/2	practising [1] 104/5	211/12	99/20 100/1 107/8
pleased [2] 208/12	policy [5] 80/5 80/18	pre [10] 88/21 89/12	presumably [10]	119/4 128/22 128/25
	82/4 199/19 210/24	90/10 90/22 92/11	27/13 30/23 31/10	130/17 137/6 153/8

<p>P</p> <p>process... [14] 161/6 161/15 162/9 182/20 195/6 195/9 198/25 199/7 199/14 199/15 209/6 210/18 210/23 212/11</p> <p>processes [1] 128/6</p> <p>produce [1] 49/3</p> <p>produced [2] 22/19 57/9</p> <p>producing [1] 61/21</p> <p>profession [6] 213/11 213/18 213/21 214/2 214/3 214/5</p> <p>professional [13] 3/5 18/7 33/14 105/15 152/12 192/24 193/1 193/7 203/6 205/10 212/8 213/10 213/16</p> <p>professionally [4] 19/10 30/24 199/1 199/14</p> <p>professionals [1] 213/4</p> <p>progress [1] 106/2</p> <p>progressed [1] 87/8</p> <p>progressing [1] 87/16</p> <p>prompt [1] 117/19</p> <p>prompted [1] 185/20</p> <p>proper [1] 210/4</p> <p>properly [8] 15/5 47/23 100/13 128/12 128/16 205/21 206/1 206/14</p> <p>protect [1] 108/16</p> <p>protecting [2] 191/18 191/24</p> <p>protocol [1] 83/15</p> <p>protocols [2] 107/6 107/9</p> <p>proved [1] 194/8</p> <p>provide [2] 73/21 207/17</p> <p>provided [11] 1/21 16/23 28/22 57/20 61/2 77/4 115/7 135/16 142/14 187/22 207/15</p> <p>provider [1] 14/8</p> <p>provides [1] 143/25</p> <p>providing [3] 37/17 96/12 140/10</p> <p>provoked [1] 150/24</p> <p>public [2] 173/1 173/8</p> <p>publicly [1] 196/23</p> <p>published [6] 84/10 119/16 122/14 122/17 123/9 123/14</p> <p>pulled [1] 60/4</p> <p>purpose [12] 4/17</p>	<p>6/10 24/22 26/6 26/8 78/20 143/22 175/10 181/20 181/22 181/24 191/9</p> <p>purposes [3] 14/25 16/7 79/6</p> <p>pursuant [1] 26/14</p> <p>pursue [1] 109/1</p> <p>pursuing [4] 13/12 133/6 160/20 160/21</p> <p>pushing [1] 199/19</p> <p>put [11] 6/7 6/18 38/14 65/16 85/19 104/22 115/23 143/13 201/2 204/2 211/21</p> <p>Q</p> <p>QC [1] 177/17</p> <p>QSPEC [1] 12/3</p> <p>qualifications [1] 1/13</p> <p>qualified [7] 1/14 56/3 211/24 211/25 212/5 213/22 214/14</p> <p>qualify [1] 77/10</p> <p>quality [4] 95/21 96/8 214/18 217/24</p> <p>quarterly [2] 22/21 188/25</p> <p>quarters [1] 168/9</p> <p>Queen's [2] 1/14 1/16</p> <p>question [12] 32/4 38/24 39/4 50/7 85/13 110/1 140/14 183/12 185/18 193/16 199/8 215/11</p> <p>questioned [1] 167/7</p> <p>questioning [1] 70/5</p> <p>questions [26] 1/10 1/11 2/14 2/23 13/23 39/18 42/6 62/6 75/25 76/2 76/3 76/4 76/24 78/16 113/15 141/22 141/23 141/24 142/11 187/4 187/21 218/5 219/4 219/6 219/8 219/10</p> <p>quickly [2] 53/3 83/19</p> <p>quiet [1] 179/18</p> <p>quite [29] 19/6 20/8 46/14 52/15 60/11 65/10 81/13 83/16 96/24 111/3 112/3 121/10 121/20 124/10 138/15 141/5 141/6 141/7 141/9 141/16 148/1 148/17 159/9 164/14 166/15 167/12 172/25 203/5 213/5</p> <p>quorate [1] 170/17</p> <p>quotation [1] 67/3</p>	<p>R</p> <p>R's [1] 38/25</p> <p>raise [13] 2/17 26/20 74/17 79/11 106/23 107/25 108/25 119/9 129/1 149/21 156/11 183/12 202/20</p> <p>raised [21] 10/24 18/24 20/1 20/1 26/21 69/8 85/7 103/11 173/3 186/1 191/8 191/13 192/24 193/2 193/18 214/20 214/23 215/9 215/12 215/13 217/8</p> <p>raising [5] 36/14 64/19 69/2 95/16 113/15</p> <p>rang [2] 53/19 55/15</p> <p>rapidly [1] 208/13</p> <p>rare [6] 8/20 37/23 37/24 63/18 74/18 214/9</p> <p>rareness [1] 20/15</p> <p>rash [2] 19/25 20/15</p> <p>rashes [1] 103/12</p> <p>rate [3] 41/1 49/13 124/10</p> <p>rates [6] 43/16 117/14 140/10 155/16 155/20 158/25</p> <p>rather [7] 56/6 88/14 106/21 108/18 112/5 113/15 119/1</p> <p>rationale [1] 14/4</p> <p>Ravi [8] 60/1 64/22 66/17 67/20 104/24 134/22 134/25 202/2</p> <p>Ravi Jayaram [1] 60/1</p> <p>RCPCH [15] 35/25 36/8 36/11 36/19 62/20 64/7 69/15 77/12 106/6 129/8 177/15 178/6 192/12 203/15 207/21</p> <p>reach [1] 72/21</p> <p>reached [4] 72/25 73/1 103/23 186/19</p> <p>reacting [1] 186/20</p> <p>reaction [2] 83/18 135/16</p> <p>read [38] 2/4 17/7 17/25 19/16 20/2 27/5 30/13 36/8 46/2 57/9 57/11 63/8 73/15 112/15 112/21 116/13 117/2 117/20 118/6 123/4 123/10 123/13 123/16 126/23 127/12 132/22 133/14 133/21 133/22 138/8 175/11 191/1 195/18 195/19</p>	<p>196/21 203/15 204/10 205/8</p> <p>reading [5] 50/19 51/6 51/7 204/23 205/4</p> <p>ready [1] 114/5</p> <p>real [3] 139/19 139/20 140/5</p> <p>real-time [2] 139/19 139/20</p> <p>realisation [1] 73/12</p> <p>realise [2] 30/8 33/6</p> <p>realised [6] 16/14 75/7 75/9 75/11 135/25 201/7</p> <p>really [45] 10/13 19/8 25/7 25/10 29/19 32/15 42/4 42/19 49/3 53/3 57/14 58/24 60/7 61/8 64/21 70/5 81/12 94/25 122/8 122/21 124/2 124/6 125/1 125/4 127/14 132/9 132/10 132/23 135/24 135/24 135/25 140/7 148/20 154/16 159/23 166/16 173/24 178/1 184/22 190/14 192/14 192/14 196/14 197/11 211/18</p> <p>realms [1] 66/1</p> <p>reason [5] 26/12 29/10 40/22 43/11 90/4</p> <p>reasonable [3] 59/9 121/10 218/2</p> <p>reasoning [2] 126/22 150/3</p> <p>reasons [5] 11/14 14/22 124/23 168/2 217/7</p> <p>reassurance [2] 26/3 163/8</p> <p>reassure [2] 162/17 192/18</p> <p>recall [20] 6/3 85/2 85/12 104/20 107/21 110/17 110/20 117/22 121/9 122/6 130/25 144/13 145/23 155/21 161/19 167/24 167/25 177/2 179/12 179/17</p> <p>recalled [1] 121/21</p> <p>receive [1] 112/16</p> <p>received [10] 48/9 87/24 110/15 112/1 113/17 117/6 119/5 123/12 131/18 132/5</p> <p>recent [3] 5/11 90/6 208/14</p> <p>recently [5] 24/1 57/20 58/13 64/24 83/11</p> <p>recipient [1] 111/11</p>	<p>recognise [6] 103/17 117/2 118/18 120/17 122/2 204/7</p> <p>recognised [1] 197/7</p> <p>recollect [8] 8/12 14/15 31/15 37/1 110/14 155/19 164/23 165/1</p> <p>recollection [21] 36/18 63/6 68/5 69/25 70/4 70/8 81/14 81/15 92/21 112/9 116/16 118/11 119/3 119/20 120/2 120/19 121/3 121/5 121/23 157/23 164/15</p> <p>recollections [2] 110/18 118/19</p> <p>recommendation [3] 138/7 138/10 185/20</p> <p>recommendations [6] 115/12 119/15 123/3 124/6 127/13 206/24</p> <p>recommended [2] 206/23 206/25</p> <p>reconciliation [1] 184/17</p> <p>reconsider [1] 162/9</p> <p>record [13] 6/22 6/23 6/23 16/3 16/4 19/5 24/9 25/2 69/17 101/24 120/4 120/13 154/11</p> <p>record-keeping [2] 24/9 25/2</p> <p>recorded [3] 44/11 120/23 195/18</p> <p>records [3] 22/2 120/10 215/10</p> <p>recurrence [1] 103/24</p> <p>recurrent [1] 103/12</p> <p>redacted [10] 111/8 156/21 157/11 157/13 165/17 178/6 191/4 191/6 206/7 206/11</p> <p>redo [1] 12/7</p> <p>reeling [1] 51/21</p> <p>Rees [1] 195/18</p> <p>refer [8] 2/25 46/25 102/20 191/5 193/14 204/1 209/5 213/9</p> <p>reference [18] 4/13 4/16 14/5 15/10 106/10 111/6 144/7 144/13 179/2 180/14 182/18 183/25 184/1 184/2 194/19 196/6 216/8 216/25</p> <p>references [1] 58/17</p> <p>referral [5] 194/4 194/6 202/22 202/24 209/16</p>
--	---	--	---	--

R	158/11 referred [11] 38/23 40/17 47/24 49/12 57/17 73/21 173/14 180/1 180/12 181/9 202/14 referring [14] 17/9 36/13 111/17 165/9 166/6 168/15 168/16 180/21 182/22 182/24 197/2 199/18 215/5 216/4 refers [3] 9/16 180/18 185/17 reflect [4] 19/4 70/13 177/8 181/16 reflected [6] 83/5 125/24 135/24 144/17 177/7 211/4 reflecting [2] 120/13 125/21 reflection [4] 22/14 165/6 185/25 186/21 reflections [5] 73/19 136/18 185/23 215/22 216/7 reflects [1] 84/23 refresh [1] 111/15 refusing [2] 133/4 136/5 regard [4] 71/15 82/22 120/13 188/22 regarded [1] 161/21 regarding [9] 68/8 147/1 148/11 155/24 158/21 166/23 178/5 179/3 186/1 regardless [1] 141/17 regimental [1] 197/21 regional [1] 151/7 regionally [2] 159/21 159/22 registered [1] 190/20 Registrar [6] 5/10 5/14 84/8 84/17 126/9 126/16 Registrars [1] 126/9 registration [1] 160/12 regret [2] 161/13 161/16 regular [5] 35/24 38/3 138/19 151/22 151/23 regularly [6] 15/1 146/1 148/14 148/17 150/16 167/11 reinstated [1] 191/15 reinstatement [1] 191/10 reintroduced [1]	158/11 relate [3] 21/17 21/20 151/23 related [7] 58/9 71/3 71/3 159/3 170/20 172/5 190/22 relates [1] 185/4 relating [12] 18/16 18/18 25/22 25/24 26/17 27/18 30/9 32/1 58/6 117/14 195/6 215/5 relation [25] 12/19 14/7 14/18 20/10 21/2 30/15 30/19 32/18 42/3 45/16 46/8 48/20 65/19 65/23 68/4 70/6 70/24 71/5 71/10 72/15 81/21 82/11 83/21 107/17 152/15 relationship [11] 9/6 9/21 10/5 10/20 93/21 132/2 167/8 172/7 172/21 180/5 188/24 relationships [14] 89/22 92/9 94/1 94/9 94/11 95/1 165/13 166/14 172/11 189/9 189/10 189/13 213/2 214/18 relative [2] 137/11 139/16 relatively [6] 87/14 116/23 137/9 137/15 138/9 162/5 relatives [1] 193/13 release [2] 87/25 88/3 released [1] 123/6 releases [1] 36/22 relentlessly [2] 13/12 109/1 relevant [2] 17/11 107/2 remained [1] 126/17 remaining [1] 205/15 remark [6] 52/20 60/4 62/1 62/4 67/18 199/21 remarkable [1] 119/1 remarks [6] 67/15 67/16 137/25 193/4 196/18 197/25 remember [63] 19/8 31/14 34/3 36/14 36/20 41/4 54/3 54/4 56/7 59/13 59/18 64/20 66/13 80/21 80/22 81/9 84/16 90/8 90/8 90/11 90/12 90/14 92/12 92/19 92/25 93/10 94/17 104/18 106/14 107/14 107/16 109/16 109/19	113/5 113/5 115/5 115/18 115/24 118/14 118/23 119/22 121/12 121/14 121/25 122/7 122/8 129/13 130/23 146/6 149/6 155/10 155/18 155/22 177/4 191/1 191/25 194/3 195/9 195/19 196/7 196/13 202/15 217/5 remembered [2] 59/15 80/16 remembering [3] 155/11 155/12 193/25 remembers [2] 36/6 202/9 remind [2] 48/19 90/13 reminds [1] 74/13 remit [3] 16/25 24/18 108/25 removal [1] 185/7 removed [5] 154/25 155/4 158/4 191/11 215/2 removing [1] 42/7 renowned [1] 217/13 repeat [1] 199/8 repeated [3] 105/7 105/20 179/2 repeatedly [1] 69/11 repeating [1] 72/5 replied [2] 52/24 59/22 report [70] 16/10 17/6 17/25 18/1 22/20 22/22 22/23 24/3 24/7 24/19 25/14 25/22 25/23 27/25 28/12 28/16 34/5 35/12 36/19 48/9 50/10 50/19 50/21 55/16 55/24 55/25 56/1 56/15 57/9 57/9 57/16 57/19 61/9 61/21 69/18 112/13 112/14 112/20 112/21 115/20 122/9 122/13 122/17 122/22 122/25 123/5 123/7 123/12 123/19 129/19 138/7 138/9 156/19 156/22 157/12 157/13 161/12 165/18 165/22 166/2 178/7 191/7 203/15 204/11 204/12 206/1 206/8 206/16 207/8 217/24 reported [13] 21/11 21/14 21/16 28/17 28/20 58/7 70/20 118/19 120/18 159/14 181/11 195/5 203/1 reporting [2] 153/10 193/19	reports [21] 5/22 19/17 28/1 47/22 104/10 110/8 110/10 110/12 110/22 112/11 119/4 122/11 163/12 190/25 195/25 195/25 197/17 204/10 204/24 207/23 208/14 represent [4] 24/12 27/1 63/7 105/11 representation [3] 111/1 144/25 145/2 representative [7] 63/2 145/4 188/17 188/18 189/21 200/25 201/9 representatives [1] 189/18 represented [2] 70/2 150/10 representing [1] 134/16 represents [1] 143/25 reproduce [1] 176/25 reps [1] 111/18 republished [1] 84/10 reputation [3] 91/24 124/9 133/10 request [6] 18/14 51/15 132/5 146/15 191/22 200/18 requested [2] 41/18 190/2 Requests [1] 45/6 required [5] 60/25 61/1 68/14 168/3 185/15 requirement [1] 34/18 research [5] 203/23 203/24 217/12 217/14 217/15 researchers [1] 216/2 reserved [1] 200/22 resilience [1] 2/10 resolution [1] 68/20 resonate [1] 37/22 Resources [1] 189/18 respect [4] 18/14 26/21 41/15 186/13 respected [2] 159/18 159/22 respond [3] 19/15 82/2 186/20 responded [1] 105/2 responding [1] 102/13 responds [1] 172/20 response [14] 51/19 52/8 56/13 83/17 84/1	84/22 159/7 162/15 165/18 166/11 172/19 196/9 208/7 216/24 responses [1] 166/10 responsibilities [2] 3/5 4/4 responsibility [5] 100/4 152/11 186/6 186/22 204/20 responsible [4] 32/16 49/17 51/23 211/11 rest [1] 37/24 restricted [1] 31/22 restriction [3] 29/5 29/13 29/18 restrictions [1] 160/12 restructuring [1] 151/1 result [10] 34/8 73/10 117/25 183/14 190/23 191/14 195/15 201/13 213/8 215/19 resulted [2] 22/11 95/15 resulting [1] 62/2 results [3] 29/21 40/10 115/14 resume [1] 76/9 resuscitate [2] 10/3 30/11 resuscitation [12] 19/16 20/20 78/23 79/3 79/9 79/15 79/19 79/24 80/2 80/7 80/9 105/2 resuscitations [1] 78/24 retire [1] 145/14 retired [3] 61/12 173/17 188/8 retrospect [3] 163/2 186/14 186/25 retrospectively [1] 11/6 return [2] 2/13 185/23 returned [1] 58/16 returning [2] 119/12 196/1 revealed [1] 115/22 review [89] 6/5 14/11 15/15 15/16 15/24 17/7 17/8 18/15 23/16 23/24 24/9 24/10 24/14 24/15 24/22 25/5 25/7 25/8 25/10 25/12 25/20 26/2 26/6 26/8 26/10 26/17 27/24 28/3 29/10 29/11 38/23 40/5 40/6 40/11 40/23 41/4
----------	---	--	--	--	---

R	158/10 174/8 186/25 204/15 risks [2] 16/19 102/14 rivalry [1] 213/10 RJ [1] 182/17 road [1] 134/1 role [40] 3/18 3/19 74/7 74/18 96/23 97/12 100/8 100/23 101/18 102/21 102/23 102/25 138/2 138/5 138/12 139/7 139/20 140/5 143/1 143/5 143/22 146/20 146/23 146/24 146/25 147/15 148/7 148/15 149/18 150/18 151/25 157/6 159/11 161/20 164/17 188/19 188/24 191/12 198/7 201/11 roles [7] 63/23 86/1 99/4 102/16 139/3 139/7 139/9 roll [1] 188/14 room [12] 2/22 53/10 64/1 89/2 114/15 114/17 114/20 119/19 141/13 154/8 169/17 211/25 rota [3] 125/19 126/3 126/9 rotate [2] 91/22 126/10 rotated [1] 89/25 rotating [1] 80/16 round [7] 63/25 67/4 80/16 110/2 114/18 164/2 194/1 route [6] 85/22 87/5 87/7 87/11 87/13 87/16 routine [2] 81/9 81/16 routinely [1] 6/25 Royal [20] 1/17 1/19 65/2 67/23 90/16 104/9 106/2 115/10 119/15 122/13 122/17 124/5 127/12 138/7 138/10 142/20 156/18 157/12 163/12 206/1 Rule [2] 141/24 187/4 Rule 10 [2] 141/24 187/4 rules [1] 84/21 rumour [5] 154/18 154/19 154/24 155/3 155/11 run [2] 98/2 179/16 running [6] 123/8 165/21 165/25 168/13 195/5 199/1	S	196/13 196/14 196/22 197/1 197/6 197/8 199/2 200/21 200/25 201/5 201/15 201/18 201/21 201/22 202/6 202/24 203/1 209/10 Saladi [1] 180/1 same [22] 2/18 2/20 2/21 5/14 15/7 28/7 29/16 39/24 41/3 57/21 63/19 73/9 74/14 80/13 81/20 84/20 108/15 154/9 164/12 178/16 183/11 186/15 samples [1] 205/16 Sarah [2] 40/8 69/16 sat [11] 12/3 17/23 20/12 44/22 55/18 63/25 114/18 115/2 119/22 167/20 203/21 satisfactory [1] 189/2 satisfied [2] 95/19 207/22 Saturday [1] 131/1 saw [15] 13/15 29/10 34/8 34/15 57/21 62/23 62/25 95/18 120/7 146/25 172/10 178/6 185/2 201/2 206/8 say [147] 2/4 3/2 3/4 9/5 13/9 17/18 18/9 19/10 20/2 27/11 27/16 31/6 32/10 32/12 33/2 33/3 33/13 33/17 34/20 34/23 35/10 39/19 39/22 41/13 42/14 44/5 46/5 51/22 52/8 52/22 53/24 54/6 54/7 54/25 55/22 56/6 56/16 58/3 59/2 59/2 59/4 59/10 60/12 63/14 65/12 65/12 66/23 67/25 68/3 68/25 68/25 69/1 69/2 69/6 70/19 72/20 73/7 74/20 75/15 88/16 94/7 98/21 101/12 116/22 119/19 121/10 121/19 122/23 122/25 125/17 132/15 134/4 134/23 136/18 137/14 138/23 143/24 144/15 146/24 148/11 148/24 151/21 152/15 153/23 154/12 156/2 156/9 159/14 159/25 160/2 161/6 161/19 161/22 162/11 163/3 163/21 164/16 164/21 165/2 165/18 166/5 166/21 168/9 168/14	168/25 169/20 170/24 172/2 172/4 172/16 174/14 174/21 179/20 183/1 185/24 186/15 189/4 189/8 191/23 192/3 192/11 192/12 192/14 192/23 194/1 194/14 194/21 194/24 195/8 196/9 196/17 197/13 197/14 198/3 198/9 202/4 205/3 209/15 212/12 212/14 213/1 214/16 214/22 214/25 215/1 215/23 216/14 saying [61] 9/15 19/3 30/17 35/10 35/15 36/7 36/15 43/21 44/11 44/14 50/19 52/23 53/24 54/4 54/5 54/6 54/21 54/24 56/4 56/13 58/25 60/12 66/3 66/6 66/7 67/8 67/11 68/6 71/4 73/3 104/20 110/2 110/21 115/7 115/24 121/10 121/13 121/15 122/6 122/7 122/9 129/11 130/5 130/7 133/1 136/4 157/7 160/1 160/21 164/23 165/1 167/24 169/3 170/1 187/1 193/20 202/10 202/15 202/15 204/6 208/20 says [11] 7/15 7/17 16/22 37/19 38/13 55/9 69/15 167/18 172/24 187/7 202/9 SBAR [3] 16/7 17/21 49/5 SBARs [1] 27/24 scalp [1] 113/9 scan [2] 37/19 46/9 scans [2] 38/3 38/3 scapegoated [1] 113/12 scenario [2] 7/23 75/13 scene [1] 67/12 School [1] 142/19 screen [6] 64/13 111/7 117/1 196/5 198/23 204/2 scrutinise [1] 35/7 scrutinised [1] 26/4 scrutiny [2] 50/7 73/21 se [1] 31/2 SEAN [2] 187/20 219/9 seat [2] 97/24 170/21 seated [4] 114/24 114/25 116/7 119/20
----------	--	----------	---	--

S	72/13 74/11 97/8 103/13 111/10 117/21 120/6 122/20 127/15 128/7 191/18 194/17 194/23 204/11 204/11 204/12 204/13 206/11 212/7	series [1] 192/6 serious [20] 16/19 20/9 27/1 27/2 27/19 28/4 28/10 46/9 46/17 64/5 91/19 120/1 122/23 158/21 160/15 177/10 178/5 204/15 217/1 217/2	she'd [5] 116/19 116/20 117/24 132/19 135/7 she's [2] 37/6 206/17 shift [2] 103/19 125/20 shifts [2] 103/20 103/21 Shipman [1] 206/23 SHO [1] 84/7 shock [3] 51/21 179/18 200/15 shocked [4] 8/18 52/25 72/4 123/25 shocking [2] 123/12 197/11 short [9] 3/19 76/13 99/19 109/19 126/1 166/15 185/9 187/14 187/24 shortages [2] 127/17 127/18 should [59] 3/2 23/3 23/23 28/17 28/20 37/10 37/11 37/14 41/2 41/3 43/16 46/6 48/23 49/1 58/20 66/21 70/19 72/16 72/25 73/1 74/7 75/21 81/4 85/17 85/22 88/8 93/12 106/13 108/7 108/8 131/5 140/14 146/10 152/12 153/17 159/23 160/1 160/3 160/9 161/1 161/5 162/23 162/24 163/2 163/19 163/20 164/17 165/7 165/22 175/13 186/3 186/16 191/22 201/12 209/7 209/24 211/2 215/2 215/10 shouldn't [4] 57/14 130/5 150/1 179/8 shouting [1] 120/2 showed [5] 3/20 22/24 60/5 111/4 210/11 showing [1] 192/16 shown [6] 2/10 46/9 57/17 149/7 176/24 184/24 shows [1] 194/12 SI [2] 26/24 27/12 sibling [1] 141/14 siblings' [1] 141/13 sick [6] 34/11 35/8 35/9 105/1 126/12 148/18 side [2] 114/20 115/2 sided [1] 197/12 sides [1] 140/16 sight [1] 122/12 sign [1] 46/3 signal [1] 2/15	signed [1] 63/17 significant [10] 19/9 25/14 82/14 99/5 99/19 102/16 124/7 127/25 164/14 204/15 significantly [1] 191/6 similar [6] 80/19 91/21 117/22 118/3 134/1 174/1 similarities [1] 205/5 similarly [1] 206/12 simple [1] 166/18 simply [5] 14/13 94/14 95/15 111/7 112/15 since [9] 73/11 77/15 81/15 82/9 84/7 84/11 118/22 143/19 152/7 sincere [1] 2/8 single [5] 97/15 104/19 108/25 129/13 217/6 sinister [1] 111/9 Sir [13] 145/10 163/23 164/8 164/10 164/15 164/19 173/6 173/16 174/11 175/19 176/11 183/20 184/20 Sir Duncan [12] 145/10 163/23 164/10 164/15 164/19 173/6 173/16 174/11 175/19 176/11 183/20 184/20 Sir Duncan Nichol [1] 164/8 sit [4] 76/22 142/10 191/16 198/8 site [1] 217/11 sitting [10] 16/16 59/25 76/6 118/11 138/11 170/12 171/12 211/22 213/14 214/13 situ [2] 8/9 109/9 situation [27] 17/17 44/3 62/3 81/24 85/3 85/6 86/16 93/15 93/16 95/8 96/17 101/25 103/8 107/24 108/1 108/13 109/14 123/23 132/19 132/25 133/2 134/2 134/22 135/22 136/24 190/18 214/8 situations [2] 9/25 132/18 six [9] 3/11 41/3 50/14 63/12 63/15 64/3 126/10 146/11 170/13 six months [2] 3/11 126/10 six weeks [1] 146/11 skin [1] 103/13
----------	---	---	---	--

S	72/16 73/13 79/17 83/16 85/1 93/12 94/14 94/15 96/15 107/5 111/1 126/4 129/10 134/8 137/14 138/25 148/10 150/6 155/2 162/25 163/14 165/7 166/20 167/24 175/22 192/17 192/19 200/19 204/7 206/25	specific [10] 27/2 31/15 35/21 58/17 67/18 107/14 158/25 165/15 167/25 211/8 specifically [16] 29/11 58/14 61/19 65/25 107/3 157/3 160/2 168/15 169/3 177/4 183/9 185/17 186/7 196/14 198/8 215/12 specifics [1] 155/10 specified [1] 180/19 specimens [1] 46/1 speculation [1] 155/5 spend [3] 100/16 100/20 101/3 spending [1] 141/15 spike [4] 90/15 101/21 103/8 124/8 split [1] 101/5 spoke [13] 31/5 66/16 66/17 89/11 113/12 120/16 132/14 132/18 156/6 164/10 180/17 181/3 195/2 spoken [3] 87/15 110/7 138/22 spokesman [2] 159/11 160/4 spokesperson [5] 146/18 146/20 146/25 147/16 148/1 spreading [1] 127/10 SR [1] 16/13 stable [2] 8/10 35/8 staff [105] 3/12 5/3 6/2 6/9 6/18 7/3 7/8 7/9 8/2 8/18 13/21 15/13 22/8 24/4 48/5 49/4 52/14 53/11 53/24 54/5 56/7 58/8 70/19 70/24 71/1 71/2 71/10 79/3 79/7 79/8 79/13 79/13 85/7 86/25 103/19 103/19 105/22 107/15 127/18 140/22 141/8 143/5 143/7 143/12 143/16 143/20 143/25 144/3 144/7 144/11 144/19 144/23 144/24 146/5 146/18 147/2 148/25 149/4 149/18 149/25 149/25 150/2 150/10 150/13 150/19 152/17 154/22 154/25 157/6 158/13 162/13 162/20 163/5 163/14 163/17 165/7 166/17 167/16 167/23 168/3 168/4 168/12 168/15 168/23 168/24 169/2 169/4 170/6 170/9 170/19	170/21 172/8 172/14 173/23 174/4 174/20 174/22 174/22 179/7 182/2 182/7 184/5 184/8 189/20 205/10 staffing [7] 126/8 127/19 127/21 128/1 147/13 197/19 216/25 stage [19] 20/5 20/6 38/9 40/25 43/19 44/25 52/25 65/14 66/3 68/15 71/6 72/15 91/6 158/24 159/3 160/11 160/13 171/7 210/20 stake [1] 201/10 stance [1] 171/6 stand [4] 67/4 119/2 176/13 176/17 standard [5] 23/21 23/23 85/17 85/20 133/5 standards [2] 101/7 199/3 standing [3] 54/21 61/12 145/7 start [9] 2/7 20/21 43/10 79/20 114/5 140/3 140/4 204/6 212/19 started [12] 15/5 16/14 43/2 91/11 92/4 92/4 93/24 97/13 111/12 128/4 164/19 197/15 starting [1] 98/14 starts [3] 62/12 126/22 194/20 state [2] 105/11 142/12 stated [7] 122/4 163/6 163/10 166/6 184/3 198/24 199/13 statement [64] 1/21 1/23 2/25 9/3 16/11 26/19 27/11 30/4 41/13 45/5 51/12 59/14 59/19 62/21 73/15 77/4 77/7 90/11 93/25 95/23 96/16 98/21 105/10 110/19 115/23 116/13 116/22 116/23 117/2 118/6 118/10 118/15 121/7 126/20 126/21 131/17 132/4 136/18 139/22 142/14 143/23 146/22 146/24 148/24 151/21 153/23 158/15 159/25 161/18 162/23 167/15 169/18 175/10 175/12 185/23 187/24 189/24 195/18 195/19 196/20 196/21 199/22 213/1	216/9 statements [7] 99/8 118/16 166/21 179/2 181/4 187/23 215/22 States [1] 205/9 stating [4] 160/24 163/20 175/12 207/24 statistical [3] 139/24 190/21 217/15 status [2] 90/17 90/20 stay [2] 21/5 141/12 STEIS [4] 28/12 28/16 28/17 28/20 step [1] 76/17 Stephen [4] 63/4 65/16 66/10 66/18 Stephen Cross [3] 65/16 66/10 66/18 Stephen Cross's [1] 63/4 stepped [1] 125/20 stern [2] 120/1 121/20 Steve [6] 55/22 56/11 64/22 66/17 134/22 135/1 Steve Brearey [2] 55/22 56/11 stick [1] 202/12 still [27] 5/11 11/24 11/25 24/13 32/2 37/12 37/20 37/24 45/2 54/23 69/9 69/10 71/14 73/14 74/14 102/22 107/8 119/2 125/4 128/24 131/9 154/7 174/20 181/14 200/23 204/20 208/20 stillbirth [8] 14/5 14/17 14/20 14/21 38/23 41/1 45/16 45/20 stillbirths [11] 5/22 40/7 40/25 41/1 41/9 45/9 46/8 47/20 48/15 48/18 69/22 stimulate [1] 162/9 Stockport [1] 105/19 stood [2] 92/21 116/9 stop [3] 17/6 95/18 168/14 stopped [4] 3/16 5/5 63/23 103/22 stopping [2] 95/16 154/19 storage [1] 112/3 straight [2] 46/19 89/2 strained [2] 94/9 94/13 strange [2] 43/24 44/10 strategy [1] 37/8
----------	--	--	--	---

S	suggested [3] 50/11 115/16 180/24	surrounding [2] 12/18 50/2	101/7 104/15 164/8	84/21 85/4 91/15
strength [1] 2/9	suggesting [1] 20/12	survival [1] 43/16	talk [13] 25/13 44/18	93/13 94/22 95/21
stress [1] 161/20	suggestion [5] 47/13 66/21 74/1 122/16	Susan [4] 175/19 175/25 176/13 183/20	44/20 71/14 74/4 74/9	102/2 102/12 106/10
stressed [2] 101/25 171/17	158/5	Susan Gilby [1] 176/13	100/14 126/24 127/3	106/17 108/9 110/15
stressful [1] 58/5	suggestions [1] 196/6	suspect [5] 87/12 87/13 129/18 130/10	134/21 177/2 177/2 204/18	117/19 117/19 120/16
strictly [1] 31/6	suited [1] 5/8	187/7	talked [3] 89/2 93/12 180/5	122/2 130/18 139/20
striking [1] 118/24	summaries [1] 6/1	suspend [1] 215/20	talking [22] 8/22 23/13 27/18 31/10	144/7 144/13 152/10
strong [3] 46/12 159/19 215/19	summarise [1] 116/18	suspended [2] 194/9 203/11	33/7 44/15 44/19 55/5	157/14 169/1 188/20
struck [6] 98/24 101/14 105/8 121/22	summary [11] 5/24 6/15 16/16 40/8 40/9	203/11	57/10 67/16 68/7	188/22 201/11 215/22
136/19 213/13	95/10 115/7 115/10	suspicion [3] 50/7 124/25 203/8	69/20 79/21 93/5 93/6	terrible [2] 2/8 199/9
structure [15] 11/1 11/7 11/9 11/10 12/12	121/2 179/23 207/25	suspicious [1] 44/17	96/4 96/5 102/19	tested [1] 207/2
16/1 19/2 70/17 70/21	Sunday [1] 200/8	suspicious [2] 124/23 205/25	102/20 115/9 126/21	tests [1] 29/24
85/20 96/18 97/5	superficial [1] 167/12	switch [1] 76/7	145/9	text [3] 60/22 60/24 70/7
97/11 149/3 151/2	supplementary [1] 47/23	sworn [4] 1/5 142/8 142/9 219/7	talks [3] 157/16 177/9 185/14	than [25] 15/6 49/12
structures [2] 97/5 108/24	support [20] 75/18 79/7 79/13 82/16	sympathy [4] 2/8 210/17 211/15 212/9	tape [6] 66/20 66/23 67/3 67/4 67/8 67/13	52/16 56/6 84/5 88/14
stuck [1] 138/21	98/22 99/13 99/25	synopsis [1] 49/3	targets [1] 127/23	90/5 106/21 108/18
stupid [1] 68/1	100/10 102/1 147/23	system [5] 23/5 28/17 80/25 82/23	teaching [1] 46/1	112/5 113/15 118/18
style [5] 116/10 166/20 166/23 166/25	148/20 158/13 161/2	82/24	team [34] 9/6 10/3 14/14 16/5 16/7 22/7	136/3 139/19 146/15
167/3	162/17 162/21 165/3	systemic [1] 104/4	22/17 22/18 22/19	154/23 157/19 161/8
subject [2] 15/14 155/3	165/11 171/4 171/19 185/8		22/20 23/13 27/23	165/8 167/22 169/3
subjected [1] 205/14	supported [1] 92/1	T	28/1 32/16 41/18	169/14 175/4 197/18
subsequent [7] 36/7 36/15 47/3 72/22	supporting [2] 99/23 148/2	tab [9] 144/5 147/7 154/3 167/14 170/7	44/24 53/8 54/24	213/17
72/23 200/11 203/18	supportive [5] 64/21 67/18 94/5 184/20	170/7 171/9 171/21 173/13	61/25 63/11 63/11	thank [55] 1/7 1/9
subsequently [4] 57/2 194/13 212/22	191/23	tab 11 [1] 173/13	64/3 80/6 92/2 100/11	2/11 8/6 17/14 21/12
217/23	suppose [2] 108/21 162/4	tab 2 [1] 154/3	117/15 153/7 153/16	24/8 24/25 40/21
substance [1] 78/15	supposed [2] 57/22 136/8	tab 3 [1] 167/14	162/10 165/24 196/23	48/23 49/10 50/24
substantial [1] 126/20	supposition [1] 213/13	tab 6 [1] 144/5	197/7 197/8 207/21	62/9 66/8 70/22 75/24
substantially [2] 127/18 127/20	sure [32] 8/24 16/12 18/19 18/20 20/17	tab 7 [1] 147/7	teams [2] 89/23 150/14	75/25 76/1 76/3 76/5
substantive [1] 89/8	26/7 26/9 31/21 33/18	tab 8 [2] 170/7 170/7	teamworking [1] 10/1	76/8 76/16 76/22 98/8
successfully [1] 37/21	42/23 50/9 56/8 75/3	tab 9 [1] 171/9	telephone [2] 55/10 132/5	100/24 114/6 114/7
such [14] 86/18 87/11 89/1 99/19	98/20 101/9 104/3	table [10] 12/22 97/24 114/18 114/18	tell [40] 2/6 3/2 3/6 4/4 4/17 10/7 13/20	114/12 118/5 123/21
141/6 167/23 167/25	104/6 107/12 107/21	114/22 114/23 115/2	17/21 18/19 26/25	131/14 141/21 141/25
173/20 183/23 188/18	135/5 137/6 138/14	119/21 119/23 121/21	28/19 30/4 55/11	142/1 142/4 143/4
189/10 189/12 196/24	154/9 172/25 198/17	tables [1] 117/14	62/13 73/19 86/15	145/6 146/8 148/6
201/8	198/22 198/22 201/22	take [29] 9/14 28/8 41/12 57/16 67/11	90/5 90/9 92/16 93/25	148/22 169/19 170/5
sudden [16] 8/9 13/5 19/15 50/13 51/4	209/9 209/13 215/11 217/2	80/3 80/10 106/8	98/25 101/15 108/23	175/5 178/23 178/24
69/10 81/17 82/11	surely [1] 214/10	108/14 114/16 115/18	111/5 116/12 121/14	183/19 187/3 187/5
83/14 83/21 83/25	surgeon [2] 144/10 167/16	117/6 118/5 123/21	131/17 135/7 136/23	187/6 187/10 199/24
84/18 84/23 84/24	surgical [1] 97/17	128/22 131/14 162/1	138/3 188/14 189/9	208/5 218/4 218/6
105/1 105/20	surprise [3] 54/12 54/23 200/15	177/3 177/22 184/21	189/24 190/5 199/22	218/11
suddenly [4] 46/15 67/5 104/19 105/6	surprised [6] 54/8 58/23 59/1 59/5 96/24	187/12 187/19 190/13	203/16 204/3 204/4	thanked [1] 183/22
SUDiC [2] 83/19 83/20	208/12	191/2 192/21 201/22	211/4 212/24	thanks [4] 14/16 30/2 60/6 183/20
suffering [2] 2/9 116/19	surprising [1] 66/15	204/25 205/19 209/5	telling [4] 6/24 57/7 212/1 216/5	that [1769]
sufficient [1] 125/1	surrounded [1] 211/23	taken [9] 14/6 23/7 40/21 52/25 79/19	tells [1] 31/8	that's [99] 7/6 7/22
suggest [4] 27/15 39/2 182/4 211/12		113/2 182/6 211/2 212/16	tenure [2] 3/15 189/17	8/20 8/24 10/24 13/8

T	150/15 154/20 155/25 161/2 162/18 162/21 165/4 165/23 167/11 175/16 191/1 191/23 198/15 198/15 200/16 200/21 201/3 201/12 201/15 204/13 204/22 208/23 212/19 213/19 217/6 thematic [7] 47/1 47/5 47/7 49/7 49/12 49/16 50/4 theme [1] 168/6 themes [1] 49/17 themselves [7] 42/8 46/22 72/5 165/13 210/2 210/5 211/6 then [119] 3/15 5/7 5/9 7/16 11/19 11/19 11/22 15/7 16/5 17/4 17/24 17/24 18/9 28/3 32/10 33/17 38/9 48/2 49/4 49/5 49/11 55/10 56/16 61/6 65/12 65/13 65/14 67/25 68/3 68/23 72/6 72/22 72/23 74/5 74/10 74/10 79/13 88/15 93/24 97/20 98/6 101/12 101/19 104/2 104/11 110/6 112/21 113/14 118/2 118/22 121/17 129/17 134/24 134/25 143/14 144/21 145/6 145/11 146/12 146/16 148/23 149/12 149/16 149/19 151/18 153/7 153/13 156/4 156/21 157/7 158/4 158/15 159/12 160/8 163/21 165/15 169/16 171/21 173/4 174/14 175/5 175/18 176/22 177/12 177/15 177/15 177/17 178/3 178/4 178/10 178/25 180/3 180/21 181/3 181/18 182/1 182/5 182/11 182/25 183/18 183/22 189/5 200/1 201/25 203/11 203/14 203/17 203/23 204/17 204/25 207/4 209/5 209/15 211/20 212/22 213/9 214/25 215/11 216/9 there [350] there's [35] 7/18 18/12 28/13 35/7 35/13 38/1 47/3 54/6 68/10 79/18 83/2 83/12 83/25 85/25 86/25 88/16 94/10 102/2 104/7 108/14 118/21 123/1 123/1	124/15 137/1 137/4 137/23 139/12 139/12 141/13 143/14 173/14 179/1 200/21 203/10 therefore [23] 35/6 82/1 103/23 104/8 110/4 110/9 113/13 125/2 125/24 128/11 133/17 150/1 150/17 158/12 174/2 174/9 179/9 186/10 186/24 191/9 204/16 206/3 214/6 these [61] 5/20 5/24 6/1 19/21 27/1 41/17 42/1 44/13 45/2 46/10 49/22 49/25 49/25 49/25 50/4 51/11 51/14 54/9 54/16 56/8 62/23 72/10 74/11 74/13 79/22 83/6 99/9 106/7 110/8 110/21 122/11 122/24 128/8 128/10 128/24 134/1 140/24 144/6 144/13 145/25 157/8 158/22 161/24 162/1 162/12 163/21 164/6 166/10 173/2 174/24 176/24 179/13 179/14 180/3 183/19 185/19 186/3 196/18 209/18 214/17 218/2 they [250] they'd [10] 46/15 90/17 103/13 103/22 103/23 104/8 119/5 119/7 157/10 175/4 they'll [1] 68/12 they're [14] 22/17 34/19 34/20 34/23 34/23 63/1 63/2 63/4 120/15 137/11 141/8 141/12 141/18 144/8 they've [5] 2/10 28/7 34/24 68/12 73/24 thing [23] 25/18 46/18 46/21 59/9 61/5 66/15 101/7 108/16 122/8 128/13 140/20 141/17 141/19 141/20 159/16 194/7 194/11 194/17 197/24 201/14 202/25 203/2 212/22 things [33] 10/20 10/21 19/16 33/13 46/17 53/4 65/22 74/13 79/12 83/7 90/1 91/15 91/16 93/6 99/9 100/22 101/9 101/18 102/12 107/12 108/14 109/18 120/17 120/19 123/2 133/9 139/12 140/3 140/4 140/25	180/24 199/2 203/8 think [270] thinking [23] 30/14 44/2 51/23 53/6 54/9 72/8 79/9 81/12 86/7 105/17 106/9 106/18 106/21 107/17 108/13 108/17 108/21 124/15 135/19 136/1 138/17 150/3 206/18 thinks [1] 155/19 third [3] 94/19 95/6 131/3 this [251] thorough [2] 207/25 212/20 thoroughly [1] 131/12 those [82] 2/13 4/11 5/6 5/9 5/13 5/19 12/4 19/20 20/10 22/10 22/10 22/25 22/25 26/3 27/4 28/1 30/2 30/2 36/11 37/11 41/21 50/18 59/20 63/25 67/14 68/25 72/5 75/24 79/6 80/12 80/21 81/19 82/21 85/14 87/7 88/6 90/15 90/19 91/18 94/8 94/23 95/14 98/5 99/4 101/9 103/11 104/10 104/15 106/1 108/9 108/13 109/18 110/10 120/10 120/12 122/8 130/2 131/7 133/10 139/3 139/7 139/9 141/23 145/18 148/7 149/22 150/17 163/23 175/18 176/15 176/25 180/1 182/9 186/25 188/22 189/5 193/1 193/6 193/6 206/10 207/23 215/10 though [10] 19/7 27/10 40/12 51/24 64/23 74/17 130/5 166/7 167/11 179/6 thought [43] 11/23 13/1 30/9 36/15 37/3 39/8 41/6 43/21 60/4 60/16 60/18 61/7 61/10 63/8 63/12 64/23 64/24 64/25 68/18 74/7 74/7 75/19 75/21 83/23 84/15 95/24 104/23 106/24 108/4 129/22 130/20 135/8 137/9 137/12 139/1 141/20 159/19 195/23 201/6 201/13 203/7 208/18 211/1 thoughts [3] 93/8 125/22 134/2	thousand [1] 41/2 threat [3] 201/12 202/17 202/23 threatened [5] 162/19 183/11 193/14 193/23 193/24 threats [3] 201/3 202/6 202/21 three [27] 5/17 5/23 6/9 15/6 17/23 25/18 27/6 28/6 28/7 39/10 39/17 40/3 43/14 50/10 52/12 54/15 54/24 62/5 69/16 95/4 98/5 118/25 131/3 131/15 152/8 168/9 177/11 three days [1] 131/15 three months [1] 95/4 three quarters [1] 168/9 three weeks [3] 5/17 50/10 118/25 three years [1] 15/6 three-day [1] 131/3 three-yearly [1] 152/8 threefold [1] 143/24 threshold [2] 72/18 72/21 through [37] 16/14 16/17 21/25 28/17 28/20 44/23 53/16 57/3 57/4 69/19 69/22 70/20 87/3 87/19 88/13 88/13 89/3 106/2 106/9 107/8 108/13 118/13 126/24 127/3 128/25 135/20 150/19 152/9 153/8 162/10 174/25 177/2 179/16 188/25 189/4 209/7 210/4 throughout [4] 114/19 151/23 151/24 152/3 thumped [1] 121/22 Thursday [1] 131/1 tick [2] 22/25 23/11 ticked [2] 22/12 22/21 ticking [2] 22/11 22/17 ticks [1] 26/25 tier [1] 86/20 Tighe [13] 155/18 187/17 187/20 187/22 189/24 193/11 207/14 208/8 209/13 216/18 218/4 218/7 219/9 time [150] 3/22 5/15 5/15 8/19 11/22 12/21 18/3 28/5 28/7 29/16
----------	---	--	--	--

T	told [49] 19/9 30/20 31/9 36/10 42/21 54/9 69/23 89/6 89/18 90/9 90/21 90/25 91/3 91/8 91/18 92/8 94/15 101/11 103/2 104/17 106/16 112/10 112/16 115/15 129/7 129/11 131/23 133/22 133/23 160/25 161/14 167/19 167/21 169/7 171/3 171/16 175/18 176/11 176/12 182/19 190/23 191/8 191/11 195/24 201/4 203/21 208/4 208/5 214/14	156/17 168/9	206/20 207/10 208/12 210/2 210/4 210/17 216/3 217/19	U
time... [140] 35/24 36/4 38/10 39/10 43/10 43/12 43/24 45/13 45/23 50/14 50/17 50/22 51/4 53/2 53/18 55/9 55/15 56/24 57/2 57/6 58/5 58/20 61/19 62/7 62/7 62/23 62/25 63/22 67/21 68/17 68/20 68/25 69/3 70/18 71/25 72/3 73/12 74/23 75/22 79/7 79/10 81/11 81/13 81/15 83/9 83/11 85/2 87/10 87/14 92/18 92/24 94/25 98/22 99/4 99/6 99/10 99/17 99/20 100/11 100/12 100/20 100/21 100/22 101/3 101/13 101/24 102/11 102/21 102/23 105/5 105/8 105/12 110/2 111/22 111/24 112/16 113/20 113/23 120/12 127/24 128/21 129/3 129/4 129/5 129/11 130/14 130/18 130/23 130/24 132/12 136/1 138/20 139/19 139/20 139/25 140/5 140/23 141/1 141/3 141/6 141/15 151/11 151/24 153/3 153/19 156/21 162/16 164/2 164/20 165/10 165/12 166/3 170/19 171/25 173/20 176/14 176/16 178/1 178/18 179/5 179/18 184/4 184/14 185/2 185/12 186/15 186/23 189/7 190/15 191/13 192/21 195/10 198/3 199/2 199/19 206/11 209/9 210/8 210/10 210/13	tomorrow [3] 218/13 218/14 218/16	toxicology [4] 131/9 205/15 206/22 206/25	ultimately [6] 79/24 100/5 100/10 123/5 129/18 139/7	ultimately [6] 79/24 100/5 100/10 123/5 129/18 139/7
timeline [3] 99/7 177/5 178/2	tone [14] 66/21 116/7 118/3 119/18 119/24 119/25 119/25 120/1 121/19 121/20 197/9 197/14 197/20 198/2	track [1] 86/20	trusted [2] 161/9 176/8	unable [3] 20/16 20/16 61/11
timelines [1] 137/22	tony [28] 60/20 60/25 61/1 114/23 118/7 119/3 119/19 120/23 121/3 121/22 125/11 125/24 134/6 135/5 135/12 136/2 145/9 159/13 166/24 167/4 167/21 168/11 169/1 176/12 176/17 177/21 181/10 181/23	Tracy [3] 131/19 131/19 131/20	truths [1] 61/23	unbelievable [1] 214/9
times [7] 69/13 126/6 126/7 126/11 141/4 141/7 146/11	Tony Chambers [24] 60/20 60/25 61/1 114/23 118/7 119/3 119/19 120/23 121/3 125/11 125/24 134/6 135/5 135/12 136/2 159/13 167/4 168/11 169/1 176/12 176/17 177/21 181/10 181/23	Tracy Bullock [3] 131/19 131/19 131/20	try [8] 25/19 46/13 58/15 99/18 110/2 141/10 165/3 165/4	uncertain [1] 181/8
timing [1] 150/23	too [1] 199/11	trail [1] 173/5	trying [17] 42/22 70/11 86/23 98/15 99/20 101/21 102/10 108/16 137/5 137/6 137/14 156/10 156/13 162/6 165/11 184/21 184/21	unchanged [1] 9/8
timings [1] 164/18	took [20] 5/25 8/19 59/7 67/12 89/10 97/12 100/3 100/6 100/8 109/23 115/4 138/12 138/17 139/6 139/7 148/7 150/13 161/18 163/23 182/14	trainee [1] 107/1	Tuesday [2] 1/1 52/3	under [17] 17/8 21/10 27/23 40/22 97/10 116/21 121/17 124/25 144/22 171/15 197/23 201/2 201/18 204/14 205/1 210/9 211/12
today [2] 2/7 70/2	tool [1] 83/10	trainees [2] 91/25 92/1	turn [15] 95/12 96/16 118/10 120/11 126/19 144/5 151/19 166/19 167/13 167/17 168/7 169/15 170/16 177/8 184/22	undergo [1] 152/1
toddled [1] 60/1	top [11] 10/16 21/11 21/19 51/3 51/3 66/9 69/16 127/2 146/13 170/25 198/23	training [14] 84/17 84/17 84/19 91/24 106/22 107/1 107/15 107/22 107/23 151/22 151/24 152/2 152/8 152/21	turned [2] 91/3 149/16	undergone [2] 151/22 152/8
toddler [1] 141/14	topic [1] 151/19	transcript [1] 154/6	turning [5] 137/25 143/5 143/22 146/22 175/9	understand [29] 15/22 28/16 29/8 30/25 33/1 45/21 61/23 84/2 88/18 93/18 101/22 102/18 109/14 117/3 123/18 135/2 135/3 136/1 137/21 137/23 140/9 150/4 178/7 182/22 184/18 192/8 195/8 199/6 203/15
together [13] 52/7 69/19 84/9 93/9 97/15 99/9 112/22 113/7 113/15 125/15 134/21 152/5 200/9	Tony Chambers's [1] 121/22	transcripts [2] 2/5 2/13	turns [2] 206/9 209/25	understandably [1] 214/7
		transferring [1] 105/3	two [52] 6/17 11/19 14/23 15/6 21/16 25/15 25/18 28/1 47/22 51/5 51/8 51/14 51/14 51/19 53/4 53/6 54/15 54/17 62/5 65/21 65/23 68/15 75/16 79/7 95/4 97/4 101/1 101/4 101/5 104/10 110/18 120/8 131/2 131/14 131/16 132/13 133/7 133/8 133/10 136/7 147/20 161/23 173/14 177/9 178/5 180/8 181/7 187/23 190/24 197/17 207/5 208/14	understanding [22] 26/5 42/17 48/21 75/8 78/17 78/20 81/3 81/5 82/10 91/23 99/24 106/1 110/7 133/2 134/5 135/11 148/18 152/23 152/23 194/18 215/15 215/17
		transition [1] 101/23	two days [3] 131/14 131/16 132/13	understands [3] 51/9 112/7 171/1
		transmitted [1] 150/21	two reports [3] 28/1 47/22 197/17	understood [13] 3/13 31/21 45/2 62/16 65/3 71/21 93/20 99/13 134/12 150/24 178/2 192/17 192/19
		transmitting [1] 150/7	two years [2] 110/18 120/8	undertake [4] 4/3 41/7 45/13 70/16
		transparency [2] 14/9 111/4	two-fold [1] 79/7	undertaken [6] 23/24 33/15 33/16 45/7 50/21 190/18
		transparent [3] 7/13 165/23 176/9	two/three days [1] 54/15	undertaking [2] 45/15 47/1
		transpired [1] 101/12	type [2] 24/12 74/3	undertook [1] 40/22
		treading [1] 135/19	typed [2] 120/4 120/13	unexpected [36] 8/10 8/20 8/21 13/5 17/19 18/4 19/1 19/15 19/24 23/6 31/9 32/6 33/1 34/25 42/12 43/1 51/1 69/10 78/24 82/2 82/11 83/14 83/21
		treated [5] 118/1 159/23 176/8 182/1 183/11	types [1] 140/24	
		trend [1] 22/21	typical [1] 34/16	
		trial [1] 30/6	typo [1] 200/5	
		trigger [1] 153/9		
		triplet [5] 38/8 38/12 40/3 43/13 43/22		
		triplets [7] 37/18 37/23 44/9 51/19 54/17 72/7 72/22		
		triumvirate [1] 98/2		
		trouble [1] 199/9		
		true [5] 1/23 1/25 77/7 142/15 188/1		
		trust [48] 14/10 38/14 74/22 97/22 104/2 119/17 122/10 122/14 123/14 123/18 126/17 130/5 144/3 145/10 145/12 146/18 153/15 166/20 167/20 168/13 172/7 172/14 172/23 173/21 174/2 175/25 182/3 185/10 186/12 186/13 188/19 190/25 199/3 200/18 201/17 202/11 204/7 204/17 204/24 206/3		

<p>U</p> <p>unexpected... [13] 83/25 84/18 84/20 84/24 103/10 103/24 105/21 127/7 128/8 180/2 192/6 192/9 208/1</p> <p>unexpectedly [5] 34/21 54/17 104/19 131/2 131/3</p> <p>unexplained [24] 8/21 17/19 19/1 19/24 23/6 31/9 32/6 33/1 35/1 35/15 42/12 43/2 81/25 84/20 84/24 103/10 103/17 105/21 127/7 128/8 129/13 180/3 215/8 218/3</p> <p>unfolded [1] 94/16</p> <p>Unfortunately [1] 170/17</p> <p>unhappy [2] 56/22 57/13</p> <p>uniform [1] 23/21</p> <p>uniformly [1] 79/25</p> <p>unimaginable [1] 2/10</p> <p>unintended [1] 68/4</p> <p>uninvited [1] 149/20</p> <p>Union [7] 111/1 111/18 188/16 188/17 188/18 200/25 201/9</p> <p>Union representative [3] 188/18 200/25 201/9</p> <p>unit [88] 6/20 9/22 10/14 13/6 39/25 40/2 42/22 44/1 44/2 44/13 47/11 51/20 52/19 52/23 53/6 54/5 54/7 54/22 56/5 56/12 56/14 58/6 58/9 58/16 60/7 62/20 66/19 67/10 67/10 67/14 68/9 68/11 68/13 82/3 82/17 83/22 88/1 88/11 89/3 89/16 90/7 90/18 91/23 92/2 95/22 96/1 105/4 119/13 122/24 122/25 123/13 124/7 124/8 127/5 127/10 129/12 133/3 133/5 140/9 140/23 141/8 141/10 141/15 141/19 154/23 154/25 155/6 155/8 158/4 158/7 158/9 158/18 158/19 165/21 165/25 173/25 185/7 186/2 186/24 186/24 190/16 191/11 196/25 206/9 208/2 210/7 210/9 210/16</p>	<p>United [1] 205/9</p> <p>United States [1] 205/9</p> <p>units [7] 89/11 102/3 127/19 127/20 127/23 139/4 140/12</p> <p>University [4] 1/15 1/16 142/18 142/22</p> <p>unless [3] 95/12 155/8 200/9</p> <p>unlikely [1] 39/8</p> <p>unobtrusive [1] 67/7</p> <p>unpack [1] 133/13</p> <p>unpaid [1] 143/9</p> <p>unreasonable [1] 36/25</p> <p>unredacted [1] 204/12</p> <p>unsubstantiated [1] 185/16</p> <p>unthinkable [4] 43/3 43/8 107/4 107/10</p> <p>until [18] 30/5 47/7 48/11 57/20 72/21 76/11 78/12 95/18 133/21 157/25 173/25 184/12 187/12 194/8 194/10 203/21 218/15 218/18</p> <p>unusual [12] 10/17 14/19 50/16 51/1 52/10 104/25 105/9 110/20 127/5 128/8 129/15 207/2</p> <p>unwelcome [1] 66/21</p> <p>up [48] 3/2 6/7 18/2 38/19 50/23 54/21 55/11 60/4 61/14 66/20 67/4 67/20 76/20 90/20 91/3 91/13 95/12 95/13 96/16 111/6 112/4 113/11 113/12 117/1 118/10 120/10 121/17 126/19 137/5 137/6 137/10 138/23 147/20 149/16 149/23 151/12 152/2 154/6 157/10 168/13 169/15 170/16 175/7 196/17 196/21 197/20 198/3 205/8</p> <p>upheld [2] 191/14 193/6</p> <p>upon [11] 36/16 38/19 80/1 94/7 123/8 123/10 139/16 168/25 169/8 178/12 213/12</p> <p>upset [2] 8/19 210/19</p> <p>upsetting [2] 117/24 175/2</p> <p>urged [1] 171/20</p> <p>urgency [1] 210/14</p> <p>Urgent [2] 11/20 96/20</p>	<p>us [68] 1/12 3/2 3/6 4/4 4/17 6/24 13/20 14/19 16/9 17/23 19/9 30/4 31/8 37/24 42/21 43/12 44/6 53/7 54/9 55/11 62/13 65/6 65/7 67/16 72/3 73/19 74/13 76/25 88/17 90/9 90/21 93/25 95/24 98/25 100/9 101/15 111/23 112/8 112/10 113/6 115/8 115/15 116/12 118/13 121/14 121/17 126/24 127/3 129/7 129/11 131/17 131/23 136/23 138/3 140/20 142/2 181/18 188/14 189/9 189/24 190/5 197/5 199/22 203/16 204/3 204/4 211/4 212/24</p> <p>use [6] 5/6 23/1 65/15 80/25 105/10 184/13</p> <p>used [12] 11/15 24/2 30/15 69/1 73/4 121/6 133/8 160/6 180/25 184/11 199/7 199/16</p> <p>useful [2] 83/4 139/18</p> <p>usefulness [1] 139/17</p> <p>ushered [1] 169/16</p> <p>usual [4] 80/9 87/2 89/7 140/4</p> <p>usually [7] 9/9 27/3 45/6 46/23 78/25 81/6 106/18</p> <p>utmost [1] 159/23</p> <p>utter [1] 178/17</p> <p>utterly [1] 214/9</p> <hr/> <p>V</p> <p>valid [1] 73/9</p> <p>valuable [2] 15/3 33/9</p> <p>value [1] 169/4</p> <p>values [1] 199/3</p> <p>variation [3] 41/9 41/12 139/24</p> <p>variety [1] 86/2</p> <p>various [6] 19/17 65/22 92/7 94/10 177/16 196/6</p> <p>venue [1] 111/24</p> <p>verbatim [1] 208/13</p> <p>versa [1] 10/22</p> <p>version [1] 84/10</p> <p>very [155] 2/5 2/11 6/1 7/10 7/13 9/7 9/14 10/12 10/13 10/15 10/20 11/10 12/17 12/22 14/18 15/3 19/19 24/25 25/13</p>	<p>28/22 29/12 29/20 31/19 33/9 34/11 34/13 35/8 35/9 36/24 36/24 38/1 38/3 38/15 38/19 43/24 44/9 46/2 46/9 46/16 52/10 52/11 53/3 56/20 58/4 59/3 62/9 63/11 63/20 64/24 66/20 67/6 67/18 68/8 68/19 69/6 72/16 73/7 73/9 73/13 73/13 76/4 76/5 76/8 83/19 85/1 85/13 91/6 91/18 91/21 93/14 94/12 94/21 95/2 95/7 95/8 97/2 98/11 98/11 98/16 102/19 104/25 105/9 105/13 107/23 114/3 116/23 118/24 123/25 126/12 126/13 127/5 128/13 129/21 133/9 133/12 135/19 135/19 135/21 136/4 137/21 139/15 140/18 141/25 142/1 142/2 142/7 148/22 150/12 155/7 155/7 157/2 157/17 158/10 159/21 160/20 160/24 161/5 161/8 163/6 163/10 165/12 165/15 166/3 167/6 168/12 169/7 174/18 174/23 176/2 176/5 176/7 177/5 178/4 179/7 179/19 179/25 184/3 187/3 187/6 189/2 191/5 192/20 194/11 194/11 201/10 201/14 202/22 203/17 203/20 212/23 214/18 215/19 217/11 218/6 218/11</p> <p>via [1] 111/20</p> <p>vice [1] 10/22</p> <p>vice versa [1] 10/22</p> <p>victimisation [1] 180/8</p> <p>victimising [1] 214/12</p> <p>video [1] 141/16</p> <p>view [28] 35/4 35/5 53/1 73/22 85/15 96/17 106/4 130/13 150/5 150/7 150/21 153/11 158/7 166/17 168/22 169/1 169/10 170/22 173/8 176/1 182/6 185/25 190/17 194/18 203/3 207/22 211/6 215/2</p> <p>viewed [1] 169/1</p> <p>viewing [1] 179/13</p> <p>views [5] 125/8 125/16 150/10 175/21</p>	<p>214/2</p> <p>vigorously [1] 193/9</p> <p>visit [5] 72/23 72/23 88/21 90/10 90/22</p> <p>visits [2] 89/13 92/11</p> <p>vocal [1] 163/19</p> <p>voice [6] 98/20 98/20 136/21 137/8 137/15 181/25</p> <p>vote [5] 174/5 174/9 174/11 181/22 182/4</p> <p>vulnerable [1] 34/23</p> <hr/> <p>W</p> <p>waited [2] 129/3 157/25</p> <p>waiting [3] 14/6 110/8 184/15</p> <p>walk [3] 10/18 113/6 118/13</p> <p>walked [9] 55/18 89/3 91/20 93/14 95/7 96/17 109/15 113/7 115/3</p> <p>walking [1] 93/16</p> <p>want [37] 2/21 14/3 19/24 21/15 23/1 27/15 30/25 32/11 46/4 46/19 46/20 46/20 49/25 59/2 59/23 60/7 95/12 99/5 110/21 111/6 118/10 118/13 126/19 140/8 140/20 146/4 148/3 156/15 163/4 170/4 174/21 175/3 200/25 201/17 202/7 211/18 211/19</p> <p>wanted [20] 2/4 2/7 29/23 58/10 89/14 103/7 104/3 122/21 125/16 125/21 132/23 134/22 154/9 160/25 162/25 168/22 172/16 183/24 203/2 208/22</p> <p>wanting [3] 124/3 210/18 210/19</p> <p>wants [1] 59/19</p> <p>ward [13] 6/21 9/11 9/17 9/18 10/2 10/14 73/6 94/2 97/2 141/1 148/17 158/11 160/11</p> <p>wards [4] 67/4 92/4 98/15 140/14</p> <p>warning [3] 37/15 132/24 135/20</p> <p>was [944]</p> <p>wasn't [56] 7/2 10/17 13/3 24/10 24/15 25/8 27/8 31/6 35/8 40/12 42/23 44/4 44/25 46/21 49/19 50/6 54/12 55/14 60/7 61/10 63/23 64/20</p>
--	--	---	---	---

W	38/19 43/14 50/10 91/4 118/25 119/17 130/2 146/11 welcome [1] 141/20 welcomed [1] 95/5 welcoming [2] 141/11 167/6 well [115] 2/23 3/1 5/1 9/24 9/25 11/8 12/3 13/15 17/3 17/20 19/4 19/12 23/5 23/12 23/24 27/2 29/21 31/2 31/10 31/12 32/10 32/14 33/4 33/17 33/20 34/2 34/16 36/18 37/3 38/15 38/17 39/6 39/24 39/24 40/22 43/9 43/9 43/23 44/1 44/12 44/18 44/22 46/7 46/9 49/2 50/9 51/2 51/7 52/9 52/9 52/11 54/2 54/14 55/13 57/13 59/12 60/5 61/7 61/15 61/17 63/22 68/4 70/23 71/9 73/7 75/12 82/18 84/24 91/14 100/2 104/23 114/3 117/24 119/23 120/20 121/14 122/21 123/5 124/21 130/1 132/1 136/4 142/7 150/15 151/15 151/18 152/24 156/8 159/6 159/22 173/1 176/6 177/24 180/17 183/19 188/16 189/23 192/14 194/1 195/10 195/23 196/11 197/11 200/12 201/21 202/19 203/17 208/18 209/8 209/12 209/20 214/24 215/7 217/12 217/18 well-established [1] 217/12 well-respected [1] 159/22 went [12] 42/1 45/17 48/16 51/8 60/2 69/19 89/1 92/1 164/15 203/14 203/19 203/23 were [396] weren't [25] 29/2 30/4 37/18 45/15 51/21 57/16 69/2 69/7 69/9 70/15 101/16 119/9 126/13 127/18 127/24 144/18 144/18 154/9 158/10 160/12 164/5 168/2 168/2 186/20 215/13 west [3] 84/4 84/7 84/12 what [291]	what's [6] 33/25 88/18 138/24 144/5 183/25 205/17 whatever [9] 30/15 35/1 44/23 67/11 72/9 74/6 127/10 201/21 213/15 whatsoever [2] 70/8 75/18 when [136] 2/14 2/21 3/7 10/10 12/16 15/13 15/24 16/13 16/21 19/25 20/1 23/13 23/25 27/5 27/18 30/12 30/13 30/13 30/16 31/13 31/13 32/25 33/5 34/7 34/15 35/7 36/19 38/18 41/17 42/1 47/3 48/24 53/19 54/8 54/12 55/6 58/9 58/15 58/23 58/24 59/25 61/6 62/24 62/25 63/8 66/23 67/5 71/1 73/7 73/14 79/22 79/23 80/11 80/16 80/24 81/6 81/18 83/20 84/15 85/2 91/3 91/15 92/3 93/24 96/22 98/22 100/5 100/14 101/12 101/19 101/19 101/24 101/25 102/20 103/2 103/18 106/5 108/11 108/25 109/7 109/21 110/2 110/5 110/18 118/15 120/8 122/13 123/13 126/6 126/7 128/10 131/25 132/14 137/7 137/13 138/4 138/13 138/18 139/17 140/3 149/4 149/4 149/6 156/18 156/21 157/5 158/7 160/16 163/24 163/25 164/4 164/8 164/18 164/21 164/21 165/10 165/12 166/10 169/3 169/7 169/21 178/14 183/9 184/5 184/7 186/18 189/4 189/8 191/23 195/1 195/2 202/25 203/3 208/16 211/1 215/12 where [63] 5/2 16/8 16/12 17/17 19/8 22/25 38/4 43/10 43/13 46/5 46/16 49/4 57/11 57/22 59/14 62/19 74/12 75/14 80/23 81/7 83/18 83/25 84/3 85/8 86/16 86/25 88/23 91/12 91/21 93/6 96/11 99/21 100/9 105/5	119/21 124/1 131/21 134/20 138/16 139/11 140/4 140/24 141/8 144/1 145/15 145/19 145/24 150/10 161/18 165/24 168/14 169/14 169/15 171/22 174/1 181/10 184/3 184/14 190/1 201/10 203/19 211/14 216/14 whereas [1] 96/20 whether [38] 1/22 8/24 12/15 13/6 20/11 26/13 34/19 34/20 39/4 39/16 47/9 47/10 49/20 50/7 55/23 75/3 79/18 80/3 85/7 85/15 85/16 86/8 86/24 102/12 106/6 106/12 127/8 127/9 127/24 129/20 130/3 130/6 131/5 160/17 172/17 183/10 191/2 211/19 which [73] 9/9 9/14 11/16 15/2 15/2 16/10 23/1 29/20 30/5 30/20 38/10 40/2 52/14 56/7 62/4 64/10 72/18 72/18 79/24 81/3 81/20 82/12 85/6 85/22 87/7 90/3 97/17 98/3 98/4 98/12 102/4 102/18 102/22 103/11 103/13 103/21 105/2 109/22 111/11 113/24 115/11 115/15 117/5 118/17 118/17 125/6 130/4 140/11 140/19 145/18 149/10 158/15 166/20 170/7 171/25 172/19 173/12 177/8 179/13 185/19 189/9 189/12 191/13 196/13 200/6 201/14 204/10 204/23 207/9 212/11 212/20 212/21 216/20 whichever [2] 22/11 86/20 while [14] 2/14 13/25 68/23 90/18 104/14 116/20 119/8 127/13 138/22 141/18 152/7 154/5 165/11 188/10 whilst [3] 68/24 125/4 160/11 whistle [4] 130/3 130/7 130/8 130/9 whistle-blowing [4] 130/3 130/7 130/8 130/9 white [8] 66/20 66/23 66/25 67/1 67/3 67/4 67/8 67/13 who [89] 1/6 4/18	4/24 6/23 7/2 7/6 8/15 9/11 16/6 20/1 27/1 30/20 32/10 33/8 33/17 33/23 34/5 36/11 36/16 45/1 49/1 55/20 55/23 56/18 71/16 72/13 79/3 79/8 80/1 82/19 89/23 89/23 92/1 96/3 99/3 99/25 102/5 102/24 104/19 107/19 108/23 108/24 113/3 120/16 122/15 124/25 128/5 128/6 128/10 131/19 134/3 134/12 135/3 135/6 135/7 135/8 135/8 136/7 137/2 137/4 137/11 138/12 138/17 139/6 139/8 143/11 143/11 144/10 153/1 154/15 156/3 159/11 160/21 167/16 175/18 177/20 180/11 184/19 185/16 189/20 202/8 210/20 211/11 211/11 212/5 213/23 213/23 213/24 217/14 who'd [1] 193/18 who's [3] 61/15 133/25 183/25 who've [1] 89/25 whoever [1] 9/20 whole [10] 102/10 136/15 158/22 159/17 179/19 182/3 197/24 198/18 212/11 212/22 whom [3] 103/5 181/7 211/24 whose [4] 36/12 108/25 186/6 197/20 why [38] 11/5 11/12 14/22 17/16 17/16 31/21 39/20 39/22 54/18 65/8 71/8 71/11 73/7 79/10 90/6 93/18 109/6 109/25 117/25 122/24 123/11 126/25 127/3 129/25 134/18 134/18 136/23 137/19 138/4 151/6 154/24 157/25 159/12 162/1 173/19 198/6 206/5 212/14 will [42] 1/10 2/13 2/18 2/19 2/20 4/22 14/6 15/14 15/15 18/19 19/23 21/4 22/21 22/25 23/18 28/3 38/6 41/4 43/15 55/2 67/23 68/9 68/11 76/10 83/19 89/24 111/5 114/1 139/4 141/4 141/7 142/5 147/10 172/5 172/6
----------	---	--	--	--

W	128/4 137/2 159/20 195/16 196/2 197/24 201/17 216/5 worked [12] 9/25 77/15 80/23 83/25 84/3 89/23 89/24 92/2 97/9 127/20 131/21 148/14 working [30] 7/2 9/21 10/5 11/21 15/11 29/21 42/24 60/7 80/25 84/9 92/4 94/19 95/25 96/1 96/10 99/3 99/18 100/23 103/20 103/21 128/5 131/25 132/1 132/17 132/21 134/1 152/5 154/7 165/24 210/7 workload [1] 148/18 world [2] 93/7 123/9 worried [3] 19/9 42/11 212/2 worry [4] 30/1 40/20 41/10 128/9 worrying [1] 10/21 worse [2] 126/7 203/1 worst [1] 202/24 would [298] wouldn't [29] 17/3 17/3 18/3 18/4 20/4 20/8 23/5 31/2 31/16 31/16 31/25 32/2 32/9 32/19 32/20 32/21 33/14 33/22 39/14 42/18 42/18 67/6 81/16 113/10 122/12 155/9 166/2 170/17 175/16 write [2] 157/4 157/14 writing [5] 58/24 61/14 63/19 146/15 201/23 written [6] 60/21 70/7 110/18 116/15 118/16 202/9 wrong [8] 119/9 140/3 140/5 203/4 204/9 213/25 214/11 214/11 wrongly [1] 168/22 wrote [4] 59/3 136/23 171/25 203/24	yearly [1] 152/8 years [18] 3/3 8/11 9/24 11/22 15/6 40/24 47/21 72/1 74/12 81/15 83/7 83/13 93/8 110/18 120/8 129/12 131/22 208/3 yellow [1] 66/5 yes [190] 1/6 2/2 2/3 2/16 4/7 4/24 8/22 9/16 12/14 12/14 13/19 20/25 21/12 21/15 21/18 27/17 29/9 31/12 32/8 35/22 37/9 40/19 41/24 43/4 45/24 46/19 47/6 48/18 48/25 51/14 52/24 54/19 57/23 58/2 62/8 62/9 62/10 64/18 65/10 66/7 66/12 67/2 69/12 69/14 69/22 69/24 76/10 77/11 78/1 78/11 78/14 78/14 80/5 80/15 82/7 84/13 84/15 84/15 86/22 87/1 87/9 88/4 88/22 88/25 89/4 89/7 89/21 91/1 91/1 91/17 94/3 94/6 94/10 95/25 96/22 97/13 98/1 98/11 99/2 99/24 100/17 100/17 100/19 101/3 101/3 101/16 102/22 103/3 103/6 104/22 105/13 105/18 106/8 108/11 108/19 108/19 109/2 109/11 109/24 110/17 111/14 112/18 112/19 116/3 116/5 116/8 116/8 117/16 117/21 118/4 118/15 120/5 120/16 121/8 126/6 127/4 128/20 128/23 129/9 130/15 132/1 132/1 132/6 133/16 133/19 133/23 134/11 135/15 138/6 140/7 140/15 140/21 142/17 144/4 144/14 146/4 148/3 148/9 148/10 151/25 152/25 153/21 157/2 157/23 165/20 169/12 174/13 176/18 177/23 178/21 178/23 180/13 182/16 183/17 187/9 188/3 188/9 188/13 188/16 189/7 190/8 190/10 190/11 192/10 194/23 195/21 196/8 197/4 198/12 198/12 200/12 202/16 203/3 203/3 203/17 203/23	205/8 205/23 205/24 208/10 208/11 209/20 211/8 211/10 211/16 211/17 211/17 213/13 216/11 216/24 yet [3] 48/4 112/8 131/8 you [1099] you attended [1] 216/6 you might [1] 76/17 you spend [1] 100/20 you'd [9] 3/3 12/12 23/3 69/21 72/13 137/9 137/12 175/19 198/10 you'll [3] 71/11 75/5 117/9 you're [29] 6/24 9/14 10/10 23/13 24/24 25/23 30/22 30/22 31/10 33/1 33/7 35/4 35/5 38/18 43/5 49/11 52/6 54/6 55/3 61/12 64/19 68/7 69/20 102/19 108/16 135/10 143/13 187/11 188/8 you've [24] 9/13 17/17 17/25 18/7 18/9 22/24 50/23 54/8 84/3 90/21 112/8 112/10 129/4 129/7 129/10 130/16 136/13 142/14 149/7 151/22 158/16 165/16 184/24 204/6 younger [1] 8/19 your [187] 1/12 2/18 2/25 9/2 9/5 16/25 26/19 26/23 27/11 28/25 30/4 30/24 35/16 35/18 41/13 43/5 45/5 48/21 49/19 50/3 50/16 51/12 53/25 54/11 54/16 55/11 57/25 58/14 59/10 59/23 62/21 63/17 63/20 64/8 65/4 69/14 70/10 73/22 74/1 76/6 76/25 77/8 78/4 78/16 78/20 79/20 81/3 82/10 84/4 84/11 85/4 85/15 87/10 87/19 88/6 88/18 89/17 90/22 91/4 91/5 91/6 91/19 92/7 92/21 93/25 94/22 95/10 95/11 95/13 95/23 95/24 96/15 96/17 97/10 98/21 100/21 103/1 103/4 105/10 105/11 106/4 108/4 109/9 109/13 109/21 111/15 112/9 112/12 114/13	115/6 115/23 116/22 117/15 117/19 118/10 121/3 121/6 123/23 125/8 126/19 126/21 126/21 126/25 127/2 129/7 129/10 129/20 129/24 130/13 131/17 132/4 133/15 133/21 134/9 134/19 135/16 136/4 136/18 136/18 137/18 137/25 139/21 141/18 142/2 142/5 142/12 142/15 143/1 143/5 143/19 143/23 144/6 146/20 146/22 146/23 146/25 147/8 147/12 147/15 147/21 148/1 148/23 151/21 151/24 152/22 152/23 153/23 156/14 158/14 159/11 159/25 161/17 161/20 162/15 164/14 164/16 165/18 166/12 166/21 167/14 169/8 169/11 169/18 170/8 170/22 172/1 172/22 173/8 185/1 185/23 185/23 186/21 189/24 196/23 199/22 200/2 200/10 200/25 203/15 204/3 208/7 208/13 212/25 215/15 215/22 216/9 218/12 yours [1] 133/14 yourself [10] 51/22 58/18 72/9 90/13 94/16 117/7 143/13 161/4 173/18 207/17
	Y		Z	
	yeah [7] 21/14 54/16 64/18 90/2 90/14 123/25 183/17 year [13] 3/8 5/4 5/4 73/11 74/14 97/13 97/20 105/8 118/23 124/4 138/14 146/11 189/17		ZA [3] 180/5 180/7 202/7 zero [1] 192/21	