1 Monday, 4 November 2024
2 **(10.00 am)**
3 **LADY JUSTICE THIRLWALL:** Good morning, everybody.
4 Ms Brown.
5 **MS BROWN:** Yes, if we could call Ms Townsend,
6 please.
7 **LADY JUSTICE THIRLWALL:** Ms Townsend, would you
8 come and sit in the chair by the table, please.
9 MS KAREN TOWNSEND (affirmed)
10 **LADY JUSTICE THIRLWALL:** Do sit down.
11 **A.** Thank you.
12 Questions by MS BROWN
13 **MS BROWN:** Could you please state your full name?
14 **A.** My name is Karen Townsend.
15 **Q.** You have provided a statement to the Inquiry
16 dated 21 June 2024, is that statement true to the best
17 of your knowledge and belief?
18 **A.** It is.
19 **Q.** I think it's correct that you did not
20 previously provide a written statement to the police and
21 were not interviewed by Facere Melius?
22 **A.** Correct.
23 **Q.** In terms of your background, that is in
24 operational management in healthcare and you have no
25 medical qualifications?

1 **A.** Correct.
2 **Q.** In terms of your employment, what was your
3 role when you first started work at the hospital which
4 I believe was in 2001?
5 **A.** When I joined in 2001, I worked as a Health
6 Record Supervisor. I then moved through the outpatients
7 department, became the Assistant Outpatients Manager and
8 then progressed to be Business Performance Manager,
9 Acute Directorate Manager and then became the Interim
10 Divisional Director in 2015, and became substantive in
11 that role in I think it was May 2016 as Divisional
12 Director for Urgent Care.
13 **Q.** Yes. And being promoted in September 2015 to
14 Interim Divisional Director of Urgent Care, can you
15 recall when in September that was?
16 **A.** No, I can't, I'm sorry.
17 **Q.** It's correct that the neonatal unit fell
18 within your division?
19 **A.** At that point in time it did, yes.
20 **Q.** Who did you replace in the role of Divisional
21 Director?
22 **A.** I replaced Lorraine Burnett who was the
23 Divisional Director at that point in time and became
24 moved to be Director of Operations.
25 **Q.** Did you receive a handover from Ms Burnett

1 when you took over?
2 **A.** It was a transitional process because she was
3 still available and would still be my line manager on
4 a one-to-one basis. There was no formal handover; it
5 was more transitional.
6 **Q.** Did she or anyone else draw your attention to
7 the fact that there was a concern regarding increased
8 mortality on the neonatal ward in the three months prior
9 to starting, so between June and August?
10 **A.** No, not at all.
11 **Q.** You have referred already to the fact that you
12 were promoted from interim to the substantive post in
13 May, so you spent several months interim and then the
14 substantive post. Was there any significance in that,
15 any difference in role?
16 **A.** No, not at all.
17 **Q.** I think it is correct that you are still the
18 Divisional Director of Urgent Care?
19 **A.** I am.
20 **Q.** But that now paediatrics and the neonatal unit
21 are now within the separate Women's and Children
22 Division?
23 **A.** Yes, they have -- they have been separated and
24 made into their own division.
25 **Q.** Can you say when that occurred, when was that

1 division reformed?
2 **A.** Approximately, maybe about -- no, I can't
3 actually, I would be making a date up.
4 **Q.** I am sure someone can provide us with the
5 date.
6 If we could have up on screen, please, INQ0103833,
7 this is at tab 3, my Lady, and this is an organisational
8 chart.
9 So just so we can understand the structure. We see
10 you there, your name at the top as Interim Divisional
11 Director for Urgent Care. Reporting to you over on the
12 left we have Dr Martin Sedgwick who is the Divisional
13 Medical Director?
14 **A.** Correct.
15 **Q.** Below that, reporting to him, we have
16 Dr Jayaram, who is one of the clinical leads, the
17 clinical lead for services. Also reporting to you next
18 along we see Karen Rees who is the Head of Nursing?
19 **A.** Correct.
20 **Q.** Then if we go along to the right-hand side of
21 the page, we actually see your name appears there twice,
22 also as the Acute Directorate Manager which I think was
23 your previous post?
24 **A.** Yes.
25 **Q.** Prior to being interim, did you hold both

1 posts for a time or is that --
2 **A.** For a brief period of time I did until the
3 recruitment was undertaken to fulfil my role.
4 **Q.** So in November, so you had been there a few
5 months; that would be correct, would it?
6 **A.** That would be correct.
7 **Q.** You were still holding both posts?
8 **A.** Yes.
9 **Q.** Shortly after that, you would have
10 relinquished that role, can you remember?
11 **A.** I relinquished that role. Somebody else was
12 appointed to that role and then reported to me as the
13 Divisional Director.
14 **Q.** Can you give a date, approximate date, was
15 that before Christmas or after, for example?
16 **A.** That was probably the latter part of
17 2015/early 2016.
18 **Q.** Was that problematic, holding both roles, or
19 was it something you were able to --
20 **A.** I think the division of Urgent Care is very
21 busy and a very big part of the Trust. It is all the
22 inpatient wards, all the medical inpatient wards, it is
23 the A&E department and all the front door services and
24 in addition at that time there was the paediatrics
25 service. So it's very, big very complex service, yes.

1 **Q.** But did you feel able to perform your role as
2 Interim Divisional Director whilst holding the other
3 role as well?
4 **A.** Yes.
5 **Q.** Who did you then report to, we have seen who
6 reported to you, but who did you report to?
7 **A.** I reported to the Director of Operations.
8 **Q.** We know that eventually that became Lorraine
9 Bennett?
10 **A.** Lorraine Burnett, yes.
11 **Q.** Burnett, sorry, who was that initially? The
12 Director of Operations who were you first reporting to?
13 **A.** Prior to that? I can't recall.
14 **Q.** Once you were in the post of director of
15 Urgent Care, how did you ensure that you were aware of
16 the issues and concerns of staff on the ground, so to
17 speak, within the units that fell within it?
18 **A.** So as you can see on the organisational
19 structure there is a significant team that sits with --
20 beneath the Divisional Director, which is medical leads,
21 nursing leads and also operational leads, and I would
22 receive information from those individuals participating
23 in any discussions, attending speciality meetings and
24 through our governance forum, so our divisional
25 governance committee and our divisional committee and

1 also working with other partners, both internally and
2 externally.
3 **Q.** How often in practice would you actually visit
4 the ward or units within your division, would you
5 actually go down on to the wards and visit?
6 **A.** We would -- I would go to the wards. It was
7 not regular, that has to be said. But I would go and
8 speak to staff in some of the key departments but no, it
9 wasn't a regular part of my working week.
10 **Q.** So approximately how often would you have
11 visited the neonatal unit, would that be once a month or
12 once every six months?
13 **A.** No, I have probably been to the neonatal units
14 about once every four to six weeks in that short period
15 of time.
16 **Q.** So that is going to the neonatal unit. In
17 terms of meeting with divisional -- with the clinical
18 leads, so meeting with Dr Jayaram, obviously with
19 Dr Brearey, how often would you meet them on
20 a one-to-one basis to find out about their concerns?
21 **A.** It would have been Dr Jayaram because he was
22 the lead for paediatrics and probably about once every
23 couple of months.
24 **Q.** In terms of how you saw the role and
25 responsibility of Divisional Director, can you just --

1 are you able to sum that up?
2 **A.** Yes. So it's my responsibility to work
3 alongside the medical leads and the nursing leads to
4 provide oversight for all the operational aspects of the
5 division, for all our compliance, our finance and
6 support for our workforce and obviously the service
7 users and patients.
8 **LADY JUSTICE THIRLWALL:** I wonder if I might ask:
9 you said you work alongside them, but on the chart it
10 looks as though they report to you?
11 **A.** Yes. I appreciate that.
12 **LADY JUSTICE THIRLWALL:** Is that right?
13 **A.** But it's very much a triumvirate because I am
14 not clinically trained so I am heavily reliant on the
15 medical lead and also the nursing lead so we worked as
16 a -- we work cohesively as a team, really.
17 **LADY JUSTICE THIRLWALL:** So they don't report to
18 you or do they?
19 **A.** That indicates that they do but directly the
20 Divisional Medical Director reports to the Medical
21 Director in terms of professionalism as does the Senior
22 Nurse or Head of Nursing also reports to the Executive
23 Nurse for professionalism.
24 **LADY JUSTICE THIRLWALL:** So what do you bring, as
25 it were, to those people?

1 **A.** So operational -- all the operational aspects,
2 business, workforce, finance, compliance in terms of our
3 service delivery, in terms of our target compliance, and
4 just the overall delivery of the division in terms of
5 the day-to-day running of it.
6 **LADY JUSTICE THIRLWALL:** Thank you. But so far as
7 medical and nursing issues, that is not really your
8 responsibility -- is it your responsibility?
9 **A.** No, we would work together. If something was
10 highlighted as a senior team, so medical, nursing and
11 operational, we would come together as a team and
12 discuss those issues.
13 **LADY JUSTICE THIRLWALL:** Thank you. Thank you,
14 Ms Brown.
15 **MS BROWN:** Just turning then to the Risk Registers.
16 Can you explain the difference between the different
17 Risk Registers, there were Neonatal Unit Risk Registers,
18 Divisional Risk Registers and Executive Risk Registers.
19 Can you just set out how they interacted?
20 **A.** Yes. So locally all areas and departments
21 have the opportunity to add a risk at any point in time.
22 Those risks, if there are lower risks, can be held
23 locally in, so in essence it's up to the team or the
24 unit to be able to manage that risk. Any significant
25 risks go on are reviewed by the division and received by

1 the division and we have some oversight and input into
2 what those risks are.
3 **Q.** Just stopping you there. So when you say
4 "come to the division" that meant come to you, did it?
5 **A.** Yes, so they -- so they come through to the
6 division so that would be myself, the Divisional Medical
7 Director and the Head of Nursing that would review those
8 risks and we would provide the input depending what that
9 risk was.
10 **Q.** Then from you up to the Executive Risk
11 Register, how did that operate?
12 **A.** Yes, so at the time, anything that was graded
13 as a 15 and above would go up to the Executives and that
14 would be discussed through the Executive forum which was
15 the quality Safety and Patient Experience Committee and
16 would be held by the Executive team.
17 **Q.** When you say 15 and above, what's the -- just
18 explain the scale, please?
19 **A.** Yes, so anything that is -- anything less than
20 12 is often held as a local risk so something that the
21 department themselves can manage or resolve or address.
22 Anything 12 to 15 sometimes requires a wider input, it
23 could be financial, it could be operational, it could be
24 estate-wise. And then anything more significant than
25 that would be held -- 15 and above would go to Executive

1 level so that was where it would require something
2 outside of the divisional sphere of responsibility.
3 **Q.** What should be recorded on a Risk Register?
4 **A.** Anybody can enter a risk that they deem is
5 appropriate in terms of any aspect of estate,
6 operational, workforce or patient safety issues.
7 **Q.** You say "anyone". That was going to be my
8 next question: what are the routes by which someone
9 would put -- something would be put on to a Risk
10 Register? You say "anyone"?
11 **A.** Yes, so usually it could be a ward manager, an
12 operational manager, it could be a clinician, it could
13 be a senior manager, so anyone who identifies a risk at
14 whatever level. So local, divisional or otherwise.
15 Anyone can enter a risk on the Risk Register.
16 **Q.** You refer in your statement to the Urgent Care
17 Governance and Risk Lead. Who was that in 2015/2016?
18 **A.** That at the time I believe was -- my
19 recollection is it may have been Nicola Brown but that
20 is only -- that is a vague recollection.
21 **Q.** You say it is in paragraph 13 if you want to
22 look at it, you say that in relation to all risks
23 documented you would review the recorded risks, look at
24 all documented risks across the Urgent Care team. What
25 did that review involve, what were you reviewing for,

1 what were you looking for?
2 **A.** So I would review the risks with the
3 governance and risk leads and also in conjunction with
4 the senior nurse and the Divisional Medical Director as
5 appropriate. We would review the risk, we would
6 ascertain what the risk was to be, whether or not there
7 was any evidence to support that and whatever mitigation
8 or controls were in place to manage or support that risk
9 until it resolved.
10 So we would review that from all aspects and if we
11 felt there wasn't sufficient evidence we would go back
12 to whoever had logged that risk to ask for additional
13 information as appropriate.
14 **Q.** You say as well at paragraph 13, in addition
15 to reviewing the risks:
16 "I do also discuss risks as part of any discussion
17 I have with operational, medical or nursing leads."
18 So that is a discussion you are having with the
19 medical and nursing leads?
20 The medical lead for the neonatal unit would be
21 Dr Brearey?
22 **A.** Yes.
23 **Q.** Who would you be categorising as the nursing
24 lead for the neonatal; is that Eirian Powell?
25 **A.** Eirian, yes.

1 **Q.** Between September 2015, when you took on the
2 role, and December 2015, did you discuss risks in the
3 neonatal unit with either Dr Brearey or Eirian Powell?
4 **A.** Not with Dr Brearey. I do recall I have had
5 discussions with Eirian Powell. I think those risks
6 were associated with workforce and there was significant
7 workforce constraints on the neonatal unit at the time.
8 **Q.** So between when you took post and December,
9 which we will come to, when other matters came to your
10 attention, but up to December 2015, did Eirian Powell at
11 any point in that period raise to you a concern about
12 a risk of an increased mortality?
13 **A.** No, not at all.
14 **Q.** So looking now at when you became aware of the
15 increased mortality on the NNU, you say in your
16 statement -- this is paragraph 18 -- that you first
17 became aware of the increased mortality rates when you
18 received the Women and Children's Care Governance Board
19 minutes on 18th -- well, the minutes are dated
20 18 December 2015.
21 You were not -- that was a board that you were not
22 on, but you received their minutes?
23 **A.** Yes.
24 **Q.** You would be sent them as a matter of course
25 as Divisional Director?

1 **A.** Yes.
2 **Q.** Generally how long after the meeting?
3 **A.** Sometimes it can be some weeks afterwards.
4 That very much depends on when the minutes were made
5 available. Sometimes they often were delayed.
6 **Q.** Presumably the purpose of receiving these
7 minutes was so that you were aware of what was going
8 on --
9 **A.** Yes.
10 **Q.** -- within the units that fell within your
11 division?
12 **A.** Yes.
13 **Q.** Because the Women and Children's Care
14 Governance Board, as well as dealing with obstetrics
15 side of things which was not within your division, it
16 also dealt with paediatrics and neonatal that were
17 within your division --
18 **A.** That's correct.
19 **Q.** -- at that time?
20 **A.** Yes.
21 **Q.** So the minutes of the Women and Children's
22 Care Governance Board on 18 December, they referenced
23 stillbirth and early neonatal death review and action
24 plan and this is what you say alerted you to the
25 increase in mortality?

1 That in fact is a reference we know of the report
2 of Dr Brigham. Did you ask to see that underlying
3 report when you became aware of the increase in
4 mortality?
5 **A.** No, I didn't see that report at the time.
6 **Q.** Did you not think it was important, given the
7 importance of an increase in mortality, to see the
8 underlying report?
9 **A.** So that as I believe is associated with the
10 stillbirths and neonates and that would have fell within
11 the obstetrics and gynaecology aspect of Women and
12 Children's rather than paediatrics at that stage.
13 **Q.** So you understood that that report was an
14 obstetric report, did you?
15 **A.** Yes.
16 **Q.** But you didn't see it, that was your clear
17 understanding?
18 **A.** (Nods)
19 **LADY JUSTICE THIRLWALL:** At the time?
20 **A.** No, no, I understand that now, not at the
21 time.
22 **MS BROWN:** So the position in December then is that
23 you are aware that there is an increase in mortality?
24 **A.** (Nods).
25 **Q.** And you are aware there has been a report --

1 **A.** (Nods)
2 **Q.** -- which you haven't seen, the underlying
3 report?
4 **A.** (Nods)
5 **Q.** How are you then interrogating whether there
6 is or isn't an issue in relation to increased mortality
7 in the neonatal unit, which obviously would be a very
8 serious thing within the division?
9 **A.** Yes. So at that point I wasn't involved in
10 any discussions. I -- I was not made aware other than
11 what I had read in the minutes and I wasn't involved or
12 party to any further discussions after that.
13 **Q.** Well, you were aware there was an increase in
14 mortality --
15 **A.** Yes.
16 **Q.** -- in the neonatal unit and you were aware
17 there had been a report?
18 **A.** (Nods)
19 **Q.** So why were you not asking questions, for
20 example, of Dr Brearey or Dr Jayaram as to whether they
21 had concerns about the mortality increase in the
22 neonatal unit?
23 **A.** So I didn't meet with Dr Brearey. I had had
24 some meetings with Dr Jayaram, Dr Jayaram had never
25 raised that with me and, to be fair, I would suggest

1 that was part of my naivety of being very new in that
2 role and paediatrics and neonatal not being particularly
3 part of my career path in terms of my role to date.
4 **Q.** But you -- despite being aware in December
5 that mortality rates were going up, you didn't raise
6 that with Dr Jayaram or anyone?
7 **A.** I don't recall raising it, no.
8 **LADY JUSTICE THIRLWALL:** Can I just ask: you were
9 asked whether you asked to see the report and you said
10 you hadn't seen it.
11 **A.** I don't recall asking to see it.
12 **LADY JUSTICE THIRLWALL:** Did you ask for it?
13 **A.** No.
14 **LADY JUSTICE THIRLWALL:** No, thank you.
15 **MS BROWN:** It seems on the face of it surprising
16 that as a Divisional Director, the first that you became
17 aware of the increase in mortality was just a reference
18 to a report in minutes of a meeting.
19 Was there no system in place to alert you as
20 Divisional Director of an increase in mortality rates
21 independent of governance boards, but simply an alert to
22 mortality rates are going up?
23 **A.** Not at the time, no. I -- there was nothing
24 that I was sighted to or had in process to make me aware
25 of that.

1 **Q.** Just to be clear, you said you had some
2 meetings with Eirian Powell. That you met I think every
3 few months with -- you would have met with Dr Jayaram.
4 You never asked them about the increased mortality rates
5 when you became aware of them and is your evidence that
6 they never raised it with you either?
7 **A.** Correct. Not during that period of time at
8 all, no.
9 **Q.** At paragraph 28 of your statement, if we could
10 just look at that, you say:
11 "In my opinion, any concern associated with
12 an increase in mortality or risk to babies on the NNU
13 should have been registered as a risk on the Risk
14 Register."
15 Once you did become aware in December of the
16 increased mortality rates, why did you not at that point
17 put that on to a Risk Register?
18 **A.** So I -- I didn't have the detail associated
19 with -- associated with that and I would have felt it
20 was entirely appropriate for a member of the clinical
21 team who did have that report and have access to it to
22 put that on the Risk Register should they feel
23 appropriate to do so.
24 **Q.** But we have just been through the fact that
25 you reviewed over the board the Risk Register so you

1 would have been aware that increased mortality wasn't on
2 it. You are now aware in December, there is an issue
3 with increased mortality. Why were you not asking
4 questions or raising the fact that this was not
5 appearing on your Risk Register and there was clearly
6 an issue with increased mortality?
7 **A.** Yes, no --
8 **Q.** -- because that was coming up in your minutes?
9 **A.** -- I acknowledge that but no, I didn't do
10 that.
11 **Q.** At paragraph 29 of your statement, you say:
12 "I was not made aware through any discussion that
13 there was any risk associated with an increased
14 mortality on the NNU."
15 Just setting aside for a moment the terminology of
16 risk and Risk Registers and just looking at the facts
17 here. You were being informed in December 2015 that
18 more babies than expected were dying, that is what
19 an increased rate of mortality is, more babies dying on
20 the ward. That was a unit in your division. You hadn't
21 seen the underlying report so you didn't have a reason
22 to explain in fact that report didn't give a reason in
23 any event as to why more babies were dying.
24 Regardless of Risk Registers but why just out of
25 curiosity and out of your role as Divisional Director

1 did you not go to either Dr Jayaram or Dr Brearey and
2 say: what's this about? Is there a problem here? I am
3 being told more babies are dying, why is this? Why was
4 that question do you think not asked?
5 **A.** Yes. I think -- I think that was a gap and
6 a failing on my point but neither was that point raised
7 with me either. I didn't have that discussion with
8 Dr Jayaram or Dr Brearey. They didn't come forward with
9 that but actually no, I didn't go and ask them either.
10 **Q.** Then moving forward to paragraph 20 in your
11 statement, we then see you refer to the minutes again,
12 later minutes of the Women and Children's Care
13 Governance Board that were from a meeting of 16 June.
14 Can you recall when you would have received those
15 minutes?
16 **A.** Those minutes actually came to Divisional
17 Governance in July 2016, I think.
18 **Q.** Yes.
19 **A.** Yes.
20 **Q.** Which you go on to deal with. My question is
21 would you -- so that is when they were discussed by the
22 next board up, so to speak, but would you have received
23 and reviewed those minutes at an earlier stage?
24 **A.** No.
25 **Q.** Those minutes refer to the thematic review now

1 of the neonatal unit that was done in February --
2 **A.** Mmm mm.
3 **Q.** -- with the involvement of Dr Brearey. Prior
4 to you seeing the minutes in -- these June minutes, were
5 you aware that that review had taken place?
6 **A.** I was not, no.
7 **Q.** That was a review, as you are aware now, an
8 outside Consultant was brought in to review --
9 **A.** Yes.
10 **Q.** -- obviously the very serious issue of
11 increased mortality.
12 Why do you think it was as Divisional Director you
13 weren't aware of that?
14 **A.** So I didn't receive any -- I didn't receive
15 any handover associated with any issues with regards to
16 this issue. I didn't receive any back papers, I didn't
17 have any indication prior to that event of any situation
18 associated with the mortality on the neonatal unit.
19 **Q.** So you were aware in December that there was
20 an increased mortality. Then in June this is the first
21 you are aware these minutes, the first that you are
22 aware a review had been done in February?
23 **A.** Correct.
24 **Q.** You have explained before that you were
25 meeting every few months or so with Dr Jayaram --

1 **A.** (Nods)
2 **Q.** -- and meeting I think more regularly with
3 Eirian Powell?
4 **A.** Yes.
5 **Q.** Did you at no point, knowing that there was
6 increased mortality, raise with them what's being done
7 to look into this increased mortality on the neonatal
8 unit?
9 **A.** No, I had no discussion.
10 **Q.** But that would have fallen with something you
11 as divisional director should have looked at?
12 **A.** Had I have known that there was a thematic
13 review from 2015 I may have done something differently
14 but I -- it wasn't discussed with me, I didn't know
15 anything about it and meeting Eirian or Dr Jayaram,
16 neither of them raised that with me either.
17 **Q.** Once you did see the minutes and discovered
18 that this -- this review had gone on, this thematic
19 review, did you ask to see the report then?
20 **A.** I didn't see the report then because this came
21 out after the events and I wasn't involved in the
22 ongoing events after June 2016 at all.
23 **Q.** But did you, regardless of the fact things had
24 moved on, did you not think it was important to see what
25 review had gone on within your division in February to

1 do with mortality rates?
2 **A.** Potentially but I wasn't -- they weren't made
3 available to me.
4 **Q.** If we just look then at what you say about the
5 discussion of those minutes, that they were received --
6 paragraph 21 -- by the Urgent Care Divisional board on
7 14 July. Now by 14 July, you had spoken to Dr Jayaram
8 then so you were aware of his concerns --
9 **A.** Yes.
10 **Q.** -- that there was a member of staff harming
11 babies?
12 **A.** Mm-hm.
13 **Q.** And you were also aware that there was
14 an increased mortality issue on the neonatal unit.
15 At paragraph 23, you say:
16 "I understood from consideration of those minutes
17 [these are the Women and Children's Care Governance
18 Board minutes] no common theme had been identified
19 across all the cases and I understood there was no
20 apparent evidence to suggest there was any risk within
21 the NNU."
22 But by that time you expressly knew that Dr Jayaram
23 was saying there is a risk on the NNU and that risk is
24 a member of staff?
25 **A.** But I think what I was making reference to is

1 what was within the minutes. So within the minutes, it
2 talks about there being no apparent evidence and
3 suggestion of any risk, that was in the minutes from the
4 board, not actually the events that had taken place.
5 **Q.** Well, let's just look at the minutes, shall
6 we?
7 So if we could go to 0003212, at page 5. So this
8 is the minutes of the 16 June 2016 meeting that was then
9 discussed at divisional level. So these are the minutes
10 that you saw and were discussed at divisional. It says
11 there under "NN Thematic Review" there was a higher than
12 expected mortality rate, which you were aware of in any
13 event. Then going down, there was an external reviewer.
14 So it was of significance that someone else was
15 brought in from outside the hospital?
16 **A.** Mm-hm.
17 **Q.** It says what they were assessing was where all
18 action points were completed, any new areas of care
19 improvement, any possible common themes, discuss if
20 further action is required. There was no common theme
21 identified in all the cases.
22 So it says there is no common theme. But you can't
23 tell from that whether there were any issues, whether
24 there were areas of care improvement needed. Did you
25 not feel on seeing that note: I need to see this report,

1 I need to understand what, for example, the areas of
2 care improvement are, what the explanation is if there
3 is no explanation for the mortality?
4 **A.** No. So I received that in the July as part of
5 the Urgent Care governance. The situation had been
6 superseded by the events back in June and therefore this
7 was being dealt with very much by the Executives in
8 conjunction with the paediatricians.
9 **Q.** Yes. Just going back, just look at
10 paragraph 23 of your statement. You say there you
11 understood there was no evidence to suggest there was
12 any risk within the NNU.
13 That's wrong, isn't it, you did understand there
14 was a risk within the NNU then?
15 **A.** But I was referring to the notes in the
16 minutes, sorry, that's the way I have reported that.
17 I am referring to the minutes -- obviously I received
18 the minutes after I had had the conversation with
19 Dr Jayaram back in June.
20 **Q.** But given that you were aware of it, and you
21 were discussing this on the Urgent Care Divisional
22 board, you say there was consequently no broad
23 discussion as to these minutes within the Urgent Care
24 Divisional board.
25 Sitting on that board, the point comes up in the

1 agenda presumably to discuss this report. Didn't you
2 feel at that point you had to say: well, I now have
3 additional information, I know that there is a real
4 concern. Why was that not a point of discussion at the
5 Urgent Care Divisional board?
6 **A.** Because as this had come to light and prior to
7 that urgent board taking place, I think on 14 July, this
8 very much became an issue that was addressed between the
9 Executives and the paediatricians and it was not
10 inclusive of members of the Division of Urgent Care.
11 **Q.** If we can go then to paragraph 32 of your
12 statement. You say there if you had been aware of any
13 concerns about staff involvement and increased mortality
14 you would have expected that to be on the Risk Register.
15 You see the last line:
16 "... I would have expected that to be on the Risk
17 Register"?
18 **A.** Yes.
19 **Q.** So just understanding. I take it from that
20 that you felt that if there was a risk that a member of
21 staff was harming patients, that that was something that
22 was suitable to go on a Risk Register?
23 **A.** Yes, absolutely.
24 **Q.** Did -- external bodies such as the CQC, they
25 would have access to Risk Registers?

1 **A.** Yes.
2 **Q.** Did you consider that in fact influenced what
3 in fact was put on Risk Registers, whether there was
4 a desire to keep this sort of risk off a Risk Register?
5 **A.** No, I didn't have any -- can you repeat that,
6 sorry?
7 **Q.** Well, because they were open to outside
8 scrutiny were you aware of any move to keep these sort
9 of risks -- you say you feel those risks should go on
10 there, but were you aware of a view that those risks
11 shouldn't be put there?
12 **A.** No.
13 **Q.** We are going to come to the meeting with
14 Dr Jayaram in a moment, but on 24 June, you became aware
15 of the risk of the concerns that Dr Jayaram had about
16 a member of staff harming babies.
17 Why then at that point on 24 June did you not put
18 that on the Risk Register?
19 **A.** Because I didn't have any detail. It was
20 a very vague reference to, there was no detail
21 associated with that whatsoever, I wasn't given any
22 evidence or anything to substantiate it and I felt like
23 I needed to raise that with clinical members of the
24 senior team and -- and find some additional information.
25 **Q.** If we can just look at what was put on to the

1 Risk Register. If we could go to INQ0004657, this is
2 tab 19, my Lady, of your bundle.
3 So we see at the top there, so this is -- we see
4 Urgent Care, we are looking at the first line,
5 neonatology, the handler, what does "handler" mean?
6 **A.** The handler is normally the individual that's
7 actually input that particular risk.
8 **Q.** We see -- so this is the date the risk here
9 was added, 11 July 2016 and we see the wording there:
10 "Potential damage to reputation of neonatal service
11 and wider Trust due to apparent increased mortality
12 within the neonatal unit."
13 Where did you get that wording from?
14 **A.** That was scripted following meetings with the
15 Executive teams when we were making preparation to go
16 public with regards to the alleged increased into the
17 mortality and the change of the unit from a Level 2 to
18 Level 1 status. So that was part of those briefing
19 sessions early July.
20 **Q.** But you were putting this on to your -- within
21 your division your register as a risk?
22 **A.** Yes.
23 **Q.** What did you understand the risk that you were
24 talking about was here?
25 **A.** So at that point yes, I had already had

1 a conversation with Dr Jayaram. However, I still did
2 not have any detail or any clinical understanding of
3 what those risks were and that risk was scripted from
4 the Trust perspective as how they wanted to register
5 that risk on the Risk Register.
6 **Q.** Because the wording that -- you have explained
7 where the wording came from but it says "due to apparent
8 increased mortality"?
9 **A.** Yes.
10 **Q.** Why was the word or why did you adopt their
11 word for your Risk Register of "apparent" increased
12 mortality, because there was actual increased mortality,
13 wasn't there?
14 **A.** Because at that point in time the Trust were
15 still undertaking a number of fact-finding avenues and
16 looking at different external parties to support those
17 reviews and that was the decision that was made at the
18 time before we went public, that was part of the
19 information that went out publicly as well. That was
20 how it was asked to be added.
21 **Q.** But your understanding was on 11 July that
22 there was actual increase in mortality?
23 **A.** Well, I had received some information to
24 suggest so, but I didn't have any detail. I didn't have
25 any actual detail, I didn't have any clinical detail at

1 that point in time. It was just a raised concern.
2 **Q.** Because if there was potential damage to
3 reputation, so this is talking about the reputation of
4 the Trust, due to the apparent increased mortality, is
5 there not by definition then beneath that the more
6 serious risk which is the risk to any baby going on the
7 unit that their risk of mortality is greater?
8 **A.** Yes.
9 **Q.** The question is between September when you
10 joined and this period in July, there is nothing on any
11 Risk Registers the risks that you reviewed to record
12 that there was a risk due to increased mortality and we
13 are trying to understand why that was?
14 **A.** Yes, there were -- you are correct, there
15 wasn't. I didn't put a risk on there until I was part
16 of those later discussions, nor did any of the clinical
17 teams or the nursing teams within the neonatal or
18 paediatric unit either, nobody put those risks on.
19 **Q.** If there had been, if it had been entered on
20 a Risk Register, either the NNU or the Divisional Risk
21 Register, either in June 2015 when the three deaths
22 occurred in short succession, that was before your role,
23 or in December when you became as Divisional Director
24 aware of the increased mortality or on 16 June, when you
25 became aware of the thematic review, what difference

1 would that have made, what -- how would these Risk
2 Registers in practice working, what would have happened
3 in terms of reviews if a risk of increased mortality had
4 been put on the register?
5 **A.** So at the time, I think there would have been
6 more open conversations. I think there would be
7 a broader understanding of actions that needed to be
8 taken and reviews and discussions to be held.
9 My experience at that time was it was very much
10 dealt with in Executive level. We were removed from
11 those discussions and that process, there was a lack of
12 transparency as to what the detail was.
13 **Q.** So if we can turn now to the meeting you had
14 with Dr Jayaram on 24 June 2016 at 11 o'clock.
15 You deal with this at paragraph 40 of your witness
16 statement. So Dr Jayaram's recollection is that you met
17 at his request. Does that accord with your recollection
18 or can you not assist?
19 **A.** I don't recall whose request it was.
20 **Q.** But your evidence is I think that this
21 wouldn't have been the first time you met as with
22 a one-to-one with Dr Jayaram?
23 **A.** Correct.
24 **Q.** It wasn't the first time?
25 **A.** It wasn't the first time, no.

1 **Q.** Approximately since September, how many times
2 would you have met with Dr Jayaram, do you feel?
3 **A.** At least a couple.
4 **Q.** You describe the meeting in paragraph 41 and
5 significantly the information that you recall Dr Jayaram
6 sharing with you is that a triplet had died on the
7 neonatal unit, so a death, obviously background to this
8 you already aware of an increase in neonatal mortality?
9 **A.** Yes.
10 **Q.** But a triplet had died. Both Dr Jayaram and
11 Dr Brearey had concerns that an individual may be
12 deliberately harming babies on the neonatal unit and you
13 say that you recall that they were very concerned for
14 the remaining two triplets.
15 So this must have been incredibly shocking
16 information to receive?
17 **A.** It was.
18 **Q.** You say that you can't recall if Dr Jayaram
19 referred to Letby. Dr Jayaram's recollection is that he
20 did and that that's the recollection of Karen Rees in
21 her account to Facere Melius. It's likely, isn't it,
22 that you -- I appreciate you can't recall that, but that
23 you would have asked: who is this staff member, it is
24 a nurse or a doctor? That seems likely?
25 **A.** I think I made some very rough notes and

1 I think I put the initials, I just don't recall actually
2 hearing it.
3 **Q.** Right. So do you recall Dr Jayaram informing
4 you that he was uncomfortable with Letby remaining on
5 the unit unsupervised?
6 **A.** So we had a very brief conversation. We
7 talked about other things and then we talked very
8 briefly about the concerns that himself and Dr Brearey
9 and potentially others had and was concerned around the
10 individual being on the unit at that time, yes.
11 **Q.** At paragraph 42, you say here that -- and this
12 meeting I think took in a coffee area within the
13 hospital?
14 **A.** It was in a coffee shop, yes.
15 **Q.** You say Dr Jayaram gesticulated to a drawer of
16 doom?
17 **A.** Yes.
18 **Q.** What was he gesticulating to?
19 **A.** So he was, he was making reference to
20 Dr Brearey having a drawer of doom where apparently he
21 had information or evidence and he was kind of doing
22 this (indicated) kind of to suggest a drawer.
23 **Q.** Do I understand from that that Dr Jayaram was
24 telling you about concerns that Letby was associated
25 with previous unexpected deaths?

1 **A.** It was, he had evidence clinical evidence and
2 detail is what the reference was.
3 **Q.** That was referring to past deaths --
4 **A.** Yes.
5 **Q.** -- on the unit?
6 **A.** Yes, previous -- yes.
7 **Q.** At paragraph 45, you say:
8 "I was concerned there was a potential risk to the
9 babies on the NNU."
10 Precisely what was the risk that you were concerned
11 about at this point?
12 **A.** So in context that was a very ad hoc meeting
13 that we were having, it wasn't a formal meeting at all,
14 it was in a coffee shop in an open area it was on
15 a Friday and my immediate -- having heard that for the
16 first time, my immediate concern was that I needed to go
17 and speak to someone to see if there was any actions
18 that we needed to undertake because it was a Friday and
19 obviously going into a weekend.
20 **Q.** Just coming back to the question. What was
21 the risk that you were concerned about?
22 **A.** The risk was that there was going to be
23 further harm to babies on the neonatal unit.
24 **Q.** You say that and you have repeated I think
25 just there orally what you say in paragraph 46 about the

1 fact this was raised in an informal manner and had not
2 been raised previously.
3 Do you mean by that you were doubting that
4 Dr Jayaram's concern was genuine?
5 **A.** I wasn't doubting it. It was the first time
6 I have heard it and I just found it was quite an unusual
7 forum in which to give somebody that level of
8 information so -- or that detail. I was just quite
9 shocked when I received it at that point in time.
10 **Q.** So you were taken aback but you weren't
11 doubting that Dr Jayaram was --
12 **A.** I wasn't.
13 **Q.** -- sincere?
14 **A.** I wasn't doubting it, I think I was just
15 shocked to receive it in that manner.
16 **Q.** Other than going to Karen Rees, who was the
17 Head of Nursing, that we have seen while on the
18 structure reported to you, I think you say you worked
19 alongside --
20 **A.** Yes.
21 **Q.** -- but was certainly -- you were the
22 Divisional Director of which she was the Head of
23 Nursing, other than going to her, what did you do to
24 address that immediate risk that Dr Jayaram alerted you
25 to and which you understood was harm to babies? And in

1 fact Dr Jayaram was talking about concern for the two
2 remaining triplets, he was talking very specifically
3 about harm to babies imminent -- imminent harm, babies
4 who were on the unit then.
5 Other than speaking to Karen Rees what did you do
6 to address that harm, that risk?
7 **A.** So what I did at the time was, as I said
8 before, I was very shocked, I didn't have any clinical
9 information. It was just I think Ravi had said at the
10 time that they felt but there was no actual factual
11 information or evidence given to me.
12 So I went to speak to Karen Rees, I am not clinical
13 by background, so I went to seek her support and advice
14 and kind of ask her what should we do in terms of those
15 immediate next steps. And I think from that point on
16 Karen then went to speak or try and speak to the
17 individuals to try and gain some additional information.
18 **Q.** Because just to recap where we were at that
19 point. So this was on the morning of the 24th so one
20 triplet had died. You are being told there is concern
21 for two triplets on the -- the two remaining triplets
22 who are on the unit then.
23 You have got Dr Jayaram saying that he and
24 Dr Brearey had very -- were very concerned so the two
25 most senior clinicians were concerned. They are telling

1 you there is -- you haven't seen it but there was --
2 they have got documents that substantiate that.
3 You don't doubt that those are genuine. Why at
4 that point were you not going immediately to the
5 Executive level saying: we need to take -- immediate
6 action needs to be taken at the most senior level,
7 rather than referring it to your Head of Nursing to make
8 further enquiries because that wasn't going to address
9 the risk that there were babies at imminent risk of
10 harm?
11 **A.** No, I understand that. But I think that was
12 kind of my naivety in my role but also if Dr Jayaram and
13 Dr Brearey also had those real strong concerns, and
14 obviously they had far more detail than I -- why was
15 that then transposed to me in a coffee shop meeting and
16 why wasn't that actually escalated direct to the
17 Executives?
18 **Q.** You say naivety in role, but you had been in
19 post for a year by this time, hadn't you?
20 **A.** I hadn't been in post a year but my true
21 background is Urgent Care. Paediatrics and neonatal
22 were not within my portfolio in terms of my longer
23 career. However, I did go and speak immediately to
24 Karen Rees to seek some support in that discussion.
25 **Q.** I say a year, it wasn't quite a year was it,

1 because you started in September and this was June?
2 **A.** No.
3 **Q.** Paragraph 48 then, you say:
4 "On the day I received this information it was
5 something I did not expect to hear ... I had no detail,
6 evidence or context regarding the comments made to me.
7 I therefore did not have sufficient information for
8 these comments to be placed immediately on the Risk
9 Register."
10 Because it seems from that that there was an
11 over-reliance or over-concern about putting it on the
12 Risk Register and not sufficient recognition that
13 actually what was needed here was now immediate action
14 to remove Letby from the ward so that there could be an
15 investigation.
16 Is that -- is that fair that there was an
17 over-reliance on Risk Registers and not -- clouding the
18 actual action that was needed to the present risk?
19 **A.** No, I don't think there was an over-reliance
20 on the Risk Register at all. I think following the
21 discussion with Ravi I think yes clearly some action
22 needed to be taken but actually there needed to be some
23 evidence, there needed to be some detail of what that
24 concern was. I didn't receive it on the Friday, I am
25 not clear that Karen Rees received it on the Friday

1 either.
2 **Q.** Well, in terms of evidence, you have got the
3 two most senior clinicians saying that they have
4 concerns about imminent risk to babies. A baby has
5 already died.
6 Is that not sufficient to take the neutral role of
7 removing Letby from the ward so that an investigation
8 can then take place because that would have changed the
9 course of events, clearly?
10 **A.** So when I received that, there was -- like
11 I say there was no detail, it was just how they felt
12 about something and I felt that needed further detail
13 and needed to be delved into a bit further. Hence my
14 ask to go and speak to Karen Rees about it. But I do
15 feel if there was that urgency and not denying how
16 Dr Jayaram and Dr Brearey felt, but they also could have
17 acted on that, and like I say, they could have gone
18 direct to the Executives themselves.
19 **Q.** At paragraph 54 of your statement, you say it
20 had taken quite some time before Dr Jayaram disclosed
21 his concerns to me, which we have talked about.
22 "No concern had previously been escalated or cited
23 through the divisional process but this having now been
24 raised appears to have raised the expectation of
25 immediate action in dealing with it."

1 Did you accept that immediate action was needed?
2 **A.** What --
3 **Q.** It seems to be suggesting it wasn't but did
4 you accept that immediate action was needed?
5 **A.** What number are you looking at, I'm sorry?
6 **Q.** Sorry, paragraph 54, actually it is over the
7 page, so if you are the same pagination as me it is the
8 second half of that.
9 So you say that Dr Jayaram hadn't previously raised
10 it but once he did raise it, he appears to have raised
11 the expectation of immediate action and my question is:
12 did you think that immediate action was needed?
13 **A.** So yes. So I think that -- I think that
14 relates to an email exchange the following week.
15 Obviously the paediatricians had had -- I wasn't aware,
16 but had had some earlier conversations with the
17 Executives with regards to their concerns and following
18 the discussion I had with Dr Jayaram on the Friday and
19 the subsequent discussion with Karen Rees, that then
20 became an escalated issue. More people were involved in
21 those discussions and I think with Dr Brearey was now
22 wanting some immediate action to take place now we had
23 gone that one step further and more people were involved
24 in the discussion.
25 **Q.** When were you informed of the death of

1 Child P?
2 **A.** The Monday of the following week.
3 **Q.** You say at paragraph 59 when you became aware
4 of the second triplet had died over the weekend, if they
5 have concerns about deliberate harm being caused by
6 a member of nursing staff, you say "if" there, but there
7 were concerns there, weren't there, Dr Jayaram had
8 expressed those concerns:
9 "... I wondered why they had not been escalated
10 previously ..."
11 Then you go on to say:
12 "... I could not understand why Dr Brearey and
13 Dr Jayaram felt it was safe to go home that weekend."
14 Ms Townsend, did you feel it was safe to go home
15 that weekend when you knew that or you were -- had not
16 been told that Letby had been removed from the ward.
17 Was that not a worry that you --
18 **A.** So my understanding was Karen Rees did go and
19 seek both Dr Jayaram and Dr Brearey that same afternoon
20 and neither Dr Jayaram or Dr Brearey gave any detail or
21 evidence with regards to their concerns. I believe
22 Karen did go and speak to two of our Executives and left
23 it with the Executives at that point in time. But
24 neither -- neither of the clinicians would offer any
25 further detail at that time.

1 So from their perspective, there was very little
2 else that they could have achieved on that day.
3 **Q.** But were you concerned about the baby's safety
4 on the unit before you went home?
5 **A.** So I -- I was concerned. I was concerned but
6 also when I heard that the clinicians had not offered
7 any more information I was also -- I was a bit confused
8 as to why that would be. Surely if they had those
9 concerns and that detail why was that not raised and
10 made available on the Friday for any action to be taken?
11 **Q.** Did you take any action to ensure that Letby
12 was not working over the weekend?
13 **A.** Not on that day, no.
14 **Q.** So when you left on Friday, what actions did
15 you understand had been taken to address Dr Jayaram's
16 concerns?
17 **A.** I understood that Karen Rees had gone to speak
18 to Dr Jayaram and had also gone to speak to Dr Brearey
19 or waited for Dr Brearey, I think he was in a clinic.
20 I don't think he received any information, I don't think
21 he -- any further information was offered and I also
22 understand Karen Rees went and spoke to the neonatal
23 unit manager or nurse in charge on the day and asked if
24 they had any concerns to which the answer was no at the
25 time. And then subsequently Karen Rees then went to

1 speak to the Executive team to make them aware.
2 **Q.** Yes. If we could go to INQ0005749 and page 2
3 of that document and this is at tab 16. So while we are
4 waiting for the document, this is an email that you sent
5 to Dr Brearey and it's summing up some decisions or
6 actions from a meeting that was on 27 June.
7 Can you recall whether you were at that meeting or
8 are you just reporting it? You may not be able to
9 recall.
10 **A.** I don't recall. I am -- I am aware and
11 familiar with the email and the content but I don't
12 recall if I was in the meeting itself.
13 **Q.** Well, just looking at the content of the
14 meeting.
15 **A.** Yes.
16 **Q.** So this is the following week, so Child O and
17 Child P have died and you are aware -- we have gone
18 through the discussion you had with Dr Jayaram -- what
19 he had shared with you?
20 **A.** (Nods)
21 **Q.** You say there at six bullet points down:
22 "LL to remain on days for support, on annual leave
23 next week."
24 So it seems to be saying that that week she would
25 remain working. Did you have concerns that she should

1 be allowed to remain on the unit given the concern that
2 Dr Jayaram had in a sense escalated now because what he
3 had been very concerned about had in fact eventuated in
4 terms of the death of Baby P?
5 **A.** I think there were concerns all around. But
6 my understanding was that at that time, there was still
7 no actual evidence or detail and the Executive decision
8 at that time was to remain for Letby to remain on the
9 unit until she went on annual leave. So the concern was
10 still there but, yes that action wasn't taken.
11 **Q.** You are referring to more evidence. One baby
12 had died, now another. The two Consultants have got
13 real concerns about harm to babies. What more would
14 have been needed before removing Letby from the ward to
15 undertake an investigation?
16 **A.** I am not clinical, I don't know any of the
17 details associated with any of the babies that have died
18 unfortunately, and I am not clear what the connections
19 were or I'm not sure we knew at the time what the
20 connections were with Letby as well.
21 **Q.** I mean, if we just turn to paragraph 62 of
22 your statement where you are discussing a meeting that
23 was a discussion on 30 June about Letby returning to the
24 NNU and you have got some notes that you have referred
25 to, we don't need to go to them because you have cited

1 the bit from your notes, "SB remove nurse or go to
2 police"?
3 **A.** Yes.
4 **Q.** Just to be completely clear, "SB" would be
5 Stephen Brearey, would it?
6 **A.** Would be, yes.
7 **Q.** Can you recall the discussion about going to
8 the police on 30 June?
9 **A.** I don't -- I remember -- I recall the meeting,
10 I don't remember the absolute context to that. They
11 were talking about the clinical incident -- they were
12 talking about the incidents but I can't recall -- they
13 are my notes, I did make them in the meeting, but
14 I don't recall the detail of it, I'm afraid.
15 **Q.** What was your view then because as you say you
16 are not clinically trained, but nevertheless you are the
17 Divisional Director, you have had it reported that
18 someone is concerned about a member of staff harming
19 babies. That's obviously a crime, if that's the case?
20 **A.** (Nods)
21 **Q.** Did you consider that the police should be
22 contacted, is that something you raised or considered?
23 **A.** I didn't raise it. I felt -- I felt -- to be
24 honest, I probably felt out of my depth because I didn't
25 have the clinical insight, I didn't have the clinical

1 knowledge and this was a very, very serious situation
2 and I felt I was being very much led by how the
3 Executive team wanted to manage it at the time because
4 of how awful a scenario it was.
5 **Q.** You go on to talk about meetings in the early
6 July on the 8 July, briefings about the downgrade of the
7 NNU --
8 **A.** Yes.
9 **Q.** -- from a Level 2 to a Level 1 and the fact
10 that you liaised directly with Arrowe Park.
11 Why did you understand the unit was being
12 downgraded, what was the actual reason for the
13 downgrade?
14 **A.** The actual reason for downgrading was to
15 reduce -- was to manage the risk around the alleged
16 mortality for neonatal, so moving from a Level 2 down to
17 a Level 1 would mean the babies of a much younger age
18 would be managed in another organisation whilst the
19 Trust tried to work to understand what the situation
20 actually was and what action they needed to take.
21 **Q.** Did you have any role in speaking to the
22 parents of the babies who had died or collapsed about
23 that downgrade in terms of communications was that any
24 part of your role?
25 **A.** That was not part of my role, no.

1 **Q.** If I could just turn you to one final document
2 which is INQ0077575. So these are some emails I just
3 wonder if you can assist us with the context of this.
4 If you could just go on to page 2 first, because it
5 works backwards, so to speak.
6 There is an email there: can you confirm that the
7 protection for Lucy Letby is still to be continued? She
8 has been receiving these payments since August 16.
9 This is an email that was sent on 14 February 2018
10 and if we go back to page 1, there are there is an email
11 first of all from Karen Rees and then you respond on
12 14 February --
13 **A.** Yes.
14 **Q.** -- at 12.23: please can these continue for the
15 foreseeable future?
16 Can you just assist with what those emails are
17 talking about, what payments those are referring to?
18 **A.** So what I can understand from this is that at
19 the time Lucy Letby, although she wasn't working on the
20 neonatal unit, had been removed and was working in
21 another part of the organisation, I believe it was Risk
22 and Governance, and as she had not been formally
23 excluded she was still in receipt of her salary, so that
24 was just confirming that that was the case.
25 **Q.** That was an operational matter that came to

1 you because she was still formally within your division?
2 **A.** I'm sorry?
3 **Q.** That was a matter that formally came to you as
4 Divisional Director because she was still --
5 **A.** Yes, because even though she had been moved to
6 work in another area, she still would have been on the
7 payroll within Urgent Care, yes.
8 **MS BROWN:** Yes, those are all my questions. There
9 are going to be a few more questions.
10 **LADY JUSTICE THIRLWALL:** Mr Baker.
11 Questions by MR BAKER
12 **MR BAKER:** My Lady.
13 Mrs Townsend my name is Richard Baker. I ask
14 questions on behalf of some of the Families and in
15 particular in this case the Family of the Triplets O,
16 P&R.
17 **A.** (Nods)
18 **Q.** Your role at the time was Executive in charge
19 of Dr Jayaram and Dr Brearey's division, wasn't it?
20 **A.** Not Executive. I was Divisional Director,
21 I am not Executive -- I am not an Executive Director.
22 **Q.** But you were the most senior person within
23 that division before we reach the Executives?
24 **A.** Yes.
25 **Q.** It was a Band 8D role, which is a senior role?

1 **A.** Mm-hm, yes.
2 **Q.** Which carries a lot of responsibility --
3 **A.** Yes.
4 **Q.** -- within the NHS.
5 Now, I just wanted to pick up one point that you
6 made about the doctors, you criticise them for not
7 taking the issue to the Executives. But in fact they
8 should have taken the issue to you rather than bypassing
9 you and going directly to the Executives, shouldn't
10 they, you are the most senior person within the
11 division?
12 **A.** Yes, they could come to me.
13 **Q.** Not they could come to you, but you would
14 expect following the hierarchy that having been to
15 people like Karen Rees or Eirian Powell, you would be
16 the next most senior person to go to?
17 **A.** Yes.
18 **Q.** Do you recall what the purpose of the meeting
19 with Dr Jayaram was on 24 June?
20 **A.** It was just a general catch-up, really. It
21 wasn't a formal meeting, hence the setting in the coffee
22 shop.
23 **Q.** But you didn't have regular scheduled meetings
24 with Dr Jayaram, that was your evidence, was that they
25 would happen every couple of months but they weren't

1 organised or regular; they were ad hoc?
2 **A.** No, we used to have regular -- well, not so
3 regular but we used to have catch-ups, yes, they were
4 ad hoc unless I saw Dr Jayaram in a more formal setting.
5 **Q.** You see, Dr Jayaram's evidence is that he
6 contacted you because he wanted to discuss concerns that
7 he and his colleagues had regarding unexpected
8 unexplained deaths in the neonatal unit.
9 **A.** That is not my recollection at all, no.
10 **Q.** And he recalls that you sent him an electronic
11 calendar invite on 21 June 2016, three days earlier
12 before the meeting took place. So first of all do you
13 agree that you would have sent out an electronic
14 calendar invite on or about 21 June?
15 **A.** I don't recollect that but yes, I probably
16 would have done, yes.
17 **Q.** Yes, and what do you recall the impetus for
18 this meeting being?
19 **A.** It was a general catch-up. Like I say it was
20 in a very informal setting, so it was a coffee shop in
21 the Women and Children's building. We sat down about
22 11ish, we had some general chat. We talked about
23 a couple of the services within the paediatrics and
24 neonatal and then Dr Jayaram went on to raise his
25 concerns.

1 **Q.** Yes, but if you had meetings ad hoc,
2 presumably there would always be some impetus for
3 a meeting, Dr Jayaram would get in touch with you and
4 say: can we just have a meeting to catch up, for me to
5 raise something with you?
6 **A.** Yes, and I would do likewise, it was -- but
7 like I say, it was very informal, it was just to touch
8 base. We talked about a number of different issues.
9 **Q.** So if you arranged the meeting, I am assuming
10 you agreed where the venue would be or said where the
11 venue would be yourself?
12 **A.** I think mutually agreed/
13 **Q.** Well, if you sent out the invite to the
14 meeting presumably you also said: well, let's meet in
15 the coffee shop?
16 **A.** Like I say it was a very -- it wasn't a formal
17 meeting at all.
18 **Q.** When it comes to that, though, was that your
19 perception of it when you arranged it? It doesn't
20 necessarily mean it wasn't what Dr Jayaram was
21 expecting?
22 **A.** Correct.
23 **Q.** Now, your evidence -- again just to be very
24 clear, the meeting was arranged before the death of
25 Child O because Child O, he died on 23 June and it was

1 arranged according to Dr Jayaram on 21 June?
2 **A.** Okay, yes.
3 **Q.** But it took place after the death of
4 Child O --
5 **A.** (Nods)
6 **Q.** -- and before the death of Child P?
7 **A.** Okay.
8 **Q.** Now, are you saying, as I think you were, that
9 prior to 24 June 2016, you had no knowledge at all that
10 the Consultant body were concerned about unexpected or
11 unexplained deaths occurring over the preceding year?
12 **A.** Correct.
13 **Q.** And that you were completely unaware that the
14 Consultant body or anybody was concerned about Letby's
15 association with those deaths, not necessarily that she
16 was causing them deliberately, but that she was
17 associated with those deaths by her presence at the very
18 least?
19 **A.** Correct.
20 **Q.** So you were unaware of all of that?
21 **A.** Yes.
22 **Q.** Were you unaware that she had been moved to
23 day shifts?
24 **A.** I wasn't aware of that.
25 **Q.** Before 24 June 2016 had you ever heard

1 Lucy Letby's name before?
2 **A.** No.
3 **Q.** Now, you made a note of the meeting and it
4 appears at INQ0102357. If we go on, please, to page 2
5 it is an exhibit to your witness statement. So the note
6 in question appears at the bottom of the page,
7 24 June 2016?
8 **A.** Yes.
9 **Q.** When did you write this note?
10 **A.** On the day.
11 **Q.** Were you writing it at the same time as the
12 conversation was taking place?
13 **A.** Yes.
14 **Q.** Do you normally take notes during informal
15 meetings?
16 **A.** I take lots of -- well, you can see from the
17 prior note, I take a lot of notes. I record, I have
18 a to-do list all the time and I also record notes from
19 any meetings.
20 **Q.** Yes, but if you are having an informal chat
21 with someone in a coffee shop, you take your notebook
22 out and start writing what they are saying?
23 **A.** Well, we were talking about relevant points,
24 we were talking about aspects of the business, the
25 service.

1 **Q.** So how informal are we talking, then? Not
2 very if you are taking notes, it is obviously
3 a discussion about important things?
4 **A.** Well, they are very brief notes but yes,
5 I made notes.
6 **Q.** And the first two lines, they are nothing to
7 do with concerns about harm on the wards, are they,
8 I mean, I can't criticise --
9 **A.** No.
10 **Q.** -- handwriting, if you have seen mine, you
11 would understand why.
12 **A.** No, no, no. The first one makes reference to
13 paediatric hospital at home and some risks around the
14 service and some of the options we were discussing and
15 the other one is workforce issues, which was a regular
16 theme within the paediatric and neonatal service and the
17 resources and then that is when we went on and
18 Dr Jayaram noted the concerns that they had.
19 **Q.** So he's written NNU -- you have written,
20 sorry~--
21 **A.** Yes.
22 **Q.** -- "NNU triplets"?
23 **A.** I wrote that when as we started that aspect of
24 the conversation.
25 **Q.** So "one deceased", which is a reference to

1 Child O?
2 **A.** Yes.
3 **Q.** And then "? Second"?
4 **A.** Yes, because Dr Jayaram said that he was
5 concerned and I can't -- I can't recall if he said that
6 the triplet was unwell, I can't recall that.
7 **Q.** Well, I will come on to that then. It's not
8 concern about the other triplets or other babies; it's
9 specific concern about the second, which is Child P.
10 So it would follow, and I can take you through
11 something of a chronology in a moment, but it would
12 follow that Child P's condition was being discussed at
13 that meeting?
14 **A.** Not in any detail, no. Not in any detail.
15 It was a reference of. There was no detailed
16 clinical discussion.
17 **Q.** But it doesn't say "? Other two".
18 It says "? Second."
19 Now, we know from the medical records that Child P
20 suffered an unexpected collapse after Letby started her
21 day shift on 24 June and had required resuscitation, and
22 Child P's notes describe chest compressions occurring at
23 9.15 in the morning, so prior to your meeting taking
24 place at 11, and discussions had taken place at
25 Arrowe Park at 10.30 am to transfer Child P, okay.

1 So there was obviously concerns at or about the
2 time of your meeting at 11 am about the condition of
3 Child P because there was -- a phone conversation with
4 Arrowe Park had already taken place and Child P had
5 already had some resuscitation in the morning.
6 So in light of that, do you think it likely given
7 that you have written "? Second" that Dr Jayaram was
8 also talking to you about the condition of Child P in
9 this meeting as well?
10 **A.** I am not aware of any of the clinical detail
11 associated with that and Dr Jayaram didn't go into any
12 explicit detail. I think it was -- and I have no
13 clinical background so wouldn't retain any of that
14 information specifically.
15 However, I think he did make reference to his
16 concerns about the second triplet, but there was no
17 clinical detail. Like I say, I wasn't aware of anything
18 that you have just articulated.
19 **Q.** So he may not have put it in terms of:
20 There's been a phone call to Arrowe Park, chest
21 compressions have been given. But he must have said,
22 mustn't he: I am worried about the other one as well
23 because he has also taken a turn for the worse, or words
24 to that effect?
25 **A.** I think he said he had concerns about the

1 second triplet. There was -- you know, it was a very
2 brief discussion.
3 **Q.** Yes. But a reference to concerns about the
4 second triplet, rather than the second and third, must
5 reference the fact that the second had taken a turn for
6 the worse, mustn't it?
7 **A.** It may do, but, I can't -- there was no -- we
8 didn't have a detailed discussion.
9 **Q.** Now, the records also show that Child P had
10 deteriorated again at 11.30 in the morning, so
11 30 minutes after your meeting began, and that there are
12 noted interactions between Letby and Child P at 10.46
13 and 11 am prior to that collapse.
14 So we also can see from the notes that Letby
15 continues to interact with Child P during the course of
16 the afternoon and that there are further collapses and
17 Child P receives CPR on further occasions.
18 So to put this into context, your conversation with
19 Dr Jayaram about concerns and risk is occurring at the
20 same time as Child P is collapsing due to harm caused to
21 him by Lucy Letby, but he is still alive.
22 Now, in light of that, and on reflection, do you
23 think it required urgent action from you to escalate
24 this and remove Letby from that ward?
25 **A.** So all of what you have articulated I did not

1 know. I had no sight to nor did I hear anything.
2 The conversation I had with Dr Jayaram was very
3 brief, it was very -- he, Dr Brearey and some of his
4 colleagues, had some concerns. We didn't go into any
5 detail and there was certainly no -- no specifics that
6 you have just articulated.
7 **Q.** How much detail do you need in this situation?
8 A senior doctor says to you: I am concerned that
9 a nurse is attacking and harming babies.
10 How much of an investigation do you need before
11 somebody acts and stops that harm continuing?
12 **A.** So the terms "attacking" and "harming" weren't
13 used at all. They were raised to me and at the time,
14 based on what I had heard, which was brief, I did what
15 I believed at that point in time the right thing which
16 was to come away and contact the senior nurse in Urgent
17 Care and then, as I have already explained, subsequently
18 we then tried -- well, Karen Rees then tried to speak to
19 both Dr Jayaram and Dr Brearey to try and get some
20 further and additional detail.
21 **Q.** Isn't that an escalation down the chain to
22 Karen Rees because she is -- you are her superior in
23 terms of seniority and rank? Isn't that going down the
24 chain?
25 **A.** But I think immediately in the moment -- and

1 on reflection yes, maybe that might have been the case,
2 but my immediate was to go to my clinical colleague to
3 raise those concerns with her and seek her input as to
4 next steps.
5 **Q.** In terms of the amount of time that all of
6 this takes, Child P's family believe that there was
7 a failure to act to stop Lucy Letby attacking and
8 murdering their child on that day.
9 Now, Child P died in the evening. So there was
10 time arguably to stop this. Do you think, on
11 reflection, urgent action was actually required
12 following this information from Dr Jayaram?
13 **A.** I believe at the time, when I was given the
14 information, I did what I believed was the right thing
15 at the time to go and seek that support, to gain some
16 further information and to -- and what those next steps
17 would be. I believe Dr Brearey and Dr Jayaram did not
18 offer any further information.
19 I think Karen Rees was left then to go and speak to
20 the Executive team. And I'm sorry for the loss of those
21 children.
22 **Q.** But the point is in a dynamic situation like
23 this, there sometimes isn't time to set out a full,
24 fully articulated evidenced case against somebody.
25 There is simply a reference to risk and a need for

1 urgent action, isn't there?
2 **A.** I accept that.
3 **MR BAKER:** Thank you, my Lady, I have no more
4 questions.
5 **Questions by LADY JUSTICE THIRLWALL**
6 **LADY JUSTICE THIRLWALL:** Thank you very much,
7 Mr Baker. I wonder, just before we conclude,
8 Mrs Townsend, it is nearly finished, I just have two
9 short questions.
10 You were taken to the Risk Register where you made
11 an input --
12 **A.** Yes.
13 **LADY JUSTICE THIRLWALL:** -- of a high risk and we
14 have been through that in some detail and you mentioned
15 several times that it had been scripted for you and
16 I also inferred from what you said that it was the
17 Executive team who said that had to go on to the Risk
18 Register. Is my assumption correct?
19 **A.** Yes.
20 **LADY JUSTICE THIRLWALL:** Right, thank you.
21 So who scripted it for you?
22 **A.** A member of the communications team.
23 **LADY JUSTICE THIRLWALL:** Thank you. And that was
24 after discussions with the Executive team?
25 **A.** Yes, as part of the build up to the briefings

1 around going -- putting communication out, public
2 communications and advising all other external parties
3 of this situation.
4 **LADY JUSTICE THIRLWALL:** Yes, thank you. Which, if
5 you are aware can you let me know, which members of the
6 Executive team were involved in this decision about the
7 Risk Register?
8 **A.** I think in the meetings there would have been
9 Executive Director of nursing.
10 **LADY JUSTICE THIRLWALL:** So that is?
11 **A.** Alison Kelly, Executive HR director, which was
12 Sue Hodkinson and potentially -- I can't commit to the
13 Medical Director being there at the time, actually.
14 **LADY JUSTICE THIRLWALL:** He may have been. We can
15 check that. Thank you.
16 Then finally, when you went to Karen Rees, having
17 spoken to Dr Jayaram, what did she say?
18 **A.** Well, she asked me what do -- what was the
19 conversation, what detail did I have, what I had been
20 told and she immediately said: I will go and speak to
21 them directly to see what information I can find from
22 them.
23 And subsequently went off to speak with them.
24 **LADY JUSTICE THIRLWALL:** Did she say anything else
25 about the doctor's motivation or anything like that?

1 **A.** No.
2 **LADY JUSTICE THIRLWALL:** Right. Thank you.
3 Subject to anyone wanting to ask any questions
4 arising out of that, that concludes your evidence.
5 Thank you very much indeed, Mrs Townsend, you are
6 free to go.
7 **A.** Thank you.
8 **LADY JUSTICE THIRLWALL:** So we will start again at
9 20 to 12.
10 **(11.22 am)**
11 **(A short break)**
12 **(11.40 am)**
13 **LADY JUSTICE THIRLWALL:** Yes, Mr De La Poer.
14 **MR DE LA POER:** My Lady, the person in the witness
15 box is Mrs Ruth Millward who, as my Lady knows, has been
16 granted a number of special measures, hence the
17 arrangement of the room.
18 **LADY JUSTICE THIRLWALL:** Yes, thank you.
19 **MR DE LA POER:** I wonder if she might be sworn,
20 please.
21 MS RUTH MILLWARD (affirmed)
22 **LADY JUSTICE THIRLWALL:** Thank you.
23 Questions by MR DE LA POER
24 **MR DE LA POER:** Please could you state your full
25 name?

1 **A.** My name is Ruth Esther Millward.
2 **Q.** Mrs Millward, is it right that you provided
3 the Inquiry with a witness statement dated 7 June of
4 this year?
5 **A.** That's correct.
6 **Q.** And a statement dated 24 June of this year?
7 **A.** That's correct.
8 **Q.** Subject to I think a correction that you are
9 going to make in relation to -- this is highly
10 specific -- an SBAR written for Child A, so subject to
11 that which we will get to, is the content of those
12 statements true to the best of your knowledge and
13 belief?
14 **A.** It is.
15 **Q.** My first topic is just to introduce you and
16 your experience. Is it right that you qualified as
17 a nurse in 1997?
18 **A.** It is.
19 **Q.** The Inquiry is well sighted on the case of
20 Beverley Allitt from 1991?
21 **A.** (Nods)
22 **Q.** Did the murders committed by Beverley Allitt
23 form part of your training?
24 **A.** I don't recall. My training was adult nursing
25 rather than children's nursing but I do recall the case

1 from the press coverage.
2 **Q.** So by the time we get to 2015 would it be fair
3 to say that you were aware of Beverley Allitt's actions
4 killing whilst on duty as a nurse?
5 **A.** That's correct.
6 **Q.** Were you also aware of the murders carried out
7 at Stepping Hill Hospital in 2011?
8 **A.** I am.
9 **Q.** Were you in 2015?
10 **A.** Yes, I was in 2015.
11 **Q.** Yes. Were you aware that shortly before the
12 death of Child A, that nurse was sentenced for those
13 crimes?
14 **A.** I was.
15 **Q.** So going into the period that we are going to
16 look at closely, was that something that was in your
17 recent memory?
18 **A.** I -- I would say I was aware of those facts.
19 It's difficult to say. In my recent memory, I would say
20 I was aware of those facts at the time.
21 **Q.** Well, we will come back to those when we get
22 to our timeline.
23 Staying with your background, having qualified as
24 a nurse, did you in the same year join the Countess of
25 Chester Hospital?

1 **A.** I did.
2 **Q.** Where you worked as a nurse escalating to the
3 position of Matron; is that right?
4 **A.** That's correct.
5 **Q.** Now, on the way to becoming a Matron, did you
6 act as the Quality Improvement Facilitator between 2004
7 and 2011?
8 **A.** I did.
9 **Q.** Was that in the Risk and Patient Safety
10 Department or was that still a clinical role?
11 **A.** No, that was in the Risk and Patient Safety
12 Department, the Quality Improvement Facilitator role is
13 essentially the same as the Risk and Patient Safety
14 Leads that you heard from previously. It's just
15 a change in job title rather than a change in the
16 position.
17 **Q.** In December of 2013, were you approached by
18 the deputy Director of Nursing Sian Williams to see if
19 you were interested to go back to the Risk and Patient
20 Safety Department?
21 **A.** I was.
22 **Q.** So if we just picture this in our minds, 2011
23 you left the Risk and Patient Safety Department, became
24 a Matron?
25 **A.** Yes.

1 **Q.** And then a couple of years later invited to
2 apply to go back in but this time as the head of that
3 department?
4 **A.** That's correct.
5 **Q.** Did you commence in that role in March of 2014
6 on a secondment or temporary basis which was
7 subsequently made substantive during 2015?
8 **A.** That's correct.
9 **Q.** Now, as Head of Risk and Patient Safety, who
10 did you report to?
11 **A.** To Ms Sian Williams, the Deputy Director of
12 Nursing.
13 **Q.** How many people were in your department?
14 **A.** Initially it was a small team, around maybe 10
15 or 12 and then over the period of time I was in post
16 that increased to around 30 staff.
17 **Q.** And what sort of dates should we have in mind
18 for when it reached 30 staff?
19 **A.** I would say around June 2016, when a number of
20 the departments came under my management.
21 **Q.** Did that result in any more Risk and Patient
22 Safety roles or were they on the patient experience
23 quality side?
24 **A.** Absolutely, it was, it became more integrated
25 governance team, so the -- it wasn't more additional

1 Risk and Patient Safety Leads; it was more that, as you
2 say, patient experience, the audit and improvement work,
3 health and safety.
4 **Q.** In terms of who sat immediately beneath you in
5 the department, who were they?
6 **A.** I didn't have a deputy. So my team was almost
7 sub teams, if you like, so I had the Risk and Patient
8 Safety Leads, so there were five or so of those, I had
9 a patient experience or complaints manager, who then
10 managed a small group of co-ordinators, I also had an
11 Audit Improvement Manager who again had a small group of
12 staff underneath and then some of the staff around
13 practice development nurses, the blood transfusion
14 practitioners, health and safety and of course my
15 administrative support as well.
16 So it was a very varied team.
17 **Q.** In terms of the focus of this Inquiry, we are
18 focused upon the Urgent Care Division and in particular
19 the neonatal unit within that?
20 **A.** (Nods)
21 **Q.** So who was the person in your department as at
22 2015 who was responsible for that?
23 **A.** For the Urgent Care Division, for Urgent Care
24 it would have been a lady called Nicola -- I am trying
25 to think of her surname now, apologies.

1 **Q.** Perhaps it doesn't matter too much.
2 **A.** But --
3 **Q.** Was there a separate person dealing with women
4 and children?
5 **A.** There was indeed and that would have been
6 Ms Debbie Peacock who you met previously.
7 **Q.** How did you find working with Ms Peacock?
8 **A.** Absolutely fine, she worked really well, she
9 had a varied background which I thought was really
10 helpful in the post and I never had any concerns
11 regarding her performance.
12 **Q.** Did you have regular meetings with her to
13 understand what work she was engaged in?
14 **A.** Absolutely. We had a monthly one-to-one
15 meeting with all my Risk and Patient Safety Leads we had
16 a weekly meeting which is Mrs Sian Williams also
17 supported and we would have daily team meetings again to
18 look at priorities of the day or the week. So there
19 were many sub meetings.
20 **Q.** So would you, as Head of Risk and Patient
21 Safety, be expected to be aware of important work that
22 Debbie Peacock was undertaking?
23 **A.** That's correct.
24 **Q.** Did your role involve you attending QSPEC?
25 **A.** It did.

1 **Q.** So that is the Quality Safety and Patient
2 Experience Committee?
3 **A.** That's right.
4 **Q.** The Inquiry has heard that that is a committee
5 chaired by a Non-Executive Director that sits just below
6 board level?
7 **A.** That's correct.
8 **Q.** Was that an effective committee for ensuring
9 safety?
10 **A.** There was a cycle of business that the
11 corporate governance team or the director of legal
12 services who oversaw corporate governance coordinated.
13 There was feedback from the divisions, it wasn't written
14 feedback, it was verbal feedback and I think that's
15 potentially the gap that we had.
16 My participation was providing oversight of our
17 Serious Incident investigations and there were a number
18 of other reports that I would also support.
19 **Q.** So you will forgive me, you have described
20 what it did. My question was: was it effective?
21 **A.** My -- my impression at the time was that it
22 was effective.
23 **Q.** So was it your impression at the time that if
24 it was informed of a significant patient safety concern,
25 action would be taken?

1 **A.** That's correct. That would be my impression
2 at the time.
3 **Q.** Well, knowing what -- you have caveated what
4 you said twice with "at the time", do you now have other
5 knowledge that suggests that it wasn't as effective as
6 you thought it was at the time?
7 **A.** I think my reflections over the time since
8 the -- the events that occurred, there's been an
9 evolution of governance and how we report and how we
10 provide assurances.
11 At the time, as I say, a lot of the assurances
12 given from the divisions were verbal. In today's world
13 you would see that as a written report with levels of
14 assurance linking it to risk management and key areas of
15 concern, so the escalation of -- of issues would be
16 clearer and obviously it's around ensuring that
17 everyone's voice is heard.
18 I think when you are providing verbal feedback it's
19 easy to become distracted by the conversation that
20 happens in the room and maybe some of the other key
21 points may not be verbalised but by providing an
22 assurance report you can be sure that your key messages
23 are heard at the right level.
24 **Q.** Was that improvement something that you should
25 have ensured sooner than it did?

1 **A.** So when I am talking around assurance and
2 reporting arrangements, that is corporate governance and
3 the responsibility for that sat with the Director of
4 Legal Services.
5 So I was a contributor to the QSPEC meeting, I was
6 not -- I was not responsible for overseeing how the
7 service how QSPEC was managed.
8 What I am sharing with you, sir, is, is my
9 experience over time and that's my observations being
10 10 years later.
11 **Q.** But as the Head of Risk and Patient Safety
12 didn't you have a responsibility to make sure that that
13 committee which was just below board level was as
14 effective as it possibly could be?
15 **A.** No, that is not my responsibility. As I say,
16 what you are referring to is corporate governance,
17 assurance and reporting arrangements and the
18 responsibilities for how that runs, the cycles of
19 business, Terms of Reference that sits with the director
20 of legal services and for quality and safety
21 specifically, that sat with Mrs Kelly.
22 **Q.** But do you not have a say in this?
23 **A.** I can contribute. If I felt that I had
24 a report that needed to be submitted, I could escalate
25 that and ask for something to go on the agenda but it

1 wouldn't be my responsibility to request changes to the
2 way assurances were provided.
3 **Q.** Even if you perceived that they were not being
4 provided in as effective a way as possible?
5 **A.** As I say at that time, I felt the committee
6 was effective, the way that communications we were
7 having, we speak about the learning and the evolution of
8 governance over this time period.
9 **Q.** Just returning to your role and its progress
10 over time. Was that role the subject of a consultation
11 in early 2017 resulting in it being placed in an "at
12 risk" position?
13 **A.** That's correct.
14 **Q.** Did you, *(redacted)*, leave the Trust on
15 31 March of 2017?
16 **A.** I did.
17 **Q.** But just so that we understand your dates, and
18 we don't need to go into the detail, was there a reason
19 for you to be absent from work from the 3 March?
20 **A.** I did. *(Redacted)*.
21 **Q.** So in fact your last effective day would have
22 been around 2 March?
23 **A.** Yes.
24 **Q.** Now, in terms of improvements or changes that
25 have been made since you left, firstly can you just tell

1 us something about deteriorating patient groups?
2 **A.** So at the time one of the focus that the Trust
3 did have was around sepsis and recognising the
4 deteriorating patients. It was very adult focused and
5 it was a scheme of work that the team was looking at.
6 I think over time what organisations have looked at
7 reporting incidents and different schemes of work to
8 improve patient safety but looking at it more widely
9 than just -- just adults, so in the Trust at the time
10 that deteriorating or that sepsis group was purely
11 focused in the adult environment, it didn't capture the
12 children's, you know, service at the time.
13 So it was when you have a group like that, it
14 drives the type of incidents you may see because it is
15 used as one of the ways of monitoring the effectiveness
16 of the improvements that you are putting in place and
17 I think that may be one of the reasons why we didn't see
18 some of the incidents being reported for the children's
19 areas in the way that perhaps we did see them being
20 reported for our adult areas.
21 **Q.** Whose responsibility would it have been to
22 push for children's services to be included in the
23 deteriorating patient group?
24 **A.** Well, it was -- as I say it was a sepsis group
25 specifically which is a smaller subset, if you like, of

1 the deteriorating patients. Well, there was a Trust
2 Deteriorating Patient Lead who I believe was one of the
3 Consultant anaesthetists at the time so it would be
4 appropriate to scope that more widely, but essentially
5 it would be -- the responsibility to ensure your area
6 was involved would be would sit with the clinical lead,
7 so in this case it would be Dr Brearey.
8 **Q.** Ms Fogarty has listed in her statement, and
9 you have been asked to consider, a very large number of
10 changes that have been made since you left. Obviously
11 it's important that we are focused here on those which
12 are relevant to the Inquiry's Terms of Reference and
13 I certainly don't ask you to rehearse all of them, but
14 were there any of those changes that you would pick out
15 that you consider represent improvements that may have
16 supported a better response to the situation the
17 Countess of Chester found itself in?
18 **A.** Well, I have looked at the list, obviously it
19 is not in front of me, but I have looked at that list
20 that she has provided. A significant number of those
21 listed were things that were already in place and they
22 would just again be the natural evolution of the
23 service.
24 I think one of the positives that I did see was
25 around a newsletter, some more communication around

1 learning and again how she appears to have managed the
2 feedback from the Serious Incident Panel so I would, you
3 know, welcome those and they were good ideas.
4 **Q.** So we are going to turn now to look in
5 a little bit more detail at how your department
6 functioned when you were the head of it. Firstly, were
7 you a sufficiently well resourced department to do what
8 you needed to do?
9 **A.** I think it's very difficult to say as
10 a service adequately resourced because it is not like
11 a ward where you would have a, say, staffing level.
12 Each -- each Trust will have a slightly different model
13 for governance or patient safety and that will depend
14 upon the size of the organisation and the type of, you
15 know, organisation it is.
16 Certainly I -- the only time I became concerned
17 around my resources was in February 2016 and that was
18 when Mrs Peacock was already leaving. I had another
19 Risk and Patient Safety Lead who came to me saying that
20 she would be leaving for a promotion in another Trust
21 then I was instructed to release another of my Risk and
22 Patient Safety Leads to go to a clinical role within the
23 Planned Care Division.
24 So at that point, between February 2016 and I would
25 say May 2016, the service -- there was a fragility there

1 and I did escalate that, Mrs Kelly was aware -- was
2 essentially ultimately responsible for quality and
3 safety and I added that as a risk on the Risk Register
4 at the same time just so that again I could monitor and
5 track all the different pieces of work that I was doing.
6 I think one of the -- one of the reasons why I was
7 keen to bring in the Patient Experience Team and the
8 Audit and Improvement Team was to have a more integrated
9 governance approach but that in itself would mean that
10 there was closer collaboration and more support for
11 essentially fulfilling the duties of the team.
12 **Q.** In the period that you have described as there
13 being a fragility --
14 **A.** Mm-hm.
15 **Q.** -- do you think that that fragility impacted
16 in any practical or real way on how your department
17 responded to the situation during those months?
18 **A.** I think it was -- I think there was further
19 contribution by -- it coincided with our CQC routine
20 inspection which was a full Trust inspection. So
21 certainly that would have been my priority at the time
22 and the priority of a number of my admin team as well.
23 Without doubt having that gap in team members, you
24 know, we tried to mitigate by putting interim staff
25 members in place. However, that is not the same as

1 having that continued line of sight, you know, by
2 a member of staff who is permanent. So I have no doubt
3 it will have had an impact, we did try to mitigate as
4 much as possible.
5 **Q.** Can you just help us to understand a little
6 bit more your role as Head of Risk and Patient Safety,
7 a very important role I am sure you would agree; is that
8 fair?
9 **A.** Yes.
10 **Q.** But you have just said that at a time when
11 your department was being depleted, your focus was on
12 the CQC inspection, can you just help us to understand
13 how you see that inspection as important but it might be
14 thought that patient safety and risk is more important
15 because that affects patients' lives, so can you just
16 help us with why you chose to give your attention to
17 that CQC inspection over patient safety?
18 **A.** Well, it wouldn't be a case of that was all
19 I was focused upon. But it would definitely have been
20 my priority. The CQC inspections are routine
21 inspections that happen infrequently, when they do it is
22 a significant amount of work to prepare for.
23 A significant number of documents are required ahead of
24 the inspection and all of those need validating and
25 managing.

1 Certainly also there's work-around helping the
2 staff prepare for such an inspection, encouraging them
3 to, you know, be open and honest about what's going on
4 in their areas and ensure that they have the information
5 that they may need to hand as well.
6 During the inspection as well, which is only a few
7 days, there are again multiple calls for different
8 datasets and similarly afterwards. You know, there
9 was -- as head of risk, that was one of my key
10 responsibilities was to ensure that CQC was responded to
11 and any questions that they had that we provided that
12 information to them.
13 Obviously whilst I am saying it was my priority,
14 I had a team I worked alongside with, they had -- you
15 know, we continued with all those meetings, I explained
16 so there was opportunity for us to ensure that again
17 there was line of sight, there was escalation of things
18 that was happening and, you know, I was supporting my
19 staff at the same time.
20 **Q.** We know now that February of 2016 in terms of
21 the thematic review that was conducted that month is
22 a very important month and a very important opportunity
23 for matters to be escalated.
24 **A.** (Nods)
25 **Q.** Looking back on it, bearing in mind you have

1 told us that that was a period of the start of some
2 fragility within your department, and you have told us
3 your priority was the CQC, do you think in fact you
4 misprioritised and gave insufficient support to your
5 staff at that time?
6 **A.** No, I don't believe that's true.
7 **Q.** If you would please just expand on why you say
8 that?
9 **A.** Because -- because my team, there was
10 mitigations put in place, there were additional staff
11 that were put in place to help manage the gaps in
12 staffing, those staff were supported, I would meet with
13 them regularly, I would go through things that they were
14 raising if they had any concerns. All of that remained
15 in place.
16 What the gap, the fragility, if you like, was that
17 people rather than being able to do or commit
18 a full-time number of hours so 37 and a half hours being
19 a full-time contract, rather than being able to do that
20 it would perhaps be, you know, a half-time contract. So
21 they had to focus themselves on what they could achieve
22 in that time period. So again at that point in time the
23 incidents would always be the top priority of those
24 staff members and therefore if there was anything that
25 they were concerned about, it would be that they would

1 raise them with myself.
2 **Q.** Okay, we will come back when we look at our
3 timeline to that. Let's just deal again with
4 an overview. So the job title has changed over time, at
5 the time we are concerned with it is Risk and Patient
6 Safety Lead.
7 **A.** Mm-hm.
8 **Q.** Just help us to understand how that became
9 Risk Midwife.
10 **A.** Yes. So the Risk and Patient Safety Lead role
11 is multi-faceted, it looks at incidents, it is there
12 also to support with some national guidance a variety of
13 other schemes of work that they do support but the
14 incidents in the main.
15 In or around 2015/16 there was a lot of national
16 information around maternity safety in particular and it
17 was felt that -- certainly I felt it was an opportunity
18 with Mrs Peacock leaving to almost reframe the role so
19 that that could be part of the focus. There was
20 a number of guidelines coming in and I thought that
21 changing the role slightly would help with that and
22 support the maternity services. The maternity services
23 were always the larger part of the role anyway as
24 Patient Safety Lead.
25 **Q.** It may be only a matter of semantics but this

1 is a phrase or a title that you were supportive of
2 promoting, but it may be thought that moving from Risk
3 and Patient Safety Lead which covers all of the
4 children's services to Risk Midwife is focusing on
5 midwifery and obstetrics potentially at the expense of
6 the neonatal unit and paediatrics. Can you just help us
7 with how that didn't slip through the gaps, if it
8 didn't?
9 **A.** Absolutely. Well, obstetrics and neonatal
10 team services, they are essentially a continuation of
11 care. You know, what happens for mum and baby during
12 labour, that has an impact upon the baby going into the
13 neonatal unit. So there is natural flow. The role was
14 still to focus upon those areas. It was more, as I say,
15 the fact that there was some national guidance coming
16 out and I felt it important that the team get involved
17 in that and therefore by reframing the role slightly to
18 that as a Risk Midwife it wasn't forgetting about the
19 neonatal or the paediatric service at all; it was just
20 a case of trying to ensure that those national guidance
21 and those improvements could be supported by a member of
22 my team.
23 **Q.** Why did the title need to change if it made no
24 difference to the role?
25 **A.** Because it felt that -- I felt at the time

1 given the national focus that that was the important
2 thing to do. I felt that it would help give a --
3 give -- I felt that it would help us demonstrate that we
4 were listening and responding to the national guidance
5 at the time and show that we were taking that seriously.
6 **Q.** So that is how others in the outside world
7 would perceive you but in terms of the day-to-day,
8 internally, do you think there might have been a risk
9 that the focus of the person doing that role was
10 weighted too heavily as a result on midwifery?
11 **A.** No, because as I have said, the midwifery
12 services was always the larger part of the activity and
13 it was never -- it was never anticipated that the
14 neonatal or the paediatric services would be cast aside
15 as such. The expectation was always that that support
16 would continue.
17 **Q.** So as we have covered already, Ms Peacock left
18 in February of 2016?
19 **A.** She did.
20 **Q.** Her role, as we have heard from Ms McMahon,
21 was covered by Ms McMahon for the period February 2016
22 to May 2016.
23 **A.** (Nods)
24 **Q.** What Ms McMahon told us was that she was in
25 effect doing two full-time jobs at the same time during

1 that period. From your perspective, is that a fair
2 characterisation of what was expected of her?
3 **A.** No. So again the expectation was to keep
4 retaining oversight of the incident activity and support
5 the all of the areas with that and then escalate any
6 matters of concern to myself. It was not and never had
7 been an expectation that Ms McMahon would essentially be
8 fulfilling two jobs, it is not a possibility.
9 **Q.** So let's just understand this. Ms Peacock had
10 been a full-time role; is that right?
11 **A.** (Nods)
12 **Q.** When Ms Peacock left she was no longer able to
13 do it, that full-time role?
14 **A.** Mm-hm.
15 **Q.** Was it expected that Ms McMahon would do that
16 full-time role?
17 **A.** No, Mrs McMahon was also doing what was her
18 normal day-to-day activity. As I said, the focus for
19 Mrs McMahon in covering the gap in staffing was that she
20 would solely focus upon the incident activity. The role
21 of the Risk and Patient Safety Lead is broader than just
22 the incident activity and that was what I had asked her
23 to do to retain oversight during that period.
24 **Q.** You will just have to help us, please, you
25 have used that phrase a number of times, "incident

1 activity", please can you just tell us what you mean by
2 "incident activity"?
3 **A.** So the number of incidents that have been
4 reported by the local areas, so in that case obstetrics,
5 gynaecology, the neonatal unit and paediatrics.
6 **Q.** What about, as we will come to in much more
7 detail shortly, the thematic review that we know
8 Dr Brearey authored?
9 **A.** (Nods)
10 **Q.** Does that fall under incident activity or is
11 that something different?
12 **A.** So the thematic review was a review of
13 incidents and other deaths so yes, that would have
14 fallen under so for her to retain oversight of where
15 that was up to.
16 **Q.** As I say we will come to the detail of that in
17 due course.
18 Finally, to complete the picture of the evolution
19 of Risk and Patient Safety Lead to Risk Midwife,
20 Annemarie Lawrence took over as we understand it in May
21 of 2016?
22 **A.** She did.
23 **Q.** And just tell us what your experience was of
24 working with Ms Lawrence?
25 **A.** I thought Ms Lawrence was a really good

1 employee, she worked very well, I had no concerns about
2 her performance. We met regularly. I was aware she was
3 really struggling connecting with Dr Brearey in
4 particular. We met during our one-to-ones and spoke
5 frequently around dealing with or how to manage
6 difficult and challenging relationships, how to try and
7 ensure we are more visible and responsive as needed but
8 I had no concerns about her performance at all.
9 **Q.** So we are going to deal with the relationship
10 with Dr Brearey now and if we could please bring up
11 INQ0006769 on our screen. It's an email dated 15 July,
12 it's a snapshot in time.
13 So if we scroll to the bottom so that you can see
14 the context, you have and we are here in a situation
15 following the deaths of Child O and Child P?
16 **A.** (Nods)
17 **Q.** And the hospital's internal work, this was
18 part of it. You requested for information to be sent to
19 Dean Bennett by a particular date, we can see that at
20 the very bottom of your thread there?
21 **A.** Mm-hm.
22 **Q.** If we go up, please, in the thread and we will
23 need to go one more page but we will look at the bottom.
24 We don't need to go over every line, I am sure you
25 have had had an opportunity to consider this email both

1 at the time and subsequently.
2 But if I can summarise it in this way: Dr Brearey
3 expresses a number of concerns about Ms Lawrence?
4 **A.** Mm-hm.
5 **Q.** We can see at the bottom of the page he raises
6 concern about the creation of the role of Risk Midwife
7 which he says occurred without any discussion with
8 paediatricians or consideration that she would have to
9 cover neonatology which he described as quite
10 concerning. Let's deal with that.
11 What is your response to what Dr Brearey says
12 there?
13 **A.** With regards to the development of the role of
14 the Risk Midwife?
15 **Q.** Well, firstly is it right that the role of
16 Risk Midwife was created without any discussion with the
17 paediatricians or consideration that she would have to
18 cover neonatology?
19 **A.** I'm sorry, I didn't get the last bit.
20 **Q.** I am just reading from here, was the role of
21 Risk Midwife created without any discussion with
22 paediatricians or consideration that she would have to
23 cover neonatology?
24 **A.** So I will talk you through a bit more detail
25 so as I say there was a number of national guidance that

1 came out which demonstrated that there did -- there
2 should be a greater focus on maternity. I spoke with
3 Ms Julie Fogarty, who was Head of Midwifery at that
4 time, to explore her thoughts on that. She felt that
5 that was an appropriate change and would support her
6 area; as I am sure you would appreciate, she would say
7 that.
8 I raised that with my line manager and also with
9 Mrs Kelly and Mrs Kelly fully supported that. At the
10 point where I was going to go over to see Dr Brearey and
11 in fact Dr Jayaram, to talk through how this might work,
12 I understood that Ms Fogarty had actually already shared
13 that information without my knowledge and I therefore
14 attended a meeting with the paediatricians to talk
15 through how this could work and I had made it very, very
16 clear that this was not a case that the paediatric team
17 or the neonatal unit that we were not forgetting them,
18 that that support would continue.
19 My reflections of Dr Brearey's response is that he
20 didn't truly understand what the role was expected, if
21 I may. So Mrs Peacock had been in post for a number of
22 years. It's a smaller environment, you can get closer
23 and more involved with different pieces of work and
24 I think that Mrs Peacock did actually have those
25 relationships already there and therefore was -- was

1 being more involved than perhaps the role envisaged.
2 When Mrs Lawrence took over, we were very clear
3 through her induction as to what was expected and
4 Mrs Lawrence was following those instructions and one of
5 the reasons I say that is because in some of the
6 communications from Mr Brearey he keeps referring to
7 quality improvement, you know, I expect the team to do
8 quality improvement. Despite the previous job title
9 being Quality Improvement Facilitator, the team were
10 never involved in true quality improvement. The Trust
11 had its own Quality Improvement Team.
12 So I think this is more Dr Brearey's understanding
13 of what the role was, the role never -- well, didn't
14 change with regards to the support that was being
15 offered to paediatrics and neonatology at all, I think
16 it was his interpretation of what he thought he should
17 be getting and then obviously the Risk Midwife title
18 which as you say yes, was -- was approved by the
19 Executives before they were aware of but the opportunity
20 that I had to go and speak to them Ms Fogarty had
21 already shared that information.
22 **Q.** I think that it comes to this, the decision
23 had already been made --
24 **A.** Yes.
25 **Q.** -- before paediatrics and neonatology were

1 consulted?
2 **A.** Yes. But at no point was this going to be
3 a withdrawal of support for paediatrics, neonatology.
4 **Q.** We can see next in the following sentence he
5 says:
6 "I have concerns about Annemarie's competence.
7 Both Eirian and myself sat down with her at the
8 beginning of her job to explain her role and our
9 expectations, the most significant of [over the page,
10 please] which was to arrange and minute monthly neonatal
11 incident review meetings. This was seemingly forgotten
12 and we are now at a point where I will be meeting to go
13 through three months' worth of incidents."
14 Again, can I please invite your response to that
15 criticism?
16 **A.** Absolutely. I would say that it's not the
17 responsibility of the Risk and Patient Safety Leads to
18 set up local incident review meetings. Our role is to
19 facilitate the conversation and by providing the
20 information.
21 And I think as I was alluding to before, I think
22 Mrs Peacock perhaps went over and above because she had
23 already those that experience and had those
24 relationships but it would not be my expectation of
25 Mrs Lawrence as Risk Midwife to set up those meetings.

1 To attend and provide the information and contribute to
2 the discussion, yes, but to set them up, no.
3 **Q.** So if we just pause there. The job title has
4 changed?
5 **A.** Yes.
6 **Q.** And the level of support to neonatology that
7 was previously being offered has been reduced?
8 **A.** Obviously I would say no because my view is
9 that -- my view is that it would not be the
10 responsibility of my team to set up an incident review
11 meeting. That responsibility sits with the clinical
12 lead.
13 You know, I -- I don't know whether Mrs Peacock did
14 set up those meetings for them, because I wouldn't have
15 attended them but it would not be my expectation that
16 Mrs Lawrence would do so.
17 **Q.** It is probably my question. Whatever the job
18 description, the title has changed and the actual level
19 of support that was being offered by the person doing
20 the role had been reduced. Is that -- I mean, in
21 reality is that what Dr Brearey's experience of it will
22 have been?
23 **A.** I would say that is Dr Brearey's perception of
24 it, yes.
25 **Q.** So is there a communication problem that lies

1 behind this?
2 **A.** I -- I think, I absolutely think that that is
3 the issue. I think, you know, looking at this, you
4 know, I think perhaps if I could have explained a little
5 bit more around my expectations of Ms Lawrence and
6 explained that to Dr Brearey then perhaps we would have
7 been on the same page. It is apparent from this email
8 that we were not.
9 **Q.** How much do you think the fact that it was
10 presented not just to Dr Brearey but to the paediatric
11 and neonatologists as a fait accompli, how much do you
12 think that had to do with this breakdown?
13 **A.** I honestly don't know. I know that when
14 I attended that meeting it was very unpleasant. I've
15 referred in my statement to Dr Jayaram's approach
16 towards me, his attitude towards me at that meeting.
17 I think obviously it wasn't helpful and it would have
18 been better if we would have had the opportunity to
19 speak to them before Ms Fogarty had shared that
20 information, to give the assurances that from my view
21 definitely there was no withdrawal of support for those
22 areas.
23 **Q.** My final question upon this situation is this:
24 it is just to help us to understand the process whereby
25 midwifery were consulted before it went to the

1 Executives, but paediatrics were not.
2 **A.** Because by speaking to Ms Fogarty and
3 exploring would it be of benefit to -- to the service as
4 in having somebody with my team supporting them more
5 with these national guidance than perhaps we had been
6 involved previously, that was -- that was the primary
7 change to the role so I wanted to understand would that
8 be helpful. You know, I fully accept it would have been
9 helpful, beneficial to have spoken to Dr Brearey,
10 Dr Jayaram beforehand.
11 But at that point, it felt reasonable to go
12 directly in and seek the Executive approval.
13 **Q.** We are going to look at an email from
14 David Semple now which postdates your time in the Trust,
15 INQ0103134. So your last effective day was 2 March of
16 2017?
17 **A.** (Nods)
18 **Q.** We can see that once you left Ms Fogarty is --
19 her title -- Interim Associate Director of Risk and
20 Safety and what Mr Semple lists is a number of what he
21 describes as issues, previous poor leadership within the
22 Risk and Complaints Team, members of the Risk Team on
23 very short secondments, no time to settle into post
24 before they move back, general lack of communication
25 from the Risk Team leadership to teams and the front

1 lines staff, no feedback on Datix reports, no feedback
2 on incidents.
3 I am not going to read them all out, but each one
4 of those is of potential relevance to the matters the
5 Inquiry are investigating. I would like to give you
6 an opportunity to comment on whether those are fair and
7 accurate criticisms of the department under your
8 leadership?
9 **A.** It was very difficult to read this email. It
10 was very disappointing but I have to say not unexpected.
11 My relationship with Mr Semple was not easy and all
12 communications with him were perhaps much harder than
13 they needed to be.
14 When I read this email I see somebody who is taking
15 over a service, who has no understanding at all of the
16 continuous -- the journey of continuous improvement that
17 was put in place year-on-year but somebody who has
18 picked up a service that obviously at that point has not
19 only lost myself but had lost the Deputy Director of
20 Nursing as well so had lost two of the -- of the main
21 leadership roles. I don't agree with everything in this
22 at all.
23 A number of those things were in place. You know,
24 we refer repeatedly around feedback around incidents and
25 incident reports. You know, you only have to look at

1 the CQC reports from the time and that will tell you
2 that every single area spoke that they did get feedback
3 from incident reports. I think you have already heard
4 evidence that spoke around feedback was provided through
5 local boards of -- you know, communication boards. So
6 there were different ways and different routes of
7 providing that feedback.
8 Certain things around -- he says no training in
9 place. That's untrue. There was training in place and
10 that had been -- we actually set up a bespoke training
11 programme called Clinical Human Factors in Patient
12 Safety and that was ran by our Head of Education.
13 And again issues around report writing. Our
14 reports were commended by the CCG so I find that hard to
15 believe.
16 I think the one that concerns me and demonstrates
17 to me that Mr Semple didn't actually understand the
18 remit of the role or indeed of myself is the last bullet
19 point when he talks about this plethora of committees
20 with no clear reporting and escalation. You know, that
21 again is the corporate governance assurance reporting
22 structure and that again sat as the responsibility with
23 Mr Cross as the Director of Legal Services.
24 To -- to infer that somebody in my position, so
25 I was a Band 8A, that I would have that level of

1 influence is -- is just not plausible and just as I say
2 just demonstrates to me that he didn't really understand
3 the team and of course at that point I will have left,
4 as will have Mrs Williams, so I don't think he would
5 have had a handover to understand actually what the team
6 was, was responsible for delivering.
7 **Q.** I mean, were there a plethora of committees
8 and boards within the Trust with no clear reporting or
9 escalation structure?
10 **A.** There were -- there were obviously a series of
11 committees and boards. The structure was clear, it is
12 in the risk management strategy. I think the Women and
13 Children's Services by adding in an additional
14 governance board confused their process but the -- the
15 route of escalation for them, for the neonatal unit in
16 that case would be from the neonatal unit meetings
17 through to the division of Urgent Care and up into QSPEC
18 or the Corporate Directors Group. So there were
19 a series of meetings but there was a line of reporting.
20 **Q.** Might that email suggest that people didn't
21 actually understand because it was so complicated?
22 **A.** Well, possibly, yes. I don't -- I don't know
23 the back story to him completing this, this email.
24 **Q.** Well, you have mentioned the risk management
25 policy and we can take that down, thank you very much.

1 We are going to turn now to consider the risk
2 management policy. We will come back to some of the
3 relationships --
4 **A.** Okay.
5 **Q.** -- as we go.
6 But we will now look at that. Before we bring it
7 up on screen, I just want to remind you of something you
8 said in your witness statement.
9 You said this: at the time the risk maturity of the
10 hospital meant that the Risk Register tended to focus
11 upon current issues rather than emerging risks and
12 I would just like you to help us to understand why you
13 say that?
14 **A.** (Nods) Absolutely. So at the time the -- the
15 Risk Register and completing risk assessments was still
16 a relatively new process in the organisation, so it was
17 very much linked with problems that were already
18 happening, so current issues.
19 But with risk management you also want to look
20 ahead, so if you have a strategic objective, whether it
21 is local within the speciality or within the division,
22 so they would have had objectives that they would have
23 set themselves, what they want to deliver across the
24 next 12 months, for example.
25 If you were able to look and use a risk management

1 process you would be looking to see what risks may exist
2 to delivering those objectives and that's what I am
3 referring to as emerging risks, not necessarily things
4 that happening today but may well do if perhaps
5 a particular trajectory may continue.
6 So particularly around performance management,
7 things like that.
8 **Q.** If we look at it in practical -- and I hope
9 you will forgive me -- blunt terms, more babies dying
10 than are expected is a current risk?
11 **A.** Absolutely.
12 **Q.** That has got nothing to do with the maturity
13 level of the hospital; would you agree?
14 **A.** Yes.
15 **Q.** So would you expect that whatever the position
16 in terms of strategic planning, the hospital should have
17 been well equipped to deal with that sort of current
18 risk?
19 **A.** As in identifying the risk?
20 **Q.** Yes.
21 **A.** Yes.
22 **Q.** Well, let's have a look at the risk management
23 policy. We are going to have a look at the version
24 dated December 2015 which is part of the way through,
25 but the changes I am sure you will be able to confirm

1 are not significant in terms of what we are focused on.
2 So INQ0014962. So that is a document I hope you
3 recognise and we can go to page 3, please. Again we
4 will just, through you, Mrs Millward, introduce some of
5 the concepts which lie behind risk management according
6 to this document and we can see the heading "Principles
7 of Risk Management" and there is a list including risks
8 will be actively managed and positive assurance sought.
9 So presumably the prior step is to identify the
10 risk so that it can be actively managed?
11 **A.** (Nods)
12 **Q.** The Risk Registers will be live, actively
13 managed and review documents. The risk management is
14 the responsibility of all staff within their own sphere
15 of work, high risk areas and activities will attract
16 greatest focus and attention. Then there will be
17 learning from analysis of incidents, complaints and
18 claims and explicit rollout of identified problems.
19 So that is the list there?
20 **A.** (Nods)
21 **Q.** Perhaps it goes without saying that hospitals
22 experience death every day?
23 **A.** (Nods)
24 **Q.** But if we look at the problem that was facing
25 the neonatal unit in terms of a significant increase in

1 the mortality rate, would you agree that that can
2 properly be characterised as a high risk area relative
3 to the other risks that the hospital would be facing?
4 **A.** I'm sorry, I didn't -- I didn't get what you
5 have just said.
6 **Q.** No, I am happy to repeat it. Consider the
7 issue facing the neonatal unit, an increase
8 a significant increase in the mortality rate?
9 **A.** (Nods)
10 **Q.** Can that properly be described as a high risk
11 area for the hospital to address?
12 **A.** As in the neonatal unit or the deaths?
13 **Q.** The deaths?
14 **A.** Yes.
15 **Q.** So there is a significant increase in the
16 number of deaths?
17 **A.** Yes.
18 **Q.** Would you regard that as a high risk area?
19 **A.** I would -- I would -- it's the language there,
20 it's the language.
21 **Q.** Well, you use the words you want to --
22 **A.** Okay.
23 **Q.** -- answering my question as best you can.
24 **A.** Okay, thank you.
25 Certainly any area that would see an increase in,

1 in mortality would be an area of concern and it would be
2 an area that we would want to know about, it would be an
3 area that we would want to explore to understand.
4 So from a risk perspective it would be something
5 that we would absolutely want to understand and then if,
6 if the mitigations perhaps were not robust enough or we
7 needed to do some further work before we felt that that
8 risk was adequately managed, then that would be where
9 the Risk Register would come in. So you would
10 articulate those concerns on to the Risk Register.
11 **Q.** So we will go over the page to page 4, please.
12 It is under the heading of the "Risk management
13 structure" and we can see that there is a committee, if
14 that's the right word, called the Corporate Directors
15 Group who have delegated responsibility for reviewing
16 the Executive Risk Register and board assurance
17 framework?
18 **A.** That's correct.
19 **Q.** Now, the Inquiry has received information from
20 the Countess of Chester that the Corporate Directors
21 Group was not used for this purpose from around autumn
22 of 2016 and in fact it was what was described as Part 2
23 of the Executive Directors group that was used. Is that
24 change something that you were aware of taking place
25 while you were there?

1 **A.** I don't recall. I don't recall when, when the
2 Corporate Directors Group stopped. Obviously you have
3 provided some, some information in my bundle to assist
4 me. But I -- I don't recall and that certainly was not
5 something that would have been, you know, my, my
6 decision.
7 I can't account for the reasons why it would have
8 stopped. That would be Mr Cross who essentially oversaw
9 the CDG.
10 **Q.** As head of Risk and Patient Safety, would you
11 expect to be consulted about any structural change in
12 relation to the management of the Executive Risk
13 Register?
14 **A.** At the level that I was performing at, my
15 responsibility was to provide that information to the
16 Executive team for the decision-making and oversight.
17 It wouldn't have been my, my role to try to
18 influence the committee structure. That, that just
19 would not have been my, my remit at all.
20 **Q.** Would it have been your role to be asked
21 whether you had a view on it?
22 **A.** Probably not at that point.
23 **Q.** Just to unpick that for a moment. The title
24 of Head of Risk and Patient Safety --
25 **A.** I think -- I think --

1 **Q.** If I may.
2 **A.** Yes.
3 **Q.** -- tends to suggest that that is exactly the
4 sort of role that you would have. Can you just help us
5 to understand that apparent disconnect?
6 **A.** Yes. I think, I think the role is perhaps
7 misleading to how you may be perceiving it.
8 So my role, my responsibilities was to essentially
9 design and develop the systems and processes in place in
10 which we would have risk management or we would deliver
11 risk management and incident management, primary -- they
12 were the primary functions. But it was very much around
13 supporting the local teams in delivering their clinical
14 governance, so their incident management and risk
15 management.
16 My level of influence isn't what you -- what you or
17 what the Inquiry perhaps perceive. I think the job
18 title is a little bit misleading as to the level of
19 influence there.
20 It was very much a head of department role and
21 acting very much as an intermediary between the local
22 teams and the divisions and the Executive teams with
23 regards to decision-making.
24 **Q.** One interpretation of that title is that you
25 had principal responsibility for all matters relating to

1 Risk and Patient Safety unless the Executive Directors
2 needed to be involved. Is that not an accurate
3 characterisation of your role?
4 **A.** No. So I wouldn't have ultimate
5 responsibility for, for risk and incident matters.
6 My, my role, as I say, was very much an
7 intermediary to ensure that my team was following our
8 incident and risk management policies, that we had
9 a route of escalation and to ensure, as much as we
10 could, that the Executive team was sighted on those
11 things. But certainly the -- as I say, my level of
12 influence isn't, isn't what you have -- what you
13 believe.
14 **Q.** In terms of this document, would you have been
15 consulted or had an input into the content?
16 **A.** So this is an updated document which I believe
17 I added the -- there was a change with the meeting
18 structure further on I think in the appendices and
19 Mr Cross sent that over. So I updated it in line with,
20 with that. But the actual content I think has remained
21 the same for a period of time.
22 **Q.** If we go over the page to page 5 we can see
23 the definition of risk is given and in particular, and
24 it's just a small point, but given that you had some
25 input into the content in terms of the revision:

1 "Clinical risks are risks which have the ability to
2 affect patient care and may cause harm to the patient.
3 This covers anything related to diagnosis, treatment and
4 outcome of each patient. Psychological harm or distress
5 is also included. The following are some examples of
6 clinical risks."
7 And then there is no list.
8 **A.** (Nods)
9 **Q.** There is instead a change of topic. I mean --
10 **A.** I can't -- I can't explain that, I'm sorry.
11 It's obviously an error.
12 **Q.** Is that something that should have been picked
13 up if this is a document that is designed to help
14 employees at the Trust to understand what the position
15 is?
16 **A.** Absolutely. Well, all documents go through a
17 ratification process. This document as I say with the
18 updated committee structure would have been received at
19 QSPEC and approved by QSPEC members.
20 So obviously I haven't seen that, that line, and
21 I would also expect that the committee members would
22 have reviewed this document if they were approving it,
23 which they did.
24 **Q.** Over the page is how risk is to be managed and
25 we heard something about this this morning from

1 Ms Townsend, so we don't need to go over it in detail.
2 But can I summarise it in this way: that it's
3 expected that it starts at the local level?
4 **A.** (Nods)
5 **Q.** That it's expected that it will be escalated
6 through various boards?
7 **A.** (Nods)
8 **Q.** That there is a risk scoring system?
9 **A.** (Nods)
10 **Q.** And that when a particular risk achieves
11 a particular score, it will be escalated to the next
12 level?
13 **A.** That's correct.
14 **Q.** Well, we will look at the scoring in a moment
15 as we work our way through.
16 Page 7, the Executive Risk Register. We can see
17 here that that's a risk score of 16 or above or if the
18 risk carries significant concern but with a lower risk
19 score, and that is considered at the very top, is that
20 right?
21 **A.** That's correct.
22 **Q.** And just taking a step back for a moment.
23 Would you expect an unexpected increase in
24 mortality rate on the neonatal unit to make it up to the
25 Executive Risk Register?

1 **A.** I think it's very difficult because, as you
2 say, clinical care is, is not linear; it is, it is
3 complex. So, you know, an increase in, in, in mortality
4 rates it's about understanding what is driving that and
5 either if we hadn't got that information or that -- that
6 we had got that information, that information showed
7 that we weren't mitigating those risks or controlling
8 those risks, then absolutely I would expect it to go on
9 the risk register.
10 **Q.** Well, we'll come to what happened and the
11 timing of it in due course.
12 **A.** Thank you.
13 **Q.** If we go to page 9 we'll see your role is set
14 out:
15 "The Head of Risk and Patient Safety [this is
16 two-thirds of the way down] has the delegated
17 responsibility for maintaining the Executive Risk
18 Register. The Head of Risk and Patient Safety also
19 advises the organisation on patient safety and risk
20 issues enabling the organisation to achieve key
21 governance and risk objectives."
22 So that latter part, you had an advisory role to
23 the entirety of the hospital, is that right?
24 **A.** It is.
25 **Q.** On all matters of patient safety and risk, is

1 that right?
2 **A.** Indeed.
3 **Q.** And so if we just circle back to your
4 characterisation of your role previously and its level
5 of responsibility and its opportunity to influence.
6 According to this document you are the designated
7 adviser on these topics, including up to the Executive
8 level.
9 **A.** I would -- I would -- if the -- if an issue
10 was raised to me I would -- I would obviously look at
11 that with the, whether it's a local team, a divisional
12 team or the Executive team, I would contribute to the
13 conversation as to whether a matter needed to go on to
14 the Risk Register, whether the controls put in place
15 felt adequate or not, how that might link with our board
16 issuance framework for example.
17 But obviously a lot of this is very much dependent
18 upon things being identified at local level and -- and
19 that being shared.
20 **Q.** But you frame that in terms of if people ask
21 you. But don't you have a positive obligation to try
22 and improve all matters of patient safety and risk by
23 offering advice as and when necessary?
24 **A.** Yes.
25 **Q.** Finally by way of this document we will just

1 look at page 14, which is to see the risk scoring
2 matrix, and this will become relevant in due course.
3 Just to understand, we know that two of the risks
4 that we are going to have a look at were given one
5 a score of 20, one a score of 15. The way this table
6 works means that there are two ways you can score 20,
7 either it's an almost certain, so there's a 1 in 10
8 likelihood of a major severity event?
9 **A.** (Nods)
10 **Q.** Or that you have a likely, which is
11 characterised in with 1 in 100, catastrophic event?
12 **A.** (Nods)
13 **Q.** So either way, something very serious is at
14 risk of occurring which will require immediate action?
15 **A.** Yes.
16 **Q.** And if we have a look at moderate, 15, which
17 another risk we are going to have a look at also scores
18 that, that's either a almost certain moderate severity
19 or a possible catastrophic?
20 **A.** Yes.
21 **Q.** Is the risk of an avoidable death of a child
22 occurring catastrophic?
23 **A.** Yes. So the top line, the 1 to 5 --
24 insignificant, minor, moderate, major, catastrophic --
25 that's the -- that's obviously the severity.

1 **Q.** Yes.
2 **A.** So yes, so if we are referring to the death of
3 a child, then, yes, it would be catastrophic.
4 **Q.** The avoidable death of a child?
5 **A.** Would be catastrophic.
6 **Q.** Would be catastrophic.
7 **A.** So it's considering the worst outcome from
8 this risk.
9 **Q.** Thank you. We can take that down and we will
10 have a look at the risks that I have been referring to
11 in a moment. But before we do, there's one other
12 document I would like please for us to have a look at
13 which is the Incident Decision Tree.
14 This forms part of the Trust guidelines for the
15 conduct of formal investigations. It is INQ0003324 if
16 we can go to page 15 just to get the context of the
17 chart. So it talks about an Incident Decision Tree,
18 which we are going to have a lock at in a moment,
19 appendix 1, which is -- we have some frequently asked
20 questions. It's designed for use by any manager dealing
21 with staff involved in a patient incident.
22 So that we understand what that means, is a patient
23 incident anything that would involve a Datix being
24 produced?
25 **A.** A -- yes, with regarding to clinical care,

1 yes. Obviously the incident reporting system included
2 non-clinical incidents as well.
3 **Q.** Yes, but in terms of what the Inquiry is
4 focused on --
5 **A.** Yes.
6 **Q.** -- so a manager who is filling in a Datix
7 would be expected, would they, to have regard to this
8 Incident Tree?
9 **A.** All this was circulated to all managers, yes,
10 as part the guidelines.
11 **Q.** And ideally it should be used as soon as
12 possible after the patient safety incident?
13 **A.** (Nods)
14 **Q.** Whilst facts are still fresh in people's
15 minds?
16 **A.** That's correct.
17 **Q.** We can see that it's described as a flowchart
18 but rather than looking at the words used to describe it
19 let's actually have a look at it over the page and
20 really we don't need to get past the first step.
21 Start here in the top left-hand corner. The first
22 question that any person applying this is expected to
23 answer is under the heading "Deliberate harm test" were
24 the actions as intended -- were the actions as intended?
25 **A.** Yes.

1 **Q.** And obviously in the context of the phrase
2 "deliberate harm test", has a member of staff
3 deliberately harmed a patient?
4 **A.** Yes.
5 **Q.** That's the first question.
6 **A.** Yes.
7 **Q.** So just help us to understand, because none of
8 the doctors or nurses that we have heard from so far
9 have drawn attention to this or said that it was in
10 their mind, and that includes a number of nurse managers
11 and doctors with managerial responsibility. Whose
12 responsibility was it to circulate this and ensure that
13 everyone in the Trust understood it?
14 **A.** So it's part of the Trust guidelines. It's --
15 I'm sorry, the page has moved on so I can't tell you
16 what specific guidance it is but it's a HR -- the HR
17 processes.
18 **Q.** Yes.
19 **A.** So the responsibility obviously sits with the
20 HR team.
21 This was circulated. I can remember having various
22 conversations with managers using the Incident Decision
23 Tree. So it was -- it was in use throughout the
24 organisation. So I can't account whether the staff
25 you've spoken to was aware of it because it was -- it

1 was in use.
2 **Q.** You said it was circulated. When was it
3 circulated?
4 **A.** Well, it will have been circulated when it was
5 ratified originally and then obviously the updates.
6 The system that we had for the document management
7 system would highlight to staff when new documents had
8 been updated or if a current document had also been
9 updated. So all of that information would have been
10 there.
11 **Q.** And when applying this Incident Decision Tree,
12 what level of confidence or certainty would you have to
13 have in the answer before progressing? And let me
14 illustrate what I mean by that.
15 Were the actions as intended? Do you need to be
16 sure of that? Does it need to exist as a possibility?
17 Does it need to be more likely than not?
18 What should be -- when somebody is asking
19 themselves that question before they progress down that
20 column, which ends up with, among other things,
21 contacting the police, what level of confidence does
22 a person need to have to move downwards?
23 **A.** I think first and foremost the person needs to
24 be clear as to what the incident is, you know. So it's
25 understanding in this case with the deaths is was -- was

1 an incident -- was it a medication error for example?
2 So was it a drug, too much drug was given or too little
3 drug was given?
4 So understanding and through discussion with
5 the staff member, you know, did they intend to give that
6 level of, of medication? But did they -- did they know
7 by doing so that they were going to cause that level of
8 harm as a result of it?
9 So it's -- it's done through conjunction with the
10 individual through a reflective discussion with the
11 individual and it would be around the ward manager --
12 largely this is used for nursing staff if I'm honest --
13 having that understanding of the individual and having
14 thought whether or not there was something more
15 sinister, if you like, in their behaviour.
16 I don't think we ever sat and said: oh, there's
17 a defined level of evidence, if you like, that needed to
18 be provided and I don't think the national guidance did
19 that either. But it would be, you know, through that
20 conversation with the staff member and understanding
21 their view and obviously that local investigation that
22 that manager would be taking as well.
23 **Q.** So, in practice, if somebody had come to you
24 during 2015 and said, this person being a doctor: I am
25 concerned that a member of staff is associated with

1 an increase in mortality --
2 **A.** (Nods)
3 **Q.** -- I can't say that I have seen them do
4 anything, but I think there is a risk and that risk
5 implicitly includes that they have done this
6 deliberately, is that enough to progress down to the
7 bottom of that chart?
8 **A.** I think that would be difficult to say so
9 because, as I've said, it's about understanding what has
10 contributed to the harm.
11 If we are referring to -- to the deaths of the --
12 of the children, you know, a -- a child, it sounds awful
13 and I apologise to the families if it sounds callous and
14 it's not meant in any way, but a child -- a child may
15 die, as I say, an incident may happen, a medication --
16 medication errors are particularly easy to talk through.
17 So a medication error may happen. It would -- I'm
18 not communicating very well, I apologise.
19 So an incident may come in. It would be -- it
20 could be a medication error. It could be significant
21 enough that it has contributed to -- to the harm to
22 a death of a child, but it could also be reported as
23 a no harm event as well.
24 So it's -- it's around were the actions as
25 intended, do we intend to give that amount of

1 medication? But did we actually intend to cause the
2 level of harm? It's -- it's not as straightforward as
3 saying: We have these deaths and I have got a staff
4 member that I am concerned about.
5 It would be about understanding: Well, what do you
6 mean by that? What was that staff member's involvement
7 and what, what do we understand has contributed to the
8 death?
9 **Q.** But from a risk management point of view, you
10 only need a reasonable concern to provoke action, don't
11 you?
12 **A.** Yes, but it would be about exploring and
13 trying to understand what has happened to -- for those
14 people to have concerns about a staff member and to
15 understand what has happened for that child.
16 It's very difficult for some incidents, for -- as
17 I say, clinical care is not linear, it's sometimes
18 difficult for people to understand whether the outcome
19 has happened as a result of an incidence of something
20 unexpected or intended that's happened to the patient or
21 whether that is unfortunately the natural trajectory of
22 the patient's condition, or indeed is something in
23 response that we have tried to do to help improve the
24 patient's condition.
25 It doesn't necessarily mean a -- a very poor

1 outcome does not necessarily mean that there has been
2 a harm as such.
3 **Q.** I'm not seeking to dispute any of that with
4 you. But this column here is specifically catering for
5 a circumstance in which the police may need to be
6 involved, so it is contemplating somebody like
7 Beverley Allitt deliberately harming patients.
8 That person is unlikely to admit to it when you
9 have your discussion with them?
10 **A.** (Nods)
11 **Q.** And it may be that the only evidence before
12 the police become involved is a clinical judgement that
13 too many incidents that shouldn't have happened have
14 happened?
15 **A.** (Nods)
16 **Q.** Is that not enough for the purpose of this?
17 **A.** I don't think you would use the Incident
18 Decision Tree in that way. This is around an individual
19 incident that is then applied to an individual staff
20 member.
21 What we are referring to is multiple deaths and
22 looking essentially at understanding those deaths.
23 I don't feel that the Incident Decision Tree would be
24 used in that way.
25 **Q.** Would you expect Ms Peacock, in her role when

1 speaking to people within the neonatal unit about
2 deaths, to have this decision tree in mind?
3 **A.** Yes. Yes.
4 **Q.** Would you expect her to go so far as to talk
5 through it with the person she's discussing it with?
6 **A.** Again, we would be talking through it based
7 upon a specific incident, not -- not necessarily -- and
8 that is the difficulty some of the incident reports
9 refer to a death but they don't give a narrative as to,
10 you know, what was thought to have contributed to the
11 death.
12 **Q.** We can perhaps park that but if I can just put
13 a bookmark for you?
14 **A.** Of course.
15 **Q.** When we come and have a look at Child I it may
16 be that my questions will take on a slightly different
17 perspective.
18 But can we just look please at how this risk was
19 managed and again we have seen a little bit of this from
20 Ms Townsend but I think we are going to take it to the
21 next level now.
22 INQ0004657. So this is the Urgent Care Risk
23 Register high risks. So that is the risks rated 20, is
24 that right, because it is red?
25 **A.** I believe so. It's been many years since

1 I have used that particular scoring matrix.
2 **Q.** We can see the top one "Potential damage to
3 reputation of neonatal service and wider Trust due to
4 apparent increased mortality within the neonatal unit"
5 and it is dated 11 July, so that is where we are going
6 to start. I will ask you some questions globally, we
7 just need to work our way through the documents?
8 **A.** Yes.
9 **Q.** If we then come to the next document, please,
10 INQ0003213, this document is dated 19 July 2016.
11 Forgive me, if we could take that down. That isn't
12 in fact the correct reference. So would you just bear
13 with me one moment, please.
14 (Pause) Forgive me, I will give a different
15 reference because that one clearly doesn't work.
16 INQ0049845.
17 **LADY JUSTICE THIRLWALL:** I wonder if that might be
18 a convenient moment?
19 **MR DE LA POER:** I think it will, my Lady. I don't
20 know why that reference isn't working, but it will be my
21 fault and I apologise.
22 **LADY JUSTICE THIRLWALL:** Thank you very much. So
23 we will adjourn now and start again at 5 to 2.
24 **(12.57 pm)**
25 **(The luncheon adjournment)**

1 **(1.55 pm)**
2 **LADY JUSTICE THIRLWALL:** Yes.
3 **MR DE LA POER:** Mrs Millward, we are just tracking
4 the risks. We started at the divisional level but we
5 are going to take a step backwards now, INQ0003213,
6 please. This is eight days after that Urgent Care
7 Divisional Risk Register. We are looking at the Women
8 and Children's Care Governance Board meeting.
9 You weren't present at this meeting, but we can see
10 that Mrs McMahon, Temporary Risk and Patient Safety
11 Lead, is identified near the bottom, do you see that?
12 **A.** I do.
13 **Q.** And if we go to page 4, please, we can see new
14 risks for escalation this month and we can see at the
15 Women and Children's Care Governance Board level
16 identified first:
17 "Potential damage to reputation of neonatal service
18 and wider Trust due to apparent increased mortality
19 within the neonatal unit."
20 Given a score of 20, we are familiar with that one.
21 But we can also see as the next one down "apparent
22 increased mortality within the neonatal unit" which is
23 given a score of 15?
24 **A.** Yes.
25 **Q.** So just bear with me, one more document to

1 look at where we will see those again. Before we go
2 there we just need to note that on page 5, just so that
3 you have this in your mind when I come to my questions,
4 that according to the minutes of this meeting there was
5 nothing to report to QSPEC, that is the bottom entry?
6 **A.** Yes.
7 **Q.** So we then come, please, thank you very much,
8 to INQ0049845. This is the Executive Risk Register for
9 July of 2016. If we go to page 10, first, we will look
10 at the detail of it but just so that you can recognise
11 this. This is prepared by you, according to the bottom
12 right-hand corner there, for the Corporate Directors
13 Group on 27 July of 2016?
14 **A.** Yes, the date there refers to the date that
15 the report was pulled rather than the date of the
16 meeting.
17 **Q.** So let's go back up to the top to page 1. It
18 is not a document we have looked at previously so we
19 will just take a moment to orientate ourselves. We can
20 see that initially we have got presented in tabular form
21 a number of different ways of just gauging how many
22 there are and if we go over the page, please, we can see
23 as at 27 July there were seven risks entered into the
24 ERR.
25 **A.** Yes.

1 **Q.** The first is recorded as "potential damage to
2 reputation of neonatal service and wider Trust", that
3 one that we have seen from the Divisional Register of
4 11 July now appearing on the Executive Risk Register and
5 the second one that we saw not on that previous register
6 that we looked at but at the Women and Children's Care
7 Governance Board, "apparent increased mortality within
8 the neonatal unit" which is given a moderate
9 corresponding with its score of 15?
10 **A.** (Nods)
11 **Q.** Those are identified as 1508 and 1507
12 respectively and that is important because we can see
13 there is a note to this that you have added chairman's
14 actions were taken on 11 July 2016 to add two risks to
15 the ERR from Urgent Care and there we see the reference
16 numbers, there are no risks identified by the divisions
17 for escalation to the ERR for July 2016.
18 So this is a document that you have prepared; is
19 that correct?
20 **A.** That's correct.
21 **Q.** You have delegated responsibility for the ERR;
22 is that right?
23 **A.** That's correct, yes.
24 **Q.** So let's just break down what we can see on
25 the page here. Firstly, chairman's actions were taken

1 on 11 July to add those two risks?
2 **A.** (Nods)
3 **Q.** What is that a reference to, please?
4 **A.** So that would be in reference to another
5 meeting that has been held with the Executive team.
6 I can't tell you which meeting because the detail isn't
7 there and the decision being made to add these two
8 particular risks. And obviously that will have included
9 a discussion around the wording and the scoring, the
10 controls and actions.
11 **Q.** Now, the board chairman is Sir Duncan Nichol?
12 **A.** (Nods)
13 **Q.** Is that a reference to Sir Duncan Nichol --
14 **A.** Yes.
15 **Q.** -- when it says "chairman's"?
16 **A.** So chairman's actions will be in relation to
17 the chair of the meeting that the -- that this is going
18 to. Sir Duncan Nichol didn't -- I don't recall
19 Sir Duncan Nichol actually ever attending Corporate
20 Directors Group so it would be chairman's actions in
21 relation to either Mr Cross or Mrs Kelly or indeed
22 Mr Tony Chambers, I am not too sure who because they did
23 alternate the chair for Corporate Directors Group.
24 **Q.** Whoever was chairing on that occasion
25 according to your note and is this something that you

1 would have been told?
2 **A.** That -- that would have been something I would
3 have been in attendance for. I don't.
4 **LADY JUSTICE THIRLWALL:** So you would have been at
5 that meeting?
6 **A.** Yes. I'm not sure whether I am trying to
7 understand when the actual Corporate Director Group
8 meetings were held. I don't have a list of the reports
9 so I'm not sure if that was chairman's actions from the
10 Corporate Directors Group on 11 July, if you understand
11 what I am saying.
12 **MR DE LA POER:** Well, we know that 11 July was also
13 the date that it appeared on the Urgent Care --
14 **A.** Yes.
15 **Q.** -- Divisional Register.
16 Well, perhaps we can run that down separately.
17 I think you have given us enough information there for
18 our understanding.
19 I just want to ask you, as Ms Townsend was asked,
20 about the wording. Potential damage to reputation given
21 the highest level of rating?
22 **A.** (Nods)
23 **Q.** Why was this risk framed in terms of damage to
24 reputation?
25 **A.** So that will have been a conversation that

1 took place at the meeting with the Executive team. At
2 that time, the unit was being downgraded. Obviously
3 that had been put into the public arena and there will
4 have been concern whether, you know, how that would have
5 been received and potentially reported back on, you
6 know, through the press and of course any concerns being
7 raised directly to the Trust in relation to that.
8 **Q.** I will come back to that answer in a minute.
9 **A.** Of course.
10 **Q.** I just want to ask you about the second risk
11 which is apparently of a less high level of concern.
12 Apparent increased mortality within the neonatal unit,
13 so that one similar to the earlier risk but without
14 reference to reputation?
15 **A.** Yes.
16 **Q.** Simply focused upon the risk of death?
17 **A.** So that will have been focused upon absolutely
18 the clinical aspects of the care and, you know, as you
19 say, the risk of death.
20 I can't recall the exact conversation but my view
21 or my interpretation of that would be that the unit had
22 already been downgraded at that point and therefore that
23 would reduce, you know, the -- the challenges around
24 those, though more high acuity patients coming into the
25 unit, that was the -- that was the view at the time and

1 so I think that's why that particular risk is scored
2 slightly lower than the one around reputational damage.
3 **Q.** If you just take a step back.
4 **A.** Yes.
5 **Q.** This does rather look like the Trust is more
6 concerned with the comms messaging, reputation
7 management, than actually babies dying. Can you help us
8 with that, please?
9 **A.** Absolutely. So within the risk management
10 scoring we are looking at both the severity, so the
11 level of harm, if you like, the outcome but we are
12 looking at how much that likelihood -- you know, how
13 likely it is to have that catastrophic outcome you have
14 referred to.
15 What we are also looking at within that is the
16 controls and the measures that are already in place to
17 try and manage that. So the view would have been,
18 I believe, that because of the actions already taken to
19 downgrade the neonatal unit and therefore to take, you
20 know, a different cohort of patients that there was
21 additional mitigations in place within the Trust
22 control.
23 Of course reputational damage and media coverage
24 and so on would be outside the Trust's control so they
25 wouldn't have the same level of assurances around the

1 effectiveness of the controls and that would have meant
2 that would be reflected in the risk always being
3 slightly different.
4 **Q.** We are going to have a look at the control
5 measures in a moment.
6 **A.** Of course.
7 **Q.** What thought when these entries were being
8 devised was given to the relative acuity of the children
9 who had in fact died?
10 **A.** So this would have been a step, a moment in
11 time, on 11 July as to, you know, this is the situation
12 we are in today. These are the actions that have
13 already been taken to prevent further deaths. And that
14 would be why the score is the way the score is.
15 **Q.** Let's have a look, please, at page 4 where we
16 can see some more detail. Here we are looking at the
17 first risk and the list of controls which speak for
18 themselves in a number of respects.
19 Just again focusing here on two of the controls
20 which is the closure of the intensive care cots and the
21 use of regional hospitals for babies of particular
22 gestation. I mean, surely would that not increase
23 confidence in the unit?
24 **A.** But the risk is around reputation to the
25 Trust, so there are two different risks here. Those

1 factors would be controls and considered increased
2 confidence with regards to further cases of mortality.
3 This risk is in relation to media reputation --
4 well, reputation of the organisation and so it's
5 a different lens being applied.
6 **Q.** Well, why is the Trust so concerned with its
7 reputation?
8 **A.** Well, why wouldn't -- with respect, why
9 wouldn't the Trust be concerned with its reputation?
10 At that point in time, we had a -- you know, we had
11 a number of children who had sadly died. There was
12 a Royal College review being initiated by the Executive
13 team, there was a change in the way that the unit was
14 being managed that was going to be or that was shared
15 publicly.
16 You know, there is a level of how you manage those
17 communications to try and assure that the public using
18 our services would have confidence to come in and get
19 the care that they do need. You know, I can't give you
20 more than that, that is an executive decision.
21 **Q.** You have a role to provide advice, don't you?
22 **A.** I -- I do and I will have been part of the
23 conversation that agreed to put these two risks on the
24 Risk Register.
25 **Q.** So did you support the approach that was being

1 taken?
2 **A.** I think at the time that felt very reasonable.
3 **Q.** Let's have a look at the control measures for
4 1507 which can be found on page 8 so this is -- instead
5 of focusing on reputation, this is actually focusing
6 upon the risk of death to babies.
7 **A.** Yes.
8 **Q.** So we can see in a little more detail here,
9 reference to the thematic review. I just want to have
10 a look and understand why the Care Quality Commission
11 inspection in February 2016 did not highlight any
12 concerns is regarded as a control measure?
13 **A.** So that would -- it would be regarded as
14 a control measure because it is a level of assurance, it
15 is an external level of assurance. Therefore it's
16 considered a higher level of assurance than simply our
17 own reviews of the cases.
18 **Q.** Do you know that when you agreed to that going
19 in that the Care Quality Commission had in fact
20 investigated the increase in neonatal mortality?
21 **A.** I was not aware at that time that the CQC had
22 investigated. Obviously this is -- that line is
23 referring to the inspection and the report come back
24 from the CQC inspection.
25 **Q.** Well, wouldn't it very largely depend on what

1 the CQC was told as to whether or not that provides any
2 real assurance?
3 **A.** And of course all the different documentation
4 that is submitted and therefore validated by the CQC.
5 **Q.** Did you submit the thematic review of neonatal
6 mortality?
7 **A.** Not at that time because that was
8 February 2016 and obviously it was still being developed
9 at that point.
10 **Q.** So as far as you are concerned, or as far as
11 you are aware, the CQC never saw the thematic review?
12 **A.** As far as I am aware, they did not see that,
13 no.
14 **Q.** So again bearing in mind all of this is
15 apparently emerging from the entry above, if you knew
16 that the CQC hadn't actually seen that report, how much
17 assurance does that actually provide?
18 **A.** And that that's a valid question?
19 **Q.** Well, can you answer it?
20 **A.** I think it was -- I think it was a best effort
21 to try to understand the different levels of assurance
22 that the organisation had at that time. I think I agree
23 with what you are saying, you know, if we haven't
24 submitted the thematic review to the CQC, or if we had
25 it they may have given a different view.

1 But at the time that was the level of -- of
2 assurance that we had. It is very comprehensive, the
3 review process. It goes on for many, many months there
4 is many, many conversations around it and obviously it
5 was something that, you know, in the conversation around
6 adding these risks it was something that was felt
7 important to add in.
8 **Q.** One thing that isn't listed as a control
9 measure is the removal of a member of staff to
10 a non-patient-facing role?
11 **A.** (Nods)
12 **Q.** Why is that not included here?
13 **A.** I can't answer that. I don't know.
14 **Q.** Well, as at 27 July did you know that a member
15 of staff had been moved to your department as a control
16 measure?
17 **A.** As at 27 July, yes, I did know she had been
18 moved. Well, it was an agreement at that time.
19 **Q.** So why, bearing in mind you had delegated
20 responsibility, you are providing advice, is that not
21 listed here?
22 **A.** So to be clear around the delegated
23 responsibility, that does not mean I own the risk, it
24 means that I ensure that the risks are reviewed, that
25 the report comes through up to the Corporate Directors

1 Group, that, you know, there are actions put in place
2 and those actions are progressed in a timely manner
3 I didn't own the risk. It will have been Mrs Townsend
4 who would have owned the risk.
5 **Q.** But be that as it may, the person who had been
6 moved was by this stage working in your department. Did
7 it occur to you to suggest that that was included as
8 a control measure here?
9 **A.** I think the fact that the person involved who
10 had been moved had been moved as a HR process and a HR
11 process is a confidential process, and therefore, we
12 wouldn't normally transfer something like that into the
13 Risk Register because of the level of access and the
14 number of people that would see that.
15 **Q.** So was there a conversation around whether it
16 should or shouldn't be put in?
17 **A.** I honestly can't tell you that, I honestly
18 don't remember.
19 **Q.** If we just look at this risk and how it's
20 framed or how it begins, in terms of the control
21 measure, as it is listed, "clinical lead" is highlighted
22 and "apparent increased mortality". If it is right that
23 that is a reference to the thematic review, which we
24 know was finalised on 2 March, does it follow that at
25 the very latest, by mid-March, this risk should have

1 been put on the Executive Risk Register?
2 **A.** I think absolutely it should have been added
3 on to the Risk Register at an earlier stage, yes.
4 **Q.** Well, my question is two parts, firstly by at
5 the very latest mid-March and, secondly, as far as the
6 Executive Risk Register, which is where we see it now,
7 do you agree with both of those?
8 **A.** Yes, yes, I would agree with that.
9 **Q.** Now, just trying to understand why -- we can
10 take this down, thank you very much indeed -- you say in
11 your witness statement the governance arrangements, ie
12 ward to board reporting, were not sufficiently robust to
13 ensure that the voice of the neonatal unit, a small
14 specialty within a much bigger adult care-providing
15 division, was heard both at Divisional and Executive
16 level meetings?
17 **A.** That's correct.
18 **Q.** Now, we know that before we get to the
19 Divisional level and the Executive level, the normal
20 governance arrangements are that it would go to the
21 Women and Children's Care Governance Board?
22 **A.** Mm-hm.
23 **Q.** We also know that it didn't go to the Women
24 and Children's Care Governance Board until June of 2016,
25 so very shortly before we see these entries. So is that

1 in fact anything to do with the size of the neonatal
2 unit and is it more to do with the fact that nobody at
3 that local level was escalating it?
4 **A.** I think -- I think it's both. I think it's
5 both. I think the -- I think, you know, the neonatal
6 unit paediatrics is a much smaller specialty, the
7 division of Urgent Care, which is the former route,
8 obviously is largely adult-focused and I have reflected
9 on the escalations that went, particularly up to QSPEC,
10 and they were largely focused, they were verbal for one,
11 they were not documented levels of assurance and points
12 for escalation, but they were largely focused upon
13 patient flow because it's we -- the Trust had
14 an emergency department and obviously patient flow into
15 the hospital and obviously exit out of the hospital was
16 a primary area of concern.
17 So having them attend and raise their voice but do
18 so verbally without a document that they can send up,
19 an assurance report, not the thematic review I am
20 referring to, makes it harder for them to speak up at
21 that group and then that message, you know, continue up
22 the points of escalation.
23 But clearly as you say, the paper wasn't tabled,
24 there was a delay in tabling the paper at the Women and
25 Children's Care Governance Board as well.

1 **Q.** Well, we will come back to that and where
2 responsibility might lie. Before we just leave this
3 general topic of the Risk Register, I would like,
4 please, for you to look at INQ0042162. This is a list
5 of ongoing patient safety incidents reported on STEIS
6 dated February 2016 and in fact the entry I am going to
7 ask you to look at isn't anything as far as we are aware
8 to do with the neonatal unit.
9 **A.** Okay.
10 **Q.** So if we go to page 2, please, and it's just
11 to consider this issue of the Trust and its reputation?
12 **A.** (Nods)
13 **Q.** Do you see the penultimate entry which is
14 right in the centre of the page?
15 **A.** I do.
16 **Q.** "Potential for adverse media incident, police
17 investigation into the circumstances of the death of
18 a patient."
19 This is apparently reported on to STEIS as an NPSA
20 level 2?
21 **A.** Yes.
22 **Q.** Looking back on it, what, was there too great
23 a focus upon the Trust's reputation, do you think?
24 **A.** If you consider the Serious Incident Framework
25 and the three areas that they ask with regards to

1 reporting what is classed as a Serious Incident, the
2 potential for adverse media is included within that.
3 I think looking at this one I actually remember
4 what this case is and it would have absolutely have been
5 appropriate to escalate that as a Serious Incident.
6 It's not in relation to the reputation of the Trust,
7 that's in relation to a police investigation around
8 a patient who was deceased.
9 **Q.** So when it says adverse media?
10 **A.** Because that's the category that you would
11 select on STEIS.
12 **Q.** So that is not referring to the adverse media
13 about the Trust?
14 **A.** It's in relation to the death of a particular
15 patient. I -- I believe I know what case that is and it
16 would not be appropriate to share any further
17 information about that other than to say it was a death
18 of a patient that -- that was reported to the police,
19 was progressed through a police investigation externally
20 to the organisation. But the patient died at the Trust,
21 and therefore that does generate media interest and does
22 generate, you know, contact and under the Serious
23 Incident Framework that would be something that you
24 would report on STEIS.
25 **Q.** Thank you, we can take that down.

1 I am going to turn now to consider the policy for
2 reporting incidents and we can do so relatively briefly.
3 We heard from Ms Lawrence about this about a week and
4 a half ago. INQ0006466. We can go to page 3, please
5 and we can have what should be reported as an incident
6 and here when it says reported initially that means
7 filling out a Datix; is that right?
8 **A.** Yes, of incident reporting in Datix, Datix is
9 the incident reporting system.
10 **Q.** Now, what Ms Lawrence told us was that her
11 interpretation of what should be reported was
12 effectively harm caused by something that shouldn't have
13 happened?
14 **A.** That's correct.
15 **Q.** In that way you can have death as a no harm
16 incident because if death is a natural process, then one
17 doesn't need to identify it as an incident?
18 **A.** Yes, yes. Well, yes, you wouldn't report
19 a naturally occurring death on the incident reporting
20 system. You would only report -- you would report an
21 incident in relation to the death.
22 **Q.** If we see this, Ms Lawrence's interpretation
23 was that unnecessary harm to patients, ie meaning
24 something that shouldn't have happened and that could
25 have been avoided?

1 **A.** Yes. The language has changed over time.
2 Today you would use the words "unexpected" or
3 "unintended".
4 **Q.** And who was responsible for the language here,
5 is that taken from NHS England or is that internal to
6 the Trust?
7 **A.** That would have been taken from some national
8 guidance.
9 **Q.** Now, just bearing in mind that definition. If
10 a baby suddenly and unexpectedly deteriorates but does
11 not die, so is successfully resuscitated and there is no
12 immediate indication that anybody has done anything
13 wrong or done anything that they shouldn't have done,
14 would that be under this guidance a reportable incident?
15 **A.** So again as I said earlier it's, you know,
16 clinical care is complex. In this situation -- well,
17 normally we would be seeing if an incident has occurred
18 as you say an incident has occurred we would expect to
19 see it reported where there are unexplained situations
20 such as the collapses you refer to, if they have
21 generated a number of discussions because we can't
22 understand what has contributed to the death, then in my
23 view, yes, that should be reported as an incident.
24 **Q.** Can you just help me with which part of this
25 policy you say triggers that as a reportable incident?

1 **A.** So the clinical section where it says
2 "clinical, ie affecting a patient, investigation,
3 diagnosis, treatment" and then you have "medical
4 equipment" so on and so forward.
5 **Q.** Yes. That's a list of I think what "clinical"
6 means, I think it is subject to what appears above about
7 "resulted or did result in unnecessary damage, loss or
8 harm to a patient"?
9 **A.** So as I say, the language as we would use
10 today has progressed, we would be talking as
11 "unexpected" or "unintended".
12 But if something is unexplained and we don't
13 understand what has happened what has taken place and it
14 has triggered further discussion, then it would be
15 absolutely reasonable to report that as a clinical
16 incident.
17 **Q.** As the Inquiry understands it, anybody can
18 report anything, they don't have to be within the
19 policy. What I am really trying to understand is
20 whether it's mandatory to report --
21 **A.** Right.
22 **Q.** -- such an event?
23 **A.** No, the incident reporting system is broader
24 than that.
25 **Q.** I think -- you tell me if I am right about

1 this -- what you are saying is you wouldn't criticise
2 someone for not reporting such an event because the
3 policy doesn't require it?
4 **A.** The policy doesn't stipulate exactly every
5 situation that an incident would be reported. As I say
6 my view is if -- if an incident occurs in such a way as
7 you say a collapse where there is a level of concern
8 because we have not understood what has happened then
9 I would expect that that is reported as an incident so
10 that that can then be further explored and supported
11 through, through using our root cause analysis process.
12 **Q.** Does what you have just said, did that make it
13 into writing or training or any policy that existed back
14 in 2015/16?
15 **A.** I think that will have happened through
16 conversations and discussions. Certainly there was
17 mandatory training that happened every two years. The
18 junior doctors also had their own bespoke mandatory
19 training, induction processes, there was an induction
20 checklist that spoke around the use of the incident
21 reporting system and when you should report and
22 essentially none of the team would ever discourage
23 somebody from reporting an incident even if, you know,
24 the outcome of the investigation showed that no actual
25 event actually happened.

1 **Q.** Well, we are going to look at it from the
2 other end of the telescope which is whether or not it is
3 appropriate to criticise someone for not reporting it
4 and the starting point, I think it is fair to say,
5 Mrs Millward, is that over the course of your time as
6 Head of Risk and Patient Safety you were critical of the
7 neonatal unit's approach to reporting; is that fair?
8 **A.** I -- I don't know if I would say I was
9 critical. I would say that, you know, there were
10 occasions when I needed to speak to Dr Brearey about
11 incidents and investigations and Dr Brearey wasn't
12 responsive.
13 **Q.** So if we have a look at a number of the
14 contemporaneous documents at INQ0001888, please.
15 So if we go to page 8. So we can see that this is
16 a paper that you drafted in July; is that right?
17 **A.** That's correct.
18 **Q.** We can see that one of the things that you
19 looked into was incident reporting?
20 **A.** That's correct.
21 **Q.** Did that enable you to form a view at that
22 time about the quality of the incident reporting on the
23 neonatal unit?
24 **A.** Yes.
25 **Q.** And in summary how did you find it?

1 **A.** I felt that the incidents being submitted were
2 limited, narrow in focus. There were a number of them,
3 if I can recall, around closure of the unit, some
4 staffing and also the quality of the information you
5 know, included in the incident reports was quite
6 limited.
7 So there was often insufficient information to say
8 what is the event that you are concerned about and
9 obviously then somebody like Mrs Peacock would go in and
10 have those conversations.
11 **Q.** So this is as at July 2016?
12 **A.** (Nods)
13 **Q.** Was that something that you had had experience
14 of before this time or was it something you only
15 discovered when you did this piece of work in July 2016?
16 **A.** I think a bit of both. We had had
17 conversations around the use of the pick lists, the
18 neonatal unit pick lists, because again they were
19 developed to -- well, they were developed by the
20 neonatal unit to help support them in driving incident
21 reporting.
22 There was a view, you know, through NHS England and
23 the Serious Incident Framework that perhaps these lists
24 were perhaps not quite as helpful and perhaps looking at
25 incidents we need to look more broadly, I think

1 Mrs Lawrence may have alluded to that in her evidence.
2 And as I say, with the cases that I did pick up in the
3 interim, I could see some of the content wasn't
4 particularly detailed and you wouldn't be able -- if you
5 received the incident you wouldn't necessarily be able
6 to see exactly what the concern was and therefore, as
7 I say, Mrs Peacock or -- would need to go in and speak
8 with the staff to understand the concern.
9 **Q.** Had Mrs Peacock complained to you that she was
10 having that difficulty with the neonatal unit?
11 **A.** I think Mrs Peacock, because of her
12 relationship with them, she was able to get the
13 information out, you know, from the conversations,
14 I don't think she found it a concern.
15 **Q.** Because the way we understand it works is that
16 the Datix is filled in by the person who reports it, it
17 comes to a handler within your department who allocates
18 it to the right person?
19 **A.** That's correct.
20 **Q.** Codes it correctly and then in the case of the
21 neonatal unit up until February 2016 Mrs Peacock would
22 receive it, consider it?
23 **A.** That's correct.
24 **Q.** You are telling us that she hadn't as at the
25 time that she left fed back to you that she thought it

1 was a problem?
2 **A.** No, as I say because I think of her
3 relationship with the unit she was able to -- to work
4 with them to -- to help understand what -- what the
5 incidents were.
6 **Q.** Now, if we look at INQ0006769, this is
7 Dr Brearey's email that we looked at earlier of 15 July.
8 If we go over the page, please, in his penultimate
9 paragraph, he says he has heard criticism of the risk in
10 Datix reporting culture there. What you tell us in your
11 statement is that your belief is that he has heard what
12 you have had to say about his department; is that right?
13 **A.** Yes. I believe that that will have happened
14 following the meeting that I had with the Executive team
15 around the position paper and the feedback and I believe
16 that that therefore has perhaps come from Mr Harvey when
17 he then met with the paediatricians but I can't be
18 certain, but that is what I believe that alludes to.
19 **Q.** And so your concern is if we are clear about
20 this, not that Datix aren't completed or is that part of
21 it? It is the quality of the content or is it both?
22 **A.** I think it's both. As I say, the use of the
23 pick lists meant that there was quite a narrow focus at
24 the time so as I say you would tend to see the same
25 sorts of incident types being reported and obviously

1 looking at some of them there was not a lot of
2 information contained with them.
3 **Q.** Certainly for all of the children named on
4 indictment, every single one of them was the subject of
5 a Datix indicating that their death was unexpected.
6 **A.** (Nods)
7 **Q.** So that wouldn't be part of the problem that
8 you are describing; is that right?
9 **A.** So again, the -- the use of the pick lists
10 means that the staff were selecting expected or
11 unexpected death but that's not necessarily an incident.
12 The incident is what has contributed to that death
13 because an unexpected or expected death is a clinical
14 outcome.
15 So what I would be looking for is to broaden the
16 pick list more and broaden the way they were reporting
17 incidents so that -- again I will give reference to the
18 medication incident that I've referred to earlier, so
19 that I would see it as a medication incident but then
20 with a level of harm that says death and then that way
21 we can more clearly trend and theme our learning rather
22 than having something saying it's a death but a no harm
23 because obviously that can be confusing and I think
24 that's caused some confusion here.
25 **Q.** Well, what it resulted in was a Datix form for

1 every single one of the deaths which might not have been
2 filled in had somebody been taking the approach of well,
3 is this an incident where something about the NHS has
4 caused harm? Answer: not that I can see, therefore no
5 Datix.
6 So can you see that there was a potential advantage
7 to the approach that was being taken on these facts?
8 **A.** Well, my understanding is that there wasn't an
9 incident report for every one of the deaths, some of the
10 deaths were not reported. I am not saying that they
11 shouldn't be reporting the death, what I am saying is
12 that within the incident reporting system the use of the
13 pick list and the category or subcategory as an
14 unexpected death was not particularly helpful because it
15 is not telling me what has contributed to the incident,
16 what element of the patient's care or treatment you want
17 us to look into, what element of the treatment you are
18 concerned about. That's what I am referring to.
19 **Q.** Now, in terms of the indictment children, all
20 of those who died, died when Mrs Peacock was responsible
21 for the department, other than Child O and Child P.
22 **A.** (Nods)
23 **Q.** So we just need to be clear about each one of
24 those deaths. So far as you were concerned did
25 Mrs Peacock express any concern to you about the way in

1 which they were reported?
2 **A.** I don't believe she did, no.
3 **Q.** Well, we will look at the detail in just
4 a moment but one last matter of ground rules to deal
5 with which is your email of 26 June of 2015.
6 INQ0008157.
7 Your email starts at the bottom, we can see it is
8 dated 26 June of 2015. If we go to the next page,
9 please, we can see you have added a note to it. We have
10 had three neonatal deaths under review via specialty
11 M&M. The plan is to arrange a specialty specific SI
12 panel for next Friday the 3rd -- in fact the meeting
13 took place on the 2nd -- to go through all three cases.
14 Then you say this:
15 "Child death is no longer included as a Serious
16 Incident by definition in the SI framework or on STEIS,
17 however it may be reported as a Serious Incident under
18 another category eg, medication error"?
19 **A.** Yes.
20 **Q.** So just help us to understand, please, why you
21 added that information to the bottom of your email and
22 what you were seeking to communicate?
23 **A.** Because as I have tried to explain that we are
24 trying to understand the incident type that has
25 contributed to the death so my understanding at that

1 time was there had been changes in the STEIS
2 categorisations and I believe it was also through
3 conversation through the Quality and Safety Regional
4 Forum.
5 So again I have used the medication error. So it's
6 not saying we will not report a child death if it has
7 been directly attributable to the incident, it's saying
8 that I wouldn't report it under a category saying "child
9 death", I would report it under a category saying
10 "medication error" because that's the incident type that
11 has occurred. The outcome is death, so in STEIS I would
12 be reporting under the categories "category: medication
13 error. Outcome: death".
14 And it would be it's the same incident, it's just
15 how it's categorised and this is important because it's
16 how the themes are drawn at national level as well as
17 local level.
18 **Q.** If we go back up, we can see the recipients of
19 this email are those who attended the Serious Incident
20 Panel. They are all operating away from a clinical
21 role.
22 Was the information that you have put there
23 communicated to the coalface, to the individual wards,
24 so that they understood what was required as well?
25 **A.** Well, STEIS reporting is only something that

1 myself and the Executive teams would do, it wouldn't
2 impact the -- the grass roots staff.
3 **Q.** But your reporting is based upon what you are
4 told?
5 **A.** Yes.
6 **Q.** So presumably it's important for people
7 further downstream or rather upstream I think it will
8 be?
9 **A.** (Nods)
10 **Q.** To know what you find useful so again was this
11 information communicated to the ward level?
12 **A.** So again the neonatal pick list you have heard
13 Mrs Lawrence explain that she was looking to try and
14 broaden the pick list because of this -- this more
15 narrowed focus and to ensure that the information that
16 we were teasing out from it was more helpful, so that
17 was work that was under way.
18 Obviously this is 2015, so that it would have been,
19 you know, literally just happening at that point in
20 time, these changes. There was a lot of changes in --
21 in, you know, very quickly things were being, you know,
22 new frameworks coming in the way that the regional
23 centre wanted or the regional quality and safety forums
24 wanted things reporting, so things were shifting and
25 that would have been at the beginning of some of that.

1 **Q.** So this is June of 2015?
2 **A.** That's correct, yes.
3 **Q.** Mrs Lawrence doesn't come into post until
4 May 2016?
5 **A.** Yes.
6 **Q.** So --
7 **A.** That is why I am saying this would be at the
8 start of that process in understanding how we need to
9 start shifting the way we are incident reporting. Very
10 much an evolving picture over this time.
11 **Q.** We are going to have a look at the Serious
12 Incident Report process in action. We will start with
13 a handwritten note INQ0003530, please. Do you know
14 whose handwriting this is?
15 **A.** That is Mrs Kelly's.
16 **Q.** I think I will be right in saying that it's
17 only really the top quarter or third of the page which
18 is concerned with this what she's described as SUI
19 review, but I think it is called the Serious Incident
20 Panel?
21 **A.** It is.
22 **Q.** We can see your initials there and Child A
23 Child C and Child D were all considered.
24 We know that only Child D was reported -- Child D's
25 death, I should say, was reported as a Serious Incident?

1 **A.** (Nods)
2 **Q.** Certainly these notes don't appear to explain
3 why that decision was made. Is that fair, using your
4 understanding of the shorthand?
5 **A.** Yes, that is Mrs Kelly's notes.
6 **Q.** Can you tell us why Child A and Child C's
7 deaths were not escalated as Serious Incidents?
8 **A.** Yes. So the Serious Incident Framework has
9 three -- essentially three criteria essentially for
10 reporting or identifying incidents as Serious Incidents.
11 So the first is around any act or omission in care that
12 has led to serious harm or death. That is the one that
13 you would hear most regularly at the time, that was
14 largely the focus that was applied at the time.
15 The second is around all never events in respect of
16 harm were reported, such as the position. Then the
17 third criteria is a broader discussion point around
18 a number of different things.
19 So at the time we were applying that first
20 criterion. So we were looking at acts or omission in
21 care that have contributed to or have led to serious
22 harm or death.
23 The information that was shared both by Ms Fogarty
24 and by Dr Brearey was that for both Child A and Child C
25 there was sufficient -- certainly they -- they found

1 that it was likely that their clinical condition was
2 more attributable to the death, if you like, so the
3 death there was a clinical -- it was progression of the
4 clinical illness that the children had rather than an
5 incident.
6 There were as part of the review aspects of
7 sub optimal care and I do recall Dr Brearey being very
8 open, actually he was very balanced in his presentation
9 in talking through some of the gaps that he had
10 identified in the care for both -- well, for all the
11 children.
12 But they weren't found to be significant enough to
13 have contributed to that level of harm and as such did
14 not meet that particular criteria of the Serious
15 Incident Framework and therefore were not reported as
16 Serious Incidents.
17 **Q.** You have mentioned the third broader
18 category --
19 **A.** Yes.
20 **Q.** -- could either of those children's deaths
21 have met the broader category?
22 **A.** So within the broader category it talks
23 about -- and forgive me, I haven't got the wording to
24 hand, but it talks largely around where there is
25 sufficient concern around the potential delivery of the

1 service or failures to the delivery of the service. The
2 wording is along those lines.
3 Had we, you know, the members of the Serious
4 Incident Panel, applied that third -- that third
5 criteria in that particular aspect as a collective, the
6 three deaths could have been considered as a Serious
7 Incident but that would have been a collective review of
8 the three deaths and more of a systems process review of
9 the neonatal unit rather than an individual Serious
10 Incident Review of Child A and Child C.
11 **Q.** So we will come to the collective nature, but
12 within that broader category, could any -- either of the
13 deaths on their own for Child A or Child C have met that
14 criteria?
15 **A.** I don't believe so, no.
16 **Q.** Let's see what was recorded for Child A.
17 INQ0000016, please. So this is the Datix. We move
18 through it, please, to the SBAR, as it's referred to,
19 which if we move through to the third page, I think it
20 is, in fact one more, please. And one more.
21 There we are. Thank you.
22 So this I think you have realised from an email is
23 an SBAR, Situation Background Assessment Recommendation,
24 that you completed?
25 **A.** Yes. I -- it would be unusual for me to

1 complete an SBAR, that obviously is the primary role of
2 the Risk and Patient Safety Leads but I have seen
3 an email and I understand from Mrs Peacock's evidence
4 that she was on leave and therefore I do believe that
5 I pulled that together, yes.
6 **Q.** So what we can see is that under the
7 assessment, at present there is no explanation for
8 sudden cardiorespiratory arrest.
9 Then in the final paragraph:
10 "The initial PM findings did not give any answers,
11 however we are awaiting results from pathology slide
12 examination. However if it was due to a cardiac
13 arrythmia then this would not show on this examination."
14 So on the face of the information that you filled
15 in an entirely unexplained death even after an initial
16 postmortem?
17 **A.** (Nods)
18 **Q.** Would that not be sufficient to make this
19 a reportable Serious Incident?
20 **A.** So the decision was that we would take this
21 through the Mortality Morbidity Review which is a more
22 detailed review than the SBAR and obviously trying to
23 join that piece of work up so it's not just an
24 obstetric review, it covers mum and baby and it was at
25 that point that Dr Brearey gave the information that he

1 did and at that point the decision was made not to take
2 that forward as a Serious Incident.
3 I think -- I think with the three deaths in short
4 succession things moved quite quickly. You know,
5 obviously this -- this -- you can see the date of the
6 SBAR being completed, you can see that the plan was to
7 take it to the SI Panel, which it did, and you can see
8 that the case was for further review.
9 Unfortunately, as you know, we then went on to have
10 the further deaths and then the decision --
11 I recommended that we pull the three cases together so
12 we had a more comprehensive understanding of each of the
13 three deaths and obviously make the decision regarding,
14 you know, Serious Incident at that meeting.
15 **Q.** So we can see the record for Child A for that
16 meeting that we have seen the handwritten note for
17 starts at the bottom, Ms Kelly present, Mr Harvey not
18 marked as present?
19 **A.** I have to advise you, sir, that that listing
20 is incorrect. A number of those people were not in post
21 at that time so there has obviously been a coding error
22 within the back of Datix, so that is incorrect.
23 **Q.** Well, we have got Ms Kelly's note of who she
24 records as being present?
25 **A.** Indeed.

1 **Q.** So let's turn over the page. We can see that
2 one of the items of discussion at the meeting in
3 relation to Child A, right in the middle, that Child B,
4 as we are referring to them, Twin 2 had similar
5 difficulties.
6 So in fact it would appear that there was
7 a discussion at this meeting not only about Child A,
8 Child C and Child D but also about Child B. Do you
9 agree that that follows?
10 **A.** I don't recall. But I certainly don't recall
11 there being a conversation that spoke around unexpected
12 collapses. It's difficult from that text to say whether
13 or not the feedback was thought that you know that again
14 that was that collapse sudden and unexplained or was
15 that something that was thought to be part of the
16 complexity of the child's condition?
17 **Q.** We can see in the four lines which appear
18 shortly below:
19 "Aware A/W PM findings finalised."
20 Can you help us with what that A/W?
21 **A.** So that would be "awaiting".
22 **Q.** So does it follow then that as far as the
23 meeting was concerned, there was still no final
24 postmortem?
25 **A.** At that point, yes, and then to proceed with

1 mortality a furthermore Mortality Morbidity Review.
2 **Q.** Is that the level of investigation M&M?
3 **A.** Yes, that's correct.
4 **Q.** Just going back to where I started this
5 questioning. You have told us that it was decided to be
6 dealt with in that way. Could this have been reported
7 as a Serious Incident, this death, on its own?
8 **A.** I can only talk you through what I recall from
9 the time and from what I recall from the time is that
10 between Dr Brearey and Ms Fogarty they gave explanations
11 as to the clinical conditions that could have left or
12 most likely had led to the death. When we talk about
13 incident reporting we talk about actual harm as we know
14 it today and therefore based upon that definition, no,
15 that again would have been why we would not have
16 reported Child A as a serious incident at that time.
17 **Q.** In terms of what you say about Dr Brearey's
18 explanation, according to the SBAR you completed, there
19 was no explanation for the collapse that led to death.
20 **A.** However this -- the Serious Incident Panel had
21 further information available because the Serious
22 Incident panel was held once the child had gone through
23 obstetric secondary review and had also gone through
24 a first review by the neonatal team so there was
25 additional information available at the Serious Incident

1 Panel than I had available at the SBAR.
2 The SBARS tend to be completed within 72 hours,
3 they are a very quick review of what we know at that
4 point in time.
5 **Q.** Can you just help us with what information is
6 recorded as having been discussed at the meeting that
7 provided the necessary assurance, is there any
8 particular entry that you have in mind?
9 **A.** Could you go up, please, so I could ...
10 So I think under the assessment section, the first
11 paragraph there, where we talk about the clinical
12 condition of mum and the complexity of the case, again
13 referring to a clear management plan, monitoring in
14 place and involvement of the specialties.
15 So again it's trying to understand what has been
16 the gap in care that has contributed to the death and
17 that essentially is the some of the assurance at least.
18 **Q.** We can take that down, thank you.
19 You told us that under the category 3 of the STEIS
20 categorisation --
21 **A.** Serious Incident Framework.
22 **Q.** Thank you, Serious Incident Framework, that
23 all three deaths could have been reported?
24 **A.** That's correct.
25 **Q.** Now, we have seen from the email of 23 June

1 that you are effectively advising people on how the
2 Serious Incident Framework operates?
3 **A.** Mm-hm.
4 **Q.** And what they need to be thinking about.
5 **A.** (Nods)
6 **Q.** Whose responsibility was it at that meeting to
7 consider that third category?
8 **A.** The decision-making always ends up with the
9 Executive team, so at that particular meeting I think it
10 was Mrs Kelly who was the Executive who was present.
11 So we would have a conversation and everybody in
12 the room would contribute to the conversation and the
13 discussion point but the final decision whether or not
14 a case would go for a Serious Incident investigation
15 would sit with the Executive.
16 **Q.** Was it your role to advise on the options?
17 **A.** Yes. And I -- I accept that. At the time, as
18 I say, the way the Serious Incident Framework has been
19 applied within the organisation was narrow, the largest
20 focus was of course upon the acts or omission criteria.
21 The third section, as I say, which talks around
22 systems failures, that wasn't really something that was
23 considered at that time.
24 **Q.** Well, were you the person at that meeting
25 expected to be most knowledgeable about that framework?

1 **A.** I think everybody at that meeting, the
2 expectation certainly -- I say everybody but Mrs Kelly,
3 you know, the Executives present should have a working
4 knowledge of the Serious Incident Framework because that
5 is what we are applying and then they are the ultimate
6 decision makers. Also in attendance would be my line
7 manager and again she would have a working knowledge and
8 obviously I would be the person who was meant to
9 operationalise it. All I can say is at the time the way
10 that the framework was applied by the organisation was
11 that the focus was always on an act or omission in care
12 that has led to serious harm or death and that was, that
13 was essentially the majority of incidents that we
14 applied.
15 I think the other side of it is, you know, Serious
16 Incidents were against individual cases, so if you were
17 to look at the list of Serious Incidents that we will
18 have reported over that 12-month period they will be
19 against individual events, individual patients. To
20 consider more a systems process was not something that
21 was really in place at that time.
22 Over time that has evolved and in fact today with
23 our new patient Safety Incident Response Framework, that
24 is very much process-driven but at the time it really
25 wasn't part of the way that that we were thinking or

1 applying the framework.
2 **Q.** Should you have been thinking in that way?
3 **A.** I think myself and everybody should have been
4 thinking that but in practice, at the time, that wasn't
5 the way -- that wasn't the approach that was being --
6 being used.
7 **Q.** Child E's death, you tell us in your
8 statement, was another opportunity to report the overall
9 increase in neonatal deaths as a Serious Incident.
10 **A.** Yes.
11 **Q.** As a matter of common sense, regardless of
12 process, wasn't that quite a serious situation that the
13 neonatal unit was facing as at August of 2015?
14 **A.** I think again when Child E died the feedback
15 that was received from the unit was again that there was
16 clinical reasons that would have contributed to the
17 death. I think as well, we didn't have the further
18 information available to us around the events of Child B
19 and also Child F and I understand from previous
20 witnesses there was also an event prior to death of
21 Child A.
22 These were not reported within the incident
23 reporting system so the fuller scope and understanding
24 of what was happening in the unit wasn't there because
25 they weren't in the Datix incident reporting system,

1 there was no one version of the truth, if you like, and
2 therefore what -- what the Serious Incident Panel were
3 looking at was deaths in which the clinical teams were
4 giving us assurances that the clinical conditions of
5 either mum or baby had more than likely contributed to.
6 And I think I do need to reinforce that it wasn't
7 like the specialties were coming and saying: all the
8 care was excellent and this -- this is just ... they
9 were very transparent about gaps in care that had
10 happened, they were very clear where there was elements
11 of sub optimal care and what they planned to do to
12 remedy that in future, and so it did feel -- certainly
13 my interpretation of it, it did feel it was a very --
14 they had undertaken a thorough multi-disciplinary review
15 of the cases.
16 **Q.** But wasn't it your role at those meetings to
17 take a step back, look at the big picture and say:
18 I think we have a problem here that we need to notify
19 NHS England about?
20 **A.** I didn't consider it in that way because --
21 **Q.** Was it your role?
22 **A.** I would say it was my role and also everybody
23 who was in attendance at the Serious Incident Panel.
24 **Q.** Had it been escalated as a Serious Incident,
25 would that have prompted a more detailed investigation?

1 **A.** It would have -- it would have looked at
2 having a review of the neonatal unit's practices so that
3 position paper that was undertaken in July 2016,
4 something along those lines would have likely been done
5 earlier and it would have likely have been done by
6 somebody external for the organisation rather than being
7 pulled together in the rushed manner that it was. So we
8 would have been given more time to have been done more
9 comprehensively.
10 **Q.** Child I died on 23 October?
11 **A.** (Nods)
12 **Q.** In the intervening period there were two
13 non-indictment baby deaths in September?
14 **A.** Mm-hm.
15 **Q.** So by the time we reached Child I, we have the
16 initial cluster of three plus Child E and two more in
17 September?
18 **A.** (Nods)
19 **Q.** And a seventh who was Child I. Was that
20 another opportunity to take a step back and report what
21 is now eight deaths in the space of four or so months,
22 five months?
23 **A.** So the -- the two deaths that occurred in
24 between I don't believe I was aware of those, they
25 weren't reported as incidents. I think it's a valid

1 position to say that at the point of Child I, we are in
2 the same situation, which is again that process could
3 have been considered reporting as a Serious Incident,
4 considering a systems failures approach, but as I say at
5 that point, at that point in time, that wasn't the
6 approach that was being taken in the organisation for
7 the Serious Incident Framework.
8 **Q.** What we do know about Child I's death is on
9 the very day of Child I's death, Eirian Powell sent
10 an email in which she indicated that she had thought
11 about going to speak straight to Alison Kelly?
12 **A.** Mm-hm.
13 **Q.** You are aware of the email that I am speaking
14 about?
15 **A.** I believe I have seen it in my bundle, so yes.
16 **Q.** And she mentions a member of your team,
17 Debbie Peacock, in that email and then that is on the
18 Friday?
19 **A.** (Nods)
20 **Q.** Then on the Monday, the 27th, Eirian Powell
21 talks about having spoken at length to Debbie Peacock.
22 One more piece of information for you to be aware of is
23 attached to the first email, 23 October, was a chart
24 with eight deaths, the seven that I have just listed to
25 you plus one that occurred in April, with Letby's name

1 marked in red against the latter seven?
2 **A.** (Nods)
3 **Q.** So that's information that was coming from the
4 neonatal unit to Ms Peacock.
5 **A.** Mmm mm.
6 **Q.** Did Ms Peacock speak to you about the fact
7 that she had received that email, had that in-depth
8 conversation and seen a chart with Letby's name in red
9 on?
10 **A.** I don't recall such a conversation, no.
11 **Q.** Just so that we are clear about what that
12 answer means, sometimes people say that because they
13 think it might have happened but they just can't exclude
14 the possibility one way or the other. It is also a way
15 of saying that definitely didn't happen because I would
16 remember it. Which are you saying?
17 **A.** I think I would have remembered having -- if
18 I had seen a chart that had said that volume of deaths.
19 **Q.** Was it something that you would have expected
20 Debbie Peacock to have told you about?
21 **A.** I would have expected Debbie to bring it to my
22 attention. Obviously there was an increased mortality
23 rate, she would have been aware of that and obviously
24 there was some -- some concerns there. So yes, I would
25 have expected her to bring that to my attention.

1 **Q.** That there was identified a common member of
2 staff with seven out of the eight deaths?
3 **A.** (Nods)
4 **Q.** And it was being treated so seriously that
5 there was talk of going over Ms Peacock's boss, you, and
6 jumping several tiers of management to go straight to
7 the Director of Nursing?
8 **A.** Yes.
9 **Q.** If you had been told that, would that have --
10 would you expect that you would have reacted to that
11 information?
12 **A.** At that time, I would have absolutely
13 questioned, you know, to understand again the usual
14 pattern of deaths that we do see in hospital in the
15 neonatal unit. I would have understood at that point
16 this was a considerably higher number of deaths and
17 understood the level of concern against that.
18 So yes, if I had seen that, I am confident I would
19 have took action and that would have been re-direct that
20 through the Serious Incident Panel. The Serious
21 Incident Panel was an opportunity to have direct
22 communications with our Executive team and because it
23 happened weekly it was generally scheduled on Monday at
24 3 o'clock, you know, you were able to raise concerns
25 quite freely there and I would have -- I am confident

1 I would have done that.
2 **Q.** Should Ms Peacock have raised what she had
3 been told with the Women and Children's Care Governance
4 Board?
5 **A.** Absolutely, I think that should have been
6 raised. You know, it's difficult to say is it Debbie's
7 responsibility? Certainly she would have been aware, it
8 would have been appropriate for her to speak about it.
9 From a responsibility perspective, if it was Ms Powell
10 who had identified it I would have expected her to
11 formally raise it there.
12 **Q.** If one looks at it this way, do you agree that
13 it was information that should have been given at that
14 stage to the Women and Children's Care Governance Board?
15 **A.** Yes, yes.
16 **Q.** And if in Ms Peacock's position, you saw that
17 neither Ms Powell nor Dr Brearey nor anybody else was
18 raising it, wouldn't there then be an obligation, given
19 her role, to raise it herself?
20 **A.** Absolutely.
21 **Q.** We will move forward to the thematic review.
22 We know that meeting took place on 8 February of 2016.
23 This was at a time very shortly before the CQC visit
24 when you have told us your priority was that.
25 Ms Peacock attended that meeting. Did you know at

1 the time that she was attending a meeting about all of
2 the deaths that had occurred recently on the neonatal
3 unit?
4 **A.** When I was preparing my statement
5 I couldn't -- I could not recall but I can see from some
6 of the correspondence that she did inform me that this
7 was -- it was taking place and I am satisfied with that
8 to know that she would have shared that with me. But
9 I don't recall, I cannot recall it. As you say, my
10 priority at that time was very much focused on the CQC
11 inspection.
12 **Q.** The Inquiry knows that the purpose of that
13 meeting was to look at all of the deaths that had
14 occurred and try and identify if there were any common
15 features?
16 **A.** Mmm mm.
17 **Q.** By then there had been a very significant
18 number, more than the position in October, even. Did
19 you have an understanding at the time of that meeting
20 that there was really something very wrong on the
21 neonatal unit?
22 **A.** No.
23 **Q.** Well, is that something that Ms Peacock should
24 have told you?
25 **A.** I think yes, but also the specialty should

1 have raised that and again through the governance
2 meetings it should have been escalated and discussed and
3 obviously I would have become aware of that route as
4 well.
5 **Q.** Well, I appreciate you may be limited in
6 answering this question as you don't have a recollection
7 beyond the emails that you have seen. But might you not
8 have expected yourself if you were told by
9 Debbie Peacock she was going to a meeting that was going
10 to try and get to the bottom of what the common factors
11 might be in all of the deaths that had taken place on
12 the neonatal unit that you would say well, hang on
13 a minute, I haven't seen anything about that at QSPEC,
14 I haven't seen anything about that from any of the
15 governance structures in place.
16 Wouldn't that be a reaction you would expect from
17 yourself?
18 **A.** I believe that my recollection at that time
19 the deaths that I was aware of were the deaths that were
20 reported within the Datix incident reporting system.
21 They were the deaths that I was aware of. I don't --
22 I can't recall being aware of any other deaths.
23 So the deaths that I was aware of because they had
24 been reported as incidents had all come through the
25 Serious Incident Panel. My understanding at the time

1 therefore was that this was a further review of those
2 deaths but with an additional lens by an external
3 Consultant to essentially see if there was any
4 additional learning available.
5 **Q.** So was it your understanding based on what you
6 had been told that such a review wouldn't need to be on
7 the radar of any of the governance committees?
8 **A.** No it should -- it should absolutely be
9 received in and should have been notified definitely
10 through the Women and Children's board that would have
11 been the most appropriate because obviously this affects
12 mum and baby.
13 **Q.** So we will come back to what the report
14 actually said, but we had the CQC visit on 16 February
15 and following and you have told us already in some
16 detail that you were overseeing the preparation for
17 that.
18 One of the aspects was a slide deck, which I think
19 you say in your statement was a presentation given to
20 the Executives?
21 **A.** That's correct.
22 **Q.** And if we can just bring up INQ0007947, and in
23 particular page 6 which you tell us in your statement is
24 a self assessment by different parts of the hospital.
25 0007947. Well, let's try page 6. I think that's

1 the slideshow at the end there. Could we crop in please
2 so we can see it more clearly. Thank you.
3 Third from the bottom, Service for Children and
4 Young People. We'll just look at what this says and
5 then we will try and understand where it came from.
6 Self rated "good" for safe, "good" for effective,
7 "outstanding" for caring, "outstanding" for responsive,
8 "good" for well led and then this:
9 "National staffing standard issues for neonatal
10 unit nursing staff are reflected locally. Trust is
11 fundraising for a new neonatal unit. Strong clinical
12 engagement with safety and quality. The Facing the
13 Future standards are a challenge to staffing which the
14 Trust is working to address. Robust processes for
15 incident review and learning."
16 So that is what's recorded there. Who is the
17 author of that self assessment or which category of
18 person would have had input into that self assessment?
19 **A.** Yes, so the head of -- the head of CQC visit
20 each of the core services, which is the areas listed
21 down the side and underwent a number of different
22 schemes at work.
23 There was a self assessment done where we had
24 a colleague who was working with me supporting the
25 specialties in completing this self assessment, so this

1 has come from the specialty themselves, this will have
2 come from Ms Powell and, as much as I understand it,
3 Dr Brearey as well. Then I have essentially lifted that
4 feedback into this slide deck.
5 **Q.** At the time that you gave this presentation to
6 the Executives, did you have any reason to think that
7 anything said there was wrong?
8 **A.** Well, it's their self assessment, it is their
9 view, their perception of the services that they deliver
10 and that was the ask of the Execs.
11 **Q.** But if you had good and strong reason to think
12 it was wrong, you would have an opportunity to say
13 something about it?
14 **A.** Yes, and we did have conversation around
15 the -- the discussions in the comment sections against
16 each of the seven key areas.
17 **Q.** So if we just look at that. At the time that
18 you made this presentation to the Executives, was there
19 any part of what the self assessment said about the
20 neonatal unit that you thought was wrong?
21 **A.** That's difficult for me to answer in the sense
22 that again it is their self assessment. My view, you
23 know, "good" is a variety, there is a wealth of
24 information that sits below each of -- each of these
25 descriptions.

1 Certainly within the "Comments" section, we were
2 aware of the staffing issues, we saw those coming
3 through the incidents and we were aware of the
4 fundraising efforts going on around the neonatal unit.
5 Their view was that there was strong engagement
6 with safety and quality and I do think that is true in
7 the sense that they were engaged because they would have
8 the conversations. The difficulty was it didn't
9 necessarily translate through to the incident reports
10 but they were having the conversations and they were --
11 my view of the teams, they were driven to give good
12 care.
13 I can't comment upon the Facing the Future
14 standards, I don't know the detail for that. And I have
15 already alluded to the process around incident review.
16 The learning, and you will have seen through the
17 CQC feedback, the learning around incident reporting,
18 staff reported that they did get feedback on incident
19 reporting and the different ways of receiving that, they
20 knew how to report incidents and they knew there was
21 a process for that.
22 So it's not incorrect for them to -- to list these
23 things. It's -- you know, obviously, you know, with
24 hindsight you would look and you would say something
25 differently.

1 **Q.** Well, at the time, wasn't that exactly
2 consistent with what Debbie Peacock was feeding back to
3 you because she wasn't telling you there was a problem
4 in any of these areas?
5 **A.** And nothing was coming through, so as I say we
6 had an additional colleague who was supporting each of
7 the services with their preparation for CQC and there
8 was nothing coming back via that route either.
9 **Q.** So does it come to this then: at the time when
10 you are presenting this to the Executives this accorded
11 with your own view of that unit?
12 **A.** I think that's reasonable to say.
13 **Q.** So when we come later to July, when we see the
14 criticisms coming through, in fact that was a change of
15 view on your part that as at January/February time, you
16 thought those things were true?
17 **A.** Yes. However, I had raised prior to -- to
18 January/February time concerns with Dr Brearey's
19 responsiveness in supporting incident investigation
20 reports through the Serious Incident Panel and I -- as
21 I say we had had conversations around the way that
22 incidents were being reported and the use of the pick
23 list.
24 **Q.** Thank you, we can take that down. Just one
25 very short topic before perhaps I could invite my Lady

1 to take a break and that is the collapse of Child K.
2 You say in your witness statement that it would
3 have been appropriate for that to have been reported as
4 an incident for further review. It is just to
5 understand it, are you there suggesting that Dr Jayaram
6 should have spoken directly to you about it or that he
7 should have filled in a Datix? What are you meaning by
8 it would have been appropriate for this to have been
9 reported as an incident?
10 **A.** So the Datix reporting system, it should be
11 completed by any staff member who has a concern around
12 the care that has happened and certainly if something
13 unexpected or unintended has -- has taken place.
14 Doctors are the same as any other member of staff,
15 there is an expectation that if they see something, they
16 have identified a problem, then they should be reporting
17 that as an incident. Obviously, at that point in time,
18 we were very much aligned with the Serious Incident --
19 well, the view was we were very much aligned with the
20 Serious Incident Framework, so that if it was a moderate
21 harm or above incident, the process was that the person
22 who identified the event should pick up the phone and
23 give us a call, so that we could support them but also
24 we could see if, you know, the patient and/or family
25 would need support as well.

1 So my view would be that if Dr Jayaram had
2 identified an area that gave him that level of cause of
3 concern then he should have completed that incident form
4 himself.
5 **MR DE LA POER:** Thank you. My Lady, I am going to
6 move to another topic, I wonder if that would be
7 a convenient moment?
8 **LADY JUSTICE THIRLWALL:** Yes, certainly. We will
9 take a break until 3.30 pm.
10 **(3.16 pm)**
11 **(A short break)**
12 **(3.29 pm)**
13 **LADY JUSTICE THIRLWALL:** Just wait a minute. I had
14 understood there was one or two missing, I didn't
15 realise quite how many. Anyway, let's get started.
16 Mr De La Poer.
17 **MR DE LA POER:** My Lady, thank you.
18 Mrs Millward, on 2 March 2016 you were emailed
19 along with other people a report by Dr Brearey entitled
20 "The Thematic Review of Neonatal Mortality".
21 **A.** Yes.
22 **Q.** In summary, that document set out an analysis
23 of each of the deaths but reached a conclusion that no
24 common cause was identified but that there was a theme
25 of sudden and unexpected deteriorations leading to death

1 and that the majority of deaths had occurred at night?
2 **A.** Yes.
3 **Q.** It also appended appendix 1, which showed the
4 nursing staff either allocated to or on duty at the time
5 of the deaths, that is the document we are talking
6 about?
7 **A.** Yes.
8 **Q.** From your point of view as Head of Risk and
9 Patient Safety, that was a concerning document, was it?
10 **A.** Yes.
11 **Q.** A document requiring action?
12 **A.** Yes, I don't recall when I first saw the
13 document but I do -- I do recall seeing it. What I took
14 from that report was that that it identified a number of
15 areas of sub optimal care which some of which had
16 already been addressed and others that were continuing
17 to be addressed.
18 **Q.** But the report did not conclude, did it, that
19 those areas of sub optimal care provided an explanation
20 for why so many babies were dying?
21 **A.** It -- from -- my interpretation of the report
22 was that it I pulled out I think four maybe five themes
23 overall which were areas of care. I can't recall more
24 than that.
25 **Q.** Well, let's have a look INQ0010037. So this

1 is the start of the report?
2 **A.** (Nods)
3 **Q.** And we will need to move down, please, to
4 page 7 to see the start of this was there was no common
5 theme identified in all the cases; so that is a red flag
6 do you agree from your point of view?
7 **A.** I -- I perceived that as there being that
8 there were a number of different factors that affected
9 each of the children and that the action plan that was
10 put in place was to tackle those different facets.
11 I didn't perceive no common theme identified in all the
12 cases as being an area of concern.
13 The -- the cases identified different aspects of
14 sub optimal care and they as far as I could see had been
15 responded to by the actions.
16 **Q.** Number 1, sudden deterioration. Some of the
17 babies suddenly and unexpectedly deteriorated and there
18 was no clear cause for the deterioration/death
19 identified at the postmortem.
20 So that is the first theme?
21 **A.** Yes.
22 **Q.** That is identified.
23 Was that not a cause of very considerable concern
24 to you?
25 **A.** I have tried to explain in my statement

1 I don't recall seeing this report in any significant
2 detail.
3 I do remember reading it and I remember going
4 specifically to the actions and -- and looking at the
5 actions. I can see reading this that yes, of course it
6 would the sudden deterioration of course that would be
7 an area of concern.
8 **Q.** You see, Mrs Peacock, who had attended the
9 meeting, was no longer available as at 2 March?
10 **A.** That's correct.
11 **Q.** You had Mrs McMahon who was effectively
12 splitting her time between responsibility that
13 Mrs Peacock had and other work that she had?
14 **A.** Yes.
15 **Q.** You were placed on copy for this report?
16 **A.** Yes.
17 **Q.** Did you not have an obligation to read it
18 carefully?
19 **A.** I must get over a hundred emails a day at that
20 time. Many will be copied into. I think there is
21 a very unhealthy culture in the NHS to copy people into
22 emails so you can say "I have told so and so" when in
23 actual fact you haven't and from what I can see of the
24 email thread if this is not a final report, this is
25 a report that says I have pulled together our learning,

1 can you all read through, can you advise if you want to
2 make any changes?
3 So there wasn't an instruction to me and certainly
4 at that time when I am still, you know, focused upon the
5 CQC, I can't -- I cannot give you any recollection that
6 says when I saw this report at the particular time.
7 I do remember seeing it, I remember focusing upon the
8 actions and seeing that the actions many had already
9 been put in place and many and some were still being,
10 being taken forward but I can't give you any further
11 recollections around this. I don't have them.
12 **Q.** My question wasn't about your recollections so
13 just focus on my question.
14 Did you have an obligation to read it carefully?
15 **A.** When you are copied into an email with no
16 specific instruction that says "Mrs Millward, can you
17 please ..." then I think it would be unfair to say that
18 I am obliged to open that email and open an attachment
19 and read it.
20 **Q.** Did you have an obligation to make sure that
21 Mrs McMahon read it carefully?
22 **A.** And in the same sense I believe that
23 Mrs McMahon was also copied into that email. The
24 communications were within the paediatric team
25 themselves for them to action it.

1 **Q.** So my question was: did you have an obligation
2 to make sure that Mrs McMahon read it carefully?
3 **A.** No, I don't believe I did have an obligation
4 to expect Mrs McMahon to open it to read it, as we were
5 both copied into an email that was for circulation to
6 the paediatricians which wasn't a final document because
7 it hadn't received all of their agreement.
8 **Q.** Well, let's have a look at the email that sent
9 it INQ0003114. So just can you help me with which part
10 of the email that you are referring to?
11 **A.** Well, the whole of the email from Dr Brearey
12 refers to as you see: I have brought together the
13 summaries of the care, thanks to ... it includes
14 basically I have been asked to be signed off at
15 governance board. That is where the report is
16 finalised.
17 So from my perspective, this isn't a finalised
18 report anyway until it's gone through the governance
19 board and has been approved. But both Mrs McMahon and
20 myself and Dr Davies has all been copied into, there is
21 no instruction there to myself or to Mrs McMahon.
22 **Q.** You are the manager of a department?
23 **A.** Yes.
24 **Q.** Do you need to be instructed to do something
25 before you do it?

1 **A.** Well, with respect with over 100 emails in
2 your inbox every day, a number of those being copied
3 into, just so that somebody can say that they have told
4 you is not -- is not an effective way of communicating.
5 If Dr Brearey felt that he needed me to do
6 something, he should have stipulated that very clearly
7 in the email. From what I can see he's already had
8 a conversation with Mr Harvey and that the report once
9 it's been finalised by the group is to go to governance
10 board.
11 **Q.** Did you have an obligation to ensure that this
12 went to the Women and Children's Care Governance Board?
13 **A.** My team were not responsible for the cycles of
14 business or agendas at the Women and Children's Care
15 Governance Board. That sat with the chair who I believe
16 was Mr McCormack.
17 **Q.** Would you -- Mr McCormack isn't on copy here.
18 Would your department have any obligation to make sure
19 that a report like this was seen at the appropriate
20 level in a timely way?
21 **A.** The appropriate that once that the report has
22 been received that it comes back to the Serious Incident
23 Panel, which I believe it did do, but as for the
24 governance board, as I say it is not our responsibility
25 to co-ordinate that meeting or the agenda. Obviously

1 once reported back from Serious Incident Panel, then
2 there would be a prompt to get this through governance
3 board at that point.
4 **Q.** Well, what we know is that once Ms Lawrence
5 saw this report, she immediately tabled it at the Women
6 and Children's Care Governance Board. That was her
7 reaction to reading it?
8 **A.** Yes.
9 **Q.** It doesn't appear that that was your reaction
10 or Ms McMahon's reaction. Should you have done that?
11 **A.** So as I say my understanding is that this
12 report came through to the Serious Incident Panel was
13 received back through the Serious Incident Panel and was
14 discussed there. You know that -- it is -- I'm sorry,
15 but it's not my responsibility or that of Mrs McMahon to
16 stipulate what is on the agenda at these governance
17 board meetings.
18 That meeting was run by the specialty and by the
19 specialties and obviously when we have line of sight of
20 something I would agree we would sit and say has it come
21 through but my understanding was that this was not -- it
22 was not a finalised paper.
23 **Q.** If we move forward in time to 17 March,
24 INQ0003089, you are copied in part way through an email
25 thread. So if we go to the bottom. Forgive me, next

1 page up.
2 We can see that Eirian Powell, not copying you in,
3 on 17 March, says that she's seeking to arrange
4 a meeting. She draws attention to the high mortality
5 and the commonality of a particular nurse and a doctor
6 was identified as a common theme however not as many as
7 the nurse and you come into it, as we can see that
8 four days later, 21 March, Alison Kelly copies you in to
9 her reply.
10 Do you see that?
11 **A.** Yes, I do.
12 **Q.** So does it follow that on 21 March, you were
13 aware of both the high mortality and the fact that
14 a particular nurse had been identified as a commonality?
15 **A.** I can't recall this email at all and I refer
16 to what I said before I have been copied into an email
17 I would have had over a hundred in a day.
18 **LADY JUSTICE THIRLWALL:** Don't worry about giving
19 the same explanation, it is understood.
20 **A.** Thank you, Ma'am.
21 **LADY JUSTICE THIRLWALL:** So you don't remember it?
22 **A.** No, I don't recall this.
23 **MR DE LA POER:** So we will move forward to
24 Annemarie Lawrence when she joined which was around May,
25 so a couple of months after that. She has told the

1 Inquiry that she read that report and that she looked
2 through the appendix carefully and she got out
3 a highlighter and she highlighted Letby's name.
4 **A.** Mmm mm.
5 **Q.** Was that an appropriate and conscientious
6 thing for her to do?
7 **A.** Absolutely.
8 **Q.** Was that her effectively doing her job well
9 within the Risk and Patient Safety Department?
10 **A.** Yes.
11 **Q.** So having done her job well, she came to see
12 you to tell you what she had found. She has described
13 you as being dismissive of her concerns?
14 **A.** (Nods)
15 **Q.** Just tell us, please, in your own words how
16 you say that conversation happened and I will just break
17 it down for you so we can be very focused. Did she have
18 the report with her?
19 **A.** I don't recall seeing Mrs Lawrence bring
20 a report to me, no.
21 **Q.** Did she tell you that she had been through the
22 thematic review report?
23 **A.** This -- the questions you are asking, sir, it
24 is difficult because Mrs Lawrence has a different
25 recollection or I have a different recollection from

1 Mrs Lawrence and I think Mrs Lawrence refers to two
2 separate occasions whereas I can only recall the one.
3 That occasion, Mrs Lawrence had been over to the
4 neonatal unit, there had been some discussion that she
5 had, you know, observed and then she came back to speak
6 to me. She shared with me that there were staff on the
7 unit talking about a particular nurse and how this nurse
8 had been present at all or some of these deaths, I can't
9 remember the exact wording.
10 We went on to have a conversation. My
11 interpretation of the conversation we had was that this
12 was a suggestion of a clinical competence or clinical
13 practice issue and I am sure you will ask: did I caution
14 her? I cautioned her with regards to repeating that.
15 A clinical competence or clinical practice issue is a HR
16 matter, it is confidential. It would not be for me or
17 any of my team to go around repeating that.
18 What I also understood from Mrs Lawrence's
19 conversation was that the concerns had already been
20 escalated up through and there had been some
21 conversations with Mrs Kelly already about this. That's
22 my recollection.
23 **Q.** So you understood that a member of staff was
24 being discussed as being a common feature of deaths
25 which had occurred?

1 **A.** That's correct.
2 **Q.** Was that not a matter that you should have
3 made it your business to find out more about?
4 **A.** It came across as being a gossipy conversation
5 and as I say, I understood that it had already been
6 escalated to the Executive team.
7 I have reflected on what actions did I take
8 following that and I have had to refer back to my
9 Facere Melius statement or transcript because I can't
10 actually recall, but in that Facere Melius transcript
11 I speak about taking this back through the Serious
12 Incident Panel and having the conversation with -- with
13 obviously the Executives who would have been there and
14 that I believe I would have done.
15 **Q.** You think that you did do that?
16 **A.** I think I did. Looking at my Facere Melius
17 statement, that would have been the action that I would
18 have took.
19 **Q.** What does that mean in practice in terms of
20 who you spoke to?
21 **A.** That would have been whichever the Executives
22 was at that the next Serious Incident Panel and it would
23 have been an informal conversation along the lines of my
24 team are hearing this, is there anything that is needed
25 from my team or is this an HR matter? And as there was

1 no further action that I was aware that I have taken
2 I can only assume that that the conversation I had ended
3 with it being, you know, it's being looked at.
4 The chair of the Serious Incident Panel tended to
5 be Mrs Kelly and it would have been an appropriate
6 conversation to have with Mrs Kelly; if it is an HR
7 matter for a nurse she would be the professional lead to
8 have that conversation with.
9 **Q.** But that isn't something that you have any
10 recollection of having done?
11 **A.** No. I can only take that from my
12 Facere Melius transcript.
13 **Q.** In terms of Ms Lawrence's recollection, she
14 told the Inquiry about going through the report,
15 highlighting it, coming to you to speak to the -- to you
16 about the product of her analysis. So not gossip but
17 analysis?
18 **A.** (Nods)
19 **Q.** Do you have any recollection of having had
20 such a conversation with Mrs Lawrence?
21 **A.** No. I have shared with you my recollection.
22 **Q.** If a member of staff had done that, would that
23 be a prompt for you to take immediate action, if they
24 say they had been through a document identified
25 a commonality and thought that action was required?

1 **A.** Yes, and again the action -- my action would
2 be the same, to take it through to the Serious Incident
3 Panel as an informal conversation again to say my staff
4 have identified this. Is there -- is there anything
5 here that you want myself and my team to act upon?
6 **Q.** So if we move forward to the Serious Incident
7 Review for Child O and Child P, just one small matter to
8 ask you about.
9 You report in your statement there was a discussion
10 about the duty of candour and that you said you were not
11 prepared to undertake initial duty of candour disclosure
12 to the parents of Child O and Child P?
13 **A.** Child O and Child P?
14 **Q.** Yes.
15 **A.** Yes, that's correct.
16 **Q.** Why did you say that?
17 **A.** Well, first and foremost the parents of
18 Child O and P had lost not just one baby but two babies,
19 obviously their third child was in another hospital,
20 a telephone call of that nature would be out of the blue
21 and given as well the timing of it that we had or the
22 Executive team had made the decision to downgrade the --
23 the unit I felt that it was not a conversation that
24 should come from me, it should come from somebody more
25 senior in the organisation and I remember feeding that

1 back through at the next Serious Incident Panel and
2 saying that I wasn't prepared to do that.
3 My recollection is that Mr Cross and Mrs Williams
4 were there and it was to them that I shared this.
5 **Q.** We are going to deal next with three meetings
6 that you had with the Executives on 29 June, 6 July and
7 13 July. This is what you say in your witness
8 statement:
9 "The Executive team did show concern around the
10 increased mortality rate on the neonatal unit. However,
11 my interpretation of the discussions was that there was
12 a belief that the increase in mortality on the neonatal
13 unit was due to persistently higher acuity, nurse
14 staffing challenges and clinical leadership rather than
15 any deliberate act to cause harm."
16 **A.** Yes.
17 **Q.** So that we are clear about it, in those
18 meetings, did the Executives say anything about what the
19 doctors suspected might be happening?
20 **A.** I don't recall for the first two. The only
21 thing I can remember about the doctors would be in the
22 third meeting, that I think is the 13 June and that was,
23 it was more in relation to the doctors stating that they
24 would not have Lucy back on the unit, rather than
25 an explicit concern being, being said.

1 **Q.** In terms of where the Executives appeared to
2 be getting their belief from, due to persistent higher
3 acuity, nurse staffing challenges and clinical
4 leadership, what was the source of that belief so far as
5 you could discern?
6 **A.** Yes. So as you will know from the position
7 paper there was a number of graphs and charts that were
8 produced by the senior data analyst. They had been
9 developed so Mrs Kelly and I believe Mr Harvey also had
10 conversations with the senior data analysts around what
11 graphs they wanted to see what data they wanted to see
12 and I believe that was, that was shared and obviously
13 had some conversations that I wasn't party to and
14 I think that was -- that was the result, that they
15 interpreted it in that way.
16 **Q.** Well, we have already looked at it and we are
17 going to look at it again in just a moment you put those
18 graphs, I think this is right to say, in that position
19 paper and commented upon them?
20 **A.** I would say the comments are what came from
21 the data analyst. I am not a data analyst, my job was
22 to pull together the different data sources and put them
23 into a paper that could be tabled for the Executives to
24 use to make a decision about next steps.
25 So the analysis or the comments are very much

1 driven -- were very much driven by the data analyst or
2 data analysts.
3 **Q.** Alongside that piece of work, and as I say we
4 will come to it, we know that Dr Gibbs and
5 Nurse Anne Martyn were commissioned to do a piece of
6 work which they say resulted in them being concerned
7 about six cases that they looked at?
8 **A.** (Nods)
9 **Q.** They were effectively looking at transfers out
10 as a proxy for non-fatal collapses?
11 **A.** Yes.
12 **Q.** We also know that Ms Williams conducted
13 a staffing analysis and we will hear from Ms Williams
14 tomorrow but we know what she said in her witness
15 statement what she saw according to her witness
16 statement made her so concerned she thought the police
17 needed to be contacted. Were either Dr Gibbs or
18 Ms Williams' conclusions discussed at any of the
19 meetings that you attended?
20 **A.** I don't recall receiving anything back from
21 Dr Gibbs and I think I have alluded in my statement to
22 say that I understand from his statement he did submit
23 them to somebody. But they didn't make their way to me
24 and I think I have referenced in the position paper that
25 there would be a need to do a further case review

1 because there was a suggestion that there may be other
2 cases that needed to be looked at but I didn't have that
3 information.
4 With regards to the staffing review Ms Williams and
5 Ms Fogarty did as I understood it, that was largely
6 discussed on 13 July in the final meeting. There was
7 a spreadsheet that we had pulled that we, myself and
8 Mr Bennett who is one of my administrators, we had
9 pulled together which brought together a number of
10 different datasets and data sources and that also
11 included the staffing.
12 So that would have been on the screen in front of
13 the Executives for that final discussion.
14 **Q.** And was Ms Williams present at that meeting?
15 **A.** Mrs Williams was present.
16 **Q.** Mrs Williams?
17 **A.** Yes.
18 **Q.** Did Mrs Williams voice what her conclusions
19 were based on her analysis at that meeting?
20 **A.** The only reference to the police that I can
21 remember at that meeting was Mr Cross -- at the end of
22 the meeting Mr Cross stating that he would have an
23 informal conversation with -- he had worked with the
24 police previously and he had said he would have an
25 informal conversation around the decision-making that

1 had been made.
2 I don't recall any other conversation that spoke
3 about discussing this with the police at that meeting.
4 **Q.** Now, in terms of the spreadsheet that you
5 talked being put up on screen, we are not going to put
6 it up on screen --
7 **A.** Of course.
8 **Q.** -- because in its current form it has not been
9 ciphered but so that everybody knows what we are talking
10 about, I know you do, it is INQ0002836,so people can
11 make a note of that so that they understand, but you
12 I know Mrs Millward do know which one we are talking
13 about?
14 **A.** I do.
15 **Q.** I think your initial recollection that of the
16 13 deaths, seven of them had an association with Letby.
17 That was going into the Inquiry process.
18 **A.** That's correct.
19 **Q.** But you have now had a chance to refresh your
20 memory from the chart that you know was shown at that
21 meeting. Is this right: in relation to those 13 deaths,
22 Letby was shown as being on duty at the time of 10 of
23 them and that --
24 **A.** Yes.
25 **Q.** There were two more, so 12 of the 13, those

1 latter two being Letby on duty at an adjoining shift?
2 **A.** I believe -- gosh, I am trying to think now.
3 I believe that it was -- I think it was nine and
4 an additional one at an adjoining shift, I am afraid
5 I can't be more --
6 **Q.** The data will speak for itself.
7 **A.** Thank you.
8 **Q.** The point is your initial recollection of
9 seven you realised was wrong?
10 **A.** Yes.
11 **Q.** But actually it was closer than that to 13?
12 **A.** Yes. But to reiterate, that information was
13 on the board and that is just my recollection since
14 events.
15 **Q.** So let's have a look at the position paper
16 that you have spoken about, INQ0001888. Now, what you
17 say in your witness statement is that your understanding
18 at this time was that the increase in the mortality rate
19 was being attributed to persistently higher acuity,
20 nurse staffing challenges and clinical leadership?
21 **A.** Yes.
22 **Q.** We have heard that phrase before.
23 In fact, let's have a look at page 1:
24 "The purpose of this paper is to provide the
25 Executive team with key mortality data and supplementary

1 narrative to enable an assessment of the patient safety
2 concerns identified by the neonatal clinicians relating
3 to an apparent increase in the number of neonatal
4 deaths."
5 So is that your text?
6 **A.** Yes.
7 **Q.** So the patient safety concerns, as the Inquiry
8 understand it, are that Letby may be deliberately
9 harming babies, that's what our understanding of the
10 neonatal clinician's concerns were.
11 Did you have a different understanding when you
12 wrote that?
13 **A.** I think my understanding when we wrote that
14 was that there was a much higher number of patient
15 deaths than would normally be seen and that there was --
16 the Consultants were stating that there was
17 a commonality with this nurse.
18 At no -- my interpretation of that as I have said
19 before was that this was potentially a clinical
20 competency issue. At no point did any of the
21 Consultants say to me: I am concerned that Lucy Letby is
22 deliberately harming these babies. That was never
23 voiced to me and I don't recall being in a room where
24 that was ever voiced.
25 **Q.** And at any time did you approach any of them

1 to better understand their concerns?
2 **A.** Well, I attended these Silver Command
3 meetings, I did spend some time in the room with
4 Dr Gibbs and Anne Martyn. My specific role, as you know
5 from my statement, was to pull together all these
6 different datasets to understand.
7 It was to -- this was to not a comprehensive review
8 in the way it would have been if we had reported as
9 a Serious Incident; it was time limited, we only had
10 a couple of weeks -- it was to be completed whilst Lucy
11 was on leave -- to understand if there was a link in
12 some way. And, you know, from my perspective, I was
13 looking at pulling all these different data sources
14 together.
15 I didn't speak more widely with Dr Brearey other
16 than asking for some of the mortality and morbidity case
17 reviews and of course making sure I had the correct
18 paper and the same with Eirian Powell. She supplied
19 some information around the staffing issues and the
20 challenges around the BAPM standards.
21 **Q.** So let's have a look, please, at page 4.
22 Forgive me, if we go over the page, please. We can see
23 the graphs here. Did you conduct any analysis of those
24 graphs?
25 **A.** No. As I say, the graphs, the datasets that's

1 included in the graphs were taken by the senior data
2 analyst having had further conversations with Mrs Kelly
3 and I believe Mr Harvey and therefore the text to
4 describe those graphs is taken from the data analyst.
5 I have literally pulled those views, pulled those
6 comments and graphs into this report so it's in one
7 place with all the different datasets that Mrs Kelly
8 asked for.
9 **Q.** So page 11, we will see what the findings are.
10 We don't need to trouble with the common cause
11 variation because that is discounted and activity is
12 said not to be alone, able to account for the increase
13 but maybe a contributory factor. The first of the
14 factors that you identify as you thought the Executives
15 thought was responsible is acuity and if we just scroll
16 down, please, forgive me, my mistake, it's -- look down.
17 We can see that the conclusion, we don't need to look at
18 the analysis:
19 "An increased and sustained acuity level may be
20 a contributory factor."
21 So at its highest, it may have contributed?
22 **A.** (Nods)
23 **Q.** So it may not have done anything at all, but
24 it may be responsible for part?
25 **A.** Yes.

1 **Q.** As far as nurse staffing levels is
2 a contributory factor, we saw the report the self
3 assessment given to the CQC and there is other evidence
4 to suggest that the staffing level had consistently been
5 below the BAPM level and was in fact was not out of step
6 with the rest of the neonatal network?
7 **A.** (Nods)
8 **Q.** Here no conclusion is in fact reached about
9 whether it did or didn't contribute. It simply points
10 out that it doesn't meet the standard.
11 **A.** Yes, because it's -- as you see, it says
12 "findings". It is not a conclusion. It was prepared so
13 that the Executives could review the data that was made
14 available and for them to reach a conclusion and
15 decision-making around next steps.
16 **Q.** So nothing in the report that you pulled
17 together that would found such a conclusion firmly; is
18 that right?
19 **A.** It was not for me -- I didn't feel it was for
20 me to make a conclusion. The request was to gather
21 together all these different datasets and provide them
22 to the Executives so that together with the spreadsheet
23 we have spoken around that they could then make
24 a decision around next steps for the neonatal unit.
25 As I said, I am not a data analyst, so I -- it

1 would be unreasonable for me to make a conclusion from
2 that. Instead what I have done is I have pulled
3 together the findings and they were based upon the
4 conversations that had taken place.
5 **Q.** The third factor was clinical leadership.
6 **A.** (Nods)
7 **Q.** What was the basis of that because that
8 doesn't appear to be in this report?
9 **A.** No, so the clinical -- so I think really
10 around the way that they had engaged with the incident
11 reporting and that there was limited incident reporting,
12 we have alluded to the neonatal pick lists earlier,
13 I won't repeat.
14 So that was the -- that was the sense that
15 certainly I had from the conversation.
16 **Q.** The neonatal pick list is unlikely, isn't it,
17 in fact impossible for that to be the cause of
18 an increase in --
19 **A.** No. Yes.
20 **Q.** In mortality?
21 **A.** But reporting rates and reporting a breadth of
22 incidents seen past the actual harm events and trying to
23 identify incidents that caused no harm but are important
24 for learning because they identify for you where the
25 care has potential for causing harm and they give you

1 the opportunity to learn before a patient has been
2 harmed; that's really important.
3 So it's the scope of the incident reporting and the
4 responsiveness. I have already alluded to Dr Brearey
5 having somewhat not been very responsive with other
6 cases so that was my perception from the conversation
7 that took place.
8 **Q.** But I am not seeking to dispute what you say
9 about it being important, it undoubtedly is, that in
10 itself is not going to be an explanation for the
11 increase in mortality, is it?
12 **A.** No, but it is an example around clinical
13 leadership and how -- how the clinical leadership team
14 value quality and safety and are working together as
15 a multi-disciplinary team.
16 **Q.** Turn briefly to look at the decision for Letby
17 to join your department?
18 **A.** Yes.
19 **Q.** We can probably cut through this.
20 You have said in retrospect it would have been more
21 appropriate to deploy Letby to another service?
22 **A.** Yes.
23 **Q.** In fact, does one need retrospect, was it not
24 obviously a bad decision even at the time?
25 **A.** In the moment, in that room where there are

1 multiple Executives, clearly not -- having conversation
2 and stating -- I am absolutely confident that
3 Mrs Hodkinson said something along the lines of "there's
4 not enough", meaning not enough evidence "there is not
5 enough to exclude her, suspend her".
6 At that moment in that room, where I can see the
7 Executive team wanting an answer to -- and wanting --
8 for me wanting to support them, bearing in mind that
9 Mr Harvey had already voiced that he had invited the
10 Royal College in, this was going to be a very quick
11 turnaround for an Invited Review, you know, as such she
12 had -- Lucy was brought into the Complaints Team, not
13 into the Risk and Patient Safety Leads and I think, you
14 know, the team was far bigger than just the Risk and
15 Patient Safety Team. She was in a different room, she
16 was in a smaller room with my administrative staff and
17 it was always, always expected to be a temporary thing
18 for around eight weeks.
19 That was my understanding from the conversation.
20 You know, I believe I asked because I felt I wanted to
21 help, if I hadn't been in the room I probably wouldn't
22 have offered, but I felt I wanted to help, I also felt
23 that, you know, given the fact that somebody was being
24 moved with -- with no real explanation I felt that she
25 did warrant to have some support in place and I thought

1 that would be helpful to have her in an area where she
2 could be observed and -- and, you know, supported in
3 that sense.
4 You know, events took over, the Royal College
5 review as you know took much longer and then we moved
6 into this grievance, which at that point it was -- well,
7 to be honest, at that point I really should have said
8 "I think we need to move her now" because there was no
9 end in sight at that point.
10 **Q.** Now, Ms Lawrence has told us that she
11 overheard conversations in the Risk Department to the
12 effect that Letby was being treated as a scapegoat and
13 she's identified you as one of the people who were
14 associated with these conversations.
15 Firstly, did you participate in such conversations?
16 **A.** I don't recall. I have obviously read
17 Mrs Lawrence's transcript, I don't recall that at all.
18 **Q.** Did you think that Letby was a scapegoat?
19 **A.** Did I think -- no, there wasn't sufficient
20 information for me to make that comment. I generally
21 thought that the unit was being run poorly, that was my
22 view.
23 I didn't think she was necessarily being made
24 a scapegoat. I was awaiting for the Invited Review to
25 say what else is happening here.

1 **Q.** In an interview -- or a discussion,
2 "interview" is the wrong word. In a discussion with
3 Cheshire Police in 2018, I believe it was?
4 **A.** 2019.
5 **Q.** 19, thank you, there is a record made by
6 a police officer that you said that you felt it was
7 unjust that Letby was being investigated as a person of
8 possible interest given the evidence presented by the
9 Consultants.
10 Was that something that you said to the police?
11 **A.** I don't believe so, no. I have asked for my
12 statement, my statement is not available. Stating that
13 something is unjust is not words that I would use.
14 **LADY JUSTICE THIRLWALL:** Can I just ask: what word
15 might you use?
16 **A.** To be honest Ma'am, I don't know, my Lady.
17 The conversation that I had with the police was -- was
18 very, very short. It was a matter of minutes. I was
19 essentially told I had nothing more to offer them.
20 I don't even remember having a conversation around my
21 view of -- of Lucy at all.
22 **MR DE LA POER:** So I am going to turn now to your
23 section of your statement headed "Reflections" and what
24 you say is -- and you can turn it up if you want, it is
25 paragraph 263.

1 **A.** Thank you.
2 **Q.** "By working around the governance arrangements
3 in place and not utilising them for the escalation of
4 their concerns, the bundle of documents provided to me
5 by the Inquiry suggests that the Consultant
6 paediatricians' opinion of Letby was not thought to be
7 valid."
8 So you associate, if I have understood this
9 correctly, the fact that the Consultants didn't use the
10 governance process as being a reason why they were
11 effectively not taken sufficiently seriously?
12 **A.** Absolutely. So if -- so the governance
13 assurance and reporting arrangements I have spoken about
14 previously, however I would have expected if you were
15 that concerned about a -- a staff member, you -- yes,
16 escalate it to the Executive if you feel that that's
17 significant enough. However, it also needs to go
18 through what we call line of sight reporting.
19 There should be something that comes from the
20 specialty up through the division and the division
21 therefore report on it as QSPEC or Corporate Directors
22 Group. If you are that concerned that something
23 untoward is going on, on the unit, then utilise the
24 incident reporting system. So again there were these
25 sudden collapses that occurred. They were not reported.

1 So again that sits outside the governance
2 arrangements that they were given, you know, that are in
3 place for you to use to raise your concerns and to allow
4 to be reported.
5 The same with the Risk Register.
6 **Q.** So just help us to understand. What exactly
7 were you expecting the Consultants to do?
8 **A.** I would expect that they attend the Division
9 of Urgent Care Governance Group and formally feed into
10 there their concerns around the increased mortality rate
11 so then when Mrs Townsend or one of the divisional
12 management team went up to QSPEC she could raise those
13 issues on their behalf so that there was line of sight
14 reporting from the specialty through division up to the
15 Executive level and their voice -- as I have referred to
16 earlier that their voice was therefore heard. They
17 didn't do that. Because they bypassed all of that
18 system and went directly to have informal conversations
19 with the Executive team through email, there's no --
20 there's no traceability, there is no transparency, there
21 is no critical challenge that you get from having those
22 conversations in a wider group meeting and that is the
23 purpose of having the governance boards at divisional
24 level and then up to the QSPEC and Corporate Directors
25 Group.

1 **Q.** What level of responsibility, if any, your
2 department had to ensure that good governance was
3 observed bearing in mind what you know -- what you knew
4 at the time, what Ms Peacock knew?
5 **A.** Absolutely. So some of that is around
6 ensuring that our voice, the incidents are accurately
7 being reported, you are right about bringing the report
8 through in a timely manner; that is absolutely right.
9 I think that the difficulty with saying should the
10 thematic review have gone to QSPEC? Absolutely.
11 I think something along the lines, maybe an executive
12 summary of, of the thematic review could have gone to
13 QSPEC because obviously it had patient information and
14 you wouldn't send that to a committee in that way.
15 And -- and I fully accept you know, yes, I should
16 have, I should have done something around that.
17 I didn't and I can't explain why I didn't other than
18 I suspect it's because things happened very quickly,
19 I appreciate, for the Families, they won't feel that way
20 but from when the thematic review was received at the
21 Serious Incident Panel by the time it then went through
22 to the governance board we are I believe in the middle
23 of May by then and then things have moved quite quickly
24 with the sad deaths of the -- the children and then the
25 position paper and so on.

1 **MR DE LA POER:** My Lady, those are all the
2 questions that I have, Ms Millward. There is permission
3 and I see Mr Baker coming to his feet.
4 **LADY JUSTICE THIRLWALL:** Thank you, Mr De La Poer.
5 Mr Baker.
6 Questions by MR BAKER
7 **MR BAKER:** Mrs Millward.
8 **A.** Good afternoon.
9 **Q.** I ask questions on behalf of a number of the
10 Families including specifically here the Families of the
11 triplets O, P and R.
12 I just want to pick you up on something that you
13 said and I just want to be sure that I understood it
14 properly and it's what you meant?
15 **A.** Of course.
16 **Q.** You were asked a question about knowledge.
17 What you understood about the Consultants' complaints.
18 What you said was:
19 "... my interpretation of that as I have said
20 before ... this was potentially a clinical competency
21 issue. At no point did any of the Consultants say to
22 me: I am concerned that Lucy Letby is deliberately
23 harming these babies. That was never voiced to me and
24 I don't recall being in a room where that was ever
25 voiced."

1 **A.** Yes.
2 **Q.** Are you saying that at no point were you aware
3 that the Consultants were suggesting that Lucy Letby
4 deliberately harmed the children?
5 **A.** I would say that what was being -- what was
6 being said to me was that a staff member was present at
7 so many of these deaths and there was concerns about
8 that.
9 Nobody at any point said to me that that was more
10 than a concern around clinical practice.
11 **Q.** Competency?
12 **A.** Yes.
13 **Q.** So what you said there in response to
14 a question from Mr De La Poer was accurate then; is that
15 right?
16 **A.** Yes.
17 **Q.** So at no point at all was it communicated to
18 you that there were concerns by anybody that this might
19 be a criminal act?
20 **A.** The only conversation that I can recall if we
21 are talking -- you know, is I have alluded to where we
22 were in -- I was in a meeting with the Executives on the
23 13 July, when Mr Cross spoke around talking to the
24 police and with the sense of: is there anything further
25 we need to do here? Should we be considering anything

1 further?
2 That is the only conversation I can recall that
3 would have suggested anything different.
4 **Q.** Didn't that statement by Mr Cross strike you
5 as somewhat incongruous if nobody was talking about
6 a criminal act?
7 **A.** I don't really remember, sir. I -- I remember
8 being in a room full of Executives. I -- despite my job
9 title in all reality I was actually quite a junior
10 member of staff as a head of department, you know, to be
11 in a room with seven or eight Executives, you know,
12 it's -- it can be quite daunting.
13 You know, I am not -- I don't -- I don't know is
14 ...
15 **Q.** Okay, memories memory can often --
16 **A.** Yes.
17 **Q.** -- play tricks on us --
18 **A.** Yes.
19 **Q.** -- but you made a definite statement. I want
20 to be clear: is it possible that people were talking
21 about criminal acts and that is why Stephen Cross was
22 talking about calling the police and you don't remember?
23 **A.** It is possible I don't remember anybody
24 speaking to me in that way.
25 **Q.** Yes, but if Mr Cross was talking about

1 speaking with a friend of his in the police, then it
2 sounds likely, doesn't it, that criminality was being
3 discussed?
4 **A.** Well, it sounds like should we be doing
5 a different investigation to having the Royal College
6 come in and do a clinical investigation, yes.
7 **Q.** Yes, but you don't call the police for
8 competency issues, do you?
9 **A.** No, absolutely.
10 **Q.** Okay. I want to ask you some questions about
11 candour and you gave some evidence before about that.
12 Whose responsibility was it to ensure compliance with
13 the duty of candour?
14 **A.** So duty of candour is -- is difficult. There
15 are two types of duty of candour, so there is
16 professional duty of candour, which is the
17 responsibility of the clinical teams and -- and that's
18 a long-standing well-established process.
19 **Q.** But the organisation had a duty?
20 **A.** That's a statutory duty of candour. So
21 statutory duty of candour on a day-to-day basis, I would
22 oversee those conversations.
23 In this particular case, as I have spoken about,
24 I passed that responsibility back to the Executive
25 teams. I didn't feel it was appropriate, that I was an

1 appropriate level in the organisation to have that
2 conversation.
3 **Q.** For issues of competency, it would be
4 perfectly normal for you to have a duty of candour
5 exercise yourself, wouldn't it?
6 **A.** I'm not sure what you mean by that.
7 **Q.** Well, if I put it this way, you passed it on
8 to the managers -- the Executives, not the managers, the
9 Executives?
10 **A.** Yes.
11 **Q.** Because of the severity of the allegations
12 that were being made, that is why you asked more senior
13 people to deal with it?
14 **A.** I asked because there were two babies that had
15 passed, I understood that the father of the children had
16 become particularly distressed. I also understood that
17 the unit was being downgraded there may be some
18 questions about that that I did not feel I was in
19 a position to answer. Therefore I passed it back for
20 those reasons.
21 **Q.** You see, you had responsibility for ensuring
22 compliance with the duty of candour?
23 **A.** Yes.
24 **Q.** Organisational compliance. That doesn't
25 require you to have a conversation yourself with --

1 **A.** No.
2 **Q.** -- a family member but it does ensure but it
3 does require you to ensure that that duty is fulfilled,
4 doesn't it?
5 **A.** I would agree with that.
6 **Q.** What steps did you take to ensure that the
7 duty was fulfilled?
8 **A.** I honestly cannot remember. I have really
9 tried to reflect and to think about what has happened.
10 There would be or there should be some documentation
11 within the Datix incident report regarding duty of
12 candour conversations.
13 **Q.** Yes.
14 **A.** But outside of that, I'm afraid I can't
15 recall.
16 **Q.** Well, let me assist you then. If we could go
17 to INQ0001347, please. I am going to remain
18 specifically on the Datix for Child O.
19 Now, we can see reported date 29 June 2016, so it's
20 six days or so after Child O died.
21 We have location coding, risk grading, reference to
22 risk grading is actual harm/death caused by the
23 incident, can you see that?
24 **A.** Yes.
25 **Q.** If we go on, please, to page 2. So wave

1 reference here to employees involved. Lucy Letby.
2 **A.** Yes.
3 **Q.** Now, obviously there were lots of individuals
4 involved in the care provided to Child O. But only
5 Lucy Letby is being named here, isn't she?
6 **A.** Yes.
7 **Q.** And we also have a reference further down
8 under "Linked records to Child P"?
9 **A.** (Nods)
10 **Q.** And a reference there to death caused by the
11 incident.
12 Now, looking at that, it's clear, isn't it, that
13 this Datix is referring to an incident causing child or
14 potentially causing Child O's death, potentially causing
15 Child P's death and linking Lucy Letby to that as the
16 only employee referred to?
17 **A.** Yes by -- and that's the incident reporter who
18 has submitted that information.
19 **Q.** Yes. But that's -- if I put it this way,
20 isn't that reflecting concerns that Lucy Letby
21 deliberately or unintentionally was the cause of death
22 in this case?
23 **A.** You would have to ask Mrs Powell why she only
24 gave Lucy's detail at that point. As you quite rightly
25 say, there will have been other staff involved.

1 **Q.** If we go then, please, to page 7. This is
2 a duty of candour assessment. Now, these forms are
3 created for almost all of the children I represent and
4 they are all the same, the duty of candour assessment is
5 blank?
6 **A.** Okay.
7 **Q.** Why is it blank?
8 **A.** I don't know. I don't know why it's blank.
9 **Q.** So if the Trust were complying with its duty
10 of candour responsibilities, that should be filled in,
11 shouldn't it?
12 **A.** Yes.
13 **Q.** If you could go please to the final page of
14 that document. Again to confirm, your name appears
15 under "Notifications" --
16 **A.** Yes.
17 **Q.** -- as it does in many of these forms. Is it
18 part of your responsibility to ensure the duty of
19 candour is complied with?
20 **A.** Well, yes, in my role, yes. The notifications
21 list there is -- is the notifications when a incident of
22 a given level of harm goes to just a core number of
23 people so that they have -- they are aware it's been
24 received. That's what that particular section refers
25 to.

1 **Q.** You see, one of the criticisms made by
2 Mr Semple in his email that you were taken to earlier
3 was about no feedback on Datix reports?
4 **A.** Yes.
5 **Q.** Evidently nobody fed back in any of these
6 cases that duty of candour was being omitted entirely
7 from the Datix forms, nobody was filling them in. Can
8 you explain why that was --
9 **A.** The duty of candour section would be completed
10 by my team, not by the local team and the duty of
11 candour section is not feedback on incident reports,
12 feedback on incident reports is around learning from
13 events that have happened from themes, from -- in
14 a specific individual instance.
15 **Q.** But in this case, duty of candour isn't about
16 learning, it's about notifying or informing family
17 members if there is a suspicion --
18 **A.** Yes.
19 **Q.** -- that something serious may have happened?
20 **A.** Yes, that is what -- that is what I am saying,
21 you are referring to Mr Semple's email around lack of
22 feedback around incidents. But the duty of candour
23 section is that there's not feedback around incidents.
24 **Q.** Well, let me offer an additional criticism
25 then to Mr Semple. In the case of Child O at the very

1 least, by July 2016, there are very serious
2 conversations going on about potential harm being caused
3 to Child O --
4 **A.** (Nods)
5 **Q.** -- by an individual.
6 **A.** (Nods)
7 **Q.** The families should have been informed at the
8 outset about that, shouldn't they?
9 **A.** Yes, they should.
10 **Q.** Can I suggest a reason? Reputation. Because
11 if word got out to family members that there was concern
12 amongst hospital staff that a member of staff was
13 harming patients, that would have been released to the
14 world, wouldn't it, if families had been told about
15 that?
16 **A.** Absolutely, but to reassure you at no point
17 did I ever hear a conversation that spoke around
18 prioritising reputation over the families or the
19 learning or completing a Serious Incident investigation.
20 That was never said in -- I was never present at any
21 such conversations.
22 **Q.** You see, I suggest that reputation and
23 reputational harm was seen as being the primary risk to
24 the Trust out of this incident; that's correct, isn't
25 it?

1 **A.** I can't comment on that. That would be
2 a decision for the Executives.
3 **MR BAKER:** Thank you, my Lady, I have no more
4 questions.
5 **LADY JUSTICE THIRLWALL:** Thank you. Just one or
6 two -- I am so sorry, are you about to ask some
7 questions?
8 **MS WOODS:** Yes, my Lady, would you like me to wait?
9 **LADY JUSTICE THIRLWALL:** No, not at all, I will go
10 at the end.
11 Questions by MS WOODS
12 **LADY JUSTICE THIRLWALL:** There is no rush.
13 **MS WOODS:** Thank you. Ms Millward, my name is
14 Leanne Woods. I am asking questions on behalf of
15 another group of Families which includes Child A.
16 My questions are going to focus on Child A who,
17 just to help you, was murdered by Letby on 8 June 2015
18 and his Inquest was 16 months later on 10 October 2016.
19 **A.** Okay.
20 **Q.** Can I ask first about your role in providing
21 information for Inquest. So I can probably
22 short-circuit it Sarah Harper-Lea, who was the Head of
23 Legal Services at the Trust, says that the Head of Risk
24 and Patient Safety was responsible for providing copies
25 of any incident reports and Trust reviews for onward

1 disclosure to the Coroner; do you agree with that?
2 **A.** Yes.
3 **Q.** Did you have any other role in the preparation
4 for Inquests?
5 **A.** No.
6 **Q.** You attended the SI Panel meetings which
7 I believe were held on a weekly basis; is that right?
8 **A.** That's correct.
9 **Q.** Other Executives attended too?
10 **A.** Yes.
11 **Q.** While they were called SI Panel meetings, is
12 it right that it wasn't just SIs and potential SIs that
13 were discussed, it was also cases that were involved in
14 legal processes?
15 **A.** That's correct. So we triangulated the
16 information so that included both the incidents that
17 were for decision-making for serious investigation or
18 not around new complaints or complaints that were
19 complex and maybe needed some support and as you say,
20 any new legal claims or closure of legal claims as well
21 as any new Inquest notifications or feedback from
22 Inquests as well.
23 **Q.** So if there was an ongoing Coronial process,
24 issues relevant to that may be discussed at the SI Panel
25 meeting?

1 **A.** Yes.
2 **Q.** Okay. Do you recall that from the end of
3 January 2016 right through to Child A's Inquest in
4 October 2016, the Coroner was repeatedly suggesting to
5 the hospital that an SI should be done in relation to
6 Child A?
7 **A.** I didn't recall until I saw some email
8 correspondence in the bundle that was provided to me
9 this morning. So that is -- was not something I could
10 automatically recall prior to that.
11 **Q.** But you are aware of that now?
12 **A.** I have seen those emails, yes.
13 **Q.** I am just going to bring up a couple of
14 documents on that, please. Could we have INQ0102364 and
15 it is page 53, please. Thank you.
16 So you will see at the bottom of this page there is
17 an email from Sarah Harper-Lea who the Head of Legal
18 Services, to Debbie Peacock and you as well. Do you see
19 that?
20 **A.** Yes -- sorry, yes, I was reading.
21 **Q.** 8 February 2016. I think you have seen this
22 email before?
23 **A.** Yes, I saw this this morning, yes.
24 **Q.** Okay. The bit I want to ask you about is
25 Sarah Harper-Lea is saying that the Coroner has asked

1 the Trust to consider an SI due to complications in the
2 long line and catheter insertion?
3 **A.** Yes.
4 **Q.** Okay and the reply from Debbie Peacock is
5 above which says:
6 "Dear Sarah,
7 "Unfortunately I did not see your email prior to
8 the thematic review yesterday. I have discussed this
9 with Ruth this morning and she has advised that
10 a decision regarding the next steps will be taken once
11 we receive the thematic review report from Dr Brearey."
12 So you were aware the Coroner was suggesting an SI
13 agree?
14 **A.** Yes, from this, yes.
15 **Q.** You were also aware that the thematic review
16 was being done and indeed a meeting had taken place?
17 **A.** That's correct.
18 **Q.** What's being said and with discussion with you
19 was that you were going to wait for that thematic review
20 report and then decide what should be done about an SI
21 for Child A; is that right?
22 **A.** Yes, to take the thematic review back to the
23 SI Panel for a decision to be made there.
24 **Q.** Would you agree that in order to make that
25 decision or be part of that decision-making, you would

1 need to read the thematic review?
2 **A.** Yes. It was presented to the SI Panel.
3 **Q.** You would need to read the detail of it?
4 **A.** Yes, at that point, yes.
5 **Q.** So just to be fair to you, so you gave oral
6 evidence today about reading the thematic review and
7 what you were saying was that you didn't recall reading
8 it in detail you were talking about the somewhat
9 injudicious use of copying people into emails but you
10 agree that to make a decision about Child A and what to
11 do next, you were under an obligation to read the
12 thematic review?
13 **A.** Yes, and there is another document, an email
14 from Mr Harper-Lea which tells you that it went to the
15 Serious Incident Panel which is where the decision would
16 have been discussed with the Executives around whether
17 or not the case was to go to Serious Incident or not.
18 **Q.** Okay. Put that to the side one second?
19 **A.** Okay.
20 **Q.** I am asking you about you reading the thematic
21 review?
22 **A.** Yes, yes.
23 **Q.** And did you read it?
24 **A.** When it came to the Serious Incident Panel
25 I am confident that I would have participated in the

1 conversation there and therefore I would have had to
2 have read it at the time, yes.
3 **Q.** Just focusing on what it said about Child A.
4 I can bring it up if we need to but what it said about
5 Child A was that it was considered unlikely that the
6 long line insertion had contributed to his death, do you
7 recall that?
8 **A.** I -- you would have to bring it up, I'm sorry.
9 **Q.** But do you recall that well, ultimately
10 Child A's death remained unexpected and unexplained?
11 **A.** My -- I can only take you back through what
12 I can remember and what I remember is the information
13 from the specialty that was clearly saying that there
14 was clinical conditions, that the child had clinical
15 conditions that they believed had largely contributed to
16 the death.
17 I don't remember the detail of the thematic review,
18 I'm sorry.
19 **LADY JUSTICE THIRLWALL:** Do you want to bring it
20 up?
21 **MS WOODS:** Yes, I believe it's -- bear with me --
22 INQ0010037, I think. I hope. Yes, and I think Child A
23 is on page 3, I believe.
24 Okay. So if we start at the bottom of that page or
25 that box in relation to Child A it says:

1 "Agreement today that line related complication
2 very unlikely to have caused arrest."
3 Do you see that?
4 **A.** I do.
5 **Q.** Then it says:
6 "No PM evidence of line or UVC related to
7 complication."
8 Do you see that?
9 **A.** I do.
10 **Q.** Let me approach it in a different way. Were
11 you aware that the final postmortem report was received
12 by the Trust just before Christmas 2015?
13 **A.** I -- I can't recall. I am not -- I am not
14 that close to the -- you know, the pathology reports as
15 the legal team would be.
16 **Q.** Okay. Were you aware that it -- well, it was
17 taken to the SI Panel meeting that the conclusion of
18 that postmortem was that Child A's death was
19 unascertained. Do you recall that?
20 **A.** I don't recall that. I believe I have seen
21 some emails and correspondence this morning, but I don't
22 actually recall that itself.
23 **Q.** Okay.
24 In any event, if I go then, please, to April 2026,
25 please, so could we bring up the document INQ0102364 and

1 it is page 89, please. Thank you.
2 So again another email from Sarah Harper-Lea, this
3 time to you, Ms Millward, you know Debbie Peacock had
4 left at this stage?
5 **A.** (Nods)
6 **Q.** It's saying -- it relates to Child A,
7 submission deadline to HM Coroner:
8 "We have today submitted the majority of the
9 witness reports required by the Coroner for this Inquest
10 and we now need to disclose the relevant investigation
11 reports and action plan."
12 Then the next paragraph:
13 "Can you have a review of this matter as soon as
14 possible? Last time we talked this one through you were
15 going to have a look at the OSR report ..."
16 Just pausing there, that is the obstetrics
17 secondary review, is it?
18 **A.** Yes.
19 **Q.** "... and NNU review and chase up the action
20 plan and consider duty of candour."
21 Is the NNU review the thematic review?
22 **A.** I can -- I would suggest it is but I don't
23 recall these events, so it's very difficult for me to
24 say but I would think that is the thematic review.
25 **Q.** What else could it be?

1 **A.** Well, it could be the Mortality Morbidity
2 Review for the individual patients.
3 **Q.** Given that the email we previously looked at
4 in February 2016 talks about next steps being dependent
5 on the thematic review --
6 **A.** Yes.
7 **Q.** -- it's likely that it is the thematic review,
8 isn't it?
9 **A.** It is, it is just the fact that it's referring
10 to the OSR report which is an obstetric -- essentially
11 an obstetric mortality review essentially in this case.
12 So that's what's confusing here, but it's very
13 difficult, I don't have any recollection.
14 **Q.** Okay. We are two and a half months on from
15 that email in February 2016. What had you done in
16 relation to reports and reviews for Child A?
17 **A.** My understanding here is that the case, the
18 thematic review had already gone back, gone to Serious
19 Incident Panel. There is an -- I saw in my bundle,
20 I was sent this morning an additional email that showed
21 that Mrs Harper-Lea had tabled it for discussion at the
22 Serious Incident Panel.
23 Bearing in mind that no Serious Incident Report was
24 submitted on STEIS I can only conclude that the
25 conversation that took place at the Serious Incident

1 Panel was that there was not going to be a further
2 Serious Incident investigation into Child I.
3 **Q.** Okay. Just look at this email if we could.
4 So what Ms Harper-Lea is saying and she's the one who
5 prepares the legal reports for the SI panels, isn't she?
6 **A.** She does.
7 **Q.** We now need to disclose the relevant
8 investigation reports and action plan so that's --
9 that's your job to try to assist with?
10 **A.** If it is a Serious Incident, yes. But this
11 case did not go to a Serious Incident investigation.
12 **Q.** It's saying can you have a review of this
13 matter? Last time we talked this one through you were
14 going to have a look at the OSR report, the NNU review
15 and chase up the action plan.
16 So what had you done?
17 **A.** So as I have just said my understanding from
18 the papers I have seen this morning is that the thematic
19 review went to the Serious Incident Panel, that at that
20 point because there was no Serious Incident report then
21 completed on STEIS the decision there would have been
22 made not to progress as a Serious Incident.
23 Therefore it wouldn't be for me to progress any
24 further investigation. So I can't answer in regards to
25 the points that Sarah's written because I don't have

1 that information available to me.
2 **Q.** Should I take from that that you don't think
3 you had done anything?
4 **A.** You can take from that that no Serious
5 Incident investigation was -- was agreed at the panel.
6 It was not reported on STEIS, therefore statutory duty
7 of candour which is, you are correct, is my obligation
8 would not have been required and it would sit under
9 professional duty of candour which would require Sarah
10 to go back and liaise with the clinical teams.
11 **Q.** So when it says here an unconsidered duty of
12 candour, what do you understand by that?
13 **A.** So that will have been a conversation around
14 the child's care with -- with the clinical teams.
15 I would only be involved if it was a statutory duty of
16 candour and at that time duty of candour was quite
17 a mechanical process, it is not as fluid as we would see
18 today so the statutory duty of candour only came in for
19 incidents that were reported as a Serious Incident, so
20 my assumption from that is there must have been some
21 concerns raised by the family of Child A and Sarah's
22 feeling was that there should be some conversation with
23 the family ahead of the Inquest. But I am surmising,
24 I do not know.
25 **Q.** So just so I am clear, are you saying that the

1 statutory duty of candour only applied if there was an
2 SI --
3 **A.** So.
4 **Q.** -- incident?
5 **A.** Yes, so if you look at -- so statutory duty of
6 candour applies when it is a notifiable safety incident,
7 so that applies whether it is moderate harm or above and
8 so they would be cases where we would review them as
9 a Serious Incident. Lower level harms would be classed
10 as a professional duty of candour, a normal in
11 a situation where something has happened and a clinician
12 would speak with the patient or the family about their
13 care.
14 So at that time, unless a case was being taken
15 through a patient's safety incident review, so
16 predominantly as an SI, the statutory duty of candour
17 the bit that I am responsible for or was responsible for
18 I would not be involved in that duty of candour
19 conversation.
20 **Q.** Would you agree that the way this email is
21 written from Ms Harper-Lea suggests that a decision had
22 not been taken at this point that an SI would not be
23 done, that it was still a decision that was pending?
24 **A.** I -- I don't actually know what her email is
25 saying because if a decision had been made that we were

1 going ahead with an SI it would have been reported on
2 STEIS and it would have been done after the Serious
3 Incident Panel.
4 This -- and there would have been a decision made
5 at that point. This -- I don't know. I don't know.
6 **Q.** Okay. So if a decision for an SI is taken,
7 a positive decision --
8 **A.** Yes.
9 **Q.** -- that can lead to a certain steps?
10 **A.** Yes.
11 **Q.** If a decision that an SI is not going to be
12 done, well, that's also a positive decision, isn't it?
13 **A.** Yes.
14 **Q.** But there's that grey area in the middle where
15 it is still undecided as to whether an SI is going to be
16 done. Is that what's going on here?
17 **A.** That would be very unlikely because the sort
18 of responsibility of the Serious Incident Panel is to
19 make that decision, so we wouldn't have cases just on
20 a list waiting for a decision to be made.
21 So you know the outcome of the Serious Incident
22 Panel is to make a decision one way or the other.
23 **Q.** You have read the witness statement of
24 Sarah Harper-Lea, have you?
25 **A.** Yes, I have a few pages that I have seen.

1 **Q.** So in her statement she says that after this
2 email she had to escalate the delay in decision-making
3 and action from you to Mr Cross, who arranged a meeting
4 with you to discuss it. Do you recall that meeting?
5 **A.** I don't recall that. I have seen the emails.
6 **Q.** No recollection whatsoever?
7 **A.** I just don't -- I have -- I am really sorry
8 for the Family of Child A because I -- I just don't have
9 any recollection of this at all which says to me that
10 the decision wasn't being made or wasn't made around
11 a Serious Incident because had that decision been made
12 one way or another, I would have known because as you
13 say it's a positive outcome either which way.
14 **Q.** Okay. Let's jump on, please, to events at the
15 end of June 2016 and the beginning of July. Now, you
16 have already been asked lots of questions about the
17 chronology but can I ask you about an NNU action
18 planning meeting on 30 June. It is at INQ0014125.
19 Okay. So you see at the top the nature of the
20 meeting. You will see that you attended --
21 **A.** Yes.
22 **Q.** -- Ms Millward. Okay.
23 You will see that there is a series of quite
24 generalised actions to be taken including, about halfway
25 down the page, "Confirm off-duty for LL"; do you see

1 that that?
2 **A.** Yes.
3 **Q.** Okay. If we could look -- I think it's on the
4 next page, please, yes. So again about halfway down the
5 page it's got "Child A review Inquest prep" and it's
6 allocated to you and is SC Mr Cross?
7 **A.** That would be Mr Cross.
8 **Q.** Okay. Then it says:
9 "Case for the Coroner, date to be determined soon
10 SB will be a witness. SE chasing report from SB to
11 support this case."
12 Do you recall why in the context of this action
13 planning meeting, why you were being asked to review the
14 Inquest prep for Child A?
15 **A.** I have no idea. I mean, again it's referring
16 to chasing a report. But as to what report that is, it
17 doesn't state. I don't know.
18 **Q.** Do you recall what you did to review the
19 Inquest preparation?
20 **A.** There was a meeting, wasn't there, put in,
21 Sarah had put a meeting in. I don't know if that
22 coincides with timewise.
23 **Q.** Was the Inquest preparation for Child A's
24 Inquest being discussed in the context of this meeting
25 because it was a recognised it was recognised that there

1 was a concern about Child A's death?
2 **A.** I honestly don't know. I can't, I can't
3 remember. I barely remember this meeting. I remember
4 attending a meeting in which there was conversations
5 around -- particularly around communication line being
6 set up but I don't remember much more than that.
7 **Q.** Okay. You have told us about the decision not
8 to do an SI into Child A, the decision made in
9 July 2015?
10 **A.** Yes.
11 **Q.** Things had significantly moved on by
12 June/July 2016, hadn't they?
13 **A.** Yes.
14 **Q.** So there was postmortem examination that you
15 have no explanation for Child A's death. The Coroner
16 had been asking for an SI report. There had been
17 a thematic review which didn't identify a clear
18 explanation for Child A's death.
19 Mother A had raised concerns which I think you are
20 aware of. There were further deaths including Child O
21 which we know did lead to an SI investigation?
22 **A.** (Nods)
23 **Q.** And there were very serious concerns about the
24 involvement of a nurse whether that is a question of
25 competency or something else, ie police getting

1 involved.
2 At this point in time, an SI investigation should
3 have been opened into Child A's death, do you agree?
4 **A.** I don't have -- you are providing a lot of
5 information there that I don't have in front of me to
6 apply the Serious Incident Framework to -- to say that.
7 Certainly at that time, you know, the concern of
8 the organisation was to report a Serious Incident around
9 the overall increase in -- in neonatal deaths with the
10 understanding as I had at that time that each of the
11 children's cases would be reviewed individually. As we
12 know, the Royal College review didn't actually do that
13 and there was a subsequent case review done.
14 So it's difficult for me, without this extra
15 information you are providing in front of me, to apply
16 the framework.
17 **Q.** What extra information am I providing --
18 **A.** Well, you are providing me this information,
19 I don't have it to hand to be able to review it myself
20 and to determine how much of that applies to the
21 framework and in any which case it's not my decision.
22 The decision is made at the SI Panel with the Executive
23 Team with the conversation and discussion that takes
24 place.
25 **Q.** Did you ever suggest to the SI Panel: actually

1 we need to look again at Child A's death, we need to
2 have an SI investigation?
3 **A.** No. Because as I said, we had invited, there
4 was a Serious Incident Report submitted in relation to
5 the Royal College review. At that time, it was my
6 understanding certainly that each of the children
7 affected, their case would have an individual review by
8 the Royal College. As I said, we subsequently found out
9 that that wasn't the case and I understood that there
10 was another Consultant who was going to take forward and
11 review each of those cases.
12 **Q.** Could we please bring up INQ0008587. Okay, so
13 just the first page so you see what this document is.
14 So it is described as an SUI panel so that is Serious
15 Untowards Incident, but it is the same as the SI --
16 **A.** SI Panel yes.
17 **Q.** 4 August 2016. If we could turn, please, to
18 page 7. Okay. So there is quite a lot of detail here
19 in relation to Child I but can we look in the middle
20 column which has -- sorry, Child A, which has
21 a description and towards the bottom of the page it
22 says:
23 "Format of NNU investigation thought to be
24 equivalent of SUI."
25 Do you agree again the NNU investigation is likely

1 to be the thematic review?
2 **A.** There's no -- there's no dates attached next
3 to it but it would suggest that, yes.
4 **Q.** Okay. Do you know who thought this, that the
5 thematic review was equivalent of an SI?
6 **A.** I don't because we wouldn't be able to release
7 it to the Coroner because -- or to the family because
8 obviously it was involving a core number of children and
9 it was a thematic review so I don't know and as I say
10 because there is no dates next to it, I can't tell you
11 further.
12 **Q.** So I think from your answers that you agree
13 that the thematic review would not be the equivalent of
14 an SI investigation?
15 **A.** No, you could use the information from the
16 thematic review to firstly give you a steer whether or
17 not a Serious Incident could be -- should be undertaken
18 if it fits the criteria, or indeed use some of that
19 information from it and provide a slightly different
20 format of a report, but it would obviously have to be
21 individualised for the individual case.
22 **Q.** Because when you have an SI, one of the key
23 things about an SI is that the family or the patient is
24 brought into the process, is that right?
25 **A.** Yes.

1 **Q.** Families can put questions, they can meet with
2 investigators to describe their concerns --
3 **A.** Yes.
4 **Q.** -- that's right, isn't it?
5 **A.** Yes.
6 **Q.** And then typically a draft SI report is
7 provided for comment --
8 **A.** Not at that time, no.
9 **Q.** Okay.
10 **A.** That's subsequent with the new piece of
11 legislation --
12 **Q.** I see. But ultimately a family for a patient
13 will receive a copy of the final --
14 **A.** Yes.
15 **Q.** -- SI report?
16 And as you say that, that wouldn't be the case with
17 the thematic review?
18 **A.** No.
19 **Q.** And as this Inquiry knows, Mother A did not
20 receive a copy of the thematic review?
21 **A.** (Nods)
22 **Q.** There are other differences though, aren't
23 there, as well between an SI report and the thematic
24 review? So the SI report would go up internal reporting
25 processes, do you agree?

1 **A.** Yes.
2 **Q.** And also would be -- would have to be reported
3 externally?
4 **A.** That's correct, yes.
5 **Q.** So to the CCG?
6 **A.** To the CCG there was a Serious Incident group
7 that they received on a monthly basis and they would
8 receive all Serious Incident investigation reports.
9 **Q.** Do I take it from your earlier answer then
10 that you -- well, can you recall expressing the view
11 that the thematic review is not the same as an SI and it
12 shouldn't be treated in the same way?
13 **A.** Yes, it's not. You could, however, tease out
14 the specific learning and ensure that that was formatted
15 in some way. But it wouldn't give certainly the format
16 of the -- of the thematic review that I have seen
17 wouldn't give the level of detail that we would normally
18 provide in a Serious Incident investigation report.
19 **Q.** And we know that wasn't done.
20 **A.** Yes.
21 **Q.** There wasn't an -- (overspeaking) --
22 **A.** Yes.
23 **Q.** There wasn't --
24 **A.** No, it wasn't done. No.
25 **Q.** The third or the final column on this page.

1 So you can see red font, capital letters, underlined --
2 **A.** Yes.
3 **Q.** -- "Urgent and outstanding: duty of candour to
4 be considered following neonatal review."
5 Can you help us with that?
6 **A.** Well, unfortunately it's Sarah's report, so
7 I -- I don't -- I don't know because it's, as I say,
8 it's not my report. Clearly there was -- you know,
9 Mrs Harper-Lea had a concern around duty of candour,
10 it's a theme in her email correspondence.
11 This, this obviously goes through to the Serious
12 Incident Panel for discussion and she's clearly flagging
13 she's got a concern there.
14 **Q.** And I think you said earlier that you would be
15 the person who would be responsible for duty of candour
16 discussions with families?
17 **A.** Statutory duty of candour, yes.
18 **Q.** Okay. Do you recall raising this and saying:
19 Well, why is this still on -- in this paper?
20 **A.** Well, to be honest I don't, but this is the
21 Inquest monitoring process. I -- I don't recall. I'm
22 really sorry, I just don't recall at all around this.
23 **Q.** Can you help us with this then. By
24 late September 2016 both the Coroner and Child A's
25 family still thought there was going to be an SI

1 investigation, a thorough SI investigation.
2 So if we can pull up a document, please,
3 INQ0008943. So this is a file note of a call in from
4 the Coroner's office to somebody in the Legal Services
5 department:
6 "Spoke to Mag at Coroner's office. Urgently
7 requiring the SUI report for Child A. Was expecting it
8 by Friday, 23 September."
9 Can you help us with why the Coroner, at this late
10 stage, still thought there was going to be an SI
11 investigation?
12 **A.** So I would have no liaison directly with the
13 Coroner in my post at all. So I don't know the
14 conversation. The only thing of relevance I think I can
15 say is that although the Coroner may recommend a Serious
16 Incident investigation, it wouldn't have been the
17 Coroner's decision to do that; that decision process
18 sits with the hospital and with the Executive team. It
19 would have been the legal team's responsibility to feed
20 that information back to the Coroner.
21 Other than that, I can't give you any further
22 information on that file note.
23 **Q.** Well, the Inquiry will hear from the Coroner
24 in due course and there's correspondence we don't need
25 to go to which demonstrates clearly that the Coroner

1 understood he could not tell the hospital to undertake
2 an SI?
3 **A.** (Nods)
4 **Q.** But what it looks like is that for whatever
5 reason the Coroner believed that there was going to be
6 an SI. Are you saying you just can't help us with that?
7 **A.** I'm afraid I -- I wouldn't be speaking with
8 the Coroner, so I don't know the communications that
9 would have took place with, with them at all.
10 **Q.** Could we please have INQ0002042 and it is
11 page 155, please. Okay. So this is a letter from
12 solicitors acting for the family of Child A and it's
13 dated 28 September 2016, and you will see it says:
14 "I write further to disclosure of the one-page
15 summary [we will come back to that] regarding Child A's
16 death which was provided today by the Countess of
17 Chester Hospital. We were of the understanding that
18 a full investigation is taking place at the Trust
19 regarding Child A's death which would result in an
20 a report detailing the chronology, the issues involved,
21 whether any errors were made, whether such errors could
22 have caused or contributed to Child A's death and the
23 lessons learnt."
24 So that's, in effect, an SI report, isn't it?
25 **A.** Yes.

1 **Q.** "We were told in August 2016 that this
2 investigation was ongoing and we would be provided with
3 the Serious Untoward Incident Report."
4 So again, just to give you the opportunity as you
5 have told us at the outset that you were the person who
6 would be responsible for disclosing those kinds of
7 reports to the Coroner, can you help with --
8 **A.** So to be clear, I wouldn't give them directly
9 to the Coroner. They would go to Sarah and to the legal
10 team who would then act as the connection between the
11 Trust and that.
12 But obviously that's only going to be for cases
13 that have a serious incident investigation and in fact
14 we would liaise with the -- or the legal team would
15 liaise with the Coroner regularly around timeframes, so
16 we could make sure that we did have Serious Incident
17 investigations ready ahead of Inquest dates.
18 With regards to this, I -- I don't have any
19 recollection of this and what I can offer is that the
20 expectation would be that this would be fed through the
21 Serious Incident panel through the legal services
22 updates and then a further conversation happened at the
23 Serious Incident panel.
24 But, I can't give you anything further. I can't
25 add anything further to that.

1 **Q.** So based on either your memory or your review
2 of the documents, when do you say a decision, a positive
3 decision was taken not to do an SI investigation --
4 **A.** So from --
5 **Q.** -- on Child A's death?
6 **A.** So from the bundle of documents I saw this
7 morning, there was an email that Mrs Harper-Lea sent
8 through to the Serious Incident Panel and then there was
9 a feedback chain.
10 I think it was either late March or April 2016.
11 **Q.** So do you -- it's clear from this letter, well
12 and the previous file note, that both the Coroner and
13 more importantly Child A's family thought that there was
14 going to be an SI report right up to the end
15 of September 2016.
16 Do you agree that it's -- that that's entirely
17 unacceptable that they were led, that they were led to
18 believe that when you say a decision had been taken
19 months before that there would be no such investigation?
20 **A.** Yes, absolutely, and as I say, the liaison
21 between or the liaison to the Coroner and then from the
22 Coroner to the family that comes from the legal team and
23 the discussions at Serious Incident Panel.
24 **Q.** Just one final document. If I could bring up
25 please -- in fact it's in the same document but it's

1 page 777. Okay.
2 So this -- I will just give you an opportunity to
3 look at that. This is the document that Child A's
4 family were provided with in the Inquest process?
5 **A.** All right.
6 **Q.** It's dated 1 July 2015, do you see that?
7 **A.** I do.
8 **Q.** Okay. Do you agree that providing that
9 document to the family 15 months later was entirely
10 unacceptable?
11 **A.** Well, yes, but it's provided for -- to the
12 Coroner. That's obviously the summary of the cases that
13 Dr Brearey did at the time with regards to the three
14 cases that were reviewed and clearly it's a clinical
15 review in that sense.
16 **Q.** But the document, it's out of date for
17 a start, isn't it?
18 **A.** Well, it's the review that was completed at
19 the -- at the time, isn't it, from the -- I -- I --
20 **LADY JUSTICE THIRLWALL:** I wonder, Ms Woods, if
21 there might be other witnesses who could perhaps deal
22 with this more helpfully?
23 **MS WOODS:** My Lady, the problem we have is that
24 neither Mr Cross nor Ms Harper-Lea are giving evidence
25 to assist us with this.

1 **LADY JUSTICE THIRLWALL:** And are they the only
2 other two who might have been able to help?
3 **MS WOODS:** Based on I think our review.
4 **LADY JUSTICE THIRLWALL:** All right. Well, then
5 this is the witness you have got.
6 **MS WOODS:** My Lady, I appreciate the witness may
7 not be able to help, but I think it's important for the
8 Family to try to ask.
9 **LADY JUSTICE THIRLWALL:** No, I quite understand.
10 **MS WOODS:** I'm grateful.
11 **A.** It certainly is not in the style or format of
12 report that we would share with the family for an
13 incident investigation and I can -- I can say that, but
14 I am not in a -- I don't provide the information to
15 the -- to the Coroner other than with regards to the
16 Serious Incident investigations that those are the
17 reports that I provide.
18 This isn't a Serious Incident investigation so
19 I wouldn't have had -- I probably would have had
20 knowledge that this was within a bundle, but not with
21 the recognition that this was all the family would have
22 received.
23 **Q.** And just going back to the earlier documents
24 we have seen, where it's suggested that the thematic
25 review is the equivalent of an SI investigation.

1 **A.** Yes.
2 **Q.** This is obviously not the thematic review --
3 **A.** No.
4 **Q.** -- or any element of the thematic review, is
5 it?
6 **A.** No, this is -- this will have been from
7 Dr Brearey's initial review that was conducted as it
8 says in July 2015. The thematic review, as we know,
9 was February/March 2016.
10 **Q.** By -- well, by the Inquest, by October 2016,
11 so quite far on in the chronology, you -- well, do you
12 agree that you were aware that there were concerns that
13 Letby had harmed babies including Child A?
14 **A.** I don't know -- not necessarily that Lucy had
15 harmed babies. That there was a concern that she was
16 present; yes. But not, no -- she...
17 My understanding, as I have said before, is that
18 yes, I understood she was present at a number of cases,
19 but where you are talking about deliberately harming
20 babies and that, as I say, was not what was being said.
21 **Q.** Okay. I think what your evidence was earlier
22 was that at the very least you were aware there were
23 concerns about whether her competencies were --
24 **A.** Yes.
25 **Q.** -- linked with babies coming to harm, if I put

1 it like that.
2 **A.** Yes, but that's -- that's not the same as
3 deliberate harm. That's a clinical competence issue.
4 **Q.** Okay. And that would mean that something she
5 was doing, some kind of substandard care, was leading to
6 babies coming to harm, do you agree?
7 **A.** Well, that was the suggestion with the
8 staffing grid that was produced, yes.
9 **Q.** Did you give any consideration to whether that
10 information should be provided to the Coroner?
11 **A.** From the review that we did internally, you
12 mean?
13 **Q.** It doesn't really matter whether it's a review
14 or not. You were aware that there were concerns about
15 this link between Letby and babies coming to harm,
16 including Child A. Did you give any consideration to
17 making the Coroner aware of that?
18 **A.** I think I believe I understood that the
19 Coroner was being informed of the Royal College review
20 and that that was where we were -- where the Trust was
21 looking and obviously the cases were being further
22 reviewed.
23 I -- I don't believe I raised it or discussed it to
24 suggest that we should, you know, disclose that we have
25 an individual who's been moved out of the unit because

1 of these concerns.
2 **Q.** And is the reason for that because you thought
3 others were informing the Coroner of that?
4 **A.** To be honest, I don't know. I don't know
5 whether it's because it didn't come to mind or because
6 at that point my view was still that was, was that this
7 was a -- potentially a clinical competence issue for her
8 rather -- and a service issue for the unit rather than
9 anything more deliberate.
10 **Q.** And is that still not relevant to the Coroner?
11 **A.** Yes.
12 **MS WOODS:** Thank you, Ma'am.
13 Questions by LADY JUSTICE THIRLWALL
14 **LADY JUSTICE THIRLWALL:** Thank you, Ms Woods.
15 Just a few short questions from me.
16 **A.** Thank you.
17 **LADY JUSTICE THIRLWALL:** Rather than bring you back
18 another day. I think you would prefer to finish off
19 today.
20 **A.** Thank you.
21 **LADY JUSTICE THIRLWALL:** You mentioned, very early
22 on in your evidence, when there was the shift from the
23 name of the role that was taken on by
24 Annemarie Lawrence, the shift between that and what had
25 occurred before with Debbie Peacock.

1 **A.** Yes.
2 **LADY JUSTICE THIRLWALL:** And as I understand it,
3 there was a lot of guidance and a lot of focus on
4 maternity services as there have been, has been on
5 a number of occasions --
6 **A.** Yes.
7 **LADY JUSTICE THIRLWALL:** -- over the years.
8 And you were keen, as it were, to signal externally
9 that this was being taken seriously by the Countess and
10 so you re-badged that job as Risk Midwife?
11 **A.** Yes, that's correct.
12 **LADY JUSTICE THIRLWALL:** But it didn't change the
13 role?
14 **A.** There was no significant change other than
15 Mrs Lawrence would be -- was going to be asked to be
16 more involved with the response to those national
17 guidance.
18 **LADY JUSTICE THIRLWALL:** Yes, and that's on
19 maternity?
20 **A.** Yes.
21 **LADY JUSTICE THIRLWALL:** Understood, thank you.
22 Secondly, you were taken to the decision tree,
23 which again Mrs Peacock had given evidence about last
24 week, and said she kept it on her desk so that she
25 always had it to hand. But when I asked her about it

1 she said it had never been relevant in this case and at
2 that point I, for myself, hadn't seen the decision tree.
3 I have now seen it with you.
4 But it seems to me that that decision tree isn't
5 really adequate to deal with this situation, is it?
6 **A.** That's right. The Incident Decision Tree is
7 about a specific patient safety incident and a specific
8 staff member and --
9 **LADY JUSTICE THIRLWALL:** If I can just pause
10 there --
11 **A.** Sorry.
12 **LADY JUSTICE THIRLWALL:** -- because you very
13 helpfully told us that earlier. But what you really
14 need is not just a specific person; you need to know who
15 the person is and you need to know what they have done
16 before you can activate the decision tree?
17 **A.** Yes.
18 **LADY JUSTICE THIRLWALL:** So it doesn't help you,
19 does it, at all, if there were a number of concerns
20 about in this case babies dying and a lot of worry about
21 it, but you never get as far as the decision tree.
22 **A.** No.
23 **LADY JUSTICE THIRLWALL:** In fact, none of these
24 processes that you have been taken through help with
25 that, do they?

1 **A.** The Incident Decision Tree didn't help in this
2 situation.
3 **LADY JUSTICE THIRLWALL:** No, and none of the other
4 processes did either, did they?
5 **A.** No, no.
6 **LADY JUSTICE THIRLWALL:** No. All right, thank you.
7 And then moving to Mrs Lawrence. You said that you
8 had no memory of her showing you the list --
9 **A.** Yes.
10 **LADY JUSTICE THIRLWALL:** -- which she had
11 highlighted, and I just want to go back because
12 obviously that was the list that had been sent to you --
13 **A.** Yes.
14 **LADY JUSTICE THIRLWALL:** -- in the email.
15 I quite understand that you were getting a hundred
16 a day, but for a busy professional that's not
17 particularly unusual, is it? So when you saw an email
18 coming in, I have forgotten, was it from Alison Kelly or
19 from Dr Brearey?
20 **A.** So the email originally came from Dr Brearey.
21 So forgive me, my Lady --
22 **LADY JUSTICE THIRLWALL:** But that didn't come to
23 you, did it, the one from Dr Brearey?
24 **A.** I was copied into that.
25 **LADY JUSTICE THIRLWALL:** I beg your pardon.

1 **A.** With regards to Mrs Lawrence, what I was
2 trying to say --
3 **LADY JUSTICE THIRLWALL:** No, I am going to come
4 back to Mrs Lawrence. I just want to set the scene
5 before we get there. Sorry to cut across you.
6 So you were copied in on an email which was a reply
7 to someone else.
8 **A.** Yes.
9 **LADY JUSTICE THIRLWALL:** And obviously that came
10 into you. Presumably you would have clicked on it
11 because you didn't know that it was a copy only?
12 **A.** Yes.
13 **LADY JUSTICE THIRLWALL:** And what was your usual
14 system? If you saw something like that, did you just
15 ignore it or did you read it quickly and think: I will
16 come back to that.
17 **A.** I would have read it quickly to see if there
18 was anything in there that I needed to action urgently.
19 **LADY JUSTICE THIRLWALL:** Right. But you didn't --
20 you wouldn't have clicked on the attachment, would you?
21 **A.** With regards to the thematic review?
22 **LADY JUSTICE THIRLWALL:** Yes.
23 **A.** I -- I am sure that I did.
24 **LADY JUSTICE THIRLWALL:** Yes.
25 **A.** Because I remember, I remember reading and

1 I remember there was green writing on it and that's
2 the -- and I remember looking at the actions.
3 So I do believe I looked at it.
4 **LADY JUSTICE THIRLWALL:** At the time?
5 **A.** And I understood from the -- from the email
6 that there was -- they were going to have some further
7 conversation and then take it through to the governance
8 board.
9 **LADY JUSTICE THIRLWALL:** And you knew then there
10 was the table on the back of it with the people who had
11 been on?
12 **A.** I don't recall scrolling as far down. I don't
13 recall seeing that, the actual table with the staffing,
14 and as I say -- but I accept that it was there in that
15 attachment.
16 **LADY JUSTICE THIRLWALL:** Yes. So you may have seen
17 it, but you didn't look at it carefully as you recall
18 it?
19 **A.** Yes.
20 **LADY JUSTICE THIRLWALL:** Is that a fair way of
21 putting it?
22 **A.** Yes, that's a fair comment, yes.
23 **LADY JUSTICE THIRLWALL:** Right. Thank you. So
24 then a little while later Mrs Lawrence comes to you and
25 she says something to you which you regarded as gossip,

1 that she was passing on gossip. What did she actually
2 say?
3 **A.** She said something along the lines, she said
4 she had been to the unit, she had been speaking with the
5 staff and she reported back to me that the staff were
6 talking about this nurse and that this nurse had been at
7 all of these, some or all of these deaths, words along
8 those lines.
9 We had a -- there was a further conversation.
10 I don't remember the detail, but certainly it came
11 across that that the unit was gossiping. There was no
12 sense of alarm or concern. There was certainly no
13 suggestion of the thoughts of what was being said, said
14 subsequently.
15 **LADY JUSTICE THIRLWALL:** Well, why do you think
16 Mrs Lawrence was telling you about it?
17 **A.** Because she was new in post and came back to
18 see me to say: what do I do with this information?
19 **LADY JUSTICE THIRLWALL:** And your response was to
20 say it's an HR matter.
21 **A.** My response to her with regards to repeating
22 the matter was that it was an HR issue and as I had
23 said, I believe from my Facere Melius notes that I did
24 raise it through the Serious Incident Panel.
25 **LADY JUSTICE THIRLWALL:** And did it occur to you to

1 say -- to think about the issue of risk?
2 **A.** Well, I think -- I think I would have because
3 I would have took it through to the Serious Incident
4 Panel, so the issue of risk would have -- I don't
5 believe I outwardly dismissed it but by taking through
6 to the Serious Incident Panel to ask, you know, is there
7 something that needs to be considered from a Patient
8 Safety Incident Investigation because the HR
9 investigation and Patient Safety Investigation are very,
10 very different.
11 **LADY JUSTICE THIRLWALL:** Just so that you are aware
12 of this, she described it as having been very
13 embarrassing --
14 **A.** Yes.
15 **LADY JUSTICE THIRLWALL:** -- that you told her not
16 to, you know, make those sort of allegations lightly,
17 they were very serious. That is my recollection of how
18 she put it.
19 **A.** Yes, yes.
20 **LADY JUSTICE THIRLWALL:** Was that fair that she
21 thought that?
22 **A.** Well, I wouldn't want any of my staff to feel
23 embarrassed coming to me and raising a concern, they are
24 absolutely right to raise a concern and talk it through.
25 Certainly the view I had from our conversation was,

1 as I say, this is an HR matter, HR matters are
2 confidential, I wouldn't want for our team to be seen as
3 gossiping or adding to the gossip. You know, obviously
4 I'm sorry that Mrs Lawrence felt that way, but it wasn't
5 said in a way to make her feel that. It was to say, you
6 know, if it is a HR matter we need to leave it to HR but
7 clearly I do feel that I did raise it with the SI Panel.
8 **LADY JUSTICE THIRLWALL:** I think that is all of my
9 questions. Anybody want to ask anything else? No.
10 Thank you very much, Mr De La Poer. Thank you very
11 much indeed, Ms Millward, you are free to go.
12 **A.** Thank you very much.
13 **LADY JUSTICE THIRLWALL:** We will rise now until
14 10 o'clock tomorrow morning.
15 **(5.18 pm)**
16 **(The Inquiry was adjourned until 10 o'clock**
17 **on Tuesday, 5 November 2024)**
18
19
20
21
22
23
24
25

1 INDEX
2
3 MS KAREN TOWNSEND (affirmed) 1
4 Questions by MS BROWN 1
5 Questions by MR BAKER 48
6 Questions by LADY JUSTICE THIRLWALL 60
7 MS RUTH MILLWARD (affirmed) 62
8 Questions by MR DE LA POER 62
9 Questions by MR BAKER 207
10 Questions by MS WOODS 217
11 Questions by LADY JUSTICE THIRLWALL 247
12
13
14
15
16
17
18
19
20
21
22
23
24
25

LADY JUSTICE THIRLWALL: [82] 1/3 1/7 1/10 8/8 8/12 8/17 8/24 9/6 9/13 15/19 17/8 17/12 17/14 48/10 60/6 60/13 60/20 60/23 61/4 61/10 61/14 61/24 62/2 62/8 62/13 62/18 62/22 118/17 118/22 119/2 123/4 175/8 175/13 183/18 183/21 203/14 207/4 217/5 217/9 217/12 222/19 243/20 244/1 244/4 244/9 247/14 247/17 247/21 248/2 248/7 248/12 248/18 248/21 249/9 249/12 249/18 249/23 250/3 250/6 250/10 250/14 250/22 250/25 251/3 251/9 251/13 251/19 251/22 251/24 252/4 252/9 252/16 252/20 252/23 253/15 253/19 253/25 254/11 254/15 254/20 255/8 255/13
MR BAKER: [4] 48/12 60/3 207/7 217/3
MR DE LA POER: [11] 62/14 62/19 62/24 118/19 119/3 123/12 175/5 175/17 183/23 203/22 207/1
MS BROWN: [6] 1/5 1/13 9/15 15/22 17/15 48/8
MS WOODS: [8] 217/8 217/13 222/21 243/23 244/3 244/6 244/10 247/12

0

0003212 [1] 24/7
0007947 [1] 169/25

1

1 July 2015 [1] 243/6
1.55 pm [1] 119/1
10 [4] 66/14 108/7 120/9 193/22
10 o'clock [2] 255/14 255/16
10 October 2016 [1] 217/18
10 years [1] 71/10
10.00 [1] 1/2
10.30 am [1] 55/25
10.46 [1] 57/12
100 [2] 108/11 181/1
11 [2] 55/24 197/9
11 am [2] 56/2 57/13
11 July [7] 29/21 118/5 121/4 122/1 123/10 123/12 126/11
11 July 2016 [2] 28/9 121/14
11 o'clock [1] 31/14
11.22 am [1] 62/10
11.30 [1] 57/10
11.40 [1] 62/12
11ish [1] 50/22
12 [5] 10/20 10/22 62/9 66/15 193/25
12 months [1] 96/24
12-month [1] 159/18
12.23 [1] 47/14
12.57 pm [1] 118/24
13 [6] 11/21 12/14 193/16 193/21 193/25 194/11
13 July [3] 189/7 192/6 208/23
13 June [1] 189/22
14 [1] 108/1
14 February [1] 47/12
14 February 2018 [1] 47/9
14 July [3] 23/7 23/7 26/7
15 [10] 10/13 10/17 10/22 10/25 108/5 108/16 109/16 119/23 121/9 243/9
15 July [2] 85/11 143/7
1507 [2] 121/11 128/4
1508 [1] 121/11
155 [1] 240/11
16 [5] 43/3 47/8 80/15 105/17 139/14
16 February [1] 169/14
16 June [2] 20/13 30/24
16 June 2016 [1] 24/8
16 months [1] 217/18
17 March [2] 182/23 183/3
18 [1] 13/16
18 December [1] 14/22
18 December 2015 [1] 13/20
18th [1] 13/19
19 [2] 28/2 203/5
19 July 2016 [1] 118/10
1991 [1] 63/20
1997 [1] 63/17

2

2 March [4] 72/22 92/15 131/24 178/9
2 March 2016 [1] 175/18
20 [6] 20/10 62/9 108/5 108/6 117/23 119/20
2001 [2] 2/4 2/5
2004 [1] 65/6
2011 [3] 64/7 65/7 65/22
2013 [1] 65/17
2014 [1] 66/5
2015 [26] 2/10 2/13 13/1 13/2 13/10 13/20 19/17 22/13 30/21 64/2 64/9 64/10 66/7 67/22 97/24 113/24 146/5 146/8 148/18 149/1 160/13 217/17 223/12 232/9 243/6 245/8
2015/16 [2] 80/15 139/14
2015/2016 [1] 11/17
2015/early [1] 5/17
2016 [56] 2/11 5/17 11/17 20/17 22/22 24/8 28/9 31/14 50/11 52/9 52/25 53/7 66/19 75/17 75/24 75/25 78/20 82/18 82/21 82/22 84/21 100/22 118/10 120/9 120/13 121/14 121/17 128/11 129/8 132/24 134/6 141/11 141/15 142/21 149/4 162/3 166/22 175/18 212/19 216/1 217/18 219/3 219/4 219/21 225/4 225/15 230/15 232/12 234/17 238/24 240/13 241/1 242/10 242/15 245/9 245/10
2017 [3] 72/11 72/15 92/16
2018 [2] 47/9 203/3
2019 [1] 203/4
2024 [3] 1/1 1/16 255/17
2026 [1] 223/24
21 [2] 23/6 50/11
21 June [2] 50/14 52/1
21 June 2024 [1] 1/16
21 March [2] 183/8 183/12
23 [2] 23/15 25/10
23 June [2] 51/25 157/25
23 October [2] 162/10 163/23
23 September [1] 239/8
24 June [6] 27/14 27/17 49/19 52/9 55/21 63/6
24 June 2016 [3] 31/14 52/25 53/7
24th [1] 36/19
26 June [2] 146/5 146/8
263 [1] 203/25
27 July [4] 120/13 120/23 130/14 130/17
27 June [1] 43/6
27th [1] 163/20
28 [1] 18/9
28 September 2016 [1] 240/13
29 [1] 19/11
29 June [1] 189/6
29 June 2016 [1] 212/19
2nd [1] 146/13

3

3 March [1] 72/19
3 o'clock [1] 165/24
3.16 pm [1] 175/10
3.29 pm [1] 175/12
3.30 pm [1] 175/9
30 [2] 66/16 66/18
30 June [3] 44/23 45/8 230/18
30 minutes [1] 57/11
31 March [1] 72/15
32 [1] 26/11
37 [1] 79/18
3rd [1] 146/12

4

4 August 2016 [1] 234/17
4 November 2024 [1] 1/1
40 [1] 31/15
41 [1] 32/4
42 [1] 33/11
45 [1] 34/7
46 [1] 34/25
48 [1] 38/3

5

5 November 2024 [1] 255/17
5 to [1] 118/23
5.18 pm [1] 255/15
53 [1] 219/15
54 [2] 39/19 40/6
59 [1] 41/3

6

6 July [1] 189/6
62 [1] 44/21

7

7 June [1] 63/3
72 hours [1] 157/2
777 [1] 243/1

8

8 February [1] 166/22
8 February 2016 [1] 219/21
8 July [1] 46/6
8 June 2015 [1] 217/17
89 [1] 224/1
8A [1] 94/25
8D [1] 48/25

9

9.15 [1] 55/23

A

A's [16] 219/3 222/10 223/18 231/23 232/1 232/15 232/18 233/3 234/1 238/24 240/15 240/19 240/22 242/5 242/13 243/3
a, [1] 75/11
a, say [1] 75/11
aback [1] 35/10
ability [1] 104/1
able [20] 5/19 6/1 8/1 9/24 43/8 79/17 79/19 83/12 96/25 97/25 142/4 142/5 142/12 143/3 165/24 197/12 233/19 235/6 244/2 244/7
about [203] 4/2 7/14 7/20 7/22 13/11 16/21 18/4 20/2 22/15 23/4 24/2 26/13 27/15 28/24 30/3 33/7 33/8 33/24 34/11 34/21 34/25 36/1 36/3 38/11 39/4 39/12 39/14 39/21 41/5 42/3 44/3 44/13 44/23 45/7 45/11 45/12 45/18 46/5 46/6 46/22 47/17 49/6 50/14 50/21 50/22 51/8 52/10 52/14 53/23 53/24 54/3 54/7 55/8 55/9 56/1 56/2 56/8 56/16 56/22 56/25 57/3 57/19 61/6 61/25 72/7 73/1 78/3 79/25 81/18 84/6 85/1 85/8 86/3 86/6 89/6 94/19 100/2 101/11 104/25 106/4 109/17 114/9 115/4

A

about... [120] 115/5 115/12 115/14 117/1 123/20 124/10 135/13 135/17 136/3 136/3 138/6 138/25 140/10 140/22 141/8 143/12 143/19 145/3 145/18 145/23 145/25 151/23 155/7 155/8 156/12 156/13 156/17 157/11 158/4 158/25 161/9 161/19 163/8 163/11 163/14 163/21 164/6 164/11 164/20 166/8 167/1 168/13 168/14 171/13 171/19 174/6 176/6 179/12 183/18 185/7 185/21 186/3 186/11 187/14 187/16 188/8 188/10 189/17 189/18 189/21 190/24 191/7 193/3 193/10 193/13 194/16 198/8 200/9 204/13 204/15 206/7 207/16 207/17 208/7 209/5 209/21 209/22 209/25 210/10 210/11 210/23 211/18 212/9 215/3 215/15 215/16 216/2 216/8 216/14 217/6 217/20 219/24 220/20 221/6 221/8 221/10 221/20 222/3 222/4 225/4 228/12 230/16 230/17 230/24 231/4 232/1 232/7 232/23 235/23 245/19 245/23 246/14 248/23 248/25 249/7 249/20 249/20 253/6 253/16 254/1
above [10] 10/13 10/17 10/25 89/22 105/17 129/15 138/6 174/21 220/5 228/7
absent [1] 72/19
absolute [1] 45/10
absolutely [31] 26/23 66/24 68/8 68/14 81/9 89/16 91/2 96/14 97/11 100/5 104/16 106/8 124/17 125/9 132/2 135/4 138/15 165/12 166/5 166/20 169/8 184/7 201/2 204/12 206/5 206/8 206/10 210/9 216/16 242/20 254/24
accept [7] 40/1 40/4 60/2 92/8 158/17 206/15 252/14
access [3] 18/21 26/25 131/13
accompli [1] 91/11
accord [1] 31/17
accorded [1] 173/10
according [8] 52/1 98/5 107/6 120/4 120/11 122/25 156/18 191/15
account [4] 32/21 101/7 111/24 197/12
accurate [3] 93/7 103/2 208/14
accurately [1] 206/6
achieve [2] 79/21 106/20
achieved [1] 42/2
achieves [1] 105/10
acknowledge [1] 19/9
across [6] 11/24 23/19 96/23 186/4 251/5 253/11
act [9] 59/7 65/6 150/11 159/11 188/5 189/15 208/19 209/6 241/10
acted [1] 39/17
acting [2] 102/21 240/12
action [42] 14/23 24/18 24/20 37/6 38/13 38/18 38/21 39/25 40/1 40/4 40/11 40/12 40/22 42/10 42/11 44/10 46/20 57/23 59/11 60/1 69/25 108/14 115/10 149/12 165/19 176/11 177/9 179/25 186/17 187/1 187/23 187/25 188/1 188/1 224/11 224/19 226/8 226/15 230/3 230/17 231/12 251/18
actions [27] 31/7 34/17 42/14 43/6 64/3 110/24 110/24 112/15 114/24 121/14 121/25 122/10 122/16 122/20 123/9 125/18 126/12 131/1 131/2 177/15 178/4 178/5 179/8 179/8 186/7 230/24 252/2
activate [1] 249/16
actively [3] 98/8 98/10 98/12
activities [1] 98/15
activity [9] 82/12 83/4 83/18 83/20 83/22 84/1 84/2 84/10 197/11
acts [4] 58/11 150/20 158/20 209/21
actual [17] 29/12 29/22 29/25 36/10 38/18 44/7 46/12 46/14 90/18 103/20 123/7 139/24 156/13 178/23 199/22 212/22 252/13
actually [41] 4/3 4/21 7/3 7/5 20/9 20/16 24/4 28/7 33/1 37/16 38/13 38/22 40/6 46/20 59/11 61/13 87/12 87/24 94/10 94/17 95/5 95/21 110/19 115/1 122/19 125/7 128/5 129/16 129/17 135/3 139/25 151/8 169/14 186/10 194/11 209/9 223/22 228/24 233/12 233/25 253/1
acuity [7] 124/24 126/8 189/13 190/3 194/19 197/15 197/19
Acute [2] 2/9 4/22
ad [4] 34/12 50/1 50/4 51/1
ad hoc [4] 34/12 50/1 50/4 51/1
add [6] 9/21 121/14 122/1 122/7 130/7 241/25
added [8] 28/9 29/20 76/3 103/17 121/13 132/2 146/9 146/21
adding [3] 95/13 130/6 255/3
addition [2] 5/24 12/14
additional [16] 12/12 26/3 27/24 36/17 58/20 66/25 79/10 95/13 125/21 156/25 169/2 169/4 173/6 194/4 215/24 225/20
address [7] 10/21 35/24 36/6 37/8 42/15 99/11 170/14
addressed [3] 26/8 176/16 176/17
adequate [2] 107/15 249/5
adequately [2] 75/10 100/8
adjoining [2] 194/1 194/4
adjourn [1] 118/23
adjourned [1] 255/16
adjournment [1] 118/25
admin [1] 76/22
administrative [2] 67/15 201/16
administrators [1] 192/8
admit [1] 116/8
adopt [1] 29/10
adult [6] 63/24 73/4 73/11 73/20 132/14 133/8
adult-focused [1] 133/8
adults [1] 73/9
advantage [1] 145/6
adverse [4] 134/16 135/2 135/9 135/12
advice [4] 36/13 107/23 127/21 130/20
advise [3] 154/19 158/16 179/1
advised [1] 220/9
adviser [1] 107/7
advises [1] 106/19
advising [2] 61/2 158/1
advisory [1] 106/22
affect [1] 104/2
affected [2] 177/8 234/7
affecting [1] 138/2
affects [2] 77/15 169/11
affirmed [4] 1/9 62/21 256/3 256/7
afraid [4] 45/14 194/4 212/14 240/7
after [18] 5/9 5/15 14/2 16/12 22/21 22/22 25/18 52/3 55/20 57/11 60/24 110/12 119/6 153/15 183/25 212/20 229/2 230/1
after June 2016 [1] 22/22
afternoon [3] 41/19 57/16 207/8
afterwards [2] 14/3 78/8
again [56] 20/11 51/23 57/10 62/8 67/11 68/17 74/22 75/1 76/4 78/7 78/16 79/22 80/3 83/3 89/14 94/13 94/21 94/22 98/3 117/6 117/19 118/23 120/1 126/19 129/14 137/15 141/18 144/9 144/17 147/5 148/10 148/12 155/13 156/15 157/12 157/15 159/7 160/14 160/15 163/2 165/13 168/1 171/22 188/1 188/3 190/17 204/24 205/1 214/14 224/2 231/4 231/15 234/1 234/25 241/4 248/23
against [6] 59/24 159/16 159/19 164/1 165/17 171/15
age [1] 46/17
agenda [4] 26/1 71/25 181/25 182/16
agendas [1] 181/14
ago [1] 136/4
agree [26] 50/13 77/7 93/21 97/13 99/1 129/22 132/7 132/8 155/9 166/12 177/6 182/20 212/5 218/1 220/13 220/24 221/10 228/20 233/3 234/25 235/12 236/25 242/16 243/8 245/12 246/6
agreed [5] 51/10 51/12 127/23 128/18 227/5
agreement [3] 130/18 180/7 223/1
ahead [5] 77/23 96/20 227/23 229/1 241/17
alarm [1] 253/12
alert [2] 17/19 17/21
alerted [2] 14/24 35/24
aligned [2] 174/18 174/19
Alison [4] 61/11 163/11 183/8 250/18
Alison Kelly [4] 61/11 163/11 183/8 250/18
alive [1] 57/21
all [108] 3/10 3/16 5/21 5/22 5/23 8/4 8/5 9/1 9/20 11/22 11/24 12/10 13/13 18/8 22/22 23/19 24/17 24/21 34/13 38/20 44/5 47/11 48/8 50/9 50/12 51/17 52/9 52/20 53/18 57/25 58/13 59/5 61/2 68/15 74/13 76/5 77/18 77/24 78/15 79/14 81/3 81/19 83/5 85/8 88/15 93/3 93/11 93/15 93/22 98/14 101/19 102/25 104/16 106/25 107/22 110/9 110/9 112/9 129/3 129/14 144/3 145/19 146/13 147/20 149/23 150/15 151/10 157/23 159/9 161/7 167/1 167/13 168/11 168/24 177/5 177/11 179/1 180/7 180/20 183/15 185/8 196/5 196/13 197/7 197/23 198/21

A

all... [22] 202/17 203/21 205/17 207/1 208/17 209/9 214/3 214/4 217/9 230/9 237/8 238/22 239/13 240/9 243/5 244/4 244/21 249/19 250/6 253/7 253/7 255/8
allegations [2] 211/11 254/16
alleged [2] 28/16 46/15
Allitt [3] 63/20 63/22 116/7
Allitt's [1] 64/3
allocated [2] 176/4 231/6
allocates [1] 142/17
allow [1] 205/3
allowed [1] 44/1
alluded [6] 142/1 172/15 191/21 199/12 200/4 208/21
alludes [1] 143/18
alluding [1] 89/21
almost [5] 67/6 80/18 108/7 108/18 214/3
alone [1] 197/12
along [10] 4/18 4/20 152/2 162/4 175/19 186/23 201/3 206/11 253/3 253/7
alongside [5] 8/3 8/9 35/19 78/14 191/3
already [34] 3/11 28/25 32/8 39/5 56/4 56/5 58/17 74/21 75/18 82/17 87/12 87/25 88/21 88/23 89/23 94/3 96/17 124/22 125/16 125/18 126/13 169/15 172/15 176/16 179/8 181/7 185/19 185/21 186/5 190/16 200/4 201/9 225/18 230/16
also [69] 4/17 4/22 6/21 7/1 8/15 8/22 12/3 12/16 14/16 23/13 37/12 37/13 39/16 42/6 42/7 42/18 42/21 51/14 53/18 56/8 56/23 57/9 57/14 60/16 64/6 67/10 68/16 69/18 78/1 80/12 83/17 87/8 96/19 104/5 104/21 106/18 108/17 112/8 114/22 119/21 123/12 125/15 132/23 139/18 141/4 147/2 155/8 156/23 159/6 160/19 160/20 161/22 164/14 167/25 174/23 176/3 179/23 185/18 190/9 191/12 192/10 201/22 204/17 211/16 213/7 218/13 220/15 229/12 237/2
alternate [1] 122/23
although [2] 47/19 239/15
always [11] 51/2 79/23 80/23 82/12 82/15 126/2 158/8 159/11 201/17 201/17 248/25
am [87] 1/2 3/19 4/4 8/13 8/14 20/2 25/17 36/12 38/24 43/10 43/10 44/16 44/18 48/21 48/21 51/9 55/25 56/2 56/10 56/22 57/13 58/8 62/10 62/12 64/8 67/24 71/1 71/8 77/7 78/13 85/24 86/20 87/6 93/3 97/2 97/25 99/6 113/24 115/4 122/22 123/6 123/11 129/12 133/19 134/6 136/1 138/19 138/25 145/10 145/11 145/18 149/7 163/13 165/18 165/25 167/7 175/5 179/4 179/18 185/13 190/21 194/2 194/4 195/21 198/25 200/8 201/2 203/22 207/22 209/13 212/17 215/20 217/6 217/14 219/13 221/20 221/25 223/13 223/13 227/23 227/25 228/17 230/7 233/17 244/14 251/3 251/23
among [1] 112/20
amongst [1] 216/12
amount [3] 59/5 77/22 114/25
anaesthetists [1] 74/3
analysis [10] 98/17 139/11 175/22 187/16 187/17 190/25 191/13 192/19 196/23 197/18
analyst [7] 190/8 190/21 190/21 191/1 197/2 197/4 198/25
analysts [2] 190/10 191/2
Anne [2] 191/5 196/4
Anne Martyn [1] 196/4
Annemarie [3] 84/20 183/24 247/24
Annemarie Lawrence [3] 84/20 183/24 247/24
Annemarie's [1] 89/6
annual [2] 43/22 44/9
another [21] 44/12 46/18 47/21 48/6 75/18 75/20 75/21 108/17 122/4 146/18 160/8 162/20 175/6 188/19 200/21 217/15 221/13 224/2 230/12 234/10 247/18
answer [13] 42/24 110/23 112/13 124/8 129/19 130/13 145/4 164/12 171/21 201/7 211/19 226/24 237/9
answering [2] 99/23 168/6
answers [2] 153/10 235/12
anticipated [1] 82/13
any [136] 3/14 3/15 6/23 9/21 9/24 11/5 12/7 12/16 13/11 16/10 16/12 18/11 19/12 19/13 19/23 21/14 21/15 21/15 21/16 21/17 21/17 23/20 24/3 24/12 24/18 24/19 24/23 25/12 26/12 27/5 27/8 27/19 27/21 29/2 29/2 29/24 29/25 29/25 30/6 30/10 30/16 34/17 36/8 41/20 41/24 42/7 42/10 42/11 42/20 42/21 42/24 44/16 44/17 46/21 46/23 53/19 55/14 55/14 56/10 56/11 56/13 58/4 59/18 62/3 66/21 68/10 74/14 76/16 78/11 79/14 83/5 86/7 86/16 86/21 99/25 101/11 109/20 110/22 114/14 116/3 124/6 128/11 129/1 135/16 139/13 145/25 150/11 152/12 153/10 157/7 167/14 168/14 168/22 169/3 169/7 171/6 171/19 173/4 174/11 174/14 178/1 179/2 179/5 179/10 181/18 185/17 187/9 187/19 189/15 191/18 193/2 195/20 195/25 195/25 196/23 206/1 207/21 208/9 215/5 216/20 217/25 218/3 218/20 218/21 223/24 225/13 226/23 230/9 233/21 239/21 240/21 241/18 245/4 246/9 246/16 254/22
anybody [8] 11/4 52/14 137/12 138/17 166/17 208/18 209/23 255/9
anyone [7] 3/6 11/7 11/10 11/13 11/15 17/6 62/3
anything [37] 10/12 10/19 10/19 10/22 10/24 22/15 27/22 56/17 58/1 61/24 61/25 79/24 104/3 109/23 114/4 133/1 134/7 137/12 137/13 138/18 168/13 168/14 171/7 186/24 188/4 189/18 191/20 197/23 208/24 208/25 209/3 227/3 241/24 241/25 247/9 251/18 255/9
anyway [3] 80/23 175/15 180/18
apologies [1] 67/25
apologise [3] 114/13 114/18 118/21
apparent [15] 23/20 24/2 28/11 29/7 29/11 30/4 91/7 102/5 118/4 119/18 119/21 121/7 124/12 131/22 195/3
apparently [4] 33/20 124/11 129/15 134/19
appear [5] 150/2 155/6 155/17 182/9 199/8
appeared [2] 123/13 190/1
appearing [2] 19/5 121/4
appears [8] 4/21 39/24 40/10 53/4 53/6 75/1 138/6 214/14
appended [1] 176/3
appendices [1] 103/18
appendix [3] 109/19 176/3 184/2
appendix 1 [2] 109/19 176/3
applied [8] 116/19 127/5 150/14 152/4 158/19 159/10 159/14 228/1
applies [3] 228/6 228/7 233/20
apply [3] 66/2 233/6 233/15
applying [5] 110/22 112/11 150/19 159/5 160/1
appointed [1] 5/12
appreciate [6] 8/11 32/22 87/6 168/5 206/19 244/6
approach [11] 76/9 91/15 127/25 140/7 145/2 145/7 160/5 163/4 163/6 195/25 223/10
approached [1] 65/17
appropriate [21] 11/5 12/5 12/13 18/20 18/23 74/4 87/5 135/5 135/16 140/3 166/8 169/11 174/3 174/8 181/19 181/21 184/5 187/5 200/21 210/25 211/1
approval [1] 92/12
approved [3] 88/18 104/19 180/19
approving [1] 104/22
approximate [1] 5/14
approximately [3] 4/2 7/10 32/1
April [3] 163/25 223/24 242/10
are [212] 3/17 3/21 8/1 9/22 9/25 10/2 11/8 12/18 13/19 15/23 15/25 16/5 17/22 19/2 20/3 21/7 21/21 21/21 23/17 24/9 25/2 27/13 28/4 30/13 30/14 36/20 36/22 36/25 37/3 40/5 40/7 43/3 43/8 43/17 44/11 44/22 45/13 45/16 45/16 47/2 47/10 47/16 47/17 48/8 48/9 49/10 52/8 53/20 53/22 54/1 54/2 54/4 54/6 54/7 57/11 57/16 58/22 61/5 62/5 63/8 64/15 67/17 70/18 70/23 71/16 73/16 74/11 74/12 75/4 77/20 77/23 78/7 80/5 81/10 85/7 85/9 85/14 89/12 92/13 93/5 93/6 96/1 97/10 97/23 98/1 98/1 104/1 104/5 107/6 108/4 108/6 108/17 109/2 109/18 110/14 114/11 114/16 116/21 117/20 118/5 119/3 119/5 119/7 119/20 120/22 121/11 121/16 125/10 125/11 125/15 125/16 126/4 126/12 126/12 126/16 126/25 129/10 129/11 129/23 130/20 130/24 131/1 131/2 132/20 134/7 137/19

A

are... [86] 139/1 140/1 141/8 142/24 143/19 144/8 145/17 146/23 147/16 147/19 147/20 148/3 149/9 149/11 152/21 153/11 155/4 157/3 158/1 159/5 159/5 163/1 163/13 164/11 164/16 170/10 170/13 173/10 174/5 174/7 174/14 176/5 179/15 180/10 180/22 182/24 184/23 186/24 189/5 189/17 190/16 190/20 190/25 193/5 193/9 193/12 195/8 197/9 199/23 200/14 200/25 204/22 205/2 206/6 206/7 206/22 207/1 208/2 208/21 210/15 214/2 214/4 214/23 215/21 216/1 217/6 217/16 219/11 225/14 227/7 227/25 232/19 233/4 233/15 233/18 236/22 240/6 243/24 244/1 244/16 245/19 254/9 254/11 254/23 255/1 255/11
area [19] 33/12 34/14 48/6 74/5 87/6 94/2 99/2 99/11 99/18 99/25 100/1 100/2 100/3 133/16 175/2 177/12 178/7 202/1 229/14
areas [20] 9/20 24/18 24/24 25/1 70/14 73/19 73/20 78/4 81/14 83/5 84/4 91/22 98/15 134/25 170/20 171/16 173/4 176/15 176/19 176/23
aren't [2] 143/20 236/22
arena [1] 124/3
arguably [1] 59/10
arising [1] 62/4
around [96] 33/9 44/5 46/15 54/13 61/1 66/14 66/16 66/19 67/12 70/16 71/1 72/22 73/3 74/25 74/25 75/17 78/1 80/15 80/16 85/5 91/5 93/24 93/24 94/4 94/8 94/13 97/6 100/21 102/12 113/11 114/24 116/18 122/9 124/23 125/2 125/25 126/24 130/4 130/5 130/22 131/15 135/7 139/20 141/3 141/17 143/15 150/11 150/15 150/17 151/24 151/25 155/11 158/21 160/18 171/14 172/4 172/15 172/17 173/21 174/11 179/11 183/24 185/17 189/9 190/10 192/25 196/19 196/20 198/15 198/23 198/24 199/10 200/12 201/18 203/20 204/2 205/10 206/5 206/16 208/10 208/23 215/12 215/21 215/22 215/23 216/17 218/18 221/16 227/13 230/10 232/5 232/5 233/8 238/9 238/22 241/15
around June 2016 [1] 66/19
around May [1] 183/24
arrange [3] 89/10 146/11 183/3
arranged [5] 51/9 51/19 51/24 52/1 230/3
arrangement [1] 62/17
arrangements [7] 71/2 71/17 132/11 132/20 204/2 204/13 205/2
arrest [2] 153/8 223/2
Arrowe [4] 46/10 55/25 56/4 56/20
Arrowe Park [4] 46/10 55/25 56/4 56/20
arrythmia [1] 153/13
articulate [1] 100/10
articulated [4] 56/18 57/25 58/6 59/24
as [398]
ascertain [1] 12/6
aside [2] 19/15 82/14
ask [33] 8/8 12/12 15/2 17/8 17/12 20/9 22/19 36/14 39/14 48/13 62/3 71/25 74/13 107/20 118/6 123/19 124/10 134/7 134/25 171/10 185/13 188/8 203/14 207/9 210/10 213/23 217/6 217/20 219/24 230/17 244/8 254/6 255/9
asked [25] 17/9 17/9 18/4 20/4 29/20 32/23 42/23 61/18 74/9 83/22 101/20 109/19 123/19 180/14 197/8 201/20 203/11 207/16 211/12 211/14 219/25 230/16 231/13 248/15 248/25
asking [9] 16/19 17/11 19/3 112/18 184/23 196/16 217/14 221/20 232/16
aspect [4] 11/5 15/11 54/23 152/5
aspects [8] 8/4 9/1 12/10 53/24 124/18 151/6 169/18 177/13
assessing [1] 24/17
assessment [15] 152/23 153/7 157/10 169/24 170/17 170/18 170/23 170/25 171/8 171/19 171/22 195/1 198/3 214/2 214/4
assessments [1] 96/15
assist [7] 31/18 47/3 47/16 101/3 212/16 226/9 243/25
Assistant [1] 2/7
associate [2] 92/19 204/8
associated [15] 13/6 15/9 18/11 18/18 18/19 19/13 21/15 21/18 27/21 33/24 44/17 52/17 56/11 113/25 202/14
association [2] 52/15 193/16
assume [1] 187/2
assuming [1] 51/9
assumption [2] 60/18 227/20
assurance [19] 70/14 70/22 71/1 71/17 94/21 98/8 100/16 128/14 128/15 128/16 129/2 129/17 129/21 130/2 133/11 133/19 157/7 157/17 204/13
assurances [6] 70/10 70/11 72/2 91/20 125/25 161/4
assure [1] 127/17
at [458]
at August [1] 160/13
at July 2016 [1] 141/11
attached [2] 163/23 235/2
attachment [3] 179/18 251/20 252/15
attacking [3] 58/9 58/12 59/7
attend [3] 90/1 133/17 205/8
attendance [3] 123/3 159/6 161/23
attended [11] 87/14 90/15 91/14 147/19 166/25 178/8 191/19 196/2 218/6 218/9 230/20
attending [5] 6/23 68/24 122/19 167/1 232/4
attention [8] 3/6 13/10 77/16 98/16 111/9 164/22 164/25 183/4
attitude [1] 91/16
attract [1] 98/15
attributable [2] 147/7 151/2
attributed [1] 194/19
audit [3] 67/2 67/11 76/8
August [5] 3/9 47/8 160/13 234/17 241/1
August 2016 [1] 241/1
author [1] 170/17
authored [1] 84/8
automatically [1] 219/10
autumn [1] 100/21
available [13] 3/3 14/5 23/3 42/10 156/21 156/25 157/1 160/18 169/4 178/9 198/14 203/12 227/1
avenues [1] 29/15
avoidable [2] 108/21 109/4
avoided [1] 136/25
awaiting [3] 153/11 155/21 202/24
aware [87] 6/15 13/14 13/17 14/7 15/3 15/23 15/25 16/10 16/13 16/16 17/4 17/17 17/24 18/5 18/15 19/1 19/2 19/12 21/5 21/7 21/13 21/19 21/21 21/22 23/8 23/13 24/12 25/20 26/12 27/8 27/10 27/14 30/24 30/25 32/8 40/15 41/3 43/1 43/10 43/17 52/24 56/10 56/17 61/5 64/3 64/6 64/11 64/18 64/20 68/21 76/1 85/2 88/19 100/24 111/25 128/21 129/11 129/12 134/7 155/19 162/24 163/13 163/22 164/23 166/7 168/3 168/19 168/21 168/22 168/23 172/2 172/3 183/13 187/1 208/2 214/23 219/11 220/12 220/15 223/11 223/16 232/20 245/12 245/22 246/14 246/17 254/11
away [2] 58/16 147/20
awful [2] 46/4 114/12

B

babies [40] 18/12 19/18 19/19 19/23 20/3 23/11 27/16 32/12 34/9 34/23 35/25 36/3 36/3 37/9 39/4 44/13 44/17 45/19 46/17 46/22 55/8 58/9 97/9 125/7 126/21 128/6 176/20 177/17 188/18 195/9 195/22 207/23 211/14 245/13 245/15 245/20 245/25 246/6 246/15 249/20
baby [12] 30/6 39/4 44/4 44/11 81/11 81/12 137/10 153/24 161/5 162/13 169/12 188/18
Baby P [1] 44/4
baby's [1] 42/3
back [60] 12/11 21/16 25/6 25/9 25/19 34/20 47/10 64/21 65/19 66/2 78/25 80/2 92/24 95/23 96/2 105/22 107/3 120/17 124/5 124/8 125/3 128/23 134/1 134/22 139/13 142/25 147/18 154/22 156/4 161/17 162/20 169/13 173/2 173/8 181/22 182/1 182/13 185/5 186/8 186/11 189/1 189/24 191/20 210/24 211/19 215/5 220/22 222/11 225/18 227/10 239/20 240/15 244/23 247/17 250/11 251/4 251/16 252/10 253/5 253/17
background [8] 1/23 32/7 36/13 37/21 56/13 64/23 68/9 152/23
backwards [2] 47/5 119/5
bad [1] 200/24
badged [1] 248/10
Baker [9] 48/10 48/11 48/13 60/7 207/3 207/5 207/6 256/5 256/9
balanced [1] 151/8
Band [2] 48/25 94/25

B

BAPM [2] 196/20 198/5
barely [1] 232/3
base [1] 51/8
based [9] 58/14 117/6 148/3 156/14 169/5 192/19 199/3 242/1 244/3
basically [1] 180/14
basis [7] 3/4 7/20 66/6 199/7 210/21 218/7 237/7
be [346]
be able [1] 244/7
be sent [1] 13/24
bear [3] 118/12 119/25 222/21
bearing [7] 78/25 129/14 130/19 137/9 201/8 206/3 225/23
became [20] 2/7 2/9 2/10 2/23 6/8 13/14 13/17 15/3 17/16 18/5 26/8 27/14 30/23 30/25 40/20 41/3 65/23 66/24 75/16 80/8
because [131] 3/2 7/21 8/13 14/13 19/8 22/20 26/6 27/7 27/19 29/6 29/12 29/14 30/2 34/18 36/18 37/8 38/1 38/10 39/8 44/2 44/25 45/15 45/24 46/3 47/4 48/1 48/4 48/5 50/6 51/25 55/4 56/3 56/23 58/22 73/14 75/10 77/15 79/9 79/9 81/25 82/11 88/5 89/22 90/8 90/14 92/2 95/21 106/1 111/7 111/25 114/9 117/24 118/15 121/12 122/6 122/22 125/18 128/14 129/7 131/13 133/13 135/10 136/16 137/21 139/2 139/8 141/18 142/11 142/15 143/2 144/13 144/23 145/14 146/23 147/10 147/15 148/14 156/21 159/4 160/24 161/20 164/12 164/15 165/22 168/23 169/11 172/7 173/3 180/6 184/24 186/9 192/1 193/8 197/11 198/11 199/7 199/24 201/20 202/8 205/17 206/13 206/18 211/11 211/14 216/10 226/20 226/25 228/25 229/17 230/8 230/11 230/12 231/25 234/3 235/6 235/7 235/7 235/10 235/22 238/7 246/25 247/2 247/5 247/5 249/12 250/11 251/11 251/25 253/17 254/2 254/8
become [6] 18/15 70/19 108/2 116/12 168/3 211/16
becoming [1] 65/5
been [222] 3/23 5/4 7/13 7/21 11/19 15/25 16/17 18/13 18/24 19/1 21/22 23/18 25/5 26/12 30/19 30/19 31/4 31/5 31/21 32/15 35/2 37/18 37/20 39/22 39/23 41/9 41/16 41/16 42/15 44/3 44/14 47/8 47/20 47/22 48/5 48/6 49/14 52/22 56/20 56/21 59/1 60/14 60/15 61/8 61/14 61/19 62/15 67/24 68/5 70/8 72/22 72/25 73/21 74/9 74/10 76/21 77/19 82/8 83/7 83/10 84/3 87/21 88/23 90/7 90/20 90/22 91/7 91/18 92/5 92/8 94/10 97/17 101/5 101/17 101/19 101/20 103/14 104/12 104/18 109/10 112/4 112/8 112/8 112/9 116/1 117/25 122/5 123/1 123/2 123/3 123/4 123/25 124/3 124/4 124/5 124/17 124/22 125/17 126/10 126/13 127/22 130/15 130/17 131/3 131/5 131/10 131/10 132/1 132/2 135/4 136/25 137/7 145/1 145/2 147/1 147/7 148/18 148/25 152/6 152/7 154/21 156/6 156/15 157/6 157/15 157/23 158/18 160/2 160/3 161/24 162/4 162/5 162/8 162/8 163/3 164/23 165/9 165/19 166/3 166/5 166/7 166/8 166/13 167/17 168/2 168/24 169/6 169/9 169/11 174/3 174/3 174/8 174/8 176/16 177/14 179/9 180/14 180/19 180/20 181/9 181/22 183/14 183/16 184/21 185/3 185/4 185/8 185/19 185/20 186/5 186/13 186/17 186/21 186/23 187/5 187/24 190/8 192/12 193/1 193/8 196/8 198/4 200/1 200/5 200/20 201/21 213/25 214/23 216/7 216/13 216/14 221/16 226/21 227/8 227/13 227/20 228/22 228/25 229/1 229/2 229/4 230/11 230/16 232/16 232/16 233/3 239/16 239/19 242/18 244/2 245/6 246/25 248/4 248/4 249/1 249/24 250/12 252/11 253/4 253/4 253/6 254/12
before [50] 5/15 21/24 29/18 30/22 36/8 39/20 42/4 44/14 48/23 50/12 51/24 52/6 52/25 53/1 58/10 60/7 64/11 88/19 88/25 89/21 91/19 91/25 92/24 96/6 100/7 109/11 112/13 112/19 116/11 120/1 132/18 132/25 134/2 141/14 166/23 173/25 180/25 183/16 194/22 195/19 200/1 207/20 210/11 219/22 223/12 242/19 245/17 247/25 249/16 251/5
beforehand [1] 92/10
beg [1] 250/25
began [1] 57/11
beginning [3] 89/8 148/25 230/15
begins [1] 131/20
behalf [4] 48/14 205/13 207/9 217/14
behaviour [1] 113/15
behind [2] 91/1 98/5
being [113] 2/13 4/25 17/1 17/2 17/4 19/17 20/3 22/6 24/2 25/7 33/10 36/20 41/5 46/2 46/11 50/18 55/12 61/13 71/9 72/3 72/11 73/18 73/19 76/13 77/11 79/17 79/18 79/19 88/1 88/9 88/14 90/7 90/19 107/18 107/19 109/23 113/24 122/7 124/2 124/6 126/2 126/7 127/5 127/12 127/14 127/25 129/8 141/1 143/25 145/7 148/21 151/7 154/6 154/24 155/11 160/5 160/6 162/6 163/6 165/4 168/22 173/22 177/7 177/12 179/9 179/10 181/2 184/13 185/24 185/24 186/4 187/3 187/3 189/25 189/25 191/6 193/5 193/22 194/1 194/19 195/23 200/9 201/23 202/12 202/21 202/23 203/7 204/10 206/7 207/24 208/5 208/6 209/8 210/2 211/12 211/17 213/5 215/6 216/2 216/23 220/16 220/18 225/4 228/14 230/10 231/13 231/24 232/5 245/20 246/19 246/21 248/9 253/13
belief [6] 1/17 63/13 143/11 189/12 190/2 190/4
believe [50] 2/4 11/18 15/9 41/21 47/21 59/6 59/13 59/17 74/2 79/6 94/15 103/13 103/16 117/25 125/18 135/15 143/13 143/15 143/18 146/2 147/2 152/15 153/4 162/24 163/15 168/18 179/22 180/3 181/15 181/23 186/14 190/9 190/12 194/2 194/3 197/3 201/20 203/3 203/11 206/22 218/7 222/21 222/23 223/20 242/18 246/18 246/23 252/3 253/23 254/5
believed [4] 58/15 59/14 222/15 240/5
below [6] 4/15 69/5 71/13 155/18 171/24 198/5
beneath [3] 6/20 30/5 67/4
beneficial [1] 92/9
benefit [1] 92/3
Bennett [3] 6/9 85/19 192/8
bespoke [2] 94/10 139/18
best [4] 1/16 63/12 99/23 129/20
better [3] 74/16 91/18 196/1
between [18] 3/9 9/16 13/1 13/8 26/8 30/9 57/12 65/6 75/24 102/21 156/10 162/24 178/12 236/23 241/10 242/21 246/15 247/24
between February 2016 [1] 75/24
between June [1] 3/9
Between September 2015 [1] 13/1
Beverley [4] 63/20 63/22 64/3 116/7
Beverley Allitt [3] 63/20 63/22 116/7
Beverley Allitt's [1] 64/3
beyond [1] 168/7
big [3] 5/21 5/25 161/17
bigger [2] 132/14 201/14
bit [13] 39/13 42/7 45/1 75/5 77/6 86/19 86/24 91/5 102/18 117/19 141/16 219/24 228/17
blank [3] 214/5 214/7 214/8
blood [1] 67/13
blue [1] 188/20
blunt [1] 97/9
board [43] 13/18 13/21 14/14 14/22 18/25 20/13 20/22 23/6 23/18 24/4 25/22 25/24 25/25 26/5 26/7 69/6 71/13 95/14 100/16 107/15 119/8 119/15 121/7 122/11 132/12 132/21 132/24 133/25 166/4 166/14 169/10 180/15 180/19 181/10 181/12 181/15 181/24 182/3 182/6 182/17 194/13 206/22 252/8
boards [7] 17/21 94/5 94/5 95/8 95/11 105/6 205/23
bodies [1] 26/24
body [2] 52/10 52/14
bookmark [1] 117/13
boss [1] 165/5
both [26] 4/25 5/7 5/18 7/1 32/10 41/19 58/19 85/25 89/7 125/10 132/7 132/15 133/4 133/5 141/16 143/21 143/22 150/23 150/24 151/10 180/5 180/19 183/13 218/16 238/24 242/12
bottom [18] 53/6 85/13 85/20 85/23 86/5 114/7 119/11 120/5 120/11 146/7 146/21 154/17 168/10 170/3 182/25 219/16 222/24 234/21
box [2] 62/15 222/25
breadth [1] 199/21
break [6] 62/11

B

break... [5] 121/24 174/1 175/9 175/11 184/16
breakdown [1] 91/12
Brearey [55] 7/19 12/21 13/3 13/4 16/20 16/23 20/1 20/8 21/3 32/11 33/8 33/20 36/24 37/13 39/16 40/21 41/12 41/19 41/20 42/18 42/19 43/5 45/5 58/3 58/19 59/17 74/7 84/8 85/3 85/10 86/2 86/11 87/10 88/6 91/6 91/10 92/9 140/10 140/11 150/24 151/7 153/25 156/10 166/17 171/3 175/19 180/11 181/5 196/15 200/4 220/11 243/13 250/19 250/20 250/23
Brearey's [9] 48/19 87/19 88/12 90/21 90/23 143/7 156/17 173/18 245/7
brief [6] 5/2 33/6 54/4 57/2 58/3 58/14
briefing [1] 28/18
briefings [2] 46/6 60/25
briefly [3] 33/8 136/2 200/16
Brigham [1] 15/2
bring [16] 8/24 76/7 85/10 96/6 164/21 164/25 169/22 184/19 219/13 222/4 222/8 222/19 223/25 234/12 242/24 247/17
bringing [1] 206/7
broad [1] 25/22
broaden [3] 144/15 144/16 148/14
broader [8] 31/7 83/21 138/23 150/17 151/17 151/21 151/22 152/12
broadly [1] 141/25
brought [6] 21/8 24/15 180/12 192/9 201/12 235/24
Brown [5] 1/4 1/12 9/14 11/19 256/4
build [1] 60/25
building [1] 50/21
bullet [2] 43/21 94/18
bundle [8] 28/2 101/3 163/15 204/4 219/8 225/19 242/6 244/20
Burnett [4] 2/22 2/25 6/10 6/11
business [7] 2/8 9/2 53/24 69/10 71/19 181/14 186/3
busy [2] 5/21 250/16
but [293]
bypassed [1] 205/17
bypassing [1] 49/8

C

C's [1] 150/6
calendar [2] 50/11 50/14
call [7] 1/5 56/20 174/23 188/20 204/18 210/7 239/3
called [5] 67/24 94/11 100/14 149/19 218/11
calling [1] 209/22
callous [1] 114/13
calls [1] 78/7
came [21] 13/9 20/16 22/20 29/7 47/25 48/3 66/20 75/19 87/1 170/5 182/12 184/11 185/5 186/4 190/20 221/24 227/18 250/20 251/9 253/10 253/17
can [187] 2/14 3/25 4/4 4/9 5/10 5/14 6/18 7/25 9/16 9/19 9/22 10/21 11/4 11/15 14/3 17/8 20/14 26/11 27/5 27/25 31/13 31/18 39/8 43/7 45/7 47/3 47/6 47/14 47/16 47/18 51/4 53/16 55/10 57/14 61/5 61/14 61/21 70/22 71/23 72/25 77/5 77/12 77/15 81/6 84/1 85/13 85/19 86/2 86/5 87/22 89/4 89/14 92/18 95/25 98/3 98/6 98/10 99/1 99/10 99/23 100/13 102/4 103/22 105/2 105/16 108/6 109/9 109/16 110/17 111/21 117/12 117/12 117/18 118/2 119/9 119/13 119/14 119/21 120/10 120/19 120/22 121/12 121/24 123/16 125/7 126/16 128/4 128/8 129/19 132/9 133/18 135/25 136/2 136/4 136/5 136/15 137/24 138/17 139/10 140/15 140/18 141/3 144/21 144/23 145/4 145/6 146/7 146/9 147/18 149/22 150/6 153/6 154/5 154/6 154/7 154/15 155/1 155/17 155/20 156/8 157/5 157/18 159/9 167/5 169/22 170/2 173/24 178/5 178/22 178/23 179/1 179/1 179/16 180/9 181/3 181/7 183/2 183/7 184/17 185/2 187/2 187/11 189/21 192/20 193/10 196/22 197/17 200/19 201/6 203/14 203/24 208/20 209/2 209/12 209/15 212/19 212/23 215/7 216/10 217/20 217/21 222/4 222/11 222/12 224/13 224/22 225/24 226/12 227/4 229/9 230/17 234/19 236/1 236/1 237/10 238/1 238/5 238/23 239/2 239/9 239/14 241/7 241/19 244/13 244/13 249/9 249/16
can't [48] 2/16 4/2 6/13 24/22 32/18 32/22 45/12 54/8 55/5 55/5 55/6 57/7 61/12 101/7 104/10 104/10 111/15 111/24 114/3 122/6 124/20 127/19 130/13 131/17 137/21 143/17 164/13 168/22 172/13 176/23 179/5 179/10 183/15 185/8 186/9 194/5 206/17 212/14 217/1 223/13 226/24 232/2 232/2 235/10 239/21 240/6 241/24 241/24
candour [37] 188/10 188/11 210/11 210/13 210/14 210/15 210/16 210/20 210/21 211/4 211/22 212/12 214/2 214/4 214/10 214/19 215/6 215/9 215/11 215/15 215/22 224/20 227/7 227/9 227/12 227/16 227/16 227/18 228/1 228/6 228/10 228/16 228/18 238/3 238/9 238/15 238/17
cannot [3] 167/9 179/5 212/8
capital [1] 238/1
capture [1] 73/11
cardiac [1] 153/12
cardiorespiratory [1] 153/8
care [82] 2/12 2/14 3/18 4/11 5/20 6/15 11/16 11/24 13/18 14/13 14/22 20/12 23/6 23/17 24/18 24/24 25/2 25/5 25/21 25/23 26/5 26/10 28/4 37/21 48/7 58/17 67/18 67/23 67/23 75/23 81/11 95/17 104/2 106/2 109/25 115/17 117/22 119/6 119/8 119/15 121/6 121/15 123/13 124/18 126/20 127/19 128/10 128/19 132/14 132/21 132/24 133/7 133/25 137/16 145/16 150/11 150/21 151/7 151/10 157/16 159/11 161/8 161/9 161/11 166/3 166/14 172/12 174/12 176/15 176/19 176/23 177/14 180/13 181/12 181/14 182/6 199/25 205/9 213/4 227/14 228/13 246/5
care-providing [1] 132/14
career [2] 17/3 37/23
carefully [6] 178/18 179/14 179/21 180/2 184/2 252/17
caring [1] 170/7
carried [1] 64/6
carries [2] 49/2 105/18
case [41] 45/19 47/24 48/15 59/1 59/24 63/19 63/25 74/7 77/18 81/20 84/4 87/16 95/16 112/25 135/4 135/15 142/20 154/8 157/12 158/14 191/25 196/16 210/23 213/22 215/15 215/25 221/17 225/11 225/17 226/11 228/14 231/9 231/11 233/13 233/21 234/7 234/9 235/21 236/16 249/1 249/20
cases [26] 23/19 24/21 127/2 128/17 142/2 146/13 154/11 159/16 161/15 177/5 177/12 177/13 191/7 192/2 200/6 215/6 218/13 228/8 229/19 233/11 234/11 241/12 243/12 243/14 245/18 246/21
cast [1] 82/14
catastrophic [8] 108/11 108/19 108/22 108/24 109/3 109/5 109/6 125/13
catch [4] 49/20 50/3 50/19 51/4
catch-up [2] 49/20 50/19
catch-ups [1] 50/3
categories [1] 147/12
categorisation [1] 157/20
categorisations [1] 147/2
categorised [1] 147/15
categorising [1] 12/23
category [13] 135/10 145/13 146/18 147/8 147/9 147/12 151/18 151/21 151/22 152/12 157/19 158/7 170/17
category 3 [1] 157/19
catering [1] 116/4
catheter [1] 220/2
cause [12] 104/2 113/7 115/1 139/11 175/2 175/24 177/18 177/23 189/15 197/10 199/17 213/21
caused [11] 41/5 57/20 136/12 144/24 145/4 199/23 212/22 213/10 216/2 223/2 240/22
causing [5] 52/16 199/25 213/13 213/14 213/14
caution [1] 185/13
cautioned [1] 185/14
caveated [1] 70/3
CCG [3] 94/14 237/5 237/6
CDG [1] 101/9
centre [2] 134/14 148/23
certain [5] 94/8 108/7 108/18 143/18 229/9
certainly [30] 35/21 58/5 74/13 75/16 76/21 78/1 80/17 99/25 101/4 103/11 139/16 144/3 150/2 150/25 155/10 159/2 161/12 166/7 172/1 174/12 175/8 179/3 199/15 233/7 234/6 237/15 244/11 253/10 253/12 254/25
certainty [1] 112/12
chain [3] 58/21 58/24 242/9
chair [5] 1/8 122/17 122/23 181/15 187/4
chaired [1] 69/5
chairing [1] 122/24
chairman [1] 122/11
chairman's [6]

C

chairman's... [6] 121/13 121/25 122/15 122/16 122/20 123/9
challenge [2] 170/13 205/21
challenges [5] 124/23 189/14 190/3 194/20 196/20
challenging [1] 85/6
Chambers [1] 122/22
chance [1] 193/19
change [15] 28/17 65/15 65/15 81/23 87/5 88/14 92/7 100/24 101/11 103/17 104/9 127/13 173/14 248/12 248/14
changed [5] 39/8 80/4 90/4 90/18 137/1
changes [9] 72/1 72/24 74/10 74/14 97/25 147/1 148/20 148/20 179/2
changing [1] 80/21
characterisation [3] 83/2 103/3 107/4
characterised [2] 99/2 108/11
charge [2] 42/23 48/18
chart [8] 4/8 8/9 109/17 114/7 163/23 164/8 164/18 193/20
charts [1] 190/7
chase [2] 224/19 226/15
chasing [2] 231/10 231/16
chat [2] 50/22 53/20
check [1] 61/15
checklist [1] 139/20
Cheshire [1] 203/3
Cheshire Police [1] 203/3
chest [2] 55/22 56/20
Chester [4] 64/25 74/17 100/20 240/17
child [136] 41/1 43/16 43/17 51/25 51/25 52/4 52/6 55/1 55/9 55/12 55/19 55/22 55/25 56/3 56/4 56/8 57/9 57/12 57/15 57/17 57/20 59/6 59/8 59/9 63/10 64/12 85/15 85/15 108/21 109/3 109/4 114/12 114/14 114/14 114/22 115/15 117/15 145/21 145/21 146/15 147/6 147/8 149/22 149/23 149/23 149/24 149/24 150/6 150/6 150/24 150/24 152/10 152/10 152/13 152/13 152/16 154/15 155/3 155/3 155/7 155/8 155/8 155/8 156/16 156/22 160/7 160/14 160/18 160/19 160/21 162/10 162/15 162/16 162/19 163/1 163/8 163/9 174/1 188/7 188/7 188/12 188/12 188/13 188/13 188/18 188/19 212/18 212/20 213/4 213/8 213/13 213/14 213/15 215/25 216/3 217/15 217/16 219/3 219/6 220/21 221/10 222/3 222/5 222/10 222/14 222/22 222/25 223/18 224/6 225/16 226/2 227/21 230/8 231/5 231/14 231/23 232/1 232/8 232/15 232/18 232/20 233/3 234/1 234/19 234/20 238/24 239/7 240/12 240/15 240/19 240/22 242/5 242/13 243/3 245/13 246/16
Child A [34] 63/10 64/12 149/22 150/6 150/24 152/10 152/13 152/16 154/15 155/3 155/7 156/16 160/21 217/15 217/16 219/6 220/21 221/10 222/3 222/5 222/22 222/25 224/6 225/16 227/21 230/8 231/5 231/14 232/8 234/20 239/7 240/12 245/13 246/16
Child A's [15] 219/3 222/10 223/18 231/23 232/1 232/18 233/3 234/1 238/24 240/15 240/19 240/22 242/5 242/13 243/3
Child B [3] 155/3 155/8 160/18
Child C [5] 149/23 150/24 152/10 152/13 155/8
Child C's [1] 150/6
Child D [3] 149/23 149/24 155/8
Child E [2] 160/14 162/16
Child E's [1] 160/7
Child F [1] 160/19
Child I [4] 162/15 162/19 163/1 226/2
Child I but [1] 234/19
Child I died [1] 162/10
Child I it [1] 117/15
Child I's [2] 163/8 163/9
Child K [1] 174/1
Child O [17] 43/16 51/25 51/25 52/4 55/1 85/15 145/21 188/7 188/12 188/13 188/18 212/18 212/20 213/4 215/25 216/3 232/20
Child O's [1] 213/14
Child P [21] 41/1 43/17 52/6 55/9 55/19 55/25 56/3 56/4 56/8 57/9 57/12 57/15 57/17 57/20 59/9 85/15 145/21 188/7 188/12 188/13 213/8
Child P's [4] 55/12 55/22 59/6 213/15
child's [2] 155/16 227/14
children [18] 3/21 59/21 68/4 114/12 126/8 127/11 144/3 145/19 151/4 151/11 170/3 177/9 206/24 208/4 211/15 214/3 234/6 235/8
children's [27] 13/18 14/13 14/21 15/12 20/12 23/17 50/21 63/25 73/12 73/18 73/22 81/4 95/13 119/8 119/15 121/6 132/21 132/24 133/25 151/20 166/3 166/14 169/10 181/12 181/14 182/6 233/11
chose [1] 77/16
Christmas [2] 5/15 223/12
chronology [4] 55/11 230/17 240/20 245/11
ciphered [1] 193/9
circle [1] 107/3
circuit [1] 217/22
circulate [1] 111/12
circulated [5] 110/9 111/21 112/2 112/3 112/4
circulation [1] 180/5
circumstance [1] 116/5
circumstances [1] 134/17
cited [2] 39/22 44/25
claims [3] 98/18 218/20 218/20
classed [2] 135/1 228/9
clear [26] 15/16 18/1 38/25 44/18 45/4 51/24 87/16 88/2 94/20 95/8 95/11 112/24 130/22 143/19 145/23 157/13 161/10 164/11 177/18 189/17 209/20 213/12 227/25 232/17 241/8 242/11
clearer [1] 70/16
clearly [15] 19/5 38/21 39/9 118/15 133/23 144/21 170/2 181/6 201/1 222/13 238/8 238/12 239/25 243/14 255/7
clicked [2] 251/10 251/20
clinic [1] 42/19
clinical [74] 4/16 4/17 7/17 18/20 27/23 29/2 29/25 30/16 34/1 36/8 36/12 44/16 45/11 45/25 45/25 55/16 56/10 56/13 56/17 59/2 65/10 74/6 75/22 90/11 94/11 102/13 104/1 104/6 106/2 109/25 110/2 115/17 116/12 124/18 131/21 137/16 138/1 138/2 138/5 138/15 144/13 147/20 151/1 151/3 151/4 156/11 157/11 160/16 161/3 161/4 170/11 185/12 185/12 185/15 185/15 189/14 190/3 194/20 195/19 199/5 199/9 200/12 200/13 207/20 208/10 210/6 210/17 222/14 222/14 227/10 227/14 243/14 246/3 247/7
clinically [2] 8/14 45/16
clinician [2] 11/12 228/11
clinician's [1] 195/10
clinicians [5] 36/25 39/3 41/24 42/6 195/2
close [1] 223/14
closely [1] 64/16
closer [3] 76/10 87/22 194/11
closure [3] 126/20 141/3 218/20
clouding [1] 38/17
cluster [1] 162/16
co [2] 67/10 181/25
co-ordinate [1] 181/25
co-ordinators [1] 67/10
coalface [1] 147/23
Codes [1] 142/20
coding [2] 154/21 212/21
coffee [8] 33/12 33/14 34/14 37/15 49/21 50/20 51/15 53/21
cohesively [1] 8/16
cohort [1] 125/20
coincided [1] 76/19
coincides [1] 231/22
collaboration [1] 76/10
collapse [6] 55/20 57/13 139/7 155/14 156/19 174/1
collapsed [1] 46/22
collapses [5] 57/16 137/20 155/12 191/10 204/25
collapsing [1] 57/20
colleague [3] 59/2 170/24 173/6
colleagues [2] 50/7 58/4
collective [3] 152/5 152/7 152/11
College [8] 127/12 201/10 202/4 210/5 233/12 234/5 234/8 246/19
column [4] 112/20 116/4 234/20 237/25
come [50] 1/8 9/11 10/4 10/4 10/5 13/9 20/8 26/6 27/13 49/12 49/13 55/7 58/16 64/21 80/2 84/6 84/16 96/2 100/9 106/10 113/23 114/19 117/15 118/9 120/3 120/7 124/8 127/18 128/23 134/1 143/16 149/3 152/11 168/24 169/13 171/1 171/2 173/9 173/13 182/20 183/7 188/24 188/24 191/4 210/6 240/15 247/5 250/22 251/3 251/16
comes [9] 25/25 51/18 88/22 130/25 142/17 181/22 204/19 242/22 252/24
coming [19] 19/8 34/20 80/20 81/15 124/24 148/22 161/7 164/3 172/2 173/5 173/8 173/14 187/15 207/3 245/25 246/6 246/15 250/18 254/23
Command [1] 196/2
commence [1] 66/5
commended [1] 94/14
comment [7] 93/6

C

comment... [6] 171/15 172/13 202/20 217/1 236/7 252/22
commented [1] 190/19
comments [6] 38/6 38/8 172/1 190/20 190/25 197/6
Commission [2] 128/10 128/19
commissioned [1] 191/5
commit [2] 61/12 79/17
committed [1] 63/22
committee [13] 6/25 6/25 10/15 69/2 69/4 69/8 71/13 72/5 100/13 101/18 104/18 104/21 206/14
committees [4] 94/19 95/7 95/11 169/7
common [14] 23/18 24/19 24/20 24/22 160/11 165/1 167/14 168/10 175/24 177/4 177/11 183/6 185/24 197/10
commonality [4] 183/5 183/14 187/25 195/17
comms [1] 125/6
communicate [1] 146/22
communicated [3] 147/23 148/11 208/17
communicating [2] 114/18 181/4
communication [6] 61/1 74/25 90/25 92/24 94/5 232/5
communications [10] 46/23 60/22 61/2 72/6 88/6 93/12 127/17 165/22 179/24 240/8
competence [5] 89/6 185/12 185/15 246/3 247/7
competencies [1] 245/23
competency [6] 195/20 207/20 208/11 210/8 211/3 232/25
complained [1] 142/9
complaints [7] 67/9 92/22 98/17 201/12 207/17 218/18 218/18
complete [2] 84/18 153/1
completed [12] 24/18 143/20 152/24 154/6 156/18 157/2 174/11 175/3 196/10 215/9 226/21 243/18
completely [2] 45/4 52/13
completing [4] 95/23 96/15 170/25 216/19
complex [4] 5/25 106/3 137/16 218/19
complexity [2] 155/16 157/12
compliance [6] 8/5 9/2 9/3 210/12 211/22 211/24
complicated [1] 95/21
complication [2] 223/1 223/7
complications [1] 220/1
complied [1] 214/19
complying [1] 214/9
comprehensive [3] 130/2 154/12 196/7
comprehensively [1] 162/9
compressions [2] 55/22 56/21
concepts [1] 98/5
concern [51] 3/7 13/11 18/11 26/4 30/1 34/16 35/4 36/1 36/20 38/11 38/24 39/22 44/1 44/9 55/8 55/9 69/24 70/15 83/6 86/6 100/1 105/18 115/10 124/4 124/11 133/16 139/7 142/6 142/8 142/14 143/19 145/25 151/25 165/17 174/11 175/3 177/12 177/23 178/7 189/9 189/25 208/10 216/11 232/1 233/7 238/9 238/13 245/15 253/12 254/23 254/24
concerned [36] 32/13 33/9 34/8 34/10 34/21 36/24 36/25 42/3 42/5 42/5 44/3 45/18 52/10 52/14 55/5 58/8 75/16 79/25 80/5 113/25 115/4 125/6 127/6 127/9 129/10 141/8 145/18 145/24 149/18 155/23 191/6 191/16 195/21 204/15 204/22 207/22
concerning [2] 86/10 176/9
concerns [69] 6/16 7/20 16/21 23/8 26/13 27/15 32/11 33/8 33/24 37/13 39/4 39/21 40/17 41/5 41/7 41/8 41/21 42/9 42/16 42/24 43/25 44/5 44/13 50/6 50/25 54/7 54/18 56/1 56/16 56/25 57/3 57/19 58/4 59/3 68/10 79/14 85/1 85/8 86/3 89/6 94/16 100/10 115/14 124/6 128/12 164/24 165/24 173/18 184/13 185/19 195/2 195/7 195/10 196/1 204/4 205/3 205/10 208/7 208/18 213/20 227/21 232/19 232/23 236/2 245/12 245/23 246/14 247/1 249/19
conclude [3] 60/7 176/18 225/24
concludes [1] 62/4
conclusion [9] 175/23 197/17 198/8 198/12 198/14 198/17 198/20 199/1 223/17
conclusions [2] 191/18 192/18
condition [8] 55/12 56/2 56/8 115/22 115/24 151/1 155/16 157/12
conditions [4] 156/11 161/4 222/14 222/15
conduct [2] 109/15 196/23
conducted [3] 78/21 191/12 245/7
confidence [5] 112/12 112/21 126/23 127/2 127/18
confident [4] 165/18 165/25 201/2 221/25
confidential [3] 131/11 185/16 255/2
confirm [4] 47/6 97/25 214/14 230/25
confirming [1] 47/24
confused [2] 42/7 95/14
confusing [2] 144/23 225/12
confusion [1] 144/24
conjunction [3] 12/3 25/8 113/9
connecting [1] 85/3
connection [1] 241/10
connections [2] 44/18 44/20
conscientious [1] 184/5
consequently [1] 25/22
consider [16] 27/2 45/21 74/9 74/15 85/25 96/1 99/6 134/11 134/24 136/1 142/22 158/7 159/20 161/20 220/1 224/20
considerable [1] 177/23
considerably [1] 165/16
consideration [6] 23/16 86/8 86/17 86/22 246/9 246/16
considered [11] 45/22 105/19 127/1 128/16 149/23 152/6 158/23 163/3 222/5 238/4 254/7
considering [3] 109/7 163/4 208/25
consistent [1] 173/2
consistently [1] 198/4
constraints [1] 13/7
Consultant [7] 21/8 52/10 52/14 74/3 169/3 204/5 234/10
Consultants [8] 44/12 195/16 195/21 203/9 204/9 205/7 207/21 208/3
Consultants' [1] 207/17
consultation [1] 72/10
consulted [4] 89/1 91/25 101/11 103/15
contact [2] 58/16 135/22
contacted [3] 45/22 50/6 191/17
contacting [1] 112/21
contained [1] 144/2
contemplating [1] 116/6
contemporaneous [1] 140/14
content [8] 43/11 43/13 63/11 103/15 103/20 103/25 142/3 143/21
context [10] 34/12 38/6 45/10 47/3 57/18 85/14 109/16 111/1 231/12 231/24
continuation [1] 81/10
continue [5] 47/14 82/16 87/18 97/5 133/21
continued [3] 47/7 77/1 78/15
continues [1] 57/15
continuing [2] 58/11 176/16
continuous [2] 93/16 93/16
contract [2] 79/19 79/20
contribute [5] 71/23 90/1 107/12 158/12 198/9
contributed [17] 114/10 114/21 115/7 117/10 137/22 144/12 145/15 146/25 150/21 151/13 157/16 160/16 161/5 197/21 222/6 222/15 240/22
contribution [1] 76/19
contributor [1] 71/5
contributory [3] 197/13 197/20 198/2
control [10] 125/22 125/24 126/4 128/3 128/12 128/14 130/8 130/15 131/8 131/20
controlling [1] 106/7
controls [8] 12/8 107/14 122/10 125/16 126/1 126/17 126/19 127/1
convenient [2] 118/18 175/7
conversation [64] 25/18 29/1 33/6 53/12 54/24 56/3 57/18 58/2 61/19 70/19 89/19 107/13 113/20 123/25 124/20 127/23 130/5 131/15 147/3 155/11 158/11 158/12 164/8 164/10 171/14 181/8 184/16 185/10 185/11 185/19 186/4 186/12 186/23 187/2 187/6 187/8 187/20 188/3 188/23 192/23 192/25 193/2 199/15 200/6 201/1 201/19 203/17 203/20 208/20 209/2 211/2 211/25 216/17 222/1 225/25 227/13 227/22 228/19 233/23 239/14 241/22 252/7 253/9 254/25
conversations [26] 31/6 40/16 111/22 130/4 139/16 141/10 141/17 142/13 172/8 172/10 173/21 185/21 190/10 190/13 197/2 199/4 202/11 202/14 202/15 205/18 205/22 210/22 212/12 216/2

C

conversations... [2] 216/21 232/4
coordinated [1] 69/12
copied [10] 178/20 179/15 179/23 180/5 180/20 181/2 182/24 183/16 250/24 251/6
copies [2] 183/8 217/24
copy [6] 178/15 178/21 181/17 236/13 236/20 251/11
copying [2] 183/2 221/9
core [3] 170/20 214/22 235/8
corner [2] 110/21 120/12
Coroner [31] 218/1 219/4 219/25 220/12 224/7 224/9 231/9 232/15 235/7 238/24 239/9 239/13 239/15 239/20 239/23 239/25 240/5 240/8 241/7 241/9 241/15 242/12 242/21 242/22 243/12 244/15 246/10 246/17 246/19 247/3 247/10
Coroner's [3] 239/4 239/6 239/17
Coronial [1] 218/23
corporate [17] 69/11 69/12 71/2 71/16 94/21 95/18 100/14 100/20 101/2 120/12 122/19 122/23 123/7 123/10 130/25 204/21 205/24
correct [58] 1/19 1/22 2/1 2/17 3/17 4/14 4/19 5/5 5/6 14/18 18/7 21/23 30/14 31/23 51/22 52/12 52/19 60/18 63/5 63/7 64/5 65/4 66/4 66/8 68/23 69/7 70/1 72/13 100/18 105/13 105/21 110/16 118/12 121/19 121/20 121/23 132/17 136/14 140/17 140/20 142/19 142/23 149/2 156/3 157/24 169/21 178/10 186/1 188/15 193/18 196/17 216/24 218/8 218/15 220/17 227/7 237/4 248/11
correction [1] 63/8
correctly [2] 142/20 204/9
correspondence [5] 167/6 219/8 223/21 238/10 239/24
corresponding [1] 121/9
cots [1] 126/20
could [81] 1/5 1/13 4/6 10/23 10/23 10/23 11/11 11/12 11/12 18/9 24/7 28/1 38/14 39/16 39/17 41/12 42/2 43/2 47/1 47/4 49/12 49/13 62/24 71/14 71/24 76/4 79/21 80/19 81/21 85/10 87/15 91/4 103/10 114/20 114/20 114/22 118/11 136/24 142/3 151/20 152/6 152/12 156/6 156/11 157/9 157/9 157/23 163/2 167/5 170/1 173/25 174/23 174/24 177/14 190/5 190/23 198/13 198/23 202/2 205/12 206/12 212/16 214/13 219/9 219/14 223/25 224/25 225/1 226/3 231/3 234/12 234/17 235/15 235/17 237/13 240/1 240/10 240/21 241/16 242/24 243/21
couldn't [1] 167/5
Countess [5] 64/24 74/17 100/20 240/16 248/9
couple [8] 7/23 32/3 49/25 50/23 66/1 183/25 196/10 219/13
course [22] 13/24 39/9 57/15 67/14 84/17 95/3 106/11 108/2 117/14 124/6 124/9 125/23 126/6 129/3 140/5 158/20 178/5 178/6 193/7 196/17 207/15 239/24
cover [3] 86/9 86/18 86/23
coverage [2] 64/1 125/23
covered [2] 82/17 82/21
covering [1] 83/19
covers [3] 81/3 104/3 153/24
CPR [1] 57/17
CQC [23] 26/24 76/19 77/12 77/17 77/20 78/10 79/3 94/1 128/21 128/24 129/1 129/4 129/11 129/16 129/24 166/23 167/10 169/14 170/19 172/17 173/7 179/5 198/3
created [3] 86/16 86/21 214/3
creation [1] 86/6
crime [1] 45/19
crimes [1] 64/13
criminal [3] 208/19 209/6 209/21
criminality [1] 210/2
criteria [7] 150/9 150/17 151/14 152/5 152/14 158/20 235/18
criterion [1] 150/20
critical [3] 140/6 140/9 205/21
criticise [4] 49/6 54/8 139/1 140/3
criticism [3] 89/15 143/9 215/24
criticisms [3] 93/7 173/14 215/1
crop [1] 170/1
Cross [15] 94/23 101/8 103/19 122/21 189/3 192/21 192/22 208/23 209/4 209/21 209/25 230/3 231/6 231/7 243/24
culture [2] 143/10 178/21
curiosity [1] 19/25
current [6] 96/11 96/18 97/10 97/17 112/8 193/8
cut [2] 200/19 251/5
cycle [1] 69/10
cycles [2] 71/18 181/13

D

D's [1] 149/24
daily [1] 68/17
damage [10] 28/10 30/2 118/2 119/17 121/1 123/20 123/23 125/2 125/23 138/7
data [16] 190/8 190/10 190/11 190/21 190/21 190/22 191/1 191/2 192/10 194/6 194/25 196/13 197/1 197/4 198/13 198/25
datasets [6] 78/8 192/10 196/6 196/25 197/7 198/21
date [15] 4/3 4/5 5/14 5/14 17/3 28/8 85/19 120/14 120/14 120/15 123/13 154/5 212/19 231/9 243/16
dated [12] 1/16 13/19 63/3 63/6 85/11 97/24 118/5 118/10 134/6 146/8 240/13 243/6
dates [5] 66/17 72/17 235/2 235/10 241/17
Datix [23] 93/1 109/23 110/6 136/7 136/8 136/8 142/16 143/10 143/20 144/5 144/25 145/5 152/17 154/22 160/25 168/20 174/7 174/10 212/11 212/18 213/13 215/3 215/7
daunting [1] 209/12
David [1] 92/14
David Semple [1] 92/14
Davies [1] 180/20
day [26] 9/5 9/5 38/4 42/2 42/13 42/23 52/23 53/10 55/21 59/8 68/18 72/21 82/7 82/7 83/18 83/18 92/15 98/22 163/9 178/19 181/2 183/17 210/21 210/21 247/18 250/16
days [6] 43/22 50/11 78/7 119/6 183/8 212/20
De [7] 62/13 62/23 175/16 207/4 208/14 255/10 256/8
deadline [1] 224/7
deal [11] 20/20 31/15 80/3 85/9 86/10 97/17 146/4 189/5 211/13 243/21 249/5
dealing [5] 14/14 39/25 68/3 85/5 109/20
dealt [4] 14/16 25/7 31/10 156/6
Dean [1] 85/19
Dear [1] 220/6
death [77] 14/23 32/7 40/25 44/4 51/24 52/3 52/6 64/12 98/22 108/21 109/2 109/4 114/22 115/8 117/9 117/11 124/16 124/19 128/6 134/17 135/14 135/17 136/15 136/16 136/19 136/21 137/22 144/5 144/11 144/12 144/13 144/20 144/22 145/11 145/14 146/15 146/25 147/6 147/9 147/11 147/13 149/25 150/12 150/22 151/2 151/3 153/15 156/7 156/12 156/19 157/16 159/12 160/7 160/17 160/20 163/8 163/9 175/25 177/18 212/22 213/10 213/14 213/15 213/21 222/6 222/10 222/16 223/18 232/1 232/15 232/18 233/3 234/1 240/16 240/19 240/22 242/5
deaths [66] 30/21 33/25 34/3 50/8 52/11 52/15 52/17 84/13 85/15 99/12 99/13 99/16 112/25 114/11 115/3 116/21 116/22 117/2 126/13 145/1 145/9 145/10 145/24 146/10 150/7 151/20 152/6 152/8 152/13 154/3 154/10 154/13 157/23 160/9 161/3 162/13 162/21 162/23 163/24 164/18 165/2 165/14 165/16 167/2 167/13 168/11 168/19 168/19 168/21 168/22 168/23 169/2 175/23 176/1 176/5 185/8 185/24 193/16 193/21 195/4 195/15 206/24 208/7 232/20 233/9 253/7
Debbie [12] 68/6 68/22 163/17 163/21 164/20 164/21 168/9 173/2 219/18 220/4 224/3 247/25
Debbie Peacock [10] 68/22 163/17 163/21 164/20 168/9 173/2 219/18 220/4 224/3 247/25
Debbie's [1] 166/6
deceased [2] 54/25 135/8
December [14] 13/2 13/8 13/10 13/20 14/22 15/22 17/4 18/15 19/2 19/17 21/19 30/23 65/17 97/24
December 2015 [2] 13/2 97/24
decide [1] 220/20
decided [1] 156/5
decision [70] 29/17 44/7 61/6 88/22 101/6 101/16 102/23 109/13 109/17 111/22 112/11 116/18 116/23 117/2 122/7 127/20 150/3 153/20 154/1 154/10 154/13 158/8 158/13 159/6 188/22 190/24 192/25 198/15 198/24 200/16 200/24 217/2 218/17 220/10 220/23

D

decision... [35] 220/25 220/25 221/10 221/15 226/21 228/21 228/23 228/25 229/4 229/6 229/7 229/11 229/12 229/19 229/20 229/22 230/2 230/10 230/11 232/7 232/8 233/21 233/22 239/17 239/17 242/2 242/3 242/18 248/22 249/2 249/4 249/6 249/16 249/21 250/1
decision-making [8] 101/16 102/23 158/8 192/25 198/15 218/17 220/25 230/2
decisions [1] 43/5
deck [2] 169/18 171/4
deem [1] 11/4
defined [1] 113/17
definite [1] 209/19
definitely [4] 77/19 91/21 164/15 169/9
definition [5] 30/5 103/23 137/9 146/16 156/14
delay [2] 133/24 230/2
delayed [1] 14/5
delegated [5] 100/15 106/16 121/21 130/19 130/22
deliberate [6] 41/5 110/23 111/2 189/15 246/3 247/9
deliberately [11] 32/12 52/16 111/3 114/6 116/7 195/8 195/22 207/22 208/4 213/21 245/19
deliver [3] 96/23 102/10 171/9
delivering [3] 95/6 97/2 102/13
delivery [4] 9/3 9/4 151/25 152/1
delved [1] 39/13
demonstrate [1] 82/3
demonstrated [1] 87/1
demonstrates [3] 94/16 95/2 239/25
denying [1] 39/15
department [32] 2/7 5/23 10/21 65/10 65/12 65/20 65/23 66/3 66/13 67/5 67/21 75/5 75/7 76/16 77/11 79/2 93/7 102/20 130/15 131/6 133/14 142/17 143/12 145/21 180/22 181/18 184/9 200/17 202/11 206/2 209/10 239/5
departments [3] 7/8 9/20 66/20
depend [2] 75/13 128/25
dependent [2] 107/17 225/4
depending [1] 10/8
depends [1] 14/4
depleted [1] 77/11
deploy [1] 200/21
depth [2] 45/24 164/7
deputy [4] 65/18 66/11 67/6 93/19
describe [5] 32/4 55/22 110/18 197/4 236/2
described [10] 69/19 76/12 86/9 99/10 100/22 110/17 149/18 184/12 234/14 254/12
describes [1] 92/21
describing [1] 144/8
description [2] 90/18 234/21
descriptions [1] 171/25
design [1] 102/9
designated [1] 107/6
designed [2] 104/13 109/20
desire [1] 27/4
desk [1] 248/24
despite [3] 17/4 88/8 209/8
detail [51] 18/18 27/19 27/20 29/2 29/24 29/25 29/25 31/12 34/2 35/8 37/14 38/5 38/23 39/11 39/12 41/20 41/25 42/9 44/7 45/14 55/14 55/14 56/10 56/12 56/17 58/5 58/7 58/20 60/14 61/19 72/18 75/5 84/7 84/16 86/24 105/1 120/10 122/6 126/16 128/8 146/3 169/16 172/14 178/2 213/24 221/3 221/8 222/17 234/18 237/17 253/10
detailed [5] 55/15 57/8 142/4 153/22 161/25
detailing [1] 240/20
details [1] 44/17
deteriorated [2] 57/10 177/17
deteriorates [1] 137/10
deteriorating [6] 73/1 73/4 73/10 73/23 74/1 74/2
deterioration [3] 177/16 177/18 178/6
deterioration/death [1] 177/18
deteriorations [1] 175/25
determine [1] 233/20
determined [1] 231/9
develop [1] 102/9
developed [4] 129/8 141/19 141/19 190/9
development [2] 67/13 86/13
devised [1] 126/8
diagnosis [2] 104/3 138/3
did [192] 1/19 2/19 2/20 2/25 3/6 4/25 5/2 6/1 6/5 6/6 6/15 10/4 10/11 11/25 13/2 13/10 15/2 15/6 15/14 17/12 18/15 18/16 18/21 20/1 22/5 22/17 22/19 22/23 22/24 24/24 25/13 26/24 27/2 27/17 28/13 28/23 29/1 29/10 30/16 32/20 35/23 36/5 36/7 37/23 38/5 38/7 40/1 40/3 40/10 40/12 41/14 41/18 41/22 42/11 42/14 43/25 45/13 45/21 46/11 46/21 53/9 56/15 57/25 58/1 58/14 59/14 59/17 61/17 61/19 61/24 63/22 64/24 65/1 65/5 65/8 66/5 66/10 66/21 68/7 68/12 68/24 68/25 69/20 70/25 72/14 72/16 72/20 73/3 73/19 74/24 76/1 77/3 81/23 82/19 84/22 87/1 87/24 90/13 94/2 104/23 113/5 113/6 113/6 113/18 115/1 122/22 127/25 128/11 129/5 129/12 130/14 130/17 131/6 138/7 139/12 140/21 140/25 141/15 142/2 145/24 146/2 151/13 153/10 154/1 154/7 161/12 161/13 164/6 166/25 167/6 167/18 171/6 171/14 172/18 176/18 176/18 178/17 179/14 179/20 180/1 180/3 181/11 181/23 184/17 184/21 185/13 186/7 186/15 186/16 188/16 189/9 189/18 191/22 192/5 192/18 195/11 195/20 195/25 196/3 196/23 198/9 201/25 202/15 202/18 202/19 207/21 211/18 212/6 216/17 218/3 220/7 221/23 226/11 231/18 232/21 233/25 236/19 241/16 243/13 246/9 246/11 246/16 250/4 250/4 250/23 251/14 251/15 251/23 253/1 253/23 253/25 255/7
didn't [79] 15/5 15/16 16/23 17/5 18/18 19/9 19/21 19/22 20/7 20/8 20/9 21/14 21/14 21/16 21/16 22/14 22/20 26/1 27/5 27/19 29/24 29/24 29/25 30/15 36/8 38/24 45/23 45/24 45/25 49/23 56/11 57/8 58/4 67/6 71/12 73/11 73/17 81/7 81/8 86/19 87/20 88/13 94/17 95/2 95/20 99/4 99/4 122/18 131/3 132/23 160/17 161/20 164/15 172/8 175/14 177/11 191/23 192/2 196/15 198/9 198/19 202/23 204/9 205/17 206/17 206/17 209/4 210/25 219/7 221/7 232/17 233/12 247/5 248/12 250/1 250/22 251/11 251/19 252/17
die [2] 114/15 137/11
died [19] 32/6 32/10 36/20 39/5 41/4 43/17 44/12 44/17 46/22 51/25 59/9 126/9 127/11 135/20 145/20 145/20 160/14 162/10 212/20
difference [4] 3/15 9/16 30/25 81/24
differences [1] 236/22
different [43] 9/16 29/16 51/8 73/7 75/12 76/5 78/7 84/11 87/23 94/6 94/6 117/16 118/14 120/21 125/20 126/3 126/25 127/5 129/3 129/21 129/25 150/18 169/24 170/21 172/19 177/8 177/10 177/13 184/24 184/25 190/22 192/10 195/11 196/6 196/13 197/7 198/21 201/15 209/3 210/5 223/10 235/19 254/10
differently [2] 22/13 172/25
difficult [16] 64/19 75/9 85/6 93/9 106/1 114/8 115/16 115/18 155/12 166/6 171/21 184/24 210/14 224/23 225/13 233/14
difficulties [1] 155/5
difficulty [4] 117/8 142/10 172/8 206/9
direct [4] 37/16 39/18 165/19 165/21
directly [11] 8/19 46/10 49/9 61/21 92/12 124/7 147/7 174/6 205/18 239/12 241/8
director [46] 2/10 2/12 2/14 2/21 2/23 2/24 3/18 4/11 4/13 5/13 6/2 6/7 6/12 6/14 6/20 7/25 8/20 8/21 10/7 12/4 13/25 17/16 17/20 19/25 21/12 22/11 30/23 35/22 45/17 48/4 48/20 48/21 61/9 61/11 61/13 65/18 66/11 69/5 69/11 71/3 71/19 92/19 93/19 94/23 123/7 165/7
Directorate [2] 2/9 4/22
Directors [13] 95/18 100/14 100/20 100/23 101/2 103/1 120/12 122/20 122/23 123/10 130/25 204/21 205/24
disappointing [1] 93/10
discern [1] 190/5
disciplinary [2] 161/14 200/15
disclose [3] 224/10 226/7 246/24
disclosed [1] 39/20
disclosing [1] 241/6
disclosure [3] 188/11 218/1 240/14
disconnect [1] 102/5
discounted [1] 197/11
discourage [1] 139/22
discovered [2] 22/17 141/15
discuss [7] 9/12 12/16 13/2 24/19 26/1 50/6 230/4

D

discussed [19] 10/14 20/21 22/14 24/9 24/10 55/12 157/6 168/2 182/14 185/24 191/18 192/6 210/3 218/13 218/24 220/8 221/16 231/24 246/23
discussing [5] 25/21 44/22 54/14 117/5 193/3
discussion [42] 12/16 12/18 19/12 20/7 22/9 23/5 25/23 26/4 37/24 38/21 40/18 40/19 40/24 43/18 44/23 45/7 54/3 55/16 57/2 57/8 86/7 86/16 86/21 90/2 113/4 113/10 116/9 122/9 138/14 150/17 155/2 155/7 158/13 185/4 188/9 192/13 203/1 203/2 220/18 225/21 233/23 238/12
discussions [16] 6/23 13/5 16/10 16/12 30/16 31/8 31/11 40/21 55/24 60/24 137/21 139/16 171/15 189/11 238/16 242/23
dismissed [1] 254/5
dismissive [1] 184/13
dispute [2] 116/3 200/8
distracted [1] 70/19
distress [1] 104/4
distressed [1] 211/16
division [35] 2/18 3/22 3/24 4/1 5/20 7/4 8/5 9/4 9/25 10/1 10/4 10/6 14/11 14/15 14/17 16/8 19/20 22/25 26/10 28/21 48/1 48/19 48/23 49/11 67/18 67/23 75/23 95/17 96/21 132/15 133/7 204/20 204/20 205/8 205/14
divisional [50] 2/10 2/11 2/14 2/20 2/23 3/18 4/10 4/12 5/13 6/2 6/20 6/24 6/25 7/17 7/25 8/20 9/18 10/6 11/2 11/14 12/4 13/25 17/16 17/20 19/25 20/16 21/12 22/11 23/6 24/9 24/10 25/21 25/24 26/5 30/20 30/23 35/22 39/23 45/17 48/4 48/20 107/11 119/4 119/7 121/3 123/15 132/15 132/19 205/11 205/23
divisions [4] 69/13 70/12 102/22 121/16
do [157] 1/10 8/18 8/19 8/24 12/16 13/4 18/23 19/9 20/4 21/12 23/1 32/2 33/3 33/23 35/3 35/23 36/5 36/14 39/14 49/18 50/12 50/17 51/6 53/14 53/18 54/7 56/6 57/7 57/22 58/7 58/10 59/10 61/18 63/25 70/4 71/22 75/7 75/8 76/15 77/21 79/3 79/17 79/19 80/13 82/2 82/8 83/13 83/15 83/23 88/7 90/16 91/9 91/11 91/12 97/4 97/12 100/7 109/11 112/15 114/3 114/25 115/5 115/7 115/23 119/11 119/12 127/19 127/22 128/18 132/7 133/1 133/2 133/17 134/8 134/13 134/15 134/23 136/2 148/1 149/13 151/7 153/4 155/8 161/6 161/11 163/8 165/14 166/12 172/6 176/13 176/13 177/6 178/3 179/7 180/24 180/24 180/25 181/5 181/23 183/10 183/11 184/6 186/15 187/19 189/2 191/5 191/25 193/10 193/12 193/14 205/7 205/17 208/25 210/6 210/8 218/1 219/2 219/18 221/11 222/6 222/9 222/19 223/3 223/4 223/8 223/9 223/19 227/12 227/24 230/4 230/25 231/12 231/18 232/8 233/3 233/12 234/25 235/4 236/25 237/9 238/18 239/17 242/2 242/3 242/11 242/16 243/6 243/7 243/8 245/11 246/6 249/25 252/3 253/15 253/18 253/18 255/7
doctor [4] 32/24 58/8 113/24 183/5
doctor's [1] 61/25
doctors [8] 49/6 111/8 111/11 139/18 174/14 189/19 189/21 189/23
document [38] 43/3 43/4 47/1 98/2 98/6 103/14 103/16 104/13 104/17 104/22 107/6 107/25 109/12 112/6 112/8 118/9 118/10 119/25 120/18 121/18 133/18 175/22 176/5 176/9 176/11 176/13 180/6 187/24 214/14 221/13 223/25 234/13 239/2 242/24 242/25 243/3 243/9 243/16
documentation [2] 129/3 212/10
documented [3] 11/23 11/24 133/11
documents [12] 37/2 77/23 98/13 104/16 112/7 118/7 140/14 204/4 219/14 242/2 242/6 244/23
does [26] 8/21 28/5 31/17 84/10 112/16 112/17 112/21 116/1 125/5 129/17 130/23 131/24 135/21 135/21 137/10 139/12 155/22 173/9 183/12 186/19 200/23 212/2 212/3 214/17 226/6 249/19
doesn't [18] 51/19 55/17 68/1 115/25 118/15 136/17 139/3 139/4 149/3 182/9 198/10 199/8 210/2 211/24 212/4 231/17 246/13 249/18
doing [10] 33/21 76/5 82/9 82/25 83/17 90/19 113/7 184/8 210/4 246/5
don't [130] 8/17 17/7 17/11 31/19 33/1 37/3 38/19 42/20 42/20 43/10 43/11 44/16 44/25 45/9 45/10 45/14 50/15 63/24 72/18 74/13 79/6 85/24 90/13 91/13 93/21 95/4 95/22 95/22 101/1 101/1 101/4 105/1 107/21 110/20 113/16 113/18 115/10 116/17 116/23 117/9 118/19 122/18 123/3 123/8 127/21 130/13 131/18 138/12 138/18 140/8 142/14 146/2 150/2 152/15 155/10 155/10 162/24 164/10 167/9 168/6 168/21 172/14 176/12 178/1 179/11 180/3 183/18 183/21 183/22 184/19 189/20 191/20 193/2 195/23 197/10 197/17 202/16 202/17 203/11 203/16 203/20 207/24 209/7 209/13 209/13 209/22 209/23 210/7 214/8 214/8 222/17 223/20 223/21 224/22 225/13 226/25 227/2 228/24 229/5 229/5 230/5 230/7 230/8 231/17 231/21 232/2 232/6 233/4 233/5 233/19 235/6 235/9 238/7 238/7 238/20 238/21 238/22 239/13 239/24 240/8 241/18 244/14 245/14 246/23 247/4 247/4 252/12 252/12 253/10 254/4
done [37] 21/1 21/22 22/6 22/13 50/16 113/9 114/5 137/12 137/13 137/13 162/4 162/5 162/8 166/1 170/23 182/10 184/11 186/14 187/10 187/22 197/23 199/2 206/16 219/5 220/16 220/20 225/15 226/16 227/3 228/23 229/2 229/12 229/16 233/13 237/19 237/24 249/15
doom [2] 33/16 33/20
door [1] 5/23
doubt [3] 37/3 76/23 77/2
doubting [4] 35/3 35/5 35/11 35/14
down [31] 1/10 7/5 24/13 43/21 46/16 50/21 58/21 58/23 89/7 95/25 106/16 109/9 112/19 114/6 118/11 119/21 121/24 123/16 132/10 135/25 157/18 170/21 173/24 177/3 184/17 197/16 197/16 213/7 230/25 231/4 252/12
downgrade [5] 46/6 46/13 46/23 125/19 188/22
downgraded [4] 46/12 124/2 124/22 211/17
downgrading [1] 46/14
downstream [1] 148/7
downwards [1] 112/22
Dr [140] 4/12 4/16 7/18 7/19 7/21 12/21 13/3 13/4 15/2 16/20 16/20 16/23 16/24 16/24 17/6 18/3 20/1 20/1 20/8 20/8 21/3 21/25 22/15 23/7 23/22 25/19 27/14 27/15 29/1 31/14 31/16 31/22 32/2 32/5 32/10 32/11 32/18 32/19 33/3 33/8 33/15 33/20 33/23 35/4 35/11 35/24 36/1 36/23 36/24 37/12 37/13 39/16 39/16 39/20 40/9 40/18 40/21 41/7 41/12 41/13 41/19 41/19 41/20 41/20 42/15 42/18 42/18 42/19 43/5 43/18 44/2 48/19 48/19 49/19 49/24 50/4 50/5 50/24 51/3 51/20 52/1 54/18 55/4 56/7 56/11 57/19 58/2 58/3 58/19 58/19 59/12 59/17 59/17 61/17 74/7 84/8 85/3 85/10 86/2 86/11 87/10 87/11 87/19 88/12 90/21 90/23 91/6 91/10 91/15 92/9 92/10 140/10 140/11 143/7 150/24 151/7 153/25 156/10 156/17 166/17 171/3 173/18 174/5 175/1 175/19 180/11 180/20 181/5 191/4 191/17 191/21 196/4 196/15 200/4 220/11 243/13 245/7 250/19 250/20 250/23
Dr Brearey [52] 7/19 12/21 13/3 13/4 16/20 16/23 20/1 20/8 21/3 32/11 33/8 33/20 36/24 37/13 39/16 40/21 41/12 41/19 41/20 42/18 42/19 43/5 58/3 58/19 59/17 74/7 84/8 85/3 85/10 86/2 86/11 87/10 91/6 91/10 92/9 140/10 140/11 150/24 151/7 153/25 156/10 166/17 171/3 175/19 180/11 181/5 196/15 200/4 220/11 243/13 250/19 250/20
Dr Brearey's [9] 48/19 87/19 88/12 90/21 90/23 143/7 156/17 173/18 245/7
Dr Brigham [1] 15/2

D

Dr Davies [1] 180/20
Dr Gibbs [4] 191/4 191/17 191/21 196/4
Dr Jayaram [65] 4/16 7/18 7/21 16/20 16/24 16/24 17/6 18/3 20/1 20/8 21/25 22/15 23/7 23/22 25/19 27/14 27/15 29/1 31/14 31/22 32/2 32/5 32/10 32/18 33/3 33/15 33/23 35/11 35/24 36/1 36/23 37/12 39/16 39/20 40/9 40/18 41/7 41/13 41/19 41/20 42/18 43/18 44/2 48/19 49/19 49/24 50/4 50/24 51/3 51/20 52/1 54/18 55/4 56/7 56/11 57/19 58/2 58/19 59/12 59/17 61/17 87/11 92/10 174/5 175/1
Dr Jayaram's [6] 31/16 32/19 35/4 42/15 50/5 91/15
Dr Martin [1] 4/12
draft [1] 236/6
drafted [1] 140/16
draw [1] 3/6
drawer [3] 33/15 33/20 33/22
drawn [2] 111/9 147/16
draws [1] 183/4
driven [4] 159/24 172/11 191/1 191/1
drives [1] 73/14
driving [2] 106/4 141/20
drug [3] 113/2 113/2 113/3
due [15] 28/11 29/7 30/4 30/12 57/20 84/17 106/11 108/2 118/3 119/18 153/12 189/13 190/2 220/1 239/24
Duncan [4] 122/11 122/13 122/18 122/19
during [11] 18/7 53/14 57/15 66/7 76/17 78/6 81/11 82/25 83/23 85/4 113/24
duties [1] 76/11
duty [44] 64/4 176/4 188/10 188/11 193/22 194/1 210/13 210/14 210/15 210/16 210/19 210/20 210/21 211/4 211/22 212/3 212/7 212/11 214/2 214/4 214/9 214/18 215/6 215/9 215/10 215/15 215/22 224/20 227/6 227/9 227/11 227/15 227/16 227/18 228/1 228/5 228/10 228/16 228/18 230/25 238/3 238/9 238/15 238/17
dying [8] 19/18 19/19 19/23 20/3 97/9 125/7 176/20 249/20
dynamic [1] 59/22

E

E's [1] 160/7
each [16] 75/12 75/12 93/3 104/4 145/23 154/12 170/20 171/16 171/24 171/24 173/6 175/23 177/9 233/10 234/6 234/11
earlier [17] 20/23 40/16 50/11 124/13 132/3 137/15 143/7 144/18 162/5 199/12 205/16 215/2 237/9 238/14 244/23 245/21 249/13
early [6] 5/17 14/23 28/19 46/5 72/11 247/21
early July [1] 28/19
easy [3] 70/19 93/11 114/16
Education [1] 94/12
effect [4] 56/24 82/25 202/12 240/24
effective [11] 69/8 69/20 69/22 70/5 71/14 72/4 72/6 72/21 92/15 170/6 181/4
effectively [6] 136/12 158/1 178/11 184/8 191/9 204/11
effectiveness [2] 73/15 126/1
effort [1] 129/20
efforts [1] 172/4
eg [1] 146/18
eight [6] 119/6 162/21 163/24 165/2 201/18 209/11
Eirian [14] 12/24 12/25 13/3 13/5 13/10 18/2 22/3 22/15 49/15 89/7 163/9 163/20 183/2 196/18
Eirian Powell [11] 12/24 13/3 13/5 13/10 18/2 22/3 49/15 163/9 163/20 183/2 196/18
either [26] 13/3 18/6 20/1 20/7 20/9 22/16 30/18 30/20 30/21 39/1 106/5 108/7 108/13 108/18 113/19 122/21 151/20 152/12 161/5 173/8 176/4 191/17 230/13 242/1 242/10 250/4
electronic [2] 50/10 50/13
element [3] 145/16 145/17 245/4
elements [1] 161/10
else [11] 3/6 5/11 24/14 42/2 61/24 166/17 202/25 224/25 232/25 251/7 255/9
email [62] 40/14 43/4 43/11 47/6 47/9 47/10 85/11 85/25 91/7 92/13 93/9 93/14 95/20 95/23 143/7 146/5 146/7 146/21 147/19 152/22 153/3 157/25 163/10 163/13 163/17 163/23 164/7 178/24 179/15 179/18 179/23 180/5 180/8 180/10 180/11 181/7 182/24 183/15 183/16 205/19 215/2 215/21 219/7 219/17 219/22 220/7 221/13 224/2 225/3 225/15 225/20 226/3 228/20 228/24 230/2 238/10 242/7 250/14 250/17 250/20 251/6 252/5
emailed [1] 175/18
emails [10] 47/2 47/16 168/7 178/19 178/22 181/1 219/12 221/9 223/21 230/5
embarrassed [1] 254/23
embarrassing [1] 254/13
emergency [1] 133/14
emerging [3] 96/11 97/3 129/15
employee [2] 85/1 213/16
employees [2] 104/14 213/1
employment [1] 2/2
enable [2] 140/21 195/1
enabling [1] 106/20
encouraging [1] 78/2
end [8] 140/2 170/1 192/21 202/9 217/10 219/2 230/15 242/14
ended [1] 187/2
ends [2] 112/20 158/8
engaged [3] 68/13 172/7 199/10
engagement [2] 170/12 172/5
England [3] 137/5 141/22 161/19
enough [10] 100/6 114/6 114/21 116/16 123/17 151/12 201/4 201/4 201/5 204/17
enquiries [1] 37/8
ensure [22] 6/15 42/11 74/5 78/4 78/10 78/16 81/20 85/7 103/7 103/9 111/12 130/24 132/13 148/15 181/11 206/2 210/12 212/2 212/3 212/6 214/18 237/14
ensured [1] 70/25
ensuring [4] 69/8 70/16 206/6 211/21
enter [2] 11/4 11/15
entered [2] 30/19 120/23
entirely [5] 18/20 153/15 215/6 242/16 243/9
entirety [1] 106/23
entitled [1] 175/19
entries [2] 126/7 132/25
entry [5] 120/5 129/15 134/6 134/13 157/8
environment [2] 73/11 87/22
envisaged [1] 88/1
equipment [1] 138/4
equipped [1] 97/17
equivalent [4] 234/24 235/5 235/13 244/25
ERR [4] 120/24 121/15 121/17 121/21
error [9] 104/11 113/1 114/17 114/20 146/18 147/5 147/10 147/13 154/21
errors [3] 114/16 240/21 240/21
escalate [7] 57/23 71/24 76/1 83/5 135/5 204/16 230/2
escalated [13] 37/16 39/22 40/20 41/9 44/2 78/23 105/5 105/11 150/7 161/24 168/2 185/20 186/6
escalating [2] 65/2 133/3
escalation [12] 58/21 70/15 78/17 94/20 95/9 95/15 103/9 119/14 121/17 133/12 133/22 204/3
escalations [1] 133/9
essence [1] 9/23
essentially [19] 65/13 74/4 76/2 76/11 81/10 83/7 101/8 102/8 116/22 139/22 150/9 150/9 157/17 159/13 169/3 171/3 203/19 225/10 225/11
established [1] 210/18
estate [2] 10/24 11/5
estate-wise [1] 10/24
Esther [1] 63/1
even [7] 48/5 72/3 139/23 153/15 167/18 200/24 203/20
evening [1] 59/9
event [13] 19/23 21/17 24/13 108/8 108/11 114/23 138/22 139/2 139/25 141/8 160/20 174/22 223/24
events [15] 22/21 22/22 24/4 25/6 39/9 70/8 150/15 159/19 160/18 194/14 199/22 202/4 215/13 224/23 230/14
eventually [1] 6/8
eventuated [1] 44/3
ever [8] 52/25 113/16 122/19 139/22 195/24 207/24 216/17 233/25
every [15] 7/12 7/14 7/22 18/2 21/25 49/25 85/24 94/2 98/22 139/4 139/17 144/4 145/1 145/9 181/2
everybody [7] 1/3 158/11 159/1 159/2 160/3 161/22 193/9
everyone [1] 111/13
everyone's [1] 70/17
everything [1] 93/21
evidence [37] 12/7 12/11 18/5 23/20 24/2 25/11 27/22 31/20 33/21 34/1 34/1 36/11 38/6 38/23 39/2 41/21 44/7 44/11 49/24 50/5 51/23 62/4 94/4 113/17 116/11 142/1 153/3 198/3 201/4 203/8 210/11 221/6 223/6 243/24 245/21 247/22 248/23
evidenced [1] 59/24
Evidently [1] 215/5
evolution [4] 70/9 72/7 74/22 84/18

E

evolved [1] 159/22
evolving [1] 149/10
exact [2] 124/20 185/9
exactly [5] 102/3 139/4 142/6 173/1 205/6
examination [3] 153/12 153/13 232/14
example [7] 5/15 16/20 25/1 96/24 107/16 113/1 200/12
examples [1] 104/5
excellent [1] 161/8
exchange [1] 40/14
exclude [2] 164/13 201/5
excluded [1] 47/23
Execs [1] 171/10
executive [64] 8/22 9/18 10/10 10/14 10/16 10/25 28/15 31/10 37/5 43/1 44/7 46/3 48/18 48/20 48/21 48/21 59/20 60/17 60/24 61/6 61/9 61/11 69/5 92/12 100/16 100/23 101/12 101/16 102/22 103/1 103/10 105/16 105/25 106/17 107/7 107/12 120/8 121/4 122/5 124/1 127/12 127/20 132/1 132/6 132/15 132/19 143/14 148/1 158/9 158/10 158/15 165/22 186/6 188/22 189/9 194/25 201/7 204/16 205/15 205/19 206/11 210/24 233/22 239/18
Executives [37] 10/13 25/7 26/9 37/17 39/18 40/17 41/22 41/23 48/23 49/7 49/9 88/19 92/1 159/3 169/20 171/6 171/18 173/10 186/13 186/21 189/6 189/18 190/1 190/23 192/13 197/14 198/13 198/22 201/1 208/22 209/8 209/11 211/8 211/9 217/2 218/9 221/16
exercise [1] 211/5
exhibit [1] 53/5
exist [2] 97/1 112/16
existed [1] 139/13
exit [1] 133/15
expand [1] 79/7
expect [16] 38/5 49/14 88/7 97/15 101/11 104/21 105/23 106/8 116/25 117/4 137/18 139/9 165/10 168/16 180/4 205/8
expectation [10] 39/24 40/11 82/15 83/3 83/7 89/24 90/15 159/2 174/15 241/20
expectations [2] 89/9 91/5
expected [24] 19/18 24/12 26/14 26/16 68/21 83/2 83/15 87/20 88/3 97/10 105/3 105/5 110/7 110/22 144/10 144/13 158/25 164/19 164/21 164/25 166/10 168/8 201/17 204/14
expecting [3] 51/21 205/7 239/7
expense [1] 81/5
experience [14] 10/15 31/9 63/16 66/22 67/2 67/9 69/2 71/9 76/7 84/23 89/23 90/21 98/22 141/13
explain [11] 9/16 10/18 19/22 89/8 104/10 146/23 148/13 150/2 177/25 206/17 215/8
explained [6] 21/24 29/6 58/17 78/15 91/4 91/6
explanation [11] 25/2 25/3 153/7 156/18 156/19 176/19 183/19 200/10 201/24 232/15 232/18
explanations [1] 156/10
explicit [3] 56/12 98/18 189/25
explore [2] 87/4 100/3
explored [1] 139/10
exploring [2] 92/3 115/12
express [1] 145/25
expressed [1] 41/8
expresses [1] 86/3
expressing [1] 237/10
expressly [1] 23/22
external [7] 24/13 26/24 29/16 61/2 128/15 162/6 169/2
externally [4] 7/2 135/19 237/3 248/8
extra [2] 233/14 233/17

F

face [2] 17/15 153/14
Facere [7] 1/21 32/21 186/9 186/10 186/16 187/12 253/23
Facere Melius [7] 1/21 32/21 186/9 186/10 186/16 187/12 253/23
faceted [1] 80/11
facets [1] 177/10
facilitate [1] 89/19
Facilitator [3] 65/6 65/12 88/9
facing [7] 98/24 99/3 99/7 130/10 160/13 170/12 172/13
fact [48] 3/7 3/11 15/1 18/24 19/4 19/22 22/23 27/2 27/3 29/15 35/1 36/1 44/3 46/9 49/7 57/5 72/21 79/3 81/15 87/11 91/9 100/22 118/12 126/9 128/19 131/9 133/1 133/2 134/6 146/12 152/20 155/6 159/22 164/6 173/14 178/23 183/13 194/23 198/5 198/8 199/17 200/23 201/23 204/9 225/9 241/13 242/25 249/23
fact-finding [1] 29/15
factor [4] 197/13 197/20 198/2 199/5
factors [5] 94/11 127/1 168/10 177/8 197/14
facts [5] 19/16 64/18 64/20 110/14 145/7
factual [1] 36/10
failing [1] 20/6
failure [1] 59/7
failures [3] 152/1 158/22 163/4
fair [13] 16/25 38/16 64/2 77/8 83/1 93/6 140/4 140/7 150/3 221/5 252/20 252/22 254/20
fait [1] 91/11
fall [1] 84/10
fallen [2] 22/10 84/14
familiar [2] 43/11 119/20
families [11] 48/14 114/13 206/19 207/10 207/10 216/7 216/14 216/18 217/15 236/1 238/16
family [22] 48/15 59/6 174/24 212/2 215/16 216/11 227/21 227/23 228/12 230/8 235/7 235/23 236/12 238/25 240/12 242/13 242/22 243/4 243/9 244/8 244/12 244/21
far [18] 9/6 37/14 111/8 117/4 129/10 129/10 129/12 132/5 134/7 145/24 155/22 177/14 190/4 198/1 201/14 245/11 249/21 252/12
fatal [1] 191/10
father [1] 211/15
fault [1] 118/21
feature [1] 185/24
features [1] 167/15
February [22] 21/1 21/22 22/25 47/9 47/12 75/17 75/24 78/20 82/18 82/21 128/11 129/8 134/6 142/21 166/22 169/14 173/15 173/18 219/21 225/4 225/15 245/9
February 2016 [2] 129/8 134/6
fed [3] 142/25 215/5 241/20
feed [2] 205/9 239/19
feedback [24] 69/13 69/14 69/14 70/18 75/2 93/1 93/1 93/24 94/2 94/4 94/7 143/15 155/13 160/14 171/4 172/17 172/18 215/3 215/11 215/12 215/22 215/23 218/21 242/9
feeding [2] 173/2 188/25
feel [19] 6/1 18/22 24/25 26/2 27/9 32/2 39/15 41/14 116/23 161/12 161/13 198/19 204/16 206/19 210/25 211/18 254/22 255/5 255/7
feeling [1] 227/22
feet [1] 207/3
fell [4] 2/17 6/17 14/10 15/10
felt [37] 12/11 18/19 26/20 27/22 36/10 39/11 39/12 39/16 41/13 45/23 45/23 45/24 46/2 71/23 72/5 80/17 80/17 81/16 81/25 81/25 82/2 82/3 87/4 92/11 100/7 107/15 128/2 130/6 141/1 181/5 188/23 201/20 201/22 201/22 201/24 203/6 255/4
few [7] 5/4 18/3 21/25 48/9 78/6 229/25 247/15
file [3] 239/3 239/22 242/12
filled [5] 142/16 145/2 153/14 174/7 214/10
filling [3] 110/6 136/7 215/7
final [14] 47/1 91/23 153/9 155/23 158/13 178/24 180/6 192/6 192/13 214/13 223/11 236/13 237/25 242/24
finalised [6] 131/24 155/19 180/16 180/17 181/9 182/22
finally [3] 61/16 84/18 107/25
finance [2] 8/5 9/2
financial [1] 10/23
find [8] 7/20 27/24 61/21 68/7 94/14 140/25 148/10 186/3
finding [1] 29/15
findings [5] 153/10 155/19 197/9 198/12 199/3
fine [1] 68/8
finish [1] 247/18
finished [1] 60/8
firmly [1] 198/17
first [38] 2/3 6/12 13/16 17/16 21/20 21/21 28/4 31/21 31/24 31/25 34/16 35/5 47/4 47/11 50/12 54/6 54/12 63/15 110/20 110/21 111/5 112/23 119/16 120/9 121/1 126/17 150/11 150/19 156/24 157/10 163/23 176/12 177/20 188/17 189/20 197/13 217/20 234/13
firstly [7] 72/25 75/6 86/15 121/25 132/4 202/15 235/16
fits [1] 235/18
five [3] 67/8 162/22 176/22
five months [1] 162/22
five or [1] 67/8
flag [1] 177/5
flagging [1] 238/12
flow [3] 81/13 133/13 133/14
flowchart [1] 110/17
fluid [1] 227/17
focus [23] 67/17 73/2 77/11 79/21 80/19 81/14 82/1 82/9 83/18 83/20 87/2 96/10

F

focus... [11] 98/16 134/23 141/2 143/23 148/15 150/14 158/20 159/11 179/13 217/16 248/3
focused [15] 67/18 73/4 73/11 74/11 77/19 98/1 110/4 124/16 124/17 133/8 133/10 133/12 167/10 179/4 184/17
focusing [6] 81/4 126/19 128/5 128/5 179/7 222/3
Fogarty [10] 74/8 87/3 87/12 88/20 91/19 92/2 92/18 150/23 156/10 192/5
follow [5] 55/10 55/12 131/24 155/22 183/12
following [17] 28/14 38/20 40/14 40/17 41/2 43/16 49/14 59/12 85/15 88/4 89/4 103/7 104/5 143/14 169/15 186/8 238/4
follows [1] 155/9
font [1] 238/1
foremost [2] 112/23 188/17
foreseeable [1] 47/15
forgetting [2] 81/18 87/17
forgive [9] 69/19 97/9 118/11 118/14 151/23 182/25 196/22 197/16 250/21
forgotten [2] 89/11 250/18
form [6] 63/23 120/20 140/21 144/25 175/3 193/8
formal [6] 3/4 34/13 49/21 50/4 51/16 109/15
formally [5] 47/22 48/1 48/3 166/11 205/9
format [4] 234/23 235/20 237/15 244/11
formatted [1] 237/14
former [1] 133/7
forms [4] 109/14 214/2 214/17 215/7
forum [4] 6/24 10/14 35/7 147/4
forums [1] 148/23
forward [10] 20/8 20/10 138/4 154/2 166/21 179/10 182/23 183/23 188/6 234/10
found [9] 35/6 74/17 128/4 142/14 150/25 151/12 184/12 198/17 234/8
four [5] 7/14 155/17 162/21 176/22 183/8
four days [1] 183/8
fragility [5] 75/25 76/13 76/15 79/2 79/16
frame [1] 107/20
framed [2] 123/23 131/20
framework [22] 100/17 107/16 134/24 135/23 141/23 146/16 150/8 151/15 157/21 157/22 158/2 158/18 158/25 159/4 159/10 159/23 160/1 163/7 174/20 233/6 233/16 233/21
frameworks [1] 148/22
free [2] 62/6 255/11
freely [1] 165/25
frequently [2] 85/5 109/19
fresh [1] 110/14
Friday [10] 34/15 34/18 38/24 38/25 40/18 42/10 42/14 146/12 163/18 239/8
friend [1] 210/1
front [6] 5/23 74/19 92/25 192/12 233/5 233/15
fulfil [1] 5/3
fulfilled [2] 212/3 212/7
fulfilling [2] 76/11 83/8
full [12] 1/13 59/23 62/24 76/20 79/18 79/19 82/25 83/10 83/13 83/16 209/8 240/18
full-time [3] 82/25 83/13 83/16
fuller [1] 160/23
fully [4] 59/24 87/9 92/8 206/15
functioned [1] 75/6
functions [1] 102/12
fundraising [2] 170/11 172/4
further [48] 16/12 24/20 34/23 37/8 39/12 39/13 40/23 41/25 42/21 57/16 57/17 58/20 59/16 59/18 76/18 100/7 103/18 126/13 127/2 135/16 138/14 139/10 148/7 154/8 154/10 156/21 160/17 169/1 174/4 179/10 187/1 191/25 197/2 208/24 209/1 213/7 226/1 226/24 232/20 235/11 239/21 240/14 241/22 241/24 241/25 246/21 252/6 253/9
furthermore [1] 156/1
future [4] 47/15 161/12 170/13 172/13

G

gain [2] 36/17 59/15
gap [6] 20/5 69/15 76/23 79/16 83/19 157/16
gaps [4] 79/11 81/7 151/9 161/9
gather [1] 198/20
gauging [1] 120/21
gave [9] 41/20 79/4 153/25 156/10 171/5 175/2 210/11 213/24 221/5
general [5] 49/20 50/19 50/22 92/24 134/3
generalised [1] 230/24
generally [3] 14/2 165/23 202/20
generate [2] 135/21 135/22
generated [1] 137/21
genuine [2] 35/4 37/3
gestation [1] 126/22
gesticulated [1] 33/15
gesticulating [1] 33/18
get [24] 28/13 51/3 58/19 63/11 64/2 64/21 81/16 86/19 87/22 94/2 99/4 109/16 110/20 127/18 132/18 142/12 168/10 172/18 175/15 178/19 182/2 205/21 249/21 251/5
getting [4] 88/17 190/2 232/25 250/15
Gibbs [4] 191/4 191/17 191/21 196/4
give [30] 5/14 19/22 35/7 77/16 82/2 82/3 91/20 93/5 113/5 114/25 117/9 118/14 127/19 144/17 153/10 172/11 174/23 179/5 179/10 199/25 235/16 237/15 237/17 239/21 241/4 241/8 241/24 243/2 246/9 246/16
given [34] 15/6 25/20 27/21 36/11 44/1 56/6 56/21 59/13 70/12 82/1 103/23 103/24 108/4 113/2 113/3 119/20 119/23 121/8 123/17 123/20 126/8 129/25 162/8 166/13 166/18 169/19 188/21 198/3 201/23 203/8 205/2 214/22 225/3 248/23
giving [3] 161/4 183/18 243/24
globally [1] 118/6
go [103] 4/20 7/5 7/6 7/7 9/25 10/13 10/25 12/11 20/1 20/9 20/20 24/7 26/11 26/22 27/9 28/1 28/15 34/16 37/23 39/14 41/11 41/13 41/14 41/18 41/22 43/2 44/25 45/1 46/5 47/4 47/10 49/16 53/4 56/11 58/4 59/2 59/15 59/19 60/17 61/20 62/6 65/19 66/2 71/25 72/18 75/22 79/13 85/22 85/23 85/24 87/10 88/20 89/12 92/11 96/5 98/3 100/11 103/22 104/16 105/1 106/8 106/13 107/13 109/16 117/4 119/13 120/1 120/9 120/17 120/22 132/20 132/23 134/10 136/4 140/15 141/9 142/7 143/8 146/8 146/13 147/18 157/9 158/14 165/6 181/9 182/25 185/17 196/22 204/17 212/16 212/25 214/1 214/13 217/9 221/17 223/24 226/11 227/10 236/24 239/25 241/9 250/11 255/11
goes [4] 98/21 130/3 214/22 238/11
going [87] 7/16 11/7 14/7 17/5 17/22 24/13 25/9 27/13 30/6 34/19 34/22 35/16 35/23 37/4 37/8 45/7 48/9 49/9 58/23 61/1 63/9 64/15 64/15 75/4 78/3 81/12 85/9 87/10 89/2 92/13 93/3 96/1 97/23 108/4 108/17 109/18 113/7 117/20 118/5 119/5 122/17 126/4 127/14 128/18 134/6 136/1 140/1 149/11 156/4 163/11 165/5 168/9 168/9 172/4 175/5 178/3 187/14 189/5 190/17 193/5 193/17 200/10 201/10 203/22 204/23 212/17 216/2 217/16 219/13 220/19 224/15 226/1 226/14 229/1 229/11 229/15 229/16 234/10 238/25 239/10 240/5 241/12 242/14 244/23 248/15 251/3 252/6
gone [14] 22/18 22/25 39/17 40/23 42/17 42/18 43/17 156/22 156/23 180/18 206/10 206/12 225/18 225/18
good [11] 1/3 75/3 84/25 170/6 170/6 170/8 171/11 171/23 172/11 206/2 207/8
gosh [1] 194/2
gossip [4] 187/16 252/25 253/1 255/3
gossiping [2] 253/11 255/3
gossipy [1] 186/4
got [17] 36/23 37/2 39/2 44/12 44/24 97/12 106/5 106/6 115/3 120/20 151/23 154/23 184/2 216/11 231/5 238/13 244/5
governance [57] 6/24 6/25 11/17 12/3 13/18 14/14 14/22 17/21 20/13 20/17 23/17 25/5 47/22 66/25 69/11 69/12 70/9 71/2 71/16 72/8 75/13 76/9 94/21 95/14 102/14 106/21 119/8 119/15 121/7 132/11 132/20 132/21 132/24 133/25 166/3 166/14 168/1 168/15 169/7 180/15 180/18 181/9 181/12 181/15 181/24 182/2 182/6 182/16 204/2 204/10 204/12 205/1 205/9 205/23 206/2 206/22 252/7
graded [1] 10/12
grading [2] 212/21 212/22
granted [1] 62/16
graphs [9] 190/7 190/11 190/18 196/23 196/24 196/25 197/1

G
graphs... [2] 197/4 197/6
grass [1] 148/2
grateful [1] 244/10
great [1] 134/22
greater [2] 30/7 87/2
greatest [1] 98/16
green [1] 252/1
grey [1] 229/14
grid [1] 246/8
grievance [1] 202/6
ground [2] 6/16 146/4
group [25] 67/10 67/11 73/10 73/13 73/23 73/24 95/18 100/15 100/21 100/23 101/2 120/13 122/20 122/23 123/7 123/10 131/1 133/21 181/9 204/22 205/9 205/22 205/25 217/15 237/6
groups [1] 73/1
guidance [12] 80/12 81/15 81/20 82/4 86/25 92/5 111/16 113/18 137/8 137/14 248/3 248/17
guidelines [4] 80/20 109/14 110/10 111/14
gynaecology [2] 15/11 84/5

H
had [328]
hadn't [12] 17/10 19/20 37/19 37/20 40/9 106/5 129/16 142/24 180/7 201/21 232/12 249/2
half [5] 40/8 79/18 79/20 136/4 225/14
halfway [2] 230/24 231/4
hand [7] 4/20 78/5 110/21 120/12 151/24 233/19 248/25
handler [4] 28/5 28/5 28/6 142/17
handover [4] 2/25 3/4 21/15 95/5
handwriting [2] 54/10 149/14
handwritten [2] 149/13 154/16
hang [1] 168/12
happen [5] 49/25 77/21 114/15 114/17 164/15
happened [27] 31/2 106/10 115/13 115/15 115/19 115/20 116/13 116/14 136/13 136/24 138/13 139/8 139/15 139/17 139/25 143/13 161/10 164/13 165/23 174/12 184/16 206/18 212/9 215/13 215/19 228/11 241/22
happening [7] 78/18 96/18 97/4 148/19 160/24 189/19 202/25
happens [2] 70/20 81/11
happy [1] 99/6
hard [1] 94/14
harder [2] 93/12 133/20
harm [49] 34/23 35/25 36/3 36/3 36/6 37/10 41/5 44/13 54/7 57/20 58/11 104/2 104/4 110/23 111/2 113/8 114/10 114/21 114/23 115/2 116/2 125/11 136/12 136/15 136/23 138/8 144/20 144/22 145/4 150/12 150/16 150/22 151/13 156/13 159/12 174/21 189/15 199/22 199/23 199/25 212/22 214/22 216/2 216/23 228/7 245/25 246/3 246/6 246/15
harm/death [1] 212/22
harmed [5] 111/3 200/2 208/4 245/13 245/15
harming [13] 23/10 26/21 27/16 32/12 45/18 58/9 58/12 116/7 195/9 195/22 207/23 216/13 245/19
harms [1] 228/9
Harper [12] 217/22 219/17 219/25 221/14 224/2 225/21 226/4 228/21 229/24 238/9 242/7 243/24
Harper-Lea [4] 217/22 219/17 219/25 224/2
Harvey [6] 143/16 154/17 181/8 190/9 197/3 201/9
has [82] 7/7 15/25 39/4 47/8 56/23 62/15 69/4 74/8 74/20 80/4 81/12 90/3 90/7 90/18 93/15 93/17 93/18 97/12 100/19 103/20 106/16 111/2 111/15 114/9 114/21 115/7 115/13 115/15 115/19 116/1 122/5 137/1 137/12 137/17 137/18 137/22 138/10 138/13 138/13 138/14 139/8 143/9 143/11 143/16 144/12 145/3 145/15 146/24 147/6 147/11 150/8 150/12 154/21 157/15 157/16 158/18 159/12 159/22 171/1 174/11 174/12 174/13 174/13 180/19 180/20 181/21 182/20 183/25 184/12 184/24 193/8 199/25 200/1 202/10 212/9 213/18 219/25 220/9 228/11 234/20 234/20 248/4
have [587]
haven't [8] 16/2 37/1 104/20 129/23 151/23 168/13 168/14 178/23
having [36] 12/18 33/20 34/13 34/15 39/23 49/14 53/20 61/16 64/23 72/7 76/23 77/1 92/4 111/21 113/13 113/13 133/17 142/10 144/22 157/6 162/2 163/21 164/17 172/10 184/11 186/12 187/10 187/19 197/2 200/5 201/1 203/20 205/21 205/23 210/5 254/12
he [66] 7/21 32/19 33/4 33/18 33/19 33/19 33/20 33/21 34/1 36/2 36/23 40/10 40/10 42/19 42/20 42/21 43/19 44/2 50/5 50/6 50/7 50/10 51/25 55/4 55/5 56/15 56/19 56/21 56/22 56/23 56/25 56/25 57/21 58/3 61/14 86/5 86/7 86/9 87/19 88/6 88/16 88/16 89/4 92/20 94/8 94/19 95/2 95/4 143/9 143/9 143/11 143/17 151/8 151/9 153/25 174/6 175/3 181/5 181/6 191/22 192/22 192/23 192/24 192/24 201/9 240/1
he's [2] 54/19 181/7
head [28] 4/18 8/22 10/7 35/17 35/22 37/7 66/2 66/9 68/20 71/11 75/6 77/6 78/9 87/3 94/12 101/10 101/24 102/20 106/15 106/18 140/6 170/19 170/19 176/8 209/10 217/22 217/23 219/17
headed [1] 203/23
heading [3] 98/6 100/12 110/23
health [3] 2/5 67/3 67/14
healthcare [1] 1/24
hear [6] 38/5 58/1 150/13 191/13 216/17 239/23
heard [20] 34/15 35/6 42/6 52/25 58/14 65/14 69/4 70/17 70/23 82/20 94/3 104/25 111/8 132/15 136/3 143/9 143/11 148/12 194/22 205/16
hearing [2] 33/2 186/24
heavily [2] 8/14 82/10
held [9] 9/22 10/16 10/20 10/25 31/8 122/5 123/8 156/22 218/7
help [38] 77/5 77/12 77/16 79/11 80/8 80/21 81/6 82/2 82/3 83/24 91/24 96/12 102/4 104/13 111/7 115/23 125/7 137/24 141/20 143/4 146/20 155/20 157/5 180/9 201/21 201/22 205/6 217/17 238/5 238/23 239/9 240/6 241/7 244/2 244/7 249/18 249/24 250/1
helpful [8] 68/10 91/17 92/8 92/9 141/24 145/14 148/16 202/1
helpfully [2] 243/22 249/13
helping [1] 78/1
hence [3] 39/13 49/21 62/16
her [70] 32/21 35/23 36/13 36/14 47/23 52/17 55/20 58/22 59/3 59/3 67/25 68/11 68/12 74/8 82/20 83/2 83/17 83/22 84/14 85/2 85/8 87/4 87/5 88/3 89/7 89/8 89/8 92/19 116/25 117/4 136/10 142/1 142/11 143/2 164/25 166/8 166/10 166/19 178/12 182/6 183/9 184/6 184/8 184/8 184/11 184/13 184/18 185/14 185/14 187/16 191/14 191/15 191/16 192/18 192/19 201/5 201/5 202/1 202/8 228/24 230/1 238/10 245/23 247/7 248/24 248/25 250/8 253/21 254/15 255/5
here [38] 19/17 20/2 28/8 28/24 33/11 38/13 74/11 85/14 86/20 105/17 110/21 116/4 121/25 126/16 126/19 126/25 128/8 130/12 130/21 131/8 136/6 137/4 144/24 161/18 181/17 188/5 196/23 198/8 202/25 207/10 208/25 213/1 213/5 225/12 225/17 227/11 229/16 234/18
herself [1] 166/19
hierarchy [1] 49/14
high [10] 60/13 98/15 99/2 99/10 99/18 117/23 124/11 124/24 183/4 183/13
higher [7] 24/11 128/16 165/16 189/13 190/2 194/19 195/14
highest [2] 123/21 197/21
highlight [2] 112/7 128/11
highlighted [4] 9/10 131/21 184/3 250/11
highlighter [1] 184/3
highlighting [1] 187/15
highly [1] 63/9
Hill [1] 64/7
him [6] 4/15 50/10 57/21 93/12 95/23 175/2
himself [2] 33/8 175/4
hindsight [1] 172/24
his [18] 23/8 31/17 39/21 50/7 50/24 56/15 58/3 88/16 91/16 143/8 143/12 151/8 191/22 207/3 210/1 215/2 217/18 222/6
hm [13] 23/12 24/16 49/1 76/14 80/7 83/14 85/21 86/4 132/22 158/3 162/14 163/12 224/7
hoc [4] 34/12 50/1 50/4 51/1
Hodkinson [2] 61/12 201/3
hold [1] 4/25
holding [3] 5/7 5/18 6/2

H

home [4] 41/13 41/14 42/4 54/13
honest [7] 45/24 78/3 113/12 202/7 203/16 238/20 247/4
honestly [5] 91/13 131/17 131/17 212/8 232/2
hope [3] 97/8 98/2 222/22
hospital [22] 2/3 24/15 33/13 54/13 64/7 64/25 96/10 97/13 97/16 99/3 99/11 106/23 133/15 133/15 165/14 169/24 188/19 216/12 219/5 239/18 240/1 240/17
hospital's [1] 85/17
hospitals [2] 98/21 126/21
hours [3] 79/18 79/18 157/2
how [65] 6/15 7/3 7/10 7/19 7/24 9/19 10/11 14/2 16/5 29/4 29/20 31/1 32/1 39/11 39/15 46/2 46/4 54/1 58/7 58/10 66/13 68/7 70/9 70/9 71/6 71/7 71/18 75/1 75/5 76/16 77/13 80/8 81/7 82/6 85/5 85/6 87/11 87/15 91/9 91/11 102/7 104/24 107/15 117/18 120/21 124/4 125/12 125/12 127/16 129/16 131/19 131/20 140/25 147/15 147/16 149/8 158/1 172/20 175/15 184/15 185/7 200/13 200/13 233/20 254/17
however [14] 29/1 37/23 56/15 76/25 146/17 153/11 153/12 156/20 173/17 183/6 189/10 204/14 204/17 237/13
HR [16] 61/11 111/16 111/16 111/20 131/10 131/10 185/15 186/25 187/6 253/20 253/22 254/8 255/1 255/1 255/6 255/6
Human [1] 94/11
hundred [3] 178/19 183/17 250/15

I

I absolutely [1] 91/2
I accept [2] 60/2 252/14
I acknowledge [1] 19/9
I actually [1] 135/3
I added [2] 76/3 103/17
I agree [1] 129/22
I also [7] 42/21 53/18 60/16 67/10 185/18 201/22 211/16
I am [78] 3/19 4/4 8/13 8/14 20/2 25/17 36/12 38/24 43/10 43/10 44/16 44/18 48/21 51/9 56/10 56/22 58/8 64/8 67/24 71/1 71/8 77/7 78/13 85/24 86/20 87/6 93/3 97/2 97/25 99/6 113/24 115/4 122/22 123/6 123/11 129/12 133/19 134/6 136/1 138/19 138/25 145/10 145/11 145/18 149/7 163/13 165/18 165/25 167/7 175/5 179/4 179/18 185/13 190/21 194/2 194/4 195/21 198/25 200/8 201/2 203/22 207/22 209/13 212/17 215/20 217/6 217/14 219/13 221/20 221/25 223/13 223/13 227/23 227/25 228/17 230/7 244/14 251/23
I apologise [3] 114/13 114/18 118/21
I appreciate [5] 8/11 32/22 168/5 206/19 244/6
I ask [4] 48/13 207/9 217/20 230/17
I asked [3] 201/20 211/14 248/25
I attended [2] 91/14 196/2
I barely [1] 232/3
I became [1] 75/16
I beg [1] 250/25
I believe [35] 2/4 11/18 15/9 41/21 47/21 59/13 59/17 74/2 103/16 117/25 125/18 135/15 143/13 143/15 143/18 147/2 163/15 168/18 179/22 181/15 181/23 186/14 190/9 190/12 194/2 194/3 197/3 201/20 203/3 206/22 218/7 222/23 223/20 246/18 253/23
I believed [2] 58/15 59/14
I can [34] 47/18 55/10 61/21 71/23 86/2 111/21 117/12 141/3 145/4 156/8 159/9 167/5 178/5 178/23 181/7 185/2 187/2 187/11 189/21 192/20 201/6 208/20 209/2 217/21 222/4 222/11 222/12 224/22 225/24 239/14 241/19 244/13 244/13 249/9
I can't [35] 6/13 45/12 54/8 55/5 55/5 55/6 61/12 101/7 104/10 111/15 111/24 114/3 122/6 124/20 127/19 130/13 143/17 168/22 172/13 176/23 179/5 183/15 185/8 186/9 194/5 206/17 212/14 217/1 223/13 226/24 232/2 232/2 235/10 239/21 241/24
I cannot [2] 167/9 179/5
I caution [1] 185/13
I cautioned [1] 185/14
I certainly [2] 74/13 155/10
I come [1] 120/3
I could [12] 41/12 47/1 71/24 76/4 91/4 142/3 157/9 167/5 173/25 177/14 219/9 242/24
I couldn't [1] 167/5
I did [24] 5/2 36/7 37/23 38/5 45/13 57/25 58/14 59/14 65/1 65/8 72/16 72/20 74/24 76/1 130/17 142/2 180/3 186/16 196/3 211/18 220/7 251/23 253/23 255/7
I didn't [37] 15/5 16/23 18/18 20/7 21/14 21/14 21/16 21/16 22/14 22/20 27/5 27/19 29/24 29/24 29/25 30/15 36/8 38/24 45/23 45/24 45/25 67/6 86/19 99/4 99/4 131/3 161/20 175/14 177/11 192/2 196/15 198/19 202/23 206/17 206/17 210/25 219/7
I do [24] 12/16 13/4 39/14 63/25 119/12 127/22 134/15 151/7 153/4 161/6 172/6 176/13 176/13 178/3 179/7 183/11 193/14 223/4 223/9 227/24 243/7 252/3 253/18 255/7
I don't [97] 17/7 17/11 31/19 42/20 42/20 43/10 43/11 44/16 45/9 45/10 45/14 50/15 63/24 79/6 90/13 93/21 95/4 95/22 95/22 101/1 101/1 101/4 113/16 113/18 116/17 116/23 118/19 122/18 123/3 123/8 130/13 140/8 142/14 146/2 152/15 155/10 162/24 164/10 167/9 168/21 172/14 176/12 178/1 179/11 180/3 183/22 184/19 189/20 191/20 193/2 195/23 202/16 202/17 203/11 203/16 203/20 207/24 209/7 209/13 209/13 209/23 214/8 214/8 222/17 223/20 223/21 224/22 225/13 226/25 228/24 229/5 229/5 230/5 231/17 231/21 232/6 233/4 233/5 233/19 235/6 235/9 238/7 238/7 238/20 238/21 239/13 240/8 241/18 244/14 245/14 246/23 247/4 247/4 252/12 252/12 253/10 254/4
I ensure [1] 130/24
I ever [1] 216/17
I expect [1] 88/7
I explained [1] 78/15
I felt [16] 27/22 39/12 45/23 45/23 46/2 71/23 72/5 80/17 81/25 82/2 82/3 141/1 188/23 201/20 201/22 201/24
I find [1] 94/14
I first [1] 176/12
I fully [2] 92/8 206/15
I generally [1] 202/20
I go [1] 223/24
I had [32] 16/11 16/23 22/9 25/18 38/5 40/18 58/1 58/2 58/14 61/19 67/7 67/8 71/23 75/18 78/14 83/22 85/8 87/15 88/20 143/14 157/1 164/18 165/18 173/17 175/13 187/2 196/17 199/15 203/17 203/19 233/10 254/25
I hadn't [2] 37/20 201/21
I have [72] 7/13 12/17 13/4 22/12 25/16 35/6 53/17 56/12 58/17 60/3 61/19 74/18 74/19 77/2 82/11 89/6 93/10 109/10 114/3 115/3 118/1 133/8 146/23 147/5 153/2 154/19 163/15 163/24 171/3 172/14 177/25 178/22 178/25 180/12 180/14 183/16 184/25 186/7 186/8 187/1 187/21 191/21 191/24 195/18 197/5 199/2 199/2 200/4 202/16 203/11 204/8 204/13 207/2 207/19 208/21 210/23 212/8 217/3 219/12 220/8 223/20 226/17 226/18 229/25 229/25 230/5 230/7 231/15 237/16 245/17 249/3 250/18
I haven't [4] 104/20 151/23 168/13 168/14
I hear [1] 58/1
I heard [1] 42/6
I honestly [5] 91/13 131/17 131/17 212/8 232/2
I hope [3] 97/8 98/2 222/22
I joined [1] 2/5
I just [17] 17/8 33/1 35/6 47/2 49/5 60/8 96/7 123/19 124/10 128/9 203/14 207/12 207/13 230/7 238/22 250/11 251/4
I know [5] 26/3 91/13 135/15 193/10 193/12
I looked [1] 252/3
I made [2] 32/25 54/5
I may [3] 22/13 87/21 102/1
I mean [8] 44/21 54/8 90/20 95/7 104/9 112/14 126/22 231/15
I might [1] 8/8
I must [1] 178/19
I need [2] 24/25 25/1
I needed [4] 27/23 34/16 140/10 251/18
I never [1] 68/10
I outwardly [1] 254/5
I own [1] 130/23
I passed [2] 210/24 211/19
I perceived [1] 177/7
I please [1] 89/14
I probably [3] 45/24 201/21 244/19

I

I provide [1] 244/17
I pulled [2] 153/5 176/22
I put [3] 33/1 211/7 213/19
I quite [1] 250/15
I raised [2] 87/8 246/23
I read [1] 93/14
I really [1] 202/7
I recall [3] 45/9 156/8 156/9
I received [5] 25/4 25/17 35/9 38/4 39/10
I recommended [1] 154/11
I record [1] 53/17
I refer [1] 183/15
I relinquished [1] 5/11
I remember [10] 45/9 178/3 179/7 188/25 222/12 232/3 251/25 251/25 252/1 252/2
I replaced [1] 2/22
I reported [1] 6/7
I represent [1] 214/3
I said [7] 36/7 83/18 137/15 183/16 198/25 234/3 234/8
I saw [5] 50/4 179/6 219/7 225/19 242/6
I say [44] 39/11 39/17 50/19 51/7 51/16 56/17 70/11 71/15 72/5 73/24 81/14 84/16 86/25 88/5 95/1 103/6 103/11 104/17 114/15 115/17 138/9 139/5 142/2 142/7 143/2 143/22 143/24 158/18 158/21 159/2 163/4 173/5 173/21 181/24 182/11 186/5 191/3 196/25 235/9 238/7 242/20 245/20 252/14 255/1
I see [3] 93/14 207/3 236/12
I shared [1] 189/4
I should [3] 149/25 206/15 206/16
I speak [1] 186/11
I spoke [1] 87/2
I started [1] 156/4
I still [1] 29/1
I suggest [2] 216/10 216/22
I summarise [1] 105/2
I suspect [1] 206/18
I take [6] 26/19 53/16 53/17 186/7 227/2 237/9
I then [1] 2/6
I therefore [2] 38/7 87/13
I think [159] 1/19 2/11 3/17 4/22 5/20 13/5 18/2 20/5 20/5 20/17 22/2 23/25 26/7 31/5 31/6 31/20 32/25 33/1 33/12 34/24 35/14 35/18 36/9 36/15 37/11 38/20 38/21 40/13 40/13 40/21 42/19 44/5 51/12 52/8 56/12 56/15 56/25 58/25 59/19 61/8 63/8 69/14 70/7 70/18 73/6 73/17 74/24 75/9 76/6 76/18 76/18 87/24 88/12 88/15 88/22 89/21 89/21 91/2 91/3 91/4 91/17 94/3 94/16 95/12 101/25 101/25 102/6 102/17 103/18 103/20 106/1 112/23 114/4 114/8 117/20 118/19 123/17 125/1 128/2 129/20 129/20 129/22 131/9 132/2 133/4 133/4 133/4 133/5 133/5 135/3 138/5 138/6 138/25 139/15 140/4 141/16 141/25 142/11 143/2 143/22 144/23 148/7 149/16 149/19 152/19 152/22 154/3 154/3 157/10 158/9 159/1 159/15 160/3 160/14 160/17 161/6 161/18 162/25 164/17 166/5 167/25 169/18 169/25 173/12 176/22 178/20 179/17 185/1 186/16 189/22 190/14 190/18 191/21 191/24 193/15 194/3 195/13 199/9 201/13 202/8 202/19 206/9 206/11 219/21 222/22 222/22 231/3 232/19 235/12 238/14 239/14 242/10 244/3 244/7 245/21 246/18 247/18 254/2 255/8
I thought [4] 68/9 80/20 84/25 201/25
I took [1] 176/13
I understand [8] 15/20 33/23 37/11 153/3 160/19 171/2 191/22 248/2
I understood [11] 23/16 23/19 42/17 87/12 186/5 192/5 207/13 211/15 234/9 246/18 252/5
I updated [1] 103/19
I want [3] 209/19 210/10 219/24
I wanted [3] 92/7 201/20 201/22
I was [58] 16/10 17/24 19/12 21/6 23/25 25/15 30/15 34/8 35/8 35/14 36/8 42/5 42/5 42/7 42/7 43/12 46/2 48/20 59/13 64/10 64/14 64/18 64/20 65/21 66/15 71/5 71/5 71/6 75/21 76/5 76/6 77/19 78/18 85/2 87/10 89/21 94/25 101/14 128/21 140/8 162/24 167/4 168/19 168/21 168/23 187/1 196/12 202/24 203/18 208/22 209/9 210/25 211/18 216/20 219/20 225/20 250/24 251/1
I wasn't [13] 16/9 16/11 22/21 23/2 27/21 35/5 35/12 35/14 40/15 52/24 56/17 189/2 190/13
I went [2] 36/12 36/13
I will [15] 55/7 61/20 86/24 89/12 95/3 118/6 118/14 124/8 127/22 144/17 149/16 184/16 217/9 243/2 251/15
I won't [1] 199/13
I wonder [6] 8/8 60/7 62/19 118/17 175/6 243/20
I wondered [1] 41/9
I worked [2] 2/5 78/14
I would [75] 4/3 6/21 7/6 7/7 12/2 16/25 18/19 26/16 51/6 64/19 66/19 69/18 75/2 75/24 79/12 79/13 89/16 90/8 90/23 93/5 94/25 96/12 99/19 99/19 104/21 106/8 107/9 107/9 107/10 107/10 107/12 109/12 123/2 134/3 139/9 140/8 140/9 144/15 144/19 147/9 147/11 159/8 161/22 164/15 164/17 164/21 165/12 165/15 165/18 165/25 166/1 166/10 168/3 182/20 183/17 186/14 186/17 190/20 203/13 204/14 205/8 208/5 210/21 212/5 221/25 222/1 224/22 224/24 227/15 228/18 230/12 239/12 251/17 254/2 254/3
I wouldn't [6] 90/14 103/4 147/8 241/8 244/19 254/22
I write [1] 240/14
I wrote [1] 54/23
I'm [24] 2/16 40/5 44/19 45/14 48/2 59/20 86/19 99/4 104/10 111/15 113/12 114/17 116/3 123/6 123/9 182/14 211/6 212/14 222/8 222/18 238/21 240/7 244/10 255/4
I'm afraid [3] 45/14 212/14 240/7
I's [2] 163/8 163/9
I've [3] 91/14 114/9 144/18
idea [1] 231/15
ideally [1] 110/11
ideas [1] 75/3
identified [27] 23/18 24/21 98/18 107/18 119/11 119/16 121/11 121/16 151/10 165/1 166/10 174/16 174/22 175/2 175/24 176/14 177/5 177/11 177/13 177/19 177/22 183/6 183/14 187/24 188/4 195/2 202/13
identifies [1] 11/13
identify [7] 98/9 136/17 167/14 197/14 199/23 199/24 232/17
identifying [2] 97/19 150/10
ie [4] 132/11 136/23 138/2 232/25
if [221] 1/5 4/6 4/20 8/8 9/9 9/22 11/21 12/10 18/9 23/4 24/7 24/19 25/2 26/11 26/12 26/20 27/25 28/1 30/2 30/19 30/19 31/3 31/13 32/18 34/17 37/12 39/15 40/7 41/4 41/6 42/8 42/23 43/2 43/12 44/21 45/19 47/1 47/3 47/4 47/10 51/1 51/9 51/13 53/4 53/20 54/2 54/10 55/5 61/4 62/19 65/18 65/22 67/7 69/23 71/23 72/3 73/25 79/7 79/14 79/16 79/24 81/7 81/23 85/10 85/13 85/22 86/2 87/20 90/3 91/4 91/18 96/20 96/25 97/4 97/8 98/24 100/5 100/6 100/13 102/1 103/22 104/13 104/22 105/17 106/5 106/13 107/3 107/9 107/9 107/20 108/16 109/2 109/15 112/8 113/12 113/15 113/17 113/23 114/11 114/13 117/12 118/9 118/11 118/17 119/13 120/9 120/22 123/9 123/10 125/3 125/11 129/15 129/23 129/24 131/19 131/22 134/10 134/24 136/16 136/22 137/9 137/17 137/20 138/12 138/25 139/6 139/6 139/23 140/8 140/13 140/15 141/3 142/4 143/6 143/8 143/19 146/8 147/6 147/18 151/2 152/19 153/12 159/16 161/1 164/17 165/9 165/18 166/9 166/12 166/16 167/14 168/8 169/3 169/22 171/11 171/17 174/12 174/15 174/20 174/24 175/1 175/6 178/24 179/1 181/5 182/23 182/25 187/6 187/22 187/23 188/6 196/8 196/11 196/22 197/15 201/21 203/24 204/8 204/12 204/14 204/16 204/22 206/1 208/20 209/5 209/25 211/7 212/16 212/25 213/19 214/1 214/9 214/13 215/17 216/11 216/14 218/23 222/4 222/24 223/24 226/3 226/10 227/15 228/1 228/5 228/25 229/6 229/11 231/3 231/21 234/17 235/18 239/2 242/24 243/20 245/25 249/9 249/19 251/14 251/17 255/6
ignore [1] 251/15
illness [1] 151/4
illustrate [1] 112/14
immediate [16] 34/15 34/16 35/24 36/15 37/5 38/13 39/25 40/1 40/4 40/11 40/12 40/22 59/2 108/14

I

immediate... [2] 137/12 187/23
immediately [7] 37/4 37/23 38/8 58/25 61/20 67/4 182/5
imminent [4] 36/3 36/3 37/9 39/4
impact [3] 77/3 81/12 148/2
impacted [1] 76/15
impetus [2] 50/17 51/2
implicitly [1] 114/5
importance [1] 15/7
important [20] 15/6 22/24 54/3 68/21 74/11 77/7 77/13 77/14 78/22 78/22 81/16 82/1 121/12 130/7 147/15 148/6 199/23 200/2 200/9 244/7
importantly [1] 242/13
impossible [1] 199/17
impression [3] 69/21 69/23 70/1
improve [3] 73/8 107/22 115/23
improvement [15] 24/19 24/24 25/2 65/6 65/12 67/2 67/11 70/24 76/8 88/7 88/8 88/9 88/10 88/11 93/16
improvements [4] 72/24 73/16 74/15 81/21
inbox [1] 181/2
incidence [1] 115/19
incident [211] 45/11 69/17 75/2 83/4 83/20 83/22 83/25 84/2 84/10 89/11 89/18 90/10 93/25 94/3 102/11 102/14 103/5 103/8 109/13 109/17 109/21 109/23 110/1 110/8 110/12 111/22 112/11 112/24 113/1 114/15 114/19 116/17 116/19 116/23 117/7 117/8 134/16 134/24 135/1 135/5 135/23 136/5 136/8 136/9 136/16 136/17 136/19 136/21 137/14 137/17 137/18 137/23 137/25 138/16 138/23 139/5 139/6 139/9 139/20 139/23 140/19 140/22 141/5 141/20 141/23 142/5 143/25 144/11 144/12 144/18 144/19 145/3 145/9 145/12 145/15 146/16 146/17 146/24 147/7 147/10 147/14 147/19 149/9 149/12 149/19 149/25 150/8 151/5 151/15 152/4 152/7 152/10 153/19 154/2 154/14 156/7 156/13 156/16 156/20 156/22 156/25 157/21 157/22 158/2 158/14 158/18 159/4 159/23 160/9 160/22 160/25 161/2 161/23 161/24 163/3 163/7 165/20 165/21 168/20 168/25 170/15 172/9 172/15 172/17 172/18 173/19 173/20 174/4 174/9 174/17 174/18 174/20 174/21 175/3 181/22 182/1 182/12 182/13 186/12 186/22 187/4 188/2 188/6 189/1 196/9 199/10 199/11 200/3 204/24 206/21 212/11 212/23 213/11 213/13 213/17 214/21 215/11 215/12 216/19 216/24 217/25 221/15 221/17 221/24 225/19 225/22 225/23 225/25 226/2 226/10 226/11 226/19 226/20 226/22 227/5 227/19 228/4 228/6 228/9 228/15 229/3 229/18 229/21 230/11 233/6 233/8 234/4 234/15 235/17 237/6 237/8 237/18 238/12 239/16 241/3 241/13 241/16 241/21 241/23 242/8 242/23 244/13 244/16 244/18 249/6 249/7 250/1 253/24 254/3 254/6 254/8
incidents [42] 45/12 73/7 73/14 73/18 79/23 80/11 80/14 84/3 84/13 89/13 93/2 93/24 98/17 110/2 115/16 116/13 134/5 136/2 140/11 141/1 141/25 143/5 144/17 150/7 150/10 150/10 151/16 159/13 159/16 159/17 162/25 168/24 172/3 172/20 173/22 199/22 199/23 206/6 215/22 215/23 218/16 227/19
included [12] 73/22 104/5 110/1 122/8 130/12 131/7 135/2 141/5 146/15 192/11 197/1 218/16
includes [4] 111/10 114/5 180/13 217/15
including [7] 98/7 107/7 207/10 230/24 232/20 245/13 246/16
inclusive [1] 26/10
incongruous [1] 209/5
incorrect [3] 154/20 154/22 172/22
increase [29] 14/25 15/3 15/7 15/23 16/13 16/21 17/17 17/20 18/12 29/22 32/8 98/25 99/7 99/8 99/15 99/25 105/23 106/3 114/1 126/22 128/20 160/9 189/12 194/18 195/3 197/12 199/18 200/11 233/9
increased [39] 3/7 13/12 13/15 13/17 16/6 18/4 18/16 19/1 19/3 19/6 19/13 19/19 21/11 21/20 22/6 22/7 23/14 26/13 28/11 28/16 29/8 29/11 29/12 30/4 30/12 30/24 31/3 66/16 118/4 119/18 119/22 121/7 124/12 127/1 131/22 164/22 189/10 197/19 205/10
incredibly [1] 32/15
indeed [11] 62/5 68/5 94/18 107/2 115/22 122/21 132/10 154/25 220/16 235/18 255/11
independent [1] 17/21
indicated [2] 33/22 163/10
indicates [1] 8/19
indicating [1] 144/5
indication [2] 21/17 137/12
indictment [3] 144/4 145/19 162/13
individual [19] 28/6 32/11 33/10 113/10 113/11 113/13 116/18 116/19 147/23 152/9 159/16 159/19 159/19 215/14 216/5 225/2 234/7 235/21 246/25
individualised [1] 235/21
individually [1] 233/11
individuals [3] 6/22 36/17 213/3
induction [3] 88/3 139/19 139/19
infer [1] 94/24
inferred [1] 60/16
influence [6] 95/1 101/18 102/16 102/19 103/12 107/5
influenced [1] 27/2
inform [1] 167/6
informal [11] 35/1 50/20 51/7 53/14 53/20 54/1 186/23 188/3 192/23 192/25 205/18
information [83] 6/22 12/13 26/3 27/24 29/19 29/23 32/5 32/16 33/21 35/8 36/9 36/11 36/17 38/4 38/7 42/7 42/20 42/21 56/14 59/12 59/14 59/16 59/18 61/21 78/4 78/12 80/16 85/18 87/13 88/21 89/20 90/1 91/20 100/19 101/3 101/15 106/5 106/6 106/6 112/9 123/17 135/17 141/4 141/7 142/13 144/2 146/21 147/22 148/11 148/15 150/23 153/14 153/25 156/21 156/25 157/5 160/18 163/22 164/3 165/11 166/13 171/24 192/3 194/12 196/19 202/20 206/13 213/18 217/21 218/16 222/12 227/1 233/5 233/15 233/17 233/18 235/15 235/19 239/20 239/22 244/14 246/10 253/18
informed [5] 19/17 40/25 69/24 216/7 246/19
informing [3] 33/3 215/16 247/3
infrequently [1] 77/21
initial [7] 153/10 153/15 162/16 188/11 193/15 194/8 245/7
initially [4] 6/11 66/14 120/20 136/6
initials [2] 33/1 149/22
initiated [1] 127/12
injudicious [1] 221/9
inpatient [2] 5/22 5/22
input [9] 10/1 10/8 10/22 28/7 59/3 60/11 103/15 103/25 170/18
INQ0000016 [1] 152/17
INQ0001347 [1] 212/17
INQ0001888 [2] 140/14 194/16
INQ0002042 [1] 240/10
INQ0002836,so [1] 193/10
INQ0003089 [1] 182/24
INQ0003114 [1] 180/9
INQ0003213 [2] 118/10 119/5
INQ0003324 [1] 109/15
INQ0003530 [1] 149/13
INQ0004657 [2] 28/1 117/22
INQ0005749 [1] 43/2
INQ0006466 [1] 136/4
INQ0006769 [2] 85/11 143/6
INQ0007947 [1] 169/22
INQ0008157 [1] 146/6
INQ0008587 [1] 234/12
INQ0008943 [1] 239/3
INQ0010037 [2] 176/25 222/22
INQ0014125 [1] 230/18
INQ0014962 [1] 98/2
INQ0042162 [1] 134/4
INQ0049845 [2] 118/16 120/8
INQ0077575 [1] 47/2
INQ0102357 [1] 53/4
INQ0102364 [2] 219/14 223/25
INQ0103134 [1] 92/15
INQ0103833 [1] 4/6
Inquest [15] 217/18 217/21 218/21 219/3 224/9 227/23 231/5 231/14 231/19 231/23 231/24 238/21 241/17 243/4 245/10
Inquests [2] 218/4 218/22
Inquiry [19] 1/15 63/3 63/19 67/17 69/4 93/5 100/19 102/17 110/3

I

Inquiry... [10] 138/17 167/12 184/1 187/14 193/17 195/7 204/5 236/19 239/23 255/16
Inquiry's [1] 74/12
insertion [2] 220/2 222/6
insight [1] 45/25
insignificant [1] 108/24
inspection [12] 76/20 76/20 77/12 77/13 77/17 77/24 78/2 78/6 128/11 128/23 128/24 167/11
inspections [2] 77/20 77/21
instance [1] 215/14
instead [3] 104/9 128/4 199/2
instructed [2] 75/21 180/24
instruction [3] 179/3 179/16 180/21
instructions [1] 88/4
insufficient [2] 79/4 141/7
integrated [2] 66/24 76/8
intend [3] 113/5 114/25 115/1
intended [5] 110/24 110/24 112/15 114/25 115/20
intensive [1] 126/20
interact [1] 57/15
interacted [1] 9/19
interactions [1] 57/12
interest [2] 135/21 203/8
interested [1] 65/19
interim [10] 2/9 2/14 3/12 3/13 4/10 4/25 6/2 76/24 92/19 142/3
intermediary [2] 102/21 103/7
internal [3] 85/17 137/5 236/24
internally [3] 7/1 82/8 246/11
interpretation [11] 88/16 102/24 124/21 136/11 136/22 161/13 176/21 185/11 189/11 195/18 207/19
interpreted [1] 190/15
interrogating [1] 16/5
intervening [1] 162/12
interview [2] 203/1 203/2
interviewed [1] 1/21
into [51] 3/24 10/1 22/7 28/16 34/19 39/13 56/11 57/18 58/4 64/15 72/18 81/12 92/23 95/17 103/15 103/25 120/23 124/3 124/24 131/12 133/14 134/17 139/13 140/19 145/17 149/3 170/18 171/4 178/20 178/21 179/15 179/23 180/5 180/20 181/3 183/7 183/16 190/23 193/17 197/6 201/12 201/13 202/6 205/9 221/9 226/2 232/8 233/3 235/24 250/24 251/10
introduce [2] 63/15 98/4
investigated [3] 128/20 128/22 203/7
investigating [1] 93/5
investigation [47] 38/15 39/7 44/15 58/10 113/21 134/17 135/7 135/19 138/2 139/24 156/2 158/14 161/25 173/19 210/5 210/6 216/19 218/17 224/10 226/2 226/8 226/11 226/24 227/5 232/21 233/2 234/2 234/23 234/25 235/14 237/8 237/18 239/1 239/1 239/11 239/16 240/18 241/2 241/13 242/3 242/19 244/13 244/18 244/25 254/8 254/9 254/9
investigations [5] 69/17 109/15 140/11 241/17 244/16
investigators [1] 236/2
invite [5] 50/11 50/14 51/13 89/14 173/25
invited [5] 66/1 201/9 201/11 202/24 234/3
involve [3] 11/25 68/24 109/23
involved [26] 16/9 16/11 22/21 40/20 40/23 61/6 74/6 81/16 87/23 88/1 88/10 92/6 103/2 109/21 116/6 116/12 131/9 213/1 213/4 213/25 218/13 227/15 228/18 233/1 240/20 248/16
involvement [5] 21/3 26/13 115/6 157/14 232/24
involving [1] 235/8
is [637]
is June [1] 149/1
isn't [33] 16/6 25/13 32/21 58/21 58/23 59/23 60/1 102/16 103/12 103/12 118/11 118/20 122/6 130/8 134/7 180/17 181/17 187/9 199/16 213/5 213/12 213/20 215/15 216/24 225/8 226/5 229/12 236/4 240/24 243/17 243/19 244/18 249/4
issuance [1] 107/16
issue [24] 16/6 19/2 19/6 21/10 21/16 23/14 26/8 40/20 49/7 49/8 91/3 99/7 107/9 134/11 185/13 185/15 195/20 207/21 246/3 247/7 247/8 253/22 254/1 254/4
issues [22] 6/16 9/7 9/12 11/6 21/15 24/23 51/8 54/15 70/15 92/21 94/13 96/11 96/18 106/20 170/9 172/2 196/19 205/13 210/8 211/3 218/24 240/20
it [774]
it's [128] 1/19 2/17 5/25 8/2 8/13 9/23 32/21 43/5 55/7 55/8 64/19 65/14 70/16 70/18 74/11 75/9 85/11 85/12 87/22 89/16 99/19 99/20 103/24 104/11 105/2 105/5 106/1 106/4 107/11 108/7 109/7 109/20 110/17 111/14 111/14 111/16 112/24 113/9 113/9 114/9 114/14 114/24 114/24 115/2 115/2 115/16 115/17 117/25 127/4 128/15 131/19 133/4 133/4 133/13 134/10 135/6 135/14 137/15 138/20 143/22 144/22 147/5 147/7 147/14 147/14 147/15 147/15 148/6 149/16 152/18 153/23 155/12 157/15 162/25 166/6 171/8 172/22 172/23 180/18 181/9 182/15 187/3 197/6 197/16 198/11 200/3 206/18 207/14 209/12 212/19 213/12 214/8 214/23 215/16 222/21 224/6 224/23 225/7 225/9 225/12 226/12 230/13 231/3 231/5 231/5 231/15 233/14 233/21 237/13 238/6 238/7 238/8 238/10 240/12 242/11 242/16 242/25 242/25 243/6 243/11 243/14 243/16 243/18 244/7 244/24 246/13 247/5 253/20
items [1] 155/2
its [12] 72/9 88/11 107/4 107/5 121/9 127/6 127/9 134/11 156/7 193/8 197/21 214/9
itself [6] 43/12 74/17 76/9 194/6 200/10 223/22

J

January [3] 173/15 173/18 219/3
January 2016 [1] 219/3
January/February [2] 173/15 173/18
Jayaram [65] 4/16 7/18 7/21 16/20 16/24 16/24 17/6 18/3 20/1 20/8 21/25 22/15 23/7 23/22 25/19 27/14 27/15 29/1 31/14 31/22 32/2 32/5 32/10 32/18 33/3 33/15 33/23 35/11 35/24 36/1 36/23 37/12 39/16 39/20 40/9 40/18 41/7 41/13 41/19 41/20 42/18 43/18 44/2 48/19 49/19 49/24 50/4 50/24 51/3 51/20 52/1 54/18 55/4 56/7 56/11 57/19 58/2 58/19 59/12 59/17 61/17 87/11 92/10 174/5 175/1
Jayaram's [6] 31/16 32/19 35/4 42/15 50/5 91/15
job [13] 65/15 80/4 88/8 89/8 90/3 90/17 102/17 184/8 184/11 190/21 209/8 226/9 248/10
jobs [2] 82/25 83/8
join [3] 64/24 153/23 200/17
joined [3] 2/5 30/10 183/24
journey [1] 93/16
judgement [1] 116/12
Julie [1] 87/3
July [42] 20/17 23/7 23/7 25/4 26/7 28/9 28/19 29/21 30/10 46/6 46/6 85/11 118/5 118/10 120/9 120/13 120/23 121/4 121/14 121/17 122/1 123/10 123/12 126/11 130/14 130/17 140/16 141/11 141/15 143/7 162/3 173/13 189/6 189/7 192/6 208/23 216/1 230/15 232/9 232/12 243/6 245/8
July 2015 [1] 232/9
jump [1] 230/14
jumping [1] 165/6
June [42] 1/16 3/9 20/13 21/4 21/20 22/22 24/8 25/6 25/19 27/14 27/17 30/21 30/24 31/14 38/1 43/6 44/23 45/8 49/19 50/11 50/14 51/25 52/1 52/9 52/25 53/7 55/21 63/3 63/6 66/19 132/24 146/5 146/8 149/1 157/25 189/6 189/22 212/19 217/17 230/15 230/18 232/12
June 2016 [1] 50/11
June/July 2016 [1] 232/12
junior [2] 139/18 209/9
just [183] 4/9 7/25 9/4 9/15 9/19 10/3 10/17 17/8 17/17 18/1 18/10 18/24 19/15 19/16 19/24 23/4 24/5 25/9 25/9 26/19 27/25 30/1 33/1 34/20 34/25 35/6 35/8 35/14 36/9 36/18 39/11 43/8 43/13 44/21 45/4 47/1 47/2 47/4 47/16 47/24 49/5 49/20 51/4 51/7 51/23 56/18 58/6 60/7 60/8 63/15 65/14 65/22 69/5 71/13 72/9 72/17 72/25 73/9 73/9 74/22 76/4 77/5 77/10 77/12 77/15 79/7 80/3 80/8 81/6 81/19 83/9 83/21 83/24 84/1 84/23 86/20 90/3 91/10 91/24 95/1 95/1 95/2 96/7 96/12 98/4

J

just... [98] 99/5 101/18 101/23 102/4 103/24 105/22 107/3 107/25 108/3 109/16 111/7 117/12 117/18 118/7 118/12 119/3 119/25 120/2 120/2 120/10 120/19 120/21 121/24 123/19 124/10 125/3 126/19 128/9 131/19 132/9 134/2 134/10 137/9 137/24 139/12 145/23 146/3 146/20 147/14 148/19 153/23 156/4 157/5 161/8 163/24 164/11 164/13 169/22 170/4 171/17 173/24 174/4 175/13 179/13 180/9 181/3 184/15 184/16 188/7 188/18 190/17 194/13 197/15 201/14 203/14 205/6 207/12 207/13 214/22 217/5 217/17 218/12 219/13 221/5 222/3 223/12 224/16 225/9 226/3 226/17 227/25 229/19 230/7 230/8 234/13 238/22 240/6 241/4 242/24 243/2 244/23 247/15 249/9 249/14 250/11 251/4 251/14 254/11

JUSTICE [4] 60/5 247/13 256/6 256/11

K

KAREN [24] 1/9 1/14 4/18 32/20 35/16 36/5 36/12 36/16 37/24 38/25 39/14 40/19 41/18 41/22 42/17 42/22 42/25 47/11 49/15 58/18 58/22 59/19 61/16 256/3

Karen Rees [19] 4/18 32/20 35/16 36/5 36/12 37/24 38/25 39/14 40/19 41/18 42/17 42/22 42/25 47/11 49/15 58/18 58/22 59/19 61/16

Karen Townsend [1] 1/14

keen [2] 76/7 248/8

keep [3] 27/4 27/8 83/3

keeps [1] 88/6

Kelly [18] 61/11 71/21 76/1 87/9 87/9 122/21 154/17 158/10 159/2 163/11 183/8 185/21 187/5 187/6 190/9 197/2 197/7 250/18

Kelly's [3] 149/15 150/5 154/23

kept [1] 248/24

key [9] 7/8 70/14 70/20 70/22 78/9 106/20 171/16 194/25 235/22

killing [1] 64/4

kind [5] 33/21 33/22 36/14 37/12 246/5

kinds [1] 241/6

knew [9] 23/22 41/15 44/19 129/15 172/20 172/20 206/3 206/4 252/9

know [170] 6/8 15/1 22/14 26/3 44/16 55/19 57/1 58/1 61/5 73/12 75/3 75/15 76/24 77/1 78/3 78/8 78/15 78/18 78/20 79/20 81/11 84/7 88/7 90/13 90/13 91/3 91/4 91/13 91/13 92/8 93/23 93/25 94/5 94/20 95/22 100/2 101/5 106/3 108/3 112/24 113/5 113/6 113/19 114/12 117/10 118/20 123/12 124/4 124/6 124/18 124/23 125/12 125/20 126/11 127/10 127/16 127/19 128/18 129/23 130/5 130/13 130/14 130/17 131/1 131/24 132/18 132/23 133/5 133/21 135/15 135/22 137/15 139/23 140/8 140/9 141/5 141/22 142/13 148/10 148/19 148/21 148/21 149/13 149/24 152/3 154/4 154/9 154/14 155/13 156/13 157/3 159/3 159/15 163/8 165/13 165/24 166/6 166/22 166/25 167/8 171/23 172/14 172/23 172/23 174/24 179/4 182/4 182/14 185/5 187/3 190/6 191/4 191/12 191/14 193/10 193/12 193/12 193/20 196/4 196/12 201/11 201/14 201/20 201/23 202/2 202/4 202/5 203/16 205/2 206/3 206/15 208/21 209/10 209/11 209/13 209/13 214/8 214/8 223/14 224/3 227/24 228/24 229/5 229/5 229/21 231/17 231/21 232/2 232/21 233/7 233/12 235/4 235/9 237/19 238/7 238/8 239/13 240/8 245/8 245/14 246/24 247/4 247/4 249/14 249/15 251/11 254/6 254/16 255/3 255/6

knowing [2] 22/5 70/3

knowledge [10] 1/17 46/1 52/9 63/12 70/5 87/13 159/4 159/7 207/16 244/20

knowledgeable [1] 158/25

known [2] 22/12 230/12

knows [4] 62/15 167/12 193/9 236/19

L

La [7] 62/13 62/23 175/16 207/4 208/14 255/10 256/8

labour [1] 81/12

lack [3] 31/11 92/24 215/21

lady [22] 4/7 28/2 48/12 60/3 60/5 62/14 62/15 67/24 118/19 173/25 175/5 175/17 203/16 207/1 217/3 217/8 243/23 244/6 247/13 250/21 256/6 256/11

language [5] 99/19 99/20 137/1 137/4 138/9

large [1] 74/9

largely [9] 113/12 128/25 133/8 133/10 133/12 150/14 151/24 192/5 222/15

larger [2] 80/23 82/12

largest [1] 158/19

last [9] 26/15 72/21 86/19 92/15 94/18 146/4 224/14 226/13 248/23

late [3] 238/24 239/9 242/10

late March [1] 242/10

late September 2016 [1] 238/24

later [9] 20/12 30/16 66/1 71/10 173/13 183/8 217/18 243/9 252/24

latest [2] 131/25 132/5

latter [4] 5/16 106/22 164/1 194/1

Lawrence [31] 84/20 84/24 84/25 86/3 88/2 88/4 89/25 90/16 91/5 136/3 136/10 142/1 148/13 149/3 182/4 183/24 184/19 184/24 185/1 185/1 185/3 187/20 202/10 247/24 248/15 250/7 251/1 251/4 252/24 253/16 255/4

Lawrence's [4] 136/22 185/18 187/13 202/17

Lea [12] 217/22 219/17 219/25 221/14 224/2 225/21 226/4 228/21 229/24 238/9 242/7 243/24

lead [22] 4/17 7/22 8/15 8/15 11/17 12/20 12/24 74/2 74/6 75/19 80/6 80/10 80/24 81/3 83/21 84/19 90/12 119/11 131/21 187/7 229/9 232/21

leadership [10] 92/21 92/25 93/8 93/21 189/14 190/4 194/20 199/5 200/13 200/13

leading [2] 175/25 246/5

leads [18] 4/16 6/20 6/21 6/21 7/18 8/3 8/3 12/3 12/17 12/19 65/14 67/1 67/8 68/15 75/22 89/17 153/2 201/13

Leanne [1] 217/14

Leanne Woods [1] 217/14

learn [1] 200/1

learning [14] 72/7 75/1 98/17 144/21 169/4 170/15 172/16 172/17 178/25 199/24 215/12 215/16 216/19 237/14

learnt [1] 240/23

least [5] 32/3 52/18 157/17 216/1 245/22

leave [7] 43/22 44/9 72/14 134/2 153/4 196/11 255/6

leaving [3] 75/18 75/20 80/18

led [9] 46/2 150/12 150/21 156/12 156/19 159/12 170/8 242/17 242/17

left [15] 4/12 41/22 42/14 59/19 65/23 72/25 74/10 82/17 83/12 92/18 95/3 110/21 142/25 156/11 224/4

left-hand [1] 110/21

legal [17] 69/11 71/4 71/20 94/23 217/23 218/14 218/20 218/20 219/17 223/15 226/5 239/4 239/19 241/9 241/14 241/21 242/22

legislation [1] 236/11

length [1] 163/21

lens [2] 127/5 169/2

less [2] 10/19 124/11

lessons [1] 240/23

let [5] 61/5 112/13 212/16 215/24 223/10

let's [21] 24/5 51/14 80/3 83/9 86/10 97/22 110/19 120/17 121/24 126/15 128/3 152/16 155/1 169/25 175/15 176/25 180/8 194/15 194/23 196/21 230/14

Letby [39] 32/19 33/4 33/24 38/14 39/7 41/16 42/11 44/8 44/14 44/20 44/23 47/7 47/19 55/20 57/12 57/14 57/21 57/24 59/7 193/16 193/22 194/1 195/8 195/21 200/16 200/21 202/12 202/18 203/7 204/6 207/22 208/3 213/1 213/5 213/15 213/20 217/17 245/13 246/15

Letby's [5] 52/14 53/1 163/25 164/8 184/3

letter [2] 240/11 242/11

letters [1] 238/1

level [74] 11/1 11/14 24/9 28/17 28/18 31/10 35/7 37/5 37/6 46/9 46/9 46/16 46/17 69/6 70/23 71/13 75/11 90/6 90/18 94/25 97/13 101/14 102/16 102/18 103/11 105/3 105/12 107/4 107/8 107/18 112/12 112/21 113/6 113/7 113/17 115/2 117/21 119/4 119/15 123/21 124/11 125/11 125/25 127/16 128/14 128/15 128/16 130/1 131/13 132/16 132/19 132/19

L

level... [22] 133/3 134/20 139/7 144/20 147/16 147/17 148/11 151/13 156/2 165/17 175/2 181/20 197/19 198/4 198/5 205/15 205/24 206/1 211/1 214/22 228/9 237/17
level 2 [1] 134/20
levels [4] 70/13 129/21 133/11 198/1
liaise [3] 227/10 241/14 241/15
liaised [1] 46/10
liaison [3] 239/12 242/20 242/21
lie [2] 98/5 134/2
lies [1] 90/25
lifted [1] 171/3
light [3] 26/6 56/6 57/22
lightly [1] 254/16
like [36] 27/22 39/10 39/17 49/15 50/19 51/7 51/16 56/17 59/22 61/25 67/7 73/13 73/25 75/10 79/16 93/5 96/12 97/7 109/12 113/15 113/17 116/6 125/5 125/11 131/12 134/3 141/9 151/2 161/1 161/7 181/19 210/4 217/8 240/4 246/1 251/14
likelihood [2] 108/8 125/12
likely [14] 32/21 32/24 56/6 108/10 112/17 125/13 151/1 156/12 161/5 162/4 162/5 210/2 225/7 234/25
likewise [1] 51/6
limited [5] 141/2 141/6 168/5 196/9 199/11
line [21] 3/3 26/15 28/4 77/1 78/17 85/24 87/8 95/19 103/19 104/20 108/23 128/22 159/6 182/19 204/18 205/13 220/2 222/6 223/1 223/6 232/5
linear [2] 106/2 115/17
lines [10] 54/6 93/1 152/2 155/17 162/4 186/23 201/3 206/11 253/3 253/8
link [3] 107/15 196/11 246/15
linked [3] 96/17 213/8 245/25
linking [2] 70/14 213/15
list [22] 53/18 74/18 74/19 98/7 98/19 104/7 123/8 126/17 134/4 138/5 144/16 145/13 148/12 148/14 159/17 172/22 173/23 199/16 214/21 229/20 250/8 250/12
listed [7] 74/8 74/21 130/8 130/21 131/21 163/24 170/20
listening [1] 82/4
listing [1] 154/19
lists [7] 92/20 141/17 141/18 141/23 143/23 144/9 199/12
literally [2] 148/19 197/5
little [9] 42/1 75/5 77/5 91/4 102/18 113/2 117/19 128/8 252/24
live [1] 98/12
lives [1] 77/15
LL [2] 43/22 230/25
local [15] 10/20 11/14 84/4 89/18 94/5 96/21 102/13 102/21 105/3 107/11 107/18 113/21 133/3 147/17 215/10
locally [3] 9/20 9/23 170/10
location [1] 212/21
lock [1] 109/18
logged [1] 12/12
long [4] 14/2 210/18 220/2 222/6
longer [5] 37/22 83/12 146/15 178/9 202/5
look [74] 11/22 11/23 18/10 22/7 23/4 24/5 25/9 27/25 64/16 68/18 75/4 80/2 85/23 92/13 93/25 96/6 96/19 96/25 97/8 97/22 97/23 98/24 105/14 107/10 108/1 108/4 108/16 108/17 109/10 109/12 110/19 117/15 117/18 120/1 120/9 125/5 126/4 126/15 128/3 128/10 131/19 134/4 134/7 140/1 140/13 141/25 143/6 145/17 146/3 149/11 159/17 161/17 167/13 170/4 171/17 172/24 176/25 180/8 190/17 194/15 194/23 196/21 197/16 197/17 200/16 224/15 226/3 226/14 228/5 231/3 234/1 234/19 243/3 252/17
looked [16] 22/11 73/6 74/18 74/19 120/18 121/6 140/19 143/7 162/1 184/1 187/3 190/16 191/7 192/2 225/3 252/3
looking [34] 12/1 13/14 19/16 28/4 29/16 40/5 43/13 73/5 73/8 78/25 91/3 97/1 110/18 116/22 119/7 125/10 125/12 125/15 126/16 134/22 135/3 141/24 144/1 144/15 148/13 150/20 161/3 178/4 186/16 191/9 196/13 213/12 246/21 252/2
looks [4] 8/10 80/11 166/12 240/4
Lorraine [3] 2/22 6/8 6/10
loss [2] 59/20 138/7
lost [4] 93/19 93/19 93/20 188/18
lot [12] 49/2 53/17 70/11 80/15 107/17 144/1 148/20 233/4 234/18 248/3 248/3 249/20
lots [3] 53/16 213/3 230/16
lower [4] 9/22 105/18 125/2 228/9
Lucy [17] 47/7 47/19 53/1 57/21 59/7 189/24 195/21 196/10 201/12 203/21 207/22 208/3 213/1 213/5 213/15 213/20 245/14
Lucy Letby [11] 47/7 47/19 57/21 59/7 195/21 207/22 208/3 213/1 213/5 213/15 213/20
Lucy Letby's [1] 53/1
Lucy's [1] 213/24
luncheon [1] 118/25

M

Ma'am [3] 183/20 203/16 247/12
made [45] 3/24 14/4 16/10 19/12 23/2 29/17 31/1 32/25 38/6 42/10 49/6 53/3 54/5 60/10 66/7 72/25 74/10 81/23 87/15 88/23 122/7 150/3 154/1 171/18 186/3 188/22 191/16 193/1 198/13 202/23 203/5 209/19 211/12 215/1 220/23 226/22 228/25 229/4 229/20 230/10 230/10 230/11 232/8 233/22 240/21
Mag [1] 239/6
main [2] 80/14 93/20
maintaining [1] 106/17
major [2] 108/8 108/24
majority [3] 159/13 176/1 224/8
make [29] 17/24 37/7 43/1 45/13 56/15 63/9 71/12 105/24 139/12 153/18 154/13 179/2 179/20 180/2 181/18 190/24 191/23 193/11 198/20 198/23 199/1 202/20 220/24 221/10 229/19 229/22 241/16 254/16 255/5
makers [1] 159/6
makes [2] 54/12 133/20
making [14] 4/3 23/25 28/15 33/19 101/16 102/23 158/8 192/25 196/17 198/15 218/17 220/25 230/2 246/17
manage [9] 9/24 10/21 12/8 46/3 46/15 79/11 85/5 125/17 127/16
managed [11] 46/18 67/10 71/7 75/1 98/8 98/10 98/13 100/8 104/24 117/19 127/14
management [28] 1/24 66/20 70/14 95/12 95/24 96/2 96/19 96/25 97/6 97/22 98/5 98/7 98/13 100/12 101/12 102/10 102/11 102/11 102/14 102/15 103/8 112/6 115/9 125/7 125/9 157/13 165/6 205/12
manager [18] 2/7 2/8 2/9 3/3 4/22 11/11 11/12 11/13 42/23 67/9 67/11 87/8 109/20 110/6 113/11 113/22 159/7 180/22
managerial [1] 111/11
managers [5] 110/9 111/10 111/22 211/8 211/8
managing [1] 77/25
mandatory [3] 138/20 139/17 139/18
manner [5] 35/1 35/15 131/2 162/7 206/8
many [18] 32/1 66/13 68/19 116/13 117/25 120/21 130/3 130/3 130/4 130/4 175/15 176/20 178/20 179/8 179/9 183/6 208/7 214/17
March [16] 66/5 72/15 72/19 72/22 92/15 131/24 131/25 132/5 175/18 178/9 182/23 183/3 183/8 183/12 242/10 245/9
marked [2] 154/18 164/1
Martin [1] 4/12
Martyn [2] 191/5 196/4
maternity [6] 80/16 80/22 80/22 87/2 248/4 248/19
matrix [2] 108/2 118/1
Matron [3] 65/3 65/5 65/24
matter [21] 13/24 47/25 48/3 68/1 80/25 107/13 146/4 160/11 185/16 186/2 186/25 187/7 188/7 203/18 224/13 226/13 246/13 253/20 253/22 255/1 255/6
matters [9] 13/9 78/23 83/6 93/4 102/25 103/5 106/25 107/22 255/1
maturity [2] 96/9 97/12
may [53] 2/11 3/13 11/19 22/13 32/11 43/8 56/19 57/7 61/14 70/21 73/14 73/17 74/15 75/25 78/5 80/25 81/2 82/22 84/20 87/21 97/1 97/4 97/5 102/1 102/7 104/2 114/14 114/15 114/17 114/19 116/5 116/11 117/15 129/25 131/5 142/1 146/17 149/4 168/5 183/24 192/1 195/8 197/19 197/21 197/23 197/24 206/23 211/17 215/19 218/24 239/15 244/6 252/16
May 2016 [3] 75/25

M

May 2016... [2] 82/22 149/4
maybe [8] 4/2 59/1 66/14 70/20 176/22 197/13 206/11 218/19
McCormack [2] 181/16 181/17
McMahon [16] 82/20 82/21 82/24 83/7 83/15 83/17 83/19 119/10 178/11 179/21 179/23 180/2 180/4 180/19 180/21 182/15
McMahon's [1] 182/10
me [87] 5/12 16/25 17/24 20/7 22/14 22/16 23/3 36/11 37/15 38/6 39/21 40/7 49/12 51/4 58/13 61/5 61/18 69/19 74/19 75/19 91/16 91/16 94/16 94/17 95/2 97/9 101/4 107/10 112/13 118/11 118/13 118/14 119/25 137/24 138/25 145/15 151/23 152/25 167/6 167/8 170/24 171/21 179/3 180/9 181/5 182/25 184/20 185/6 185/6 185/16 188/24 191/23 195/21 195/23 196/22 197/16 198/19 198/20 199/1 201/8 202/20 204/4 207/22 207/23 208/6 208/9 209/24 212/16 215/24 217/8 219/8 222/21 223/10 224/23 226/23 227/1 230/9 233/5 233/14 233/15 233/18 247/15 249/4 250/21 253/5 253/18 254/23
mean [22] 28/5 35/3 44/21 46/17 51/20 54/8 76/9 84/1 90/20 95/7 104/9 112/14 115/6 115/25 116/1 126/22 130/23 186/19 211/6 231/15 246/4 246/12
meaning [3] 136/23 174/7 201/4
means [7] 108/6 109/22 130/24 136/6 138/6 144/10 164/12
meant [7] 10/4 96/10 114/14 126/1 143/23 159/8 207/14
measure [6] 128/12 128/14 130/9 130/16 131/8 131/21
measures [4] 62/16 125/16 126/5 128/3
mechanical [1] 227/17
media [7] 125/23 127/3 134/16 135/2 135/9 135/12 135/21
medical [18] 1/25 4/13 5/22 6/20 8/3 8/15 8/20 8/20 9/7 9/10 10/6 12/4 12/17 12/19 12/20 55/19 61/13 138/3
medication [13] 113/1 113/6 114/15 114/16 114/17 114/20 115/1 144/18 144/19 146/18 147/5 147/10 147/12
meet [7] 7/19 16/23 51/14 79/12 151/14 198/10 236/1
meeting [102] 7/17 7/18 14/2 17/18 20/13 21/25 22/2 22/15 24/8 27/13 31/13 32/4 33/12 34/12 34/13 37/15 43/6 43/7 43/12 43/14 44/22 45/9 45/13 49/18 49/21 50/12 50/18 51/3 51/4 51/9 51/14 51/17 51/24 53/3 55/13 55/23 56/2 56/9 57/11 68/15 68/16 71/5 87/14 89/12 90/11 91/14 91/16 103/17 119/8 119/9 120/4 120/16 122/5 122/6 122/17 123/5 124/1 143/14 146/12 154/14 154/16 155/2 155/7 155/23 157/6 158/6 158/9 158/24 159/1 166/22 166/25 167/1 167/13 167/19 168/9 178/9 181/25 182/18 183/4 189/22 192/6 192/14 192/19 192/21 192/22 193/3 193/21 205/22 208/22 218/25 220/16 223/17 230/3 230/4 230/18 230/20 231/13 231/20 231/21 231/24 232/3 232/4
meetings [31] 6/23 16/24 18/2 28/14 46/5 49/23 51/1 53/15 53/19 61/8 68/12 68/17 68/19 78/15 89/11 89/18 89/25 90/14 95/16 95/19 123/8 132/16 161/16 168/2 182/17 189/5 189/18 191/19 196/3 218/6 218/11
Melius [7] 1/21 32/21 186/9 186/10 186/16 187/12 253/23
member [32] 18/20 23/10 23/24 26/20 27/16 32/23 41/6 45/18 60/22 77/2 81/21 111/2 113/5 113/20 113/25 115/4 115/14 116/20 130/9 130/14 163/16 165/1 174/11 174/14 185/23 187/22 204/15 208/6 209/10 212/2 216/12 249/8
member's [1] 115/6
members [12] 26/10 27/23 61/5 76/23 76/25 79/24 92/22 104/19 104/21 152/3 215/17 216/11
memories [1] 209/15
memory [6] 64/17 64/19 193/20 209/15 242/1 250/8
mentioned [4] 60/14 95/24 151/17 247/21
mentions [1] 163/16
message [1] 133/21
messages [1] 70/22
messaging [1] 125/6
met [11] 18/2 18/3 31/16 31/21 32/2 68/6 85/2 85/4 143/17 151/21 152/13
mid [2] 131/25 132/5
mid-March [2] 131/25 132/5
middle [4] 155/3 206/22 229/14 234/19
Midwife [11] 80/9 81/4 81/18 84/19 86/6 86/14 86/16 86/21 88/17 89/25 248/10
midwifery [5] 81/5 82/10 82/11 87/3 91/25
might [19] 8/8 59/1 62/19 77/13 82/8 87/11 95/20 107/15 118/17 134/2 145/1 164/13 168/7 168/11 189/19 203/15 208/18 243/21 244/2
Millward [17] 62/15 62/21 63/1 63/2 98/4 119/3 140/5 175/18 179/16 193/12 207/2 207/7 217/13 224/3 230/22 255/11 256/7
mind [13] 66/17 78/25 111/10 117/2 120/3 129/14 130/19 137/9 157/8 201/8 206/3 225/23 247/5
minds [2] 65/22 110/15
mine [1] 54/10
minor [1] 108/24
minute [4] 89/10 124/8 168/13 175/13
minutes [35] 13/19 13/19 13/22 14/4 14/7 14/21 16/11 17/18 19/8 20/11 20/12 20/15 20/16 20/23 20/25 21/4 21/4 21/21 22/17 23/5 23/16 23/18 24/1 24/1 24/3 24/5 24/8 24/9 25/16 25/17 25/18 25/23 57/11 120/4 203/18
misleading [2] 102/7 102/18
misprioritised [1] 79/4
missing [1] 175/14
mistake [1] 197/16
mitigate [2] 76/24 77/3
mitigating [1] 106/7
mitigation [1] 12/7
mitigations [3] 79/10 100/6 125/21
mm [16] 21/2 23/12 24/16 49/1 76/14 80/7 83/14 85/21 86/4 132/22 158/3 162/14 163/12 164/5 167/16 184/4
Mm-hm [12] 23/12 24/16 49/1 76/14 80/7 83/14 85/21 86/4 132/22 158/3 162/14 163/12
Mmm [4] 21/2 164/5 167/16 184/4
Mmm mm [4] 21/2 164/5 167/16 184/4
model [1] 75/12
moderate [6] 108/16 108/18 108/24 121/8 174/20 228/7
moment [19] 19/15 27/14 55/11 58/25 101/23 105/14 105/22 109/11 109/18 118/13 118/18 120/19 126/5 126/10 146/4 175/7 190/17 200/25 201/6
Monday [4] 1/1 41/2 163/20 165/23
monitor [1] 76/4
monitoring [3] 73/15 157/13 238/21
month [5] 7/11 78/21 78/22 119/14 159/18
monthly [3] 68/14 89/10 237/7
months [18] 3/8 3/13 5/5 7/12 7/23 18/3 21/25 49/25 76/17 96/24 130/3 162/21 162/22 183/25 217/18 225/14 242/19 243/9
months' [1] 89/13
morbidity [4] 153/21 156/1 196/16 225/1
more [87] 3/5 10/24 19/18 19/19 19/23 20/3 22/2 30/5 31/6 37/14 40/20 40/23 42/7 44/11 44/13 48/9 50/4 60/3 66/21 66/24 66/25 67/1 73/8 74/4 74/25 75/5 76/8 76/10 77/6 77/14 81/14 84/6 85/7 85/23 86/24 87/23 88/1 88/12 91/5 92/4 97/9 112/17 113/14 119/25 124/24 125/5 126/16 127/20 128/8 133/2 141/25 144/16 144/21 148/14 148/16 151/2 152/8 152/20 152/20 153/21 154/12 159/20 161/5 161/25 162/8 162/8 162/16 163/22 167/18 170/2 176/23 186/3 188/24 189/23 193/25 194/5 196/15 200/20 203/19 208/9 211/12 217/3 232/6 242/13 243/22 247/9 248/16
morning [14] 1/3 36/19 55/23 56/5 57/10 104/25 219/9 219/23 220/9 223/21 225/20 226/18 242/7 255/14
mortality [78] 3/8 13/12 13/15 13/17 14/25 15/4 15/7 15/23 16/6 16/14 16/21 17/5 17/17 17/20 17/22 18/4 18/12 18/16 19/1 19/3 19/6 19/14 19/19 21/11 21/18 21/20 22/6 22/7 23/1 23/14 24/12 25/3 26/13 28/11 28/17 29/8 29/12 29/12 29/22 30/4 30/7 30/12 30/24 31/3 32/8 46/16 99/1 99/8 100/1 105/24 106/3 114/1 118/4 119/18 119/22 121/7 124/12 127/2 128/20

M

mortality... [19] 129/6 131/22 153/21 156/1 156/1 164/22 175/20 183/4 183/13 189/10 189/12 194/18 194/25 196/16 199/20 200/11 205/10 225/1 225/11
most [11] 36/25 37/6 39/3 48/22 49/10 49/16 89/9 150/13 156/12 158/25 169/11
Mother [2] 232/19 236/19
Mother A [2] 232/19 236/19
motivation [1] 61/25
move [12] 27/8 92/24 112/22 152/17 152/19 166/21 175/6 177/3 182/23 183/23 188/6 202/8
moved [17] 2/6 2/24 22/24 48/5 52/22 111/15 130/15 130/18 131/6 131/10 131/10 154/4 201/24 202/5 206/23 232/11 246/25
moving [4] 20/10 46/16 81/2 250/7
Mr [47] 48/10 48/11 60/7 62/13 62/23 88/6 92/20 93/11 94/17 94/23 101/8 103/19 122/21 122/22 143/16 154/17 175/16 181/8 181/16 181/17 189/3 190/9 192/8 192/21 192/22 197/3 201/9 207/3 207/4 207/5 207/6 208/14 208/23 209/4 209/25 215/2 215/21 215/25 221/14 230/3 231/6 231/7 243/24 255/10 256/5 256/8 256/9
Mr Baker [8] 48/10 48/11 60/7 207/3 207/5 207/6 256/5 256/9
Mr Bennett [1] 192/8
Mr Brearey [1] 88/6
Mr Cross [14] 94/23 101/8 103/19 122/21 189/3 192/21 192/22 208/23 209/4 209/25 230/3 231/6 231/7 243/24
Mr De La Poer [7] 62/13 62/23 175/16 207/4 208/14 255/10 256/8
Mr Harper-Lea [1] 221/14
Mr Harvey [6] 143/16 154/17 181/8 190/9 197/3 201/9
Mr McCormack [2] 181/16 181/17
Mr Semple [5] 92/20 93/11 94/17 215/2 215/25
Mr Semple's [1] 215/21
Mr Tony Chambers [1] 122/22
Mrs [90] 48/13 60/8 62/5 62/15 63/2 68/16 71/21 75/18 76/1 80/18 83/17 83/19 87/9 87/9 87/21 87/24 88/2 88/4 89/22 89/25 90/13 90/16 95/4 98/4 119/3 119/10 122/21 131/3 140/5 141/9 142/1 142/7 142/9 142/11 142/21 145/20 145/25 148/13 149/3 149/15 150/5 153/3 158/10 159/2 175/18 178/8 178/11 178/13 179/16 179/21 179/23 180/2 180/4 180/19 180/21 182/15 184/19 184/24 185/1 185/1 185/3 185/18 185/21 187/5 187/6 187/20 189/3 190/9 192/15 192/16 192/18 193/12 197/2 197/7 201/3 202/17 205/11 207/7 213/23 225/21 238/9 242/7 248/15 248/23 250/7 251/1 251/4 252/24 253/16 255/4
Mrs Harper-Lea [3] 225/21 238/9 242/7
Mrs Hodkinson [1] 201/3
Mrs Kelly [13] 71/21 76/1 87/9 87/9 122/21 158/10 159/2 185/21 187/5 187/6 190/9 197/2 197/7
Mrs Kelly's [2] 149/15 150/5
Mrs Lawrence [19] 88/2 88/4 89/25 90/16 142/1 148/13 149/3 184/19 184/24 185/1 185/1 185/3 187/20 248/15 250/7 251/1 252/24 253/16 255/4
Mrs Lawrence's [2] 185/18 202/17
Mrs McMahon [11] 83/17 83/19 119/10 178/11 179/21 179/23 180/2 180/4 180/19 180/21 182/15
Mrs Millward [8] 63/2 98/4 119/3 140/5 175/18 179/16 193/12 207/7
Mrs Peacock [16] 75/18 80/18 87/21 87/24 89/22 90/13 141/9 142/7 142/9 142/11 142/21 145/20 145/25 178/8 178/13 248/23
Mrs Peacock's [1] 153/3
Mrs Powell [1] 213/23
Mrs Ruth Millward [1] 62/15
Mrs Sian Williams [1] 68/16
Mrs Townsend [5] 48/13 60/8 62/5 131/3 205/11
Mrs Williams [5] 95/4 189/3 192/15 192/16 192/18
Ms [78] 1/4 1/5 1/7 1/9 1/12 2/25 9/14 41/14 62/21 66/11 68/6 68/7 74/8 82/17 82/20 82/21 82/24 83/7 83/9 83/12 83/15 84/24 84/25 86/3 87/3 87/12 88/20 91/5 91/19 92/2 92/18 105/1 116/25 117/20 123/19 136/3 136/10 136/22 150/23 154/17 154/23 156/10 164/4 164/6 165/5 166/2 166/9 166/16 166/17 166/25 167/23 171/2 182/4 182/10 187/13 191/12 191/13 191/18 192/4 192/5 192/14 202/10 206/4 207/2 217/11 217/13 224/3 226/4 228/21 230/22 243/20 243/24 247/14 255/11 256/3 256/4 256/7 256/10
Ms Brown [4] 1/4 1/12 9/14 256/4
Ms Burnett [1] 2/25
Ms Debbie Peacock [1] 68/6
Ms Fogarty [9] 74/8 87/12 88/20 91/19 92/2 92/18 150/23 156/10 192/5
Ms Harper-Lea [3] 226/4 228/21 243/24
Ms Julie Fogarty [1] 87/3
MS KAREN TOWNSEND [2] 1/9 256/3
Ms Kelly [1] 154/17
Ms Kelly's [1] 154/23
Ms Lawrence [8] 84/24 84/25 86/3 91/5 136/3 136/10 182/4 202/10
Ms Lawrence's [2] 136/22 187/13
Ms McMahon [4] 82/20 82/21 83/7 83/15
Ms McMahon's [1] 182/10
Ms Millward [5] 207/2 217/13 224/3 230/22 255/11
Ms Peacock [11] 68/7 82/17 83/9 83/12 116/25 164/4 164/6 166/2 166/25 167/23 206/4
Ms Peacock's [2] 165/5 166/16
Ms Powell [3] 166/9 166/17 171/2
Ms Sian Williams [1] 66/11
Ms Townsend [6] 1/5 1/7 41/14 105/1 117/20 123/19
Ms Williams [4] 191/12 191/13 192/4 192/14
Ms Williams' [1] 191/18
Ms Woods [1] 243/20
much [48] 8/13 14/4 25/7 26/8 31/9 46/2 46/17 58/7 58/10 60/6 62/5 68/1 77/4 84/6 91/9 91/11 93/12 95/25 96/17 102/12 102/20 102/21 103/6 103/9 107/17 113/2 118/22 120/7 125/12 129/16 132/10 132/14 133/6 149/10 159/24 167/10 171/2 174/18 174/19 190/25 191/1 195/14 202/5 232/6 233/20 255/10 255/11 255/12
multi [3] 80/11 161/14 200/15
multi-disciplinary [1] 161/14
multi-faceted [1] 80/11
multiple [3] 78/7 116/21 201/1
mum [5] 81/11 153/24 157/12 161/5 169/12
murdered [1] 217/17
murdering [1] 59/8
murders [2] 63/22 64/6
must [5] 32/15 56/21 57/4 178/19 227/20
mustn't [2] 56/22 57/6
mutually [1] 51/12
my [198] 1/14 3/3 4/7 5/3 7/9 8/2 11/7 11/18 17/1 17/3 17/3 18/11 20/6 20/20 28/2 31/9 34/15 34/16 37/12 37/12 37/20 37/22 37/22 39/13 40/11 41/18 44/6 45/13 45/24 46/25 48/8 48/12 48/13 50/9 59/2 59/2 60/3 60/18 62/14 62/15 63/1 63/15 63/24 64/19 66/20 67/6 67/14 68/15 69/16 69/20 69/21 69/21 70/1 70/7 71/8 71/9 71/15 72/1 75/17 75/21 76/21 76/22 77/20 78/9 78/13 78/18 79/9 81/22 87/8 87/13 87/19 89/24 90/8 90/9 90/10 90/15 90/17 91/5 91/15 91/20 91/23 92/4 93/11 94/24 99/23 101/3 101/5 101/5 101/14 101/17 101/17 101/19 101/19 102/8 102/8 102/16 103/6 103/6 103/7 103/11 117/16 118/19 118/20 120/3 124/20 124/21 132/4 137/22 139/6 145/8 146/25 159/6 161/13 161/22 163/15 164/21 164/25 167/4 167/9 168/18 168/25 171/22 172/11 173/25 175/1 175/5 175/17 176/21 177/25 179/12 179/13 180/1 180/17 181/13 182/11 182/15 182/21 185/10 185/17 185/22 186/8 186/16 186/23 186/25 187/11 187/21 188/1 188/3 188/5 189/3 189/11 190/21 191/21 192/8 194/13 195/13 195/18

M

my... [41] 196/4 196/5 196/12 197/16 200/6 201/16 201/19 202/21 203/11 203/12 203/16 203/20 207/1 207/19 209/8 214/20 215/10 217/3 217/8 217/13 217/16 222/11 225/17 225/19 226/17 227/7 227/20 233/21 234/5 238/8 239/13 243/23 244/6 245/17 247/6 250/21 253/21 253/23 254/17 254/22 255/8
my Lady [16] 4/7 28/2 48/12 60/3 62/14 118/19 173/25 175/5 175/17 203/16 207/1 217/3 217/8 243/23 244/6 250/21
myself [14] 10/6 80/1 83/6 89/7 93/19 94/18 148/1 160/3 180/20 180/21 188/5 192/7 233/19 249/2

N

naivety [3] 17/1 37/12 37/18
name [14] 1/13 1/14 4/10 4/21 48/13 53/1 62/25 63/1 163/25 164/8 184/3 214/14 217/13 247/23
named [2] 144/3 213/5
narrative [2] 117/9 195/1
narrow [3] 141/2 143/23 158/19
narrowed [1] 148/15
national [13] 80/12 80/15 81/15 81/20 82/1 82/4 86/25 92/5 113/18 137/7 147/16 170/9 248/16
natural [4] 74/22 81/13 115/21 136/16
naturally [1] 136/19
nature [3] 152/11 188/20 230/19
near [1] 119/11
nearly [1] 60/8
necessarily [11] 51/20 52/15 97/3 115/25 116/1 117/7 142/5 144/11 172/9 202/23 245/14
necessary [2] 107/23 157/7
need [54] 24/25 25/1 37/5 44/25 58/7 58/10 59/25 72/18 77/24 78/5 81/23 85/23 85/24 105/1 110/20 112/15 112/16 112/17 112/22 115/10 116/5 118/7 120/2 127/19 136/17 141/25 142/7 145/23 149/8 158/4 161/6 161/18 169/6 174/25 177/3 180/24 191/25 197/10 197/17 200/23 202/8 208/25 221/1 221/3 222/4 224/10 226/7 234/1 234/1 239/24 249/14 249/14 249/15 255/6
needed [32] 24/24 27/23 31/7 34/16 34/18 38/13 38/18 38/22 38/22 38/23 39/12 39/13 40/1 40/4 40/12 44/14 46/20 71/24 75/8 85/7 93/13 100/7 103/2 107/13 113/17 140/10 181/5 186/24 191/17 192/2 218/19 251/18
needs [4] 37/6 112/23 204/17 254/7
neither [7] 20/6 22/16 41/20 41/24 41/24 166/17 243/24
neonatal [101] 2/17 3/8 3/20 7/11 7/13 7/16 9/17 12/20 12/24 13/3 13/7 14/16 14/23 16/7 16/16 16/22 17/2 21/1 21/18 22/7 23/14 28/10 28/12 30/17 32/7 32/8 32/12 34/23 37/21 42/22 46/16 47/20 50/8 50/24 54/16 67/19 81/6 81/9 81/13 81/19 82/14 84/5 87/17 89/10 95/15 95/16 98/25 99/7 99/12 105/24 117/1 118/3 118/4 119/17 119/19 119/22 121/2 121/8 124/12 125/19 128/20 129/5 132/13 133/1 133/5 134/8 140/7 140/23 141/18 141/20 142/10 142/21 146/10 148/12 152/9 156/24 160/9 160/13 162/2 164/4 165/15 167/2 167/21 168/12 170/9 170/11 171/20 172/4 175/20 185/4 189/10 189/12 195/2 195/3 195/10 198/6 198/24 199/12 199/16 233/9 238/4
neonates [1] 15/10
neonatologists [1] 91/11
neonatology [8] 28/5 86/9 86/18 86/23 88/15 88/25 89/3 90/6
network [1] 198/6
neutral [1] 39/6
never [17] 16/24 18/4 18/6 68/10 82/13 82/13 83/6 88/10 88/13 129/11 150/15 195/22 207/23 216/20 216/20 249/1 249/21
nevertheless [1] 45/16
new [13] 17/1 24/18 96/16 112/7 119/13 148/22 159/23 170/11 218/18 218/20 218/21 236/10 253/17
newsletter [1] 74/25
next [30] 4/17 11/8 20/22 36/15 43/23 49/16 59/4 59/16 89/4 96/24 105/11 117/21 118/9 119/21 146/8 146/12 182/25 186/22 189/1 189/5 190/24 198/15 198/24 220/10 221/11 224/12 225/4 231/4 235/2 235/10
NHS [6] 49/4 137/5 141/22 145/3 161/19 178/21
NHS England [3] 137/5 141/22 161/19
Nichol [4] 122/11 122/13 122/18 122/19
Nicola [2] 11/19 67/24
night [1] 176/1
nine [1] 194/3
NN [1] 24/11
NNU [19] 13/15 18/12 19/14 23/21 23/23 25/12 25/14 30/20 34/9 44/24 46/7 54/19 54/22 224/19 224/21 226/14 230/17 234/23 234/25
no [188] 1/24 2/16 3/4 3/10 3/16 4/2 7/8 7/13 9/9 13/13 15/5 15/20 15/20 17/7 17/13 17/14 17/19 17/23 18/8 19/7 19/9 20/9 20/24 21/6 22/5 22/9 22/9 23/18 23/19 24/2 24/20 24/22 25/3 25/4 25/11 25/22 27/5 27/12 27/20 31/25 36/10 37/11 38/2 38/5 38/19 39/11 39/22 42/13 42/24 44/7 46/25 50/2 50/9 52/9 53/2 54/9 54/12 54/12 54/12 55/14 55/15 56/12 56/16 57/7 58/1 58/5 58/5 60/3 62/1 65/11 71/15 77/2 79/6 81/23 82/11 83/3 83/12 83/17 85/1 85/8 89/2 90/2 90/8 91/21 92/23 93/1 93/1 93/15 94/8 94/20 95/8 99/6 103/4 104/7 114/23 121/16 129/13 136/15 137/11 138/23 139/24 143/2 144/22 145/4 146/2 146/15 152/15 153/7 155/23 156/14 156/19 161/1 164/10 167/22 169/8 175/23 177/4 177/11 177/18 178/9 179/15 180/3 180/21 183/22 184/20 187/1 187/11 187/21 195/18 195/20 196/25 198/8 199/9 199/19 199/23 200/12 201/24 202/8 202/19 203/11 205/19 205/20 205/20 205/21 207/21 208/2 208/17 210/9 212/1 215/3 216/16 217/3 217/9 217/12 218/5 223/6 225/23 226/20 227/4 230/6 231/15 232/15 234/3 235/2 235/2 235/10 235/15 236/8 236/18 237/24 237/24 239/12 242/19 244/9 245/3 245/6 245/16 248/14 249/22 250/3 250/5 250/5 250/6 250/8 251/3 253/11 253/12 255/9
nobody [6] 30/18 133/2 208/9 209/5 215/5 215/7
Nods [65] 15/18 15/24 16/1 16/4 16/18 22/1 43/20 45/20 48/17 52/5 63/21 67/20 78/24 82/23 83/11 84/9 85/16 92/17 96/14 98/11 98/20 98/23 99/9 104/8 105/4 105/7 105/9 108/9 108/12 110/13 114/2 116/10 116/15 121/10 122/2 122/12 123/22 130/11 134/12 141/12 144/6 145/22 148/9 150/1 153/17 158/5 162/11 162/18 163/19 164/2 165/3 177/2 184/14 187/18 191/8 197/22 198/7 199/6 213/9 216/4 216/6 224/5 232/22 236/21 240/3
non [5] 69/5 110/2 130/10 162/13 191/10
non-clinical [1] 110/2
non-fatal [1] 191/10
non-indictment [1] 162/13
none [4] 111/7 139/22 249/23 250/3
nor [5] 30/16 58/1 166/17 166/17 243/24
normal [4] 83/18 132/19 211/4 228/10
normally [6] 28/6 53/14 131/12 137/17 195/15 237/17
not [276]
note [16] 24/25 53/3 53/5 53/9 53/17 120/2 121/13 122/25 146/9 149/13 154/16 154/23 193/11 239/3 239/22 242/12
notebook [1] 53/21
noted [2] 54/18 57/12
notes [16] 25/15 32/25 44/24 45/1 45/13 53/14 53/17 53/18 54/2 54/4 54/5 55/22 57/14 150/2 150/5 253/23
nothing [9] 17/23 30/10 54/6 97/12 120/5 173/5 173/8 198/16 203/19
notifiable [1] 228/6
notifications [4] 214/15 214/20 214/21 218/21
notified [1] 169/9
notify [1] 161/18
notifying [1] 215/16
November [3] 1/1 5/4 255/17
now [69] 3/20 3/21 13/14 15/20 19/2 20/25 21/7 23/7 26/2 31/13 38/13 39/23 40/21 40/22 44/2 44/12 49/5 51/23 52/8 53/3 55/19 57/9 57/22 59/9 65/5 66/9 67/25 70/4 72/24 75/4 78/20 85/10 89/12 92/14 96/1 96/6 100/19 117/21 118/23 119/5 121/4 122/11 132/6 132/9 132/18 136/1 136/10 137/9 143/6

N

now... [20] 145/19 157/25 162/21 193/4 193/19 194/2 194/16 202/8 202/10 203/22 212/19 213/3 213/12 214/2 219/11 224/10 226/7 230/15 249/3 255/13
NPSA [1] 134/19
number [47] 29/15 40/5 51/8 62/16 66/19 69/17 74/9 74/20 76/22 77/23 79/18 80/20 83/25 84/3 86/3 86/25 87/21 92/20 93/23 99/16 111/10 120/21 126/18 127/11 131/14 137/21 140/13 141/2 150/18 154/20 165/16 167/18 170/21 176/14 177/8 177/16 181/2 190/7 192/9 195/3 195/14 207/9 214/22 235/8 245/18 248/5 249/19
Number 1 [1] 177/16
numbers [1] 121/16
nurse [29] 8/22 8/23 12/4 32/24 42/23 45/1 58/9 58/16 63/17 64/4 64/12 64/24 65/2 111/10 183/5 183/7 183/14 185/7 185/7 187/7 189/13 190/3 191/5 194/20 195/17 198/1 232/24 253/6 253/6
Nurse Anne Martyn [1] 191/5
nurses [2] 67/13 111/8
nursing [26] 4/18 6/21 8/3 8/15 8/22 9/7 9/10 10/7 12/17 12/19 12/23 30/17 35/17 35/23 37/7 41/6 61/9 63/24 63/25 65/18 66/12 93/20 113/12 165/7 170/10 176/4

O

o'clock [4] 31/14 165/24 255/14 255/16
O's [1] 213/14
objective [1] 96/20
objectives [3] 96/22 97/2 106/21
obligation [11] 107/21 166/18 178/17 179/14 179/20 180/1 180/3 181/11 181/18 221/11 227/7
obliged [1] 179/18
observations [1] 71/9
observed [3] 185/5 202/2 206/3
obstetric [5] 15/14 153/24 156/23 225/10 225/11
obstetric review [1] 153/24
obstetrics [6] 14/14 15/11 81/5 81/9 84/4 224/16
obviously [75] 7/18 8/6 16/7 21/10 25/17 32/7 34/19 37/14 40/15 45/19 54/2 56/1 70/16 74/10 74/18 78/13 88/17 90/8 91/17 93/18 95/10 101/2 104/11 104/20 107/10 107/17 108/25 110/1 111/1 111/19 112/5 113/21 122/8 124/2 128/22 129/8 130/4 133/8 133/14 133/15 141/9 143/25 144/23 148/18 153/1 153/22 154/5 154/13 154/21 159/8 164/22 164/23 168/3 169/11 172/23 174/17 181/25 182/19 186/13 188/19 190/12 200/24 202/16 206/13 213/3 235/8 235/20 238/11 241/12 243/12 245/2 246/21 250/12 251/9 255/3
occasion [2] 122/24 185/3
occasions [4] 57/17 140/10 185/2 248/5
occur [2] 131/7 253/25
occurred [15] 3/25 30/22 70/8 86/7 137/17 137/18 147/11 162/23 163/25 167/2 167/14 176/1 185/25 204/25 247/25
occurring [6] 52/11 55/22 57/19 108/14 108/22 136/19
occurs [1] 139/6
October [6] 162/10 163/23 167/18 217/18 219/4 245/10
October 2016 [1] 219/4
off [5] 27/4 61/23 180/14 230/25 247/18
off-duty [1] 230/25
offer [5] 41/24 59/18 203/19 215/24 241/19
offered [6] 42/6 42/21 88/15 90/7 90/19 201/22
offering [1] 107/23
office [2] 239/4 239/6
officer [1] 203/6
often [7] 7/3 7/10 7/19 10/20 14/5 141/7 209/15
oh [1] 113/16
okay [39] 52/2 52/7 55/25 80/2 96/4 99/22 99/24 134/9 209/15 210/10 214/6 217/19 219/2 219/24 220/4 221/18 221/19 222/24 223/16 223/23 225/14 226/3 229/6 230/14 230/19 230/22 231/3 231/8 232/7 234/12 234/18 235/4 236/9 238/18 240/11 243/1 243/8 245/21 246/4
omission [4] 150/11 150/20 158/20 159/11
omitted [1] 215/6
on [317]
once [15] 6/14 7/11 7/12 7/14 7/22 18/15 22/17 40/10 92/18 156/22 181/8 181/21 182/1 182/4 220/10
one [89] 3/4 3/4 4/16 7/20 7/20 31/22 31/22 36/19 40/23 44/11 47/1 49/5 54/12 54/15 54/25 56/22 68/14 68/14 73/2 73/15 73/17 74/2 74/24 76/6 76/6 78/9 85/4 85/23 88/4 93/3 94/16 102/24 108/4 108/5 109/11 118/2 118/13 118/15 119/20 119/21 119/25 121/3 121/5 124/13 125/2 130/8 133/10 135/3 136/16 140/18 144/4 145/1 145/9 145/23 146/4 150/12 152/20 152/20 155/2 161/1 163/22 163/25 164/14 166/12 169/18 173/24 175/14 185/2 188/7 188/18 192/8 193/12 194/4 197/6 200/23 202/13 205/11 215/1 217/5 221/18 224/14 226/4 226/13 229/22 230/12 235/22 240/14 242/24 250/23
one-page [1] 240/14
ones [1] 85/4
ongoing [4] 22/22 134/5 218/23 241/2
only [35] 11/20 75/16 78/6 80/25 93/19 93/25 115/10 116/11 136/20 141/14 147/25 149/17 149/24 155/7 156/8 185/2 187/2 187/11 189/20 192/20 196/9 208/20 209/2 213/4 213/16 213/23 222/11 225/24 227/15 227/18 228/1 239/14 241/12 244/1 251/11
onward [1] 217/25
open [8] 27/7 31/6 34/14 78/3 151/8 179/18 179/18 180/4
opened [1] 233/3
operate [1] 10/11
operates [1] 158/2
operating [1] 147/20
operational [11] 1/24 6/21 8/4 9/1 9/1 9/11 10/23 11/6 11/12 12/17 47/25
operationalise [1] 159/9
Operations [3] 2/24 6/7 6/12
opinion [2] 18/11 204/6
opportunity [16] 9/21 78/16 78/22 80/17 85/25 88/19 91/18 93/6 107/5 160/8 162/20 165/21 171/12 200/1 241/4 243/2
optimal [5] 151/7 161/11 176/15 176/19 177/14
options [2] 54/14 158/16
or [239] 3/6 5/1 5/15 5/18 7/4 7/11 8/18 8/22 9/23 10/21 10/21 11/6 11/14 12/6 12/8 12/8 12/17 13/3 16/6 16/11 16/20 17/6 17/24 18/12 19/4 20/1 20/8 21/25 22/15 27/22 29/2 29/10 30/17 30/17 30/20 30/23 30/24 31/18 32/24 33/21 35/8 36/11 36/16 38/6 38/11 39/22 41/15 41/20 41/20 42/19 42/23 43/5 43/7 44/7 44/19 45/1 45/22 46/22 49/15 50/1 50/14 51/10 52/10 52/14 55/8 56/1 56/23 61/25 65/10 66/6 66/15 66/22 67/8 67/9 68/18 69/11 72/24 73/10 75/13 76/16 79/17 80/15 81/1 81/19 82/14 84/10 85/5 86/8 86/17 86/22 87/17 94/18 95/8 95/18 96/21 99/12 100/6 102/10 102/16 103/15 104/4 105/17 105/17 106/5 106/7 107/12 107/15 108/10 108/19 111/8 111/9 112/8 112/12 113/2 113/14 115/20 115/20 115/22 122/21 122/21 124/21 127/14 129/1 129/10 129/24 131/16 131/20 137/2 137/5 137/13 138/7 138/7 138/11 139/13 139/13 140/2 141/14 142/7 143/20 143/21 144/10 144/13 145/13 145/16 146/16 148/7 148/23 149/17 150/10 150/11 150/12 150/20 150/21 150/22 152/1 152/13 155/13 155/14 156/11 158/13 158/20 159/11 159/12 159/25 161/5 162/21 164/14 170/17 174/6 174/13 174/21 174/24 175/14 176/4 180/21 181/14 181/25 182/10 182/15 184/25 185/8 185/12 185/15 185/16 186/9 186/25 188/21 190/25 191/1 191/17 198/9 203/1 204/21 205/11 209/11 212/10 212/20 213/13 213/21 215/16 216/18 216/19 217/5 218/17 218/18 218/20 218/21 220/25 221/17 221/17 222/24 223/6 228/7 228/12 228/17 229/22 230/10 230/12 232/25 235/7 235/16 235/18 235/23 237/25 240/22 241/14 242/1 242/10 242/21 244/11 245/4 246/14 246/23 247/5 250/18 251/15 253/7 253/12 255/3
or April 2016 [1] 242/10
oral [1] 221/5
orally [1] 34/25
order [1] 220/24
ordinate [1] 181/25
ordinators [1] 67/10
organisation [19] 46/18 47/21 75/14

O

organisation... [16] 75/15 96/16 106/19 106/20 111/24 127/4 129/22 135/20 158/19 159/10 162/6 163/6 188/25 210/19 211/1 233/8
organisational [3] 4/7 6/18 211/24
organisations [1] 73/6
organised [1] 50/1
orientate [1] 120/19
originally [2] 112/5 250/20
OSR [3] 224/15 225/10 226/14
other [48] 6/2 7/1 13/9 16/10 33/7 35/16 35/23 36/5 54/15 55/8 55/8 55/17 56/22 61/2 69/18 70/4 70/20 80/13 84/13 99/3 109/11 112/20 135/17 140/2 145/21 159/15 164/14 168/22 174/14 175/19 178/13 192/1 193/2 196/15 198/3 200/5 206/17 213/25 218/3 218/9 229/22 236/22 239/21 243/21 244/2 244/15 248/14 250/3
others [4] 33/9 82/6 176/16 247/3
otherwise [1] 11/14
our [39] 6/24 6/24 6/25 8/5 8/5 8/6 9/2 9/3 41/22 64/22 65/22 69/16 73/20 76/19 80/2 85/4 85/11 89/8 89/18 94/12 94/13 103/7 105/15 107/15 118/7 123/18 127/18 128/16 139/11 144/21 159/23 165/22 178/25 181/24 195/9 206/6 244/3 254/25 255/2
ourselves [1] 120/19
out [38] 7/20 9/19 19/24 19/25 22/21 29/19 45/24 50/13 51/13 53/22 59/23 61/1 62/4 64/6 74/14 81/16 87/1 93/3 106/14 133/15 136/7 142/13 148/16 165/2 175/22 176/22 184/2 186/3 188/20 191/9 198/5 198/10 216/11 216/24 234/8 237/13 243/16 246/25
outcome [12] 104/4 109/7 115/18 116/1 125/11 125/13 139/24 144/14 147/11 147/13 229/21 230/13
outpatients [2] 2/6 2/7
outset [2] 216/8 241/5
outside [8] 11/2 21/8 24/15 27/7 82/6 125/24 205/1 212/14
outstanding [3] 170/7 170/7 238/3
outwardly [1] 254/5
over [49] 3/1 4/11 18/25 38/11 38/11 38/17 38/19 40/6 41/4 42/12 52/11 66/15 70/7 71/9 72/8 72/10 73/6 77/17 80/4 84/20 85/24 87/10 88/2 89/9 89/22 93/15 100/11 103/19 103/22 104/24 105/1 110/19 120/22 137/1 140/5 143/8 149/10 155/1 159/18 159/22 165/5 178/19 181/1 183/17 185/3 196/22 202/4 216/18 248/7
over-concern [1] 38/11
over-reliance [3] 38/11 38/17 38/19
overall [4] 9/4 160/8 176/23 233/9
overheard [1] 202/11
oversaw [2] 69/12 101/8
oversee [1] 210/22
overseeing [2] 71/6 169/16
oversight [7] 8/4 10/1 69/16 83/4 83/23 84/14 101/16
overspeaking [1] 237/21
overview [1] 80/4
own [11] 3/24 88/11 98/14 128/17 130/23 131/3 139/18 152/13 156/7 173/11 184/15
owned [1] 131/4

P

P's [4] 55/12 55/22 59/6 213/15
paediatric [8] 30/18 54/13 54/16 81/19 82/14 87/16 91/10 179/24
paediatricians [9] 25/8 26/9 40/15 86/8 86/17 86/22 87/14 143/17 180/6
paediatricians' [1] 204/6
paediatrics [15] 3/20 5/24 7/22 14/16 15/12 17/2 37/21 50/23 81/6 84/5 88/15 88/25 89/3 92/1 133/6
page [67] 4/21 24/7 40/7 43/2 47/4 47/10 53/4 53/6 85/23 86/5 89/9 91/7 98/3 100/11 100/11 103/22 103/22 104/24 105/16 106/13 108/1 109/16 110/19 111/15 119/13 120/2 120/9 120/17 120/22 121/25 126/15 128/4 134/10 134/14 136/4 140/15 143/8 146/8 149/17 152/19 155/1 169/23 169/25 177/4 183/1 194/23 196/21 196/22 197/9 212/25 214/1 214/13 219/15 219/16 222/23 222/24 224/1 230/25 231/4 231/5 234/13 234/18 234/21 237/25 240/11 240/14 243/1
page 1 [3] 47/10 120/17 194/23
page 10 [1] 120/9
page 11 [1] 197/9
page 14 [1] 108/1
page 15 [1] 109/16
page 155 [1] 240/11
page 2 [4] 43/2 53/4 134/10 212/25
page 3 [3] 98/3 136/4 222/23
page 4 [4] 100/11 119/13 126/15 196/21
page 5 [3] 24/7 103/22 120/2
page 53 [1] 219/15
page 6 [2] 169/23 169/25
page 7 [4] 105/16 177/4 214/1 234/18
page 777 [1] 243/1
page 8 [2] 128/4 140/15
page 89 [1] 224/1
page 9 [1] 106/13
pages [1] 229/25
pagination [1] 40/7
panel [54] 75/2 146/12 147/20 149/20 152/4 154/7 156/20 156/22 157/1 161/2 161/23 165/20 165/21 168/25 173/20 181/23 182/1 182/12 182/13 186/12 186/22 187/4 188/3 189/1 206/21 218/6 218/11 218/24 220/23 221/2 221/15 221/24 223/17 225/19 225/22 226/1 226/19 227/5 229/3 229/18 229/22 233/22 233/25 234/14 234/16 238/12 241/21 241/23 242/8 242/23 253/24 254/4 254/6 255/7
panels [1] 226/5
paper [15] 133/23 133/24 140/16 143/15 162/3 182/22 190/7 190/19 190/23 191/24 194/15 194/24 196/18 206/25 238/19
papers [2] 21/16 226/18
paragraph [25] 11/21 12/14 13/16 18/9 19/11 20/10 23/6 23/15 25/10 26/11 31/15 32/4 33/11 34/7 34/25 38/3 39/19 40/6 41/3 44/21 143/9 153/9 157/11 203/25 224/12
paragraph 13 [2] 11/21 12/14
paragraph 18 [1] 13/16
paragraph 20 [1] 20/10
paragraph 21 [1] 23/6
paragraph 23 [2] 23/15 25/10
paragraph 263 [1] 203/25
paragraph 28 [1] 18/9
paragraph 29 [1] 19/11
paragraph 32 [1] 26/11
paragraph 40 [1] 31/15
paragraph 41 [1] 32/4
paragraph 42 [1] 33/11
paragraph 45 [1] 34/7
paragraph 46 [1] 34/25
Paragraph 48 [1] 38/3
paragraph 54 [2] 39/19 40/6
paragraph 59 [1] 41/3
paragraph 62 [1] 44/21
pardon [1] 250/25
parents [3] 46/22 188/12 188/17
park [5] 46/10 55/25 56/4 56/20 117/12
part [39] 5/16 5/21 7/9 12/16 17/1 17/3 25/4 28/18 29/18 30/15 46/24 46/25 47/21 60/25 63/23 80/19 80/23 82/12 85/18 97/24 100/22 106/22 109/14 110/10 111/14 127/22 137/24 143/20 144/7 151/6 155/15 159/25 171/19 173/15 180/9 182/24 197/24 214/18 220/25
Part 2 [1] 100/22
participate [1] 202/15
participated [1] 221/25
participating [1] 6/22
participation [1] 69/16
particular [26] 28/7 48/15 67/18 80/16 85/4 85/19 97/5 103/23 105/10 105/11 118/1 122/8 125/1 126/21 135/14 151/14 152/5 157/8 158/9 169/23 179/6 183/5 183/14 185/7 210/23 214/24
particularly [9] 17/2 97/6 114/16 133/9 142/4 145/14 211/16 232/5 250/17
parties [2] 29/16 61/2
partners [1] 7/1
parts [2] 132/4 169/24
party [2] 16/12 190/13
passed [4] 210/24 211/7 211/15 211/19
passing [1] 253/1
past [3] 34/3 110/20 199/22
path [1] 17/3
pathology [2] 153/11 223/14
patient [86] 10/15 11/6 65/9 65/11 65/13 65/19 65/23 66/9 66/21 66/22 67/1 67/2 67/7 67/9 68/15 68/20 69/1 69/24 71/11 73/1 73/8 73/23 74/2 75/13

P

patient... [62] 75/19 75/22 76/7 77/6 77/14 77/17 80/5 80/10 80/24 81/3 83/21 84/19 89/17 94/11 101/10 101/24 103/1 104/2 104/2 104/4 106/15 106/18 106/19 106/25 107/22 109/21 109/22 110/12 111/3 115/20 119/10 130/10 133/13 133/14 134/5 134/18 135/8 135/15 135/18 135/20 138/2 138/8 140/6 153/2 159/23 174/24 176/9 184/9 195/1 195/7 195/14 200/1 201/13 201/15 206/13 217/24 228/12 235/23 236/12 249/7 254/7 254/9
patient's [4] 115/22 115/24 145/16 228/15
patients [11] 8/7 26/21 73/4 74/1 116/7 124/24 125/20 136/23 159/19 216/13 225/2
patients' [1] 77/15
pattern [1] 165/14
pause [3] 90/3 118/14 249/9
pausing [1] 224/16
payments [2] 47/8 47/17
payroll [1] 48/7
Peacock [38] 68/6 68/7 68/22 75/18 80/18 82/17 83/9 83/12 87/21 87/24 89/22 90/13 116/25 141/9 142/7 142/9 142/11 142/21 145/20 145/25 163/17 163/21 164/4 164/6 164/20 166/2 166/25 167/23 168/9 173/2 178/8 178/13 206/4 219/18 220/4 224/3 247/25 248/23
Peacock's [3] 153/3 165/5 166/16
pending [1] 228/23
penultimate [2] 134/13 143/8
people [26] 8/25 40/20 40/23 49/15 66/13 79/17 95/20 107/20 115/14 115/18 117/1 131/14 148/6 154/20 158/1 164/12 170/4 175/19 178/21 193/10 202/13 209/20 211/13 214/23 221/9 252/10
people's [1] 110/14
perceive [3] 82/7 102/17 177/11
perceived [2] 72/3 177/7
perceiving [1] 102/7
perception [4] 51/19 90/23 171/9 200/6
perfectly [1] 211/4
perform [1] 6/1
performance [5] 2/8 68/11 85/2 85/8 97/6
performing [1] 101/14
perhaps [22] 68/1 73/19 79/20 88/1 89/22 91/4 91/6 92/5 93/12 97/4 98/21 100/6 102/6 102/17 117/12 123/16 141/23 141/24 141/24 143/16 173/25 243/21
period [17] 5/2 7/14 13/11 18/7 30/10 64/15 66/15 72/8 76/12 79/1 79/22 82/21 83/1 83/23 103/21 159/18 162/12
period February 2016 [1] 82/21
permanent [1] 77/2
permission [1] 207/2
persistent [1] 190/2
persistently [2] 189/13 194/19
person [27] 48/22 49/10 49/16 62/14 67/21 68/3 82/9 90/19 110/22 112/22 112/23 113/24 116/8 117/5 131/5 131/9 142/16 142/18 158/24 159/8 170/18 174/21 203/7 238/15 241/5 249/14 249/15
perspective [8] 29/4 42/1 83/1 100/4 117/17 166/9 180/17 196/12
phone [3] 56/3 56/20 174/22
phrase [4] 81/1 83/25 111/1 194/22
pick [16] 49/5 74/14 141/17 141/18 142/2 143/23 144/9 144/16 145/13 148/12 148/14 173/22 174/22 199/12 199/16 207/12
picked [2] 93/18 104/12
picture [4] 65/22 84/18 149/10 161/17 255/15
piece [6] 141/15 153/23 163/22 191/3 191/5 236/10
pieces [2] 76/5 87/23
place [52] 12/8 17/19 21/5 24/4 26/7 39/8 40/22 50/12 52/3 53/12 55/24 55/24 56/4 73/16 74/21 76/25 79/10 79/11 79/15 93/17 93/23 94/9 94/9 100/24 102/9 107/14 124/1 125/16 125/21 131/1 138/13 146/13 157/14 159/21 166/22 167/7 168/11 168/15 174/13 177/10 179/9 197/7 199/4 200/7 201/25 204/3 205/3 220/16 225/25 233/24 240/9 240/18
placed [3] 38/8 72/11 178/15
plan [9] 14/24 146/11 154/6 157/13 177/9 224/11 224/20 226/8 226/15
planned [2] 75/23 161/11
planning [3] 97/16 230/18 231/13
plausible [1] 95/1
play [1] 209/17
please [65] 1/6 1/8 1/13 4/6 10/18 47/14 53/4 62/20 62/24 79/7 83/24 84/1 85/10 85/22 89/10 89/14 98/3 100/11 109/12 117/18 118/9 118/13 119/6 119/13 120/7 120/22 122/3 125/8 126/15 134/4 134/10 136/4 140/14 143/8 146/9 146/20 149/13 152/17 152/18 152/20 157/9 170/1 177/3 179/17 184/15 196/21 196/22 197/16 212/17 212/25 214/1 214/13 219/14 219/15 223/24 223/25 224/1 230/14 231/4 234/12 234/17 239/2 240/10 240/11 242/25
plethora [2] 94/19 95/7
plus [2] 162/16 163/25
pm [9] 118/24 119/1 153/10 155/19 175/9 175/10 175/12 223/6 255/15
Poer [7] 62/13 62/23 175/16 207/4 208/14 255/10 256/8
point [74] 2/19 2/23 9/21 13/11 16/9 18/16 20/6 20/6 22/5 25/25 26/2 26/4 27/17 28/25 29/14 30/1 34/11 35/9 36/15 36/19 37/4 41/23 49/5 58/15 59/22 75/24 79/22 87/10 89/2 89/12 92/11 93/18 94/19 95/3 101/22 103/24 115/9 124/22 127/10 129/9 140/4 148/19 150/17 153/25 154/1 155/25 157/4 158/13 163/1 163/5 163/5 165/15 174/17 176/8 177/6 182/3 194/8 195/20 202/6 202/7 202/9 207/21 208/2 208/9 208/17 213/24 216/16 221/4 226/20 228/22 229/5 233/2 247/6 249/2
points [8] 24/18 43/21 53/23 70/21 133/11 133/22 198/9 226/25
police [24] 1/20 45/2 45/8 45/21 112/21 116/5 116/12 134/16 135/7 135/18 135/19 191/16 192/20 192/24 193/3 203/3 203/6 203/10 203/17 208/24 209/22 210/1 210/7 232/25
policies [1] 103/8
policy [9] 95/25 96/2 97/23 136/1 137/25 138/19 139/3 139/4 139/13
poor [2] 92/21 115/25
poorly [1] 202/21
portfolio [1] 37/22
position [19] 15/22 65/3 65/16 72/12 94/24 97/15 104/14 143/15 150/16 162/3 163/1 166/16 167/18 190/6 190/18 191/24 194/15 206/25 211/19
positive [6] 98/8 107/21 229/7 229/12 230/13 242/2
positives [1] 74/24
possibility [3] 83/8 112/16 164/14
possible [9] 24/19 72/4 77/4 108/19 110/12 203/8 209/20 209/23 224/14
possibly [2] 71/14 95/22
post [15] 3/12 3/14 4/23 6/14 13/8 37/19 37/20 66/15 68/10 87/21 92/23 149/3 154/20 239/13 253/17
postdates [1] 92/14
postmortem [6] 153/16 155/24 177/19 223/11 223/18 232/14
posts [2] 5/1 5/7
potential [15] 28/10 30/2 34/8 93/4 118/2 119/17 121/1 123/20 134/16 135/2 145/6 151/25 199/25 216/2 218/12
potentially [11] 23/2 33/9 61/12 69/15 81/5 124/5 195/19 207/20 213/14 213/14 247/7
Powell [15] 12/24 13/3 13/5 13/10 18/2 22/3 49/15 163/9 163/20 166/9 166/17 171/2 183/2 196/18 213/23
practical [2] 76/16 97/8
practice [9] 7/3 31/2 67/13 113/23 160/4 185/13 185/15 186/19 208/10
practices [1] 162/2
practitioners [1] 67/14
preceding [1] 52/11
Precisely [1] 34/10
predominantly [1] 228/16
prefer [1] 247/18
prep [2] 231/5 231/14
preparation [6] 28/15 169/16 173/7 218/3 231/19 231/23
prepare [2] 77/22 78/2
prepared [5] 120/11 121/18 188/11 189/2 198/12
prepares [1] 226/5
preparing [1] 167/4
presence [1] 52/17
present [15] 38/18 119/9 153/7 154/17 154/18 154/24 158/10 159/3 185/8 192/14 192/15 208/6 216/20 245/16 245/18
presentation [4]

P

presentation... [4] 151/8 169/19 171/5 171/18
presented [4] 91/10 120/20 203/8 221/2
presenting [1] 173/10
press [2] 64/1 124/6
presumably [7] 14/6 26/1 51/2 51/14 98/9 148/6 251/10
prevent [1] 126/13
previous [8] 4/23 33/25 34/6 88/8 92/21 121/5 160/19 242/12
previously [14] 1/20 35/2 39/22 40/9 41/10 65/14 68/6 90/7 92/6 107/4 120/18 192/24 204/14 225/3
primary [6] 92/6 102/11 102/12 133/16 153/1 216/23
principal [1] 102/25
Principles [1] 98/6
prior [15] 3/8 4/25 6/13 21/3 21/17 26/6 52/9 53/17 55/23 57/13 98/9 160/20 173/17 219/10 220/7
priorities [1] 68/18
prioritising [1] 216/18
priority [8] 76/21 76/22 77/20 78/13 79/3 79/23 166/24 167/10
probably [11] 5/16 7/13 7/22 45/24 50/15 90/17 101/22 200/19 201/21 217/21 244/19
problem [9] 20/2 90/25 98/24 143/1 144/7 161/18 173/3 174/16 243/23
problematic [1] 5/18
problems [2] 96/17 98/18
proceed [1] 155/25
process [34] 3/2 17/24 31/11 39/23 91/24 95/14 96/16 97/1 104/17 130/3 131/10 131/11 131/11 136/16 139/11 149/8 149/12 152/8 159/20 159/24 160/12 163/2 172/15 172/21 174/21 193/17 204/10 210/18 218/23 227/17 235/24 238/21 239/17 243/4
process-driven [1] 159/24
processes [8] 102/9 111/17 139/19 170/14 218/14 236/25 249/24 250/4
produced [3] 109/24 190/8 246/8
product [1] 187/16
professional [5] 187/7 210/16 227/9 228/10 250/16
professionalism [2] 8/21 8/23
programme [1] 94/11
progress [5] 72/9 112/19 114/6 226/22 226/23
progressed [4] 2/8 131/2 135/19 138/10
progressing [1] 112/13
progression [1] 151/3
promoted [2] 2/13 3/12
promoting [1] 81/2
promotion [1] 75/20
prompt [2] 182/2 187/23
prompted [1] 161/25
properly [3] 99/2 99/10 207/14
protection [1] 47/7
provide [15] 1/20 4/4 8/4 10/8 70/10 90/1 101/15 127/21 129/17 194/24 198/21 235/19 237/18 244/14 244/17
provided [20] 1/15 63/2 72/2 72/4 74/20 78/11 94/4 101/3 113/18 157/7 176/19 204/4 213/4 219/8 236/7 240/16 241/2 243/4 243/11 246/10
provides [1] 129/1
providing [14] 69/16 70/18 70/21 89/19 94/7 130/20 132/14 217/20 217/24 233/4 233/15 233/17 233/18 243/8
provoke [1] 115/10
proxy [1] 191/10
Psychological [1] 104/4
public [5] 28/16 29/18 61/1 124/3 127/17
publicly [2] 29/19 127/15
pull [4] 154/11 190/22 196/5 239/2
pulled [11] 120/15 153/5 162/7 176/22 178/25 192/7 192/9 197/5 197/5 198/16 199/2
pulling [1] 196/13
purely [1] 73/10
purpose [7] 14/6 49/18 100/21 116/16 167/12 194/24 205/23
push [1] 73/22
put [39] 11/9 11/9 18/17 18/22 27/3 27/11 27/17 27/25 30/15 30/18 31/4 33/1 56/19 57/18 79/10 79/11 93/17 107/14 117/12 124/3 127/23 131/1 131/16 132/1 147/22 177/10 179/9 190/17 190/22 193/5 193/5 211/7 213/19 221/18 231/20 231/21 236/1 245/25 254/18
putting [6] 28/20 38/11 61/1 73/16 76/24 252/21

Q

QSPEC [14] 68/24 71/5 71/7 95/17 104/19 104/19 120/5 133/9 168/13 204/21 205/12 205/24 206/10 206/13
qualifications [1] 1/25
qualified [2] 63/16 64/23
quality [22] 10/15 65/6 65/12 66/23 69/1 71/20 76/2 88/7 88/8 88/9 88/10 88/11 128/10 128/19 140/22 141/4 143/21 147/3 148/23 170/12 172/6 200/14
quarter [1] 149/17
question [23] 11/8 20/4 20/20 30/9 34/20 40/11 53/6 69/20 90/17 91/23 99/23 110/22 111/5 112/19 129/18 132/4 168/6 179/12 179/13 180/1 207/16 208/14 232/24
questioned [1] 165/13
questioning [1] 156/5
questions [40] 1/12 16/19 19/4 48/8 48/9 48/11 48/14 60/4 60/5 60/9 62/3 62/23 78/11 109/20 117/16 118/6 120/3 184/23 207/2 207/6 207/9 210/10 211/18 217/4 217/7 217/11 217/14 217/16 230/16 236/1 247/13 247/15 255/9 256/4 256/5 256/6 256/8 256/9 256/10 256/11
quick [2] 157/3 201/10
quickly [6] 148/21 154/4 206/18 206/23 251/15 251/17
quite [22] 35/6 35/8 37/25 39/20 86/9 141/5 141/24 143/23 154/4 160/12 165/25 175/15 206/23 209/9 209/12 213/24 227/16 230/23 234/18 244/9 245/11 250/15

R

radar [1] 169/7
raise [19] 13/11 17/5 22/6 27/23 40/10 45/23 50/24 51/5 59/3 80/1 133/17 165/24 166/11 166/19 205/3 205/12 253/24 254/24 255/7
raised [24] 16/25 18/6 20/6 22/16 30/1 35/1 35/2 39/24 39/24 40/9 40/10 42/9 45/22 58/13 87/8 107/10 124/7 166/2 166/6 168/1 173/17 227/21 232/19 246/23
raises [1] 86/5
raising [6] 17/7 19/4 79/14 166/18 238/18 254/23
ran [1] 94/12
rank [1] 58/23
rate [9] 19/19 24/12 99/1 99/8 105/24 164/23 189/10 194/18 205/10
rated [2] 117/23 170/6
rates [9] 13/17 17/5 17/20 17/22 18/4 18/16 23/1 106/4 199/21
rather [22] 15/12 37/7 49/8 57/4 63/25 65/15 79/17 79/19 96/11 110/18 120/15 125/5 144/21 148/7 151/4 152/9 162/6 189/14 189/24 247/8 247/8 247/17
ratification [1] 104/17
ratified [1] 112/5
rating [1] 123/21
Ravi [2] 36/9 38/21
re [2] 165/19 248/10
re-badged [1] 248/10
re-direct [1] 165/19
reach [2] 48/23 198/14
reached [4] 66/18 162/15 175/23 198/8
reacted [1] 165/10
reaction [4] 168/16 182/7 182/9 182/10
read [21] 16/11 93/3 93/9 93/14 178/17 179/1 179/14 179/19 179/21 180/2 180/4 184/1 202/16 221/1 221/3 221/11 221/23 222/2 229/23 251/15 251/17
reading [9] 86/20 178/3 178/5 182/7 219/20 221/6 221/7 221/20 251/25
ready [1] 241/17
real [6] 26/3 37/13 44/13 76/16 129/2 201/24
realise [1] 175/15
realised [2] 152/22 194/9
reality [2] 90/21 209/9
really [25] 8/16 9/7 49/20 68/8 68/9 84/25 85/3 95/2 110/20 138/19 149/17 158/22 159/21 159/24 167/20 199/9 200/2 202/7 209/7 212/8 230/7 238/22 246/13 249/5 249/13
reason [11] 19/21 19/22 46/12 46/14 72/18 171/6 171/11 204/10 216/10 240/5 247/2
reasonable [5] 92/11 115/10 128/2 138/15 173/12
reasons [6] 73/17 76/6 88/5 101/7 160/16 211/20
reassure [1] 216/16
recall [84] 2/15 6/13 13/4 17/7 17/11 20/14 31/19 32/5 32/13 32/18 32/22 33/1 33/3 43/7 43/9 43/10 43/12 45/7 45/9 45/12 45/14 49/18 50/17 55/5 55/6 63/24 63/25 101/1

R

recall... [56] 101/1 101/4 122/18 124/20 141/3 151/7 155/10 155/10 156/8 156/9 164/10 167/5 167/9 167/9 168/22 176/12 176/13 176/23 178/1 183/15 183/22 184/19 185/2 186/10 189/20 191/20 193/2 195/23 202/16 202/17 207/24 208/20 209/2 212/15 219/2 219/7 219/10 221/7 222/7 222/9 223/13 223/19 223/20 223/22 224/23 230/4 230/5 231/12 231/18 237/10 238/18 238/21 238/22 252/12 252/13 252/17
recalls [1] 50/10
recap [1] 36/18
receipt [1] 47/23
receive [13] 2/25 6/22 21/14 21/14 21/16 32/16 35/15 38/24 142/22 220/11 236/13 236/20 237/8
received [29] 9/25 13/18 13/22 20/14 20/22 23/5 25/4 25/17 29/23 35/9 38/4 38/25 39/10 42/20 100/19 104/18 124/5 142/5 160/15 164/7 169/9 180/7 181/22 182/13 206/20 214/24 223/11 237/7 244/22
receives [1] 57/17
receiving [4] 14/6 47/8 172/19 191/20
recent [2] 64/17 64/19
recently [1] 167/2
recipients [1] 147/18
recognise [2] 98/3 120/10
recognised [2] 231/25 231/25
recognising [1] 73/3
recognition [2] 38/12 244/21
recollect [1] 50/15
recollection [26] 11/19 11/20 31/16 31/17 32/19 32/20 50/9 168/6 168/18 179/5 184/25 184/25 185/22 187/10 187/13 187/19 187/21 189/3 193/15 194/8 194/13 225/13 230/6 230/9 241/19 254/17
recollections [2] 179/11 179/12
recommend [1] 239/15
Recommendation [1] 152/23
recommended [1] 154/11
record [6] 2/6 30/11 53/17 53/18 154/15 203/5
recorded [6] 11/3 11/23 121/1 152/16 157/6 170/16
records [4] 55/19 57/9 154/24 213/8
recruitment [1] 5/3
red [5] 117/24 164/1 164/8 177/5 238/1
redacted [2] 72/14 72/20
reduce [2] 46/15 124/23
reduced [2] 90/7 90/20
Rees [19] 4/18 32/20 35/16 36/5 36/12 37/24 38/25 39/14 40/19 41/18 42/17 42/22 42/25 47/11 49/15 58/18 58/22 59/19 61/16
refer [8] 11/16 20/11 20/25 93/24 117/9 137/20 183/15 186/8
reference [31] 15/1 17/17 23/25 27/20 33/19 34/2 54/12 54/25 55/15 56/15 57/3 57/5 59/25 71/19 74/12 118/12 118/15 118/20 121/15 122/3 122/4 122/13 124/14 128/9 131/23 144/17 192/20 212/21 213/1 213/7 213/10
referenced [2] 14/22 191/24
referred [9] 3/11 32/19 44/24 91/15 125/14 144/18 152/18 205/15 213/16
referring [24] 25/15 25/17 34/3 37/7 44/11 47/17 71/16 88/6 97/3 109/2 109/10 114/11 116/21 128/23 133/20 135/12 145/18 155/4 157/13 180/10 213/13 215/21 225/9 231/15
refers [4] 120/14 180/12 185/1 214/24
reflect [1] 212/9
reflected [4] 126/2 133/8 170/10 186/7
reflecting [1] 213/20
reflection [3] 57/22 59/1 59/11
reflections [3] 70/7 87/19 203/23
reflective [1] 113/10
reformed [1] 4/1
reframe [1] 80/18
reframing [1] 81/17
refresh [1] 193/19
regard [2] 99/18 110/7
regarded [3] 128/12 128/13 252/25
regarding [10] 3/7 38/6 50/7 68/11 109/25 154/13 212/11 220/10 240/15 240/19
regardless [3] 19/24 22/23 160/11
regards [18] 21/15 28/16 40/17 41/21 86/13 88/14 102/23 127/2 134/25 185/14 192/4 226/24 241/18 243/13 244/15 251/1 251/21 253/21
regional [4] 126/21 147/3 148/22 148/23
register [54] 10/11 11/3 11/10 11/15 18/14 18/17 18/22 18/25 19/5 26/14 26/17 26/22 27/4 27/18 28/1 28/21 29/4 29/5 29/11 30/20 30/21 31/4 38/9 38/12 38/20 60/10 60/18 61/7 76/3 96/10 96/15 100/9 100/10 100/16 101/13 105/16 105/25 106/9 106/18 107/14 117/23 119/7 120/8 121/3 121/4 121/5 123/15 127/24 131/13 132/1 132/3 132/6 134/3 205/5
registered [1] 18/13
Registers [13] 9/15 9/17 9/17 9/18 9/18 19/16 19/24 26/25 27/3 30/11 31/2 38/17 98/12
regular [8] 7/7 7/9 49/23 50/1 50/2 50/3 54/15 68/12
regularly [5] 22/2 79/13 85/2 150/13 241/15
rehearse [1] 74/13
reinforce [1] 161/6
reiterate [1] 194/12
related [3] 104/3 223/1 223/6
relates [2] 40/14 224/6
relating [2] 102/25 195/2
relation [20] 11/22 16/6 63/9 101/12 122/16 122/21 124/7 127/3 135/6 135/7 135/14 136/21 155/3 189/23 193/21 219/5 222/25 225/16 234/4 234/19
relationship [4] 85/9 93/11 142/12 143/3
relationships [4] 85/6 87/25 89/24 96/3
relative [2] 99/2 126/8
relatively [2] 96/16 136/2
release [2] 75/21 235/6
released [1] 216/13
relevance [2] 93/4 239/14
relevant [8] 53/23 74/12 108/2 218/24 224/10 226/7 247/10 249/1
reliance [3] 38/11 38/17 38/19
reliant [1] 8/14
relinquished [2] 5/10 5/11
remain [6] 43/22 43/25 44/1 44/8 44/8 212/17
remained [3] 79/14 103/20 222/10
remaining [4] 32/14 33/4 36/2 36/21
remedy [1] 161/12
remember [34] 5/10 45/9 45/10 111/21 131/18 135/3 164/16 178/3 178/3 179/7 179/7 183/21 185/9 188/25 189/21 192/21 203/20 209/7 209/7 209/22 209/23 212/8 222/12 222/12 222/17 232/3 232/3 232/3 232/6 251/25 251/25 252/1 252/2 253/10
remembered [1] 164/17
remind [1] 96/7
remit [2] 94/18 101/19
removal [1] 130/9
remove [3] 38/14 45/1 57/24
removed [3] 31/10 41/16 47/20
removing [2] 39/7 44/14
repeat [3] 27/5 99/6 199/13
repeated [1] 34/24
repeatedly [2] 93/24 219/4
repeating [3] 185/14 185/17 253/21
replace [1] 2/20
replaced [1] 2/22
reply [3] 183/9 220/4 251/6
report [109] 6/5 6/6 8/10 8/17 15/1 15/3 15/5 15/8 15/13 15/14 15/25 16/3 16/17 17/9 17/18 18/21 19/21 19/22 22/19 22/20 24/25 26/1 66/10 70/9 70/13 70/22 71/24 94/13 120/5 120/15 128/23 129/16 130/25 133/19 135/24 136/18 136/20 136/20 138/15 138/18 138/20 139/21 145/9 147/6 147/8 147/9 149/12 160/8 162/20 169/13 172/20 175/19 176/14 176/18 176/21 177/1 178/1 178/15 178/24 178/25 179/6 180/15 180/18 181/8 181/19 181/21 182/5 182/12 184/1 184/18 184/20 184/22 187/14 188/9 197/6 198/2 198/16 199/8 204/21 206/7 212/11 220/11 220/20 223/11 224/15 225/10 225/23 226/14 226/20 231/10 231/16 231/16 232/16 233/8 234/4 235/20 236/6 236/15 236/23 236/24 237/18 238/6 238/8 239/7 240/20 240/24 241/3 242/14 244/12
reportable [3] 137/14 137/25 153/19
reported [52] 5/12 6/6 6/7 25/16 35/18 45/17 73/18 73/20 84/4 114/22 124/5 134/5 134/19 135/18 136/5 136/6 136/11 137/19 137/23 139/5 139/9 143/25 145/10 146/1 146/17 149/24 149/25 150/16 151/15 156/6 156/16 157/23

R

reported... [20] 159/18 160/22 162/25 168/20 168/24 172/18 173/22 174/3 174/9 182/1 196/8 204/25 205/4 206/7 212/19 227/6 227/19 229/1 237/2 253/5
reporter [1] 213/17
reporting [57] 4/11 4/15 4/17 6/12 43/8 71/2 71/17 73/7 94/20 94/21 95/8 95/19 110/1 132/12 135/1 136/2 136/8 136/9 136/19 138/23 139/2 139/21 139/23 140/3 140/7 140/19 140/22 141/21 143/10 144/16 145/11 145/12 147/12 147/25 148/3 148/24 149/9 150/10 156/13 160/23 160/25 163/3 168/20 172/17 172/19 174/10 174/16 199/11 199/11 199/21 199/21 200/3 204/13 204/18 204/24 205/14 236/24
reports [27] 8/20 8/22 69/18 93/1 93/25 94/1 94/3 94/14 117/8 123/8 141/5 142/16 172/9 173/20 215/3 215/11 215/12 217/25 223/14 224/9 224/11 225/16 226/5 226/8 237/8 241/7 244/17
represent [2] 74/15 214/3
reputation [22] 28/10 30/3 30/3 118/3 119/17 121/2 123/20 123/24 124/14 125/6 126/24 127/3 127/4 127/7 127/9 128/5 134/11 134/23 135/6 216/10 216/18 216/22
reputational [3] 125/2 125/23 216/23
request [4] 31/17 31/19 72/1 198/20
requested [1] 85/18
require [6] 11/1 108/14 139/3 211/25 212/3 227/9
required [9] 24/20 55/21 57/23 59/11 77/23 147/24 187/25 224/9 227/8
requires [1] 10/22
requiring [2] 176/11 239/7
resolve [1] 10/21
resolved [1] 12/9
resourced [2] 75/7 75/10
resources [2] 54/17 75/17
respect [3] 127/8 150/15 181/1
respectively [1] 121/12
respects [1] 126/18
respond [1] 47/11
responded [3] 76/17 78/10 177/15
responding [1] 82/4
response [10] 74/16 86/11 87/19 89/14 115/23 159/23 208/13 248/16 253/19 253/21
responsibilities [4] 71/18 78/10 102/8 214/10
responsibility [44] 7/25 8/2 9/8 9/8 11/2 49/2 71/3 71/12 71/15 72/1 73/21 74/5 89/17 90/10 90/11 94/22 98/14 100/15 101/15 102/25 103/5 106/17 107/5 111/11 111/12 111/19 121/21 130/20 130/23 134/2 158/6 166/7 166/9 178/12 181/24 182/15 206/1 210/12 210/17 210/24 211/21 214/18 229/18 239/19
responsible [14] 67/22 71/6 76/2 95/6 137/4 145/20 181/13 197/15 197/24 217/24 228/17 228/17 238/15 241/6
responsive [4] 85/7 140/12 170/7 200/5
responsiveness [2] 173/19 200/4
rest [1] 198/6
result [7] 66/21 82/10 113/8 115/19 138/7 190/14 240/19
resulted [3] 138/7 144/25 191/6
resulting [1] 72/11
results [1] 153/11
resuscitated [1] 137/11
resuscitation [2] 55/21 56/5
retain [3] 56/13 83/23 84/14
retaining [1] 83/4
retrospect [2] 200/20 200/23
returning [2] 44/23 72/9
review [129] 10/7 11/23 11/25 12/2 12/5 12/10 14/23 20/25 21/5 21/7 21/8 21/22 22/13 22/18 22/19 22/25 24/11 30/25 78/21 84/7 84/12 84/12 89/11 89/18 90/10 98/13 127/12 128/9 129/5 129/11 129/24 130/3 131/23 133/19 146/10 149/19 151/6 152/7 152/8 152/10 153/21 153/22 153/24 154/8 156/1 156/23 156/24 157/3 161/14 162/2 166/21 169/1 169/6 170/15 172/15 174/4 175/20 184/22 188/7 191/25 192/4 196/7 198/13 201/11 202/5 202/24 206/10 206/12 206/20 220/8 220/11 220/15 220/19 220/22 221/1 221/6 221/12 221/21 222/17 224/13 224/17 224/19 224/21 224/21 224/24 225/2 225/5 225/7 225/11 225/18 226/12 226/14 226/19 228/8 228/15 231/5 231/13 231/18 232/17 233/12 233/13 233/19 234/5 234/7 234/11 235/1 235/5 235/9 235/13 235/16 236/17 236/20 236/24 237/11 237/16 238/4 242/1 243/15 243/18 244/3 244/25 245/2 245/4 245/7 245/8 246/11 246/13 246/19 251/21
reviewed [9] 9/25 18/25 20/23 30/11 104/22 130/24 233/11 243/14 246/22
reviewer [1] 24/13
reviewing [3] 11/25 12/15 100/15
reviews [7] 29/17 31/3 31/8 128/17 196/17 217/25 225/16
revision [1] 103/25
Richard [1] 48/13
Richard Baker [1] 48/13
right [52] 4/20 8/12 33/3 58/15 59/14 60/20 62/2 63/2 63/16 65/3 69/3 70/23 83/10 86/15 100/14 105/20 106/23 107/1 117/24 120/12 121/22 131/22 134/14 136/7 138/21 138/25 140/16 142/18 143/12 144/8 149/16 155/3 190/18 193/21 198/18 206/7 206/8 208/15 218/7 218/12 219/3 220/21 235/24 236/4 242/14 243/5 244/4 249/6 250/6 251/19 252/23 254/24
right-hand [2] 4/20 120/12
rightly [1] 213/24
rise [1] 255/13
risk [241] 9/15 9/17 9/17 9/18 9/18 9/21 9/24 10/9 10/10 10/20 11/3 11/4 11/9 11/13 11/15 11/15 11/17 12/3 12/5 12/6 12/8 12/12 13/12 18/12 18/13 18/13 18/17 18/22 18/25 19/5 19/13 19/16 19/16 19/24 23/20 23/23 23/23 24/3 25/12 25/14 26/14 26/16 26/20 26/22 26/25 27/3 27/4 27/4 27/15 27/18 28/1 28/7 28/8 28/21 28/23 29/3 29/5 29/5 29/11 30/6 30/6 30/7 30/11 30/12 30/15 30/20 30/20 31/1 31/3 34/8 34/10 34/21 34/22 35/24 36/6 37/9 37/9 38/8 38/12 38/17 38/18 38/20 39/4 46/15 47/21 57/19 59/25 60/10 60/13 60/17 61/7 65/9 65/11 65/13 65/19 65/23 66/9 66/21 67/1 67/7 68/15 68/20 70/14 71/11 72/12 75/19 75/21 76/3 76/3 77/6 77/14 78/9 80/5 80/9 80/10 81/2 81/4 81/18 82/8 83/21 84/19 84/19 86/6 86/14 86/16 86/21 88/17 89/17 89/25 92/19 92/22 92/22 92/25 95/12 95/24 96/1 96/9 96/10 96/15 96/15 96/19 96/25 97/10 97/18 97/19 97/22 98/5 98/7 98/10 98/12 98/13 98/15 99/2 99/10 99/18 100/4 100/8 100/9 100/10 100/12 100/16 101/10 101/12 101/24 102/10 102/11 102/14 103/1 103/5 103/8 103/23 104/24 105/8 105/10 105/16 105/17 105/18 105/18 105/25 106/9 106/15 106/17 106/18 106/19 106/21 106/25 107/14 107/22 108/1 108/14 108/17 108/21 109/8 114/4 114/4 115/9 117/18 117/22 119/7 119/10 120/8 121/4 123/23 124/10 124/13 124/16 124/19 125/1 125/9 126/2 126/17 126/24 127/3 127/24 128/6 130/23 131/3 131/4 131/13 131/19 131/25 132/1 132/3 132/6 134/3 140/6 143/9 153/2 176/8 184/9 201/13 201/14 202/11 205/5 212/21 212/22 216/23 217/23 248/10 254/1 254/4
risks [45] 9/22 9/22 9/25 10/2 10/8 11/22 11/23 11/24 12/2 12/15 12/16 13/2 13/5 27/9 27/9 27/10 29/3 30/11 30/18 54/13 96/11 97/1 97/3 98/7 99/3 104/1 104/1 104/6 106/7 106/8 108/3 109/10 117/23 117/23 119/4 119/14 120/23 121/14 121/16 122/1 122/8 126/25 127/23 130/6 130/24
robust [3] 100/6 132/12 170/14
role [87] 2/3 2/11 2/20 3/15 5/3 5/10 5/11 5/12 6/1 6/3 7/24 13/2 17/2 17/3 19/25 30/22 37/12 37/18 39/6 46/21 46/24 46/25 48/18 48/25 48/25 65/10 65/12 66/5 68/24 72/9 72/10 75/22 77/6 77/7 80/10 80/18 80/21 80/23 81/13 81/17 81/24 82/9 82/20 83/10 83/13 83/16 83/20 86/6 86/13 86/15 86/20 87/20 88/1 88/13 88/13 89/8 89/18 90/20 92/7 94/18 101/17 101/20 102/4 102/6 102/8 102/20 103/3 103/6

R

role... [19] 106/13 106/22 107/4 116/25 127/21 130/10 147/21 153/1 158/16 161/16 161/21 161/22 166/19 196/4 214/20 217/20 218/3 247/23 248/13
roles [3] 5/18 66/22 93/21
rollout [1] 98/18
room [13] 62/17 70/20 158/12 195/23 196/3 200/25 201/6 201/15 201/16 201/21 207/24 209/8 209/11
root [1] 139/11
root cause [1] 139/11
roots [1] 148/2
rough [1] 32/25
route [5] 95/15 103/9 133/7 168/3 173/8
routes [2] 11/8 94/6
routine [2] 76/19 77/20
Royal [8] 127/12 201/10 202/4 210/5 233/12 234/5 234/8 246/19
Royal College [1] 246/19
rules [1] 146/4
run [3] 123/16 182/18 202/21
running [1] 9/5
runs [1] 71/18
rush [1] 217/12
rushed [1] 162/7
Ruth [5] 62/15 62/21 63/1 220/9 256/7
RUTH MILLWARD [2] 62/21 256/7

S

sad [1] 206/24
sadly [1] 127/11
safe [3] 41/13 41/14 170/6
safety [70] 10/15 11/6 42/3 65/9 65/11 65/13 65/20 65/23 66/9 66/22 67/1 67/3 67/8 67/14 68/15 68/21 69/1 69/9 69/24 71/11 71/20 73/8 75/13 75/19 75/22 76/3 77/6 77/14 77/17 80/6 80/10 80/16 80/24 81/3 83/21 84/19 89/17 92/20 94/12 101/10 101/24 103/1 106/15 106/18 106/19 106/25 107/22 110/12 119/10 134/5 140/6 147/3 148/23 153/2 159/23 170/12 172/6 176/9 184/9 195/1 195/7 200/14 201/13 201/15 217/24 228/6 228/15 249/7 254/8 254/9
said [71] 7/7 8/9 17/9 18/1 36/7 36/9 51/10 51/14 55/4 55/5 56/21 56/25 60/16 60/17 61/20 70/4 77/10 82/11 83/18 96/8 96/9 99/5 111/9 112/2 113/16 113/24 114/9 137/15 139/12 164/18 169/14 171/7 171/19 183/16 188/10 189/25 191/14 192/24 195/18 197/12 198/25 200/20 201/3 202/7 203/6 203/10 207/13 207/18 207/19 208/6 208/9 208/13 216/20 220/18 222/3 222/4 226/17 234/3 234/8 238/14 245/17 245/20 248/24 249/1 250/7 253/3 253/3 253/13 253/13 253/23 255/5
salary [1] 47/23
same [28] 40/7 41/19 53/11 57/20 64/24 65/13 76/4 76/25 78/19 82/25 91/7 103/21 125/25 143/24 147/14 163/2 174/14 179/22 183/19 188/2 196/18 205/5 214/4 234/15 237/11 237/12 242/25 246/2
Sarah [9] 217/22 219/17 219/25 220/6 224/2 227/9 229/24 231/21 241/9
Sarah Harper-Lea [1] 229/24
Sarah's [3] 226/25 227/21 238/6
sat [8] 50/21 67/4 71/3 71/21 89/7 94/22 113/16 181/15
satisfied [1] 167/7
saw [18] 7/24 24/10 50/4 121/5 129/11 166/16 172/2 176/12 179/6 182/5 191/15 198/2 219/7 219/23 225/19 242/6 250/17 251/14
say [173] 3/25 10/3 10/17 11/7 11/10 11/21 11/22 12/14 13/15 14/24 18/10 19/11 20/2 23/4 23/15 25/10 25/22 26/2 26/12 27/9 32/13 32/18 33/11 33/15 34/7 34/24 34/25 35/18 37/18 37/25 38/3 39/11 39/17 39/19 40/9 41/3 41/6 41/11 43/21 45/15 50/19 51/4 51/7 51/16 55/17 56/17 61/17 61/24 64/3 64/18 64/19 64/19 66/19 67/2 70/11 71/15 71/22 72/5 73/24 75/9 75/11 75/25 79/7 81/14 84/16 86/25 87/6 88/5 88/18 89/16 90/8 90/23 93/10 95/1 96/13 103/6 103/11 104/17 106/2 114/3 114/8 114/15 115/17 124/19 132/10 133/23 135/17 137/18 137/25 138/9 139/5 139/7 140/4 140/8 140/9 141/7 142/2 142/7 143/2 143/12 143/22 143/24 146/14 149/25 155/12 156/17 158/18 158/21 159/2 159/9 161/17 161/22 163/1 163/4 164/12 166/6 167/9 168/12 169/19 171/12 172/24 173/5 173/12 173/21 174/2 178/22 179/17 181/3 181/24 182/11 182/20 184/16 186/5 187/24 188/3 188/16 189/7 189/18 190/18 190/20 191/3 191/6 191/22 194/17 195/21 196/25 200/8 202/25 203/24 207/21 208/5 213/25 218/19 224/24 230/13 233/6 235/9 236/16 238/7 239/15 242/2 242/18 242/20 244/13 245/20 251/2 252/14 253/2 253/18 253/20 254/1 255/1 255/5
saying [40] 23/23 36/23 37/5 39/3 43/24 52/8 53/22 75/19 78/13 98/21 115/3 123/11 129/23 139/1 144/22 145/10 145/11 147/6 147/7 147/8 147/9 149/7 149/16 161/7 164/15 164/16 189/2 206/9 208/2 215/20 219/25 221/7 222/13 224/6 226/4 226/12 227/25 228/25 238/18 240/6
says [34] 24/10 24/17 24/22 29/7 55/18 58/8 86/7 86/11 89/5 94/8 122/15 135/9 136/6 138/1 143/9 144/20 170/4 178/25 179/6 179/16 183/3 198/11 217/23 220/5 222/25 223/5 227/11 230/1 230/9 231/8 234/22 240/13 245/8 252/25
SB [4] 45/1 45/4 231/10 231/10
SBAR [8] 63/10 152/18 152/23 153/1 153/22 154/6 156/18 157/1
SBARS [1] 157/2
SC [1] 231/6
scale [1] 10/18
scapegoat [3] 202/12 202/18 202/24
scenario [1] 46/4
scene [1] 251/4
scheduled [2] 49/23 165/23
scheme [1] 73/5
schemes [3] 73/7 80/13 170/22
scope [3] 74/4 160/23 200/3
score [11] 105/11 105/17 105/19 108/5 108/5 108/6 119/20 119/23 121/9 126/14 126/14
scored [1] 125/1
scores [1] 108/17
scoring [6] 105/8 105/14 108/1 118/1 122/9 125/10
screen [6] 4/6 85/11 96/7 192/12 193/5 193/6
scripted [4] 28/14 29/3 60/15 60/21
scroll [2] 85/13 197/15
scrolling [1] 252/12
scrutiny [1] 27/8
SE [1] 231/10
second [15] 40/8 41/4 55/3 55/9 55/18 56/7 56/16 57/1 57/4 57/4 57/5 121/5 124/10 150/15 221/18
secondary [2] 156/23 224/17
secondly [2] 132/5 248/22
secondment [1] 66/6
secondments [1] 92/23
section [9] 138/1 157/10 158/21 172/1 203/23 214/24 215/9 215/11 215/23
sections [1] 171/15
Sedgwick [1] 4/12
see [138] 4/9 4/18 4/21 6/18 15/2 15/5 15/7 15/16 17/9 17/11 20/11 22/17 22/19 22/20 22/24 24/25 26/15 28/3 28/3 28/8 28/9 34/17 50/5 53/16 57/14 61/21 65/18 70/13 73/14 73/17 73/19 74/24 77/13 85/13 85/19 86/5 87/10 89/4 92/18 93/14 97/1 98/6 99/25 100/13 103/22 105/16 106/13 108/1 110/17 118/2 119/9 119/11 119/13 119/14 119/21 120/1 120/20 120/22 121/12 121/15 121/24 126/16 128/8 129/12 131/14 132/6 132/25 134/13 136/22 137/19 140/15 140/18 142/3 142/6 143/24 144/19 145/4 145/6 146/7 146/9 147/18 149/22 152/16 153/6 154/5 154/6 154/7 154/15 155/1 155/17 165/14 167/5 169/3 170/2 173/13 174/15 174/24 177/4 177/14 178/5 178/8 178/23 180/12 181/7 183/2 183/7 183/10 184/11 190/11 190/11 196/22 197/9 197/17 198/11 201/6 207/3 211/21 212/19 212/23 215/1 216/22 219/16 219/18 220/7 223/3 223/8 227/17 230/19 230/20 230/23 230/25 234/13 236/12 238/1 240/13 243/6 251/17 253/18
seeing [9] 21/4 24/25 137/17 176/13 178/1 179/7 179/8 184/19 252/13
seek [6] 36/13 37/24 41/19 59/3 59/15 92/12
seeking [4] 116/3 146/22 183/3 200/8

S

seemingly [1] 89/11
seems [6] 17/15 32/24 38/10 40/3 43/24 249/4
seen [39] 6/5 16/2 17/10 19/21 35/17 37/1 54/10 104/20 114/3 117/19 121/3 129/16 153/2 154/16 157/25 163/15 164/8 164/18 165/18 168/7 168/13 168/14 172/16 181/19 195/15 199/22 216/23 219/12 219/21 223/20 226/18 229/25 230/5 237/16 244/24 249/2 249/3 252/16 255/2
select [1] 135/11
selecting [1] 144/10
self [10] 169/24 170/6 170/17 170/18 170/23 170/25 171/8 171/19 171/22 198/2
semantics [1] 80/25
Semple [6] 92/14 92/20 93/11 94/17 215/2 215/25
Semple's [1] 215/21
send [2] 133/18 206/14
senior [19] 8/21 9/10 11/13 12/4 27/24 36/25 37/6 39/3 48/22 48/25 49/10 49/16 58/8 58/16 188/25 190/8 190/10 197/1 211/12
seniority [1] 58/23
sense [10] 44/2 160/11 171/21 172/7 179/22 199/14 202/3 208/24 243/15 253/12
sent [13] 13/24 43/4 47/9 50/10 50/13 51/13 85/18 103/19 163/9 180/8 225/20 242/7 250/12
sentence [1] 89/4
sentenced [1] 64/12
separate [3] 3/21 68/3 185/2
separated [1] 3/23
separately [1] 123/16
sepsis [3] 73/3 73/10 73/24
September [12] 2/13 2/15 13/1 30/9 32/1 38/1 162/13 162/17 238/24 239/8 240/13 242/15
series [3] 95/10 95/19 230/23
serious [118] 16/8 21/10 30/6 46/1 69/17 75/2 108/13 134/24 135/1 135/5 135/22 141/23 146/15 146/17 147/19 149/11 149/19 149/25 150/7 150/8 150/10 150/12 150/21 151/14 151/16 152/3 152/6 152/9 153/19 154/2 154/14 156/7 156/16 156/20 156/21 156/25 157/21 157/22 158/2 158/14 158/18 159/4 159/12 159/15 159/17 160/9 160/12 161/2 161/23 161/24 163/3 163/7 165/20 165/20 168/25 173/20 174/18 174/20 181/22 182/1 182/12 182/13 186/11 186/22 187/4 188/2 188/6 189/1 196/9 206/21 215/19 216/1 216/19 218/17 221/15 221/17 221/24 225/18 225/22 225/23 225/25 226/2 226/10 226/11 226/19 226/20 226/22 227/4 227/19 228/9 229/2 229/18 229/21 230/11 232/23 233/6 233/8 234/4 234/14 235/17 237/6 237/8 237/18 238/11 239/15 241/3 241/13 241/16 241/21 241/23 242/8 242/23 244/16 244/18 253/24 254/3 254/6 254/17
seriously [4] 82/5 165/4 204/11 248/9
service [25] 5/25 5/25 8/6 9/3 28/10 53/25 54/14 54/16 71/7 73/12 74/23 75/10 75/25 81/19 92/3 93/15 93/18 118/3 119/17 121/2 152/1 152/1 170/3 200/21 247/8
services [24] 4/17 5/23 50/23 69/12 71/4 71/20 73/22 80/22 80/22 81/4 81/10 82/12 82/14 94/23 95/13 127/18 170/20 171/9 173/7 217/23 219/18 239/4 241/21 248/4
sessions [1] 28/19
set [13] 9/19 59/23 89/18 89/25 90/2 90/10 90/14 94/10 96/23 106/13 175/22 232/6 251/4
setting [4] 19/15 49/21 50/4 50/20
settle [1] 92/23
seven [8] 120/23 163/24 164/1 165/2 171/16 193/16 194/9 209/11
seventh [1] 162/19
several [3] 3/13 60/15 165/6
severity [5] 108/8 108/18 108/25 125/10 211/11
shall [1] 24/5
share [2] 135/16 244/12
shared [12] 43/19 87/12 88/21 91/19 107/19 127/14 150/23 167/8 185/6 187/21 189/4 190/12
sharing [2] 32/6 71/8
she [126] 3/2 3/6 35/22 43/24 43/25 44/9 47/7 47/19 47/22 47/23 48/1 48/4 48/5 48/6 52/15 52/16 52/22 58/22 61/17 61/18 61/20 61/24 62/19 68/8 68/8 68/13 74/20 75/1 75/20 82/19 82/24 83/12 83/19 84/22 85/1 85/2 86/8 86/17 86/22 87/4 87/6 89/22 130/17 142/9 142/12 142/14 142/24 142/25 142/25 143/3 146/2 148/13 153/4 154/23 159/7 163/10 163/10 163/16 164/7 164/23 166/2 166/7 167/1 167/6 167/8 168/9 173/3 178/13 182/5 183/4 183/24 183/25 184/1 184/1 184/2 184/3 184/11 184/12 184/12 184/17 184/21 184/21 185/4 185/5 185/6 187/7 187/13 191/14 191/15 191/16 196/18 201/11 201/15 201/15 201/24 202/1 202/10 202/23 205/12 213/5 213/23 220/9 226/5 226/6 230/1 230/2 245/15 245/16 245/18 246/4 248/24 248/24 249/1 250/10 252/25 253/1 253/1 253/3 253/3 253/4 253/4 253/5 253/17 254/12 254/18 254/20
she's [7] 117/5 149/18 183/3 202/13 226/4 238/12 238/13
shift [5] 55/21 194/1 194/4 247/22 247/24
shifting [2] 148/24 149/9
shifts [1] 52/23
shocked [3] 35/9 35/15 36/8
shocking [1] 32/15
shop [7] 33/14 34/14 37/15 49/22 50/20 51/15 53/21
short [11] 7/14 30/22 60/9 62/11 92/23 154/3 173/25 175/11 203/18 217/22 247/15
short-circuit [1] 217/22
shorthand [1] 150/4
shortly [6] 5/9 64/11 84/7 132/25 155/18 166/23
should [67] 11/3 18/13 18/22 22/11 27/9 36/14 43/25 45/21 49/8 66/17 70/24 87/2 88/16 97/16 104/12 110/11 112/18 131/16 131/25 132/2 136/5 136/11 137/23 139/21 149/25 159/3 160/2 160/3 166/2 166/5 166/13 167/23 167/25 168/2 169/8 169/8 169/9 174/6 174/7 174/10 174/16 174/22 175/3 181/6 182/10 186/2 188/24 188/24 202/7 204/19 206/9 206/15 206/16 208/25 210/4 212/10 214/10 216/7 216/9 219/5 220/20 227/2 227/22 233/2 235/17 246/10 246/24
shouldn't [11] 27/11 49/9 116/13 131/16 136/12 136/24 137/13 145/11 214/11 216/8 237/12
show [4] 57/9 82/5 153/13 189/9
showed [4] 106/6 139/24 176/3 225/20
showing [1] 250/8
shown [2] 193/20 193/22
SI [49] 146/11 146/16 154/7 218/6 218/11 218/24 219/5 220/1 220/12 220/20 220/23 221/2 223/17 226/5 228/2 228/16 228/22 229/1 229/6 229/11 229/15 232/8 232/16 232/21 233/2 233/22 233/25 234/2 234/15 234/16 235/5 235/14 235/22 235/23 236/6 236/15 236/23 236/24 237/11 238/25 239/1 239/10 240/2 240/6 240/24 242/3 242/14 244/25 255/7
SI Panel [9] 218/6 218/11 218/24 220/23 221/2 223/17 233/22 234/16 255/7
Sian [3] 65/18 66/11 68/16
Sian Williams [1] 65/18
side [6] 4/20 14/15 66/23 159/15 170/21 221/18
sight [7] 58/1 77/1 78/17 182/19 202/9 204/18 205/13
sighted [3] 17/24 63/19 103/10
signal [1] 248/8
signed [1] 180/14
significance [2] 3/14 24/14
significant [20] 6/19 9/24 10/24 13/6 69/24 74/20 77/22 77/23 89/9 98/1 98/25 99/8 99/15 105/18 114/20 151/12 167/17 178/1 204/17 248/14
significantly [2] 32/5 232/11
Silver [1] 196/2
similar [2] 124/13 155/4
similarly [1] 78/8
simply [5] 17/21 59/25 124/16 128/16 198/9
since [7] 32/1 47/8 70/7 72/25 74/10 117/25 194/13
since August 16 [1] 47/8
since September [1] 32/1
sincere [1] 35/13
single [3] 94/2 144/4 145/1
sinister [1] 113/15
sir [8] 71/8 122/11 122/13 122/18 122/19 154/19 184/23 209/7

S

Sir Duncan [3] 122/11 122/13 122/19
Sir Duncan Nichol [1] 122/18
Sls [2] 218/12 218/12
sit [6] 1/8 1/10 74/6 158/15 182/20 227/8
sits [8] 6/19 69/5 71/19 90/11 111/19 171/24 205/1 239/18
Sitting [1] 25/25
situation [20] 21/17 25/5 46/1 46/19 58/7 59/22 61/3 74/16 76/17 85/14 91/23 126/11 137/16 139/5 152/23 160/12 163/2 228/11 249/5 250/2
situations [1] 137/19
six [5] 7/12 7/14 43/21 191/7 212/20
six days [1] 212/20
six months [1] 7/12
six weeks [1] 7/14
size [2] 75/14 133/1
slide [3] 153/11 169/18 171/4
slideshow [1] 170/1
slightly [7] 75/12 80/21 81/17 117/16 125/2 126/3 235/19
slip [1] 81/7
small [6] 66/14 67/10 67/11 103/24 132/13 188/7
smaller [4] 73/25 87/22 133/6 201/16
snapshot [1] 85/12
so [556]
solely [1] 83/20
solicitors [1] 240/12
some [91] 7/8 10/1 14/3 16/24 18/1 27/24 29/23 32/25 36/17 37/24 38/21 38/22 38/23 39/20 40/16 40/22 43/5 44/24 47/2 48/14 50/22 51/2 54/13 54/14 56/5 58/3 58/4 58/19 59/15 60/14 67/12 70/20 73/18 74/25 79/1 80/12 81/15 88/5 96/2 98/4 100/7 101/3 101/3 103/24 104/5 109/19 115/16 117/8 118/6 126/16 137/7 141/3 142/3 144/1 144/24 145/9 148/25 151/9 157/17 164/24 164/24 167/5 169/15 176/15 177/16 179/9 185/4 185/8 185/20 190/13 196/3 196/12 196/16 196/19 201/25 206/5 210/10 210/11 211/17 212/10 217/6 218/19 219/7 223/21 227/20 227/22 235/18 237/15 246/5 252/6 253/7
somebody [20] 5/11 35/7 58/11 59/24 92/4 93/14 93/17 94/24 112/18 113/23 116/6 139/23 141/9 145/2 162/6 181/3 188/24 191/23 201/23 239/4
someone [9] 4/4 11/8 24/14 34/17 45/18 53/21 139/2 140/3 251/7
something [74] 5/19 9/9 10/20 11/1 11/9 22/10 22/13 26/21 38/5 39/12 45/22 51/5 55/11 64/16 70/24 71/25 73/1 84/11 96/7 100/4 100/24 101/5 104/12 104/25 108/13 113/14 115/19 115/22 122/25 123/2 130/5 130/6 131/12 135/23 136/12 136/24 138/12 141/13 141/14 144/22 145/3 147/25 155/15 158/22 159/20 162/4 164/19 167/20 167/23 171/13 172/24 174/12 174/15 180/24 181/6 182/20 187/9 201/3 203/10 203/13 204/19 204/22 206/11 206/16 207/12 215/19 219/9 228/11 232/25 246/4 251/14 252/25 253/3 254/7
sometimes [6] 10/22 14/3 14/5 59/23 115/17 164/12
somewhat [3] 200/5 209/5 221/8
soon [3] 110/11 224/13 231/9
sooner [1] 70/25
sorry [24] 2/16 6/11 25/16 27/6 40/5 40/6 48/2 54/20 59/20 86/19 99/4 104/10 111/15 182/14 217/6 219/20 222/8 222/18 230/7 234/20 238/22 249/11 251/5 255/4
sort [7] 27/4 27/8 66/17 97/17 102/4 229/17 254/16
sorts [1] 143/25
sought [1] 98/8
sounds [4] 114/12 114/13 210/2 210/4
source [1] 190/4
sources [3] 190/22 192/10 196/13
space [1] 162/21
speak [34] 6/17 7/8 20/22 34/17 36/12 36/16 36/16 37/23 39/14 41/22 42/17 42/18 43/1 47/5 58/18 59/19 61/20 61/23 72/7 88/20 91/19 126/17 133/20 140/10 142/7 163/11 164/6 166/8 185/5 186/11 187/15 194/6 196/15 228/12
speaking [9] 36/5 46/21 92/2 117/1 163/13 209/24 210/1 240/7 253/4
special [1] 62/16
speciality [2] 6/23 96/21
specialties [4] 157/14 161/7 170/25 182/19
specialty [10] 132/14 133/6 146/10 146/11 167/25 171/1 182/18 204/20 205/14 222/13
specific [12] 55/9 63/10 111/16 117/7 146/11 179/16 196/4 215/14 237/14 249/7 249/7 249/14
specifically [8] 36/2 56/14 71/21 73/25 116/4 178/4 207/10 212/18
specifics [1] 58/5
spend [1] 196/3
spent [1] 3/13
sphere [2] 11/2 98/14
splitting [1] 178/12
spoke [12] 42/22 85/4 87/2 94/2 94/4 139/20 155/11 186/20 193/2 208/23 216/17 239/6
spoken [10] 23/7 61/17 92/9 111/25 163/21 174/6 194/16 198/23 204/13 210/23
spreadsheet [3] 192/7 193/4 198/22
staff [62] 6/16 7/8 23/10 23/24 26/13 26/21 27/16 32/23 41/6 45/18 66/16 66/18 67/12 67/12 76/24 77/2 78/2 78/19 79/5 79/10 79/12 79/24 93/1 98/14 109/21 111/2 111/24 112/7 113/5 113/12 113/20 113/25 115/3 115/6 115/14 116/19 130/9 130/15 142/8 144/10 148/2 165/2 170/10 172/18 174/11 174/14 176/4 185/6 185/23 187/22 188/3 201/16 204/15 208/6 209/10 213/25 216/12 216/12 249/8 253/5 253/5 254/22
staffing [18] 75/11 79/12 83/19 141/4 170/9 170/13 172/2 189/14 190/3 191/13 192/4 192/11 194/20 196/19 198/1 198/4 246/8 252/13
stage [7] 15/12 20/23 131/6 132/3 166/14 224/4 239/10
standard [2] 170/9 198/10
standards [3] 170/13 172/14 196/20
standing [1] 210/18
start [13] 53/22 62/8 79/1 110/21 118/6 118/23 149/8 149/9 149/12 177/1 177/4 222/24 243/17
started [7] 2/3 38/1 54/23 55/20 119/4 156/4 175/15
starting [2] 3/9 140/4
starts [3] 105/3 146/7 154/17
state [3] 1/13 62/24 231/17
statement [44] 1/15 1/16 1/20 11/16 13/16 18/9 19/11 20/11 25/10 26/12 31/16 39/19 44/22 53/5 63/3 63/6 74/8 91/15 96/8 132/11 143/11 160/8 167/4 169/19 169/23 174/2 177/25 186/9 186/17 188/9 189/8 191/15 191/16 191/21 191/22 194/17 196/5 203/12 203/12 203/23 209/4 209/19 229/23 230/1
statements [1] 63/12
stating [5] 189/23 192/22 195/16 201/2 203/12
status [1] 28/18
statutory [9] 210/20 210/21 227/6 227/15 227/18 228/1 228/5 228/16 238/17
Staying [1] 64/23
steer [1] 235/16
STEIS [13] 134/5 134/19 135/11 135/24 146/16 147/1 147/11 147/25 157/19 225/24 226/21 227/6 229/2
step [10] 40/23 98/9 105/22 110/20 119/5 125/3 126/10 161/17 162/20 198/5
Stephen [2] 45/5 209/21
Stephen Brearey [1] 45/5
Stephen Cross [1] 209/21
Stepping [1] 64/7
steps [10] 36/15 59/4 59/16 190/24 198/15 198/24 212/6 220/10 225/4 229/9
still [29] 3/3 3/3 3/17 5/7 29/1 29/15 44/6 44/10 47/7 47/23 48/1 48/4 48/6 57/21 65/10 81/14 96/15 110/14 129/8 155/23 179/4 179/9 228/23 229/15 238/19 238/25 239/10 247/6 247/10
stillbirth [1] 14/23
stillbirths [1] 15/10
stipulate [2] 139/4 182/16
stipulated [1] 181/6
stop [2] 59/7 59/10
stopped [2] 101/2 101/8
stopping [1] 10/3
stops [1] 58/11
story [1] 95/23
straight [2] 163/11 165/6
straightforward [1] 115/2
strategic [2] 96/20 97/16
strategy [1] 95/12
strike [1] 209/4
strong [4] 37/13 170/11 171/11 172/5
structural [1] 101/11
structure [10] 4/9 6/19 35/18 94/22 95/9 95/11 100/13 101/18 103/18 104/18
structures [1] 168/15
struggling [1] 85/3
style [1] 244/11

S

sub [7] 67/7 68/19 151/7 161/11 176/15 176/19 177/14
sub meetings [1] 68/19
sub optimal [5] 151/7 161/11 176/15 176/19 177/14
sub teams [1] 67/7
subcategory [1] 145/13
subject [6] 62/3 63/8 63/10 72/10 138/6 144/4
submission [1] 224/7
submit [2] 129/5 191/22
submitted [8] 71/24 129/4 129/24 141/1 213/18 224/8 225/24 234/4
subsequent [3] 40/19 233/13 236/10
subsequently [7] 42/25 58/17 61/23 66/7 86/1 234/8 253/14
subset [1] 73/25
substandard [1] 246/5
substantiate [2] 27/22 37/2
substantive [4] 2/10 3/12 3/14 66/7
successfully [1] 137/11
succession [2] 30/22 154/4
such [19] 26/24 78/2 82/15 116/2 137/20 138/22 139/2 139/6 150/16 151/13 164/10 169/6 187/20 198/17 201/11 202/15 216/21 240/21 242/19
sudden [6] 153/8 155/14 175/25 177/16 178/6 204/25
suddenly [2] 137/10 177/17
Sue [1] 61/12
Sue Hodkinson [1] 61/12
suffered [1] 55/20
sufficient [8] 12/11 38/7 38/12 39/6 150/25 151/25 153/18 202/19
sufficiently [3] 75/7 132/12 204/11
suggest [15] 16/25 23/20 25/11 29/24 33/22 95/20 102/3 131/7 198/4 216/10 216/22 224/22 233/25 235/3 246/24
suggested [2] 209/3 244/24
suggesting [5] 40/3 174/5 208/3 219/4 220/12
suggestion [5] 24/3 185/12 192/1 246/7 253/13
suggests [3] 70/5 204/5 228/21
SUI [4] 149/18 234/14 234/24 239/7
suitable [1] 26/22
sum [1] 8/1
summaries [1] 180/13
summarise [2] 86/2 105/2
summary [5] 140/25 175/22 206/12 240/15 243/12
summing [1] 43/5
superior [1] 58/22
superseded [1] 25/6
Supervisor [1] 2/6
supplementary [1] 194/25
supplied [1] 196/18
support [32] 8/6 12/7 12/8 29/16 36/13 37/24 43/22 59/15 67/15 69/18 76/10 79/4 80/12 80/13 80/22 82/15 83/4 87/5 87/18 88/14 89/3 90/6 90/19 91/21 127/25 141/20 174/23 174/25 201/8 201/25 218/19 231/11
supported [7] 68/17 74/16 79/12 81/21 87/9 139/10 202/2
supporting [6] 78/18 92/4 102/13 170/24 173/6 173/19
supportive [1] 81/1
sure [21] 4/4 44/19 70/22 71/12 77/7 85/24 87/6 97/25 112/16 122/22 123/6 123/9 179/20 180/2 181/18 185/13 196/17 207/13 211/6 241/16 251/23
surely [2] 42/8 126/22
surmising [1] 227/23
surname [1] 67/25
surprising [1] 17/15
suspect [1] 206/18
suspected [1] 189/19
suspend [1] 201/5
suspicion [1] 215/17
sustained [1] 197/19
sworn [1] 62/19
system [17] 17/19 105/8 110/1 112/6 112/7 136/9 136/20 138/23 139/21 145/12 160/23 160/25 168/20 174/10 204/24 205/18 251/14
systems [5] 102/9 152/8 158/22 159/20 163/4

T

tab [3] 4/7 28/2 43/3
tab 16 [1] 43/3
tab 19 [1] 28/2
tab 3 [1] 4/7
table [4] 1/8 108/5 252/10 252/13
tabled [4] 133/23 182/5 190/23 225/21
tabling [1] 133/24
tabular [1] 120/20
tackle [1] 177/10
take [44] 26/19 37/5 39/6 39/8 40/22 42/11 46/20 53/14 53/16 53/17 53/21 55/10 95/25 109/9 117/16 117/20 118/11 119/5 120/19 125/3 125/19 132/10 135/25 153/20 154/1 154/7 157/18 161/17 162/20 173/24 174/1 175/9 186/7 187/11 187/23 188/2 212/6 220/22 222/11 227/2 227/4 234/10 237/9 252/7
taken [49] 21/5 24/4 31/8 35/10 37/6 38/22 39/20 42/10 42/15 44/10 49/8 55/24 56/4 56/23 57/5 60/10 69/25 121/14 121/25 125/18 126/13 128/1 137/5 137/7 138/13 145/7 163/6 168/11 174/13 179/10 187/1 197/1 197/4 199/4 204/11 215/2 220/10 220/16 223/17 228/14 228/22 229/6 230/24 242/3 242/18 247/23 248/9 248/22 249/24
takes [2] 59/6 233/23
taking [15] 26/7 49/7 53/12 54/2 55/23 82/5 93/14 100/24 105/22 113/22 145/2 167/7 186/11 240/18 254/5
talk [12] 46/5 86/24 87/11 87/14 114/16 117/4 156/8 156/12 156/13 157/11 165/5 254/24
talked [8] 33/7 33/7 39/21 50/22 51/8 193/5 224/14 226/13
talking [28] 28/24 30/3 36/1 36/2 45/11 45/12 47/17 53/23 53/24 54/1 56/8 71/1 117/6 138/10 151/9 176/5 185/7 193/9 193/12 208/21 208/23 209/5 209/20 209/22 209/25 221/8 245/19 253/6
talks [8] 24/2 94/19 109/17 151/22 151/24 158/21 163/21 225/4
target [1] 9/3
team [87] 6/19 8/16 9/10 9/11 9/23 10/16 11/24 18/21 27/24 43/1 46/3 59/20 60/17 60/22 60/24 61/6 66/14 66/25 67/6 67/16 68/17 69/11 73/5 76/7 76/8 76/11 76/22 76/23 78/14 79/9 81/10 81/16 81/22 87/16 88/7 88/9 88/11 90/10 92/4 92/22 92/22 92/25 95/3 95/5 101/16 103/7 103/10 107/11 107/12 107/12 111/20 122/5 124/1 127/13 139/22 143/14 156/24 158/9 163/16 165/22 179/24 181/13 185/17 186/6 186/24 186/25 188/5 188/22 189/9 194/25 200/13 200/15 201/7 201/12 201/14 201/15 205/12 205/19 215/10 215/10 223/15 233/23 239/18 241/10 241/14 242/22 255/2
team's [1] 239/19
teams [15] 28/15 30/17 30/17 67/7 92/25 102/13 102/22 102/22 148/1 161/3 172/11 210/17 210/25 227/10 227/14
tease [1] 237/13
teasing [1] 148/16
telephone [1] 188/20
telescope [1] 140/2
tell [18] 24/23 72/25 84/1 84/23 94/1 111/15 122/6 131/17 138/25 143/10 150/6 160/7 169/23 184/12 184/15 184/21 235/10 240/1
telling [6] 33/24 36/25 142/24 145/15 173/3 253/16
tells [1] 221/14
temporary [3] 66/6 119/10 201/17
tend [2] 143/24 157/2
tended [2] 96/10 187/4
tends [1] 102/3
terminology [1] 19/15
terms [43] 1/23 2/2 7/17 7/24 8/21 9/2 9/3 9/4 11/5 17/3 31/3 36/14 37/22 39/2 44/4 46/23 56/19 58/12 58/23 59/5 67/4 67/17 71/19 72/24 74/12 78/20 82/7 97/9 97/16 98/1 98/25 103/14 103/25 107/20 110/3 123/23 131/20 145/19 156/17 186/19 187/13 190/1 193/4
test [2] 110/23 111/2
text [3] 155/12 195/5 197/3
than [58] 10/19 10/24 15/12 16/10 19/18 24/11 35/16 35/23 36/5 37/7 37/14 49/8 57/4 63/25 65/15 70/25 73/9 79/17 79/19 83/21 88/1 92/5 93/12 96/11 97/10 110/18 112/17 120/15 125/2 125/7 127/20 128/16 135/17 138/24 144/22 145/21 151/4 152/9 153/22 157/1 161/5 162/6 167/18 176/24 189/14 189/24 194/11 195/15 196/16 201/14 206/17 208/10 232/6 239/21 244/15 247/8 247/17 248/14
thank [51] 1/11 9/6 9/13 9/13 17/14 60/3 60/6 60/20 60/23 61/4 61/15 62/2 62/5 62/7 62/18 62/22 95/25 99/24 106/12 109/9 118/22 120/7 132/10 135/25 152/21 157/18 157/22 170/2 173/24 175/5 175/17 183/20 194/7 203/5 204/1 207/4 217/3 217/5

T

thank... [13] 217/13 219/15 224/1 247/12 247/14 247/16 247/20 248/21 250/6 252/23 255/10 255/10 255/12
thanks [1] 180/13
that [1978]
that February [1] 78/20
that's [97] 14/18 25/13 25/16 28/6 32/20 45/19 45/19 63/5 63/7 64/5 65/4 66/4 66/8 68/23 69/3 69/7 69/14 70/1 71/9 72/13 79/6 94/9 97/2 100/14 100/18 105/13 105/17 105/21 108/18 108/25 108/25 110/16 111/5 115/20 121/20 121/23 125/1 129/18 132/17 135/7 135/10 136/14 138/5 140/17 140/20 142/19 142/23 144/11 144/24 145/18 147/10 149/2 156/3 157/24 164/3 169/21 169/25 171/21 173/12 178/10 185/21 186/1 188/15 193/18 195/9 196/25 200/2 204/16 210/17 210/20 213/17 213/19 214/24 216/24 218/8 218/15 220/17 225/12 226/8 226/9 229/12 236/4 236/10 237/4 240/24 241/12 242/16 243/12 246/2 246/2 246/3 248/11 248/18 249/6 250/16 252/1 252/22
their [41] 3/24 7/20 13/22 29/10 30/7 40/17 41/21 42/1 59/8 78/4 95/14 98/14 102/13 102/14 111/10 113/15 113/21 133/17 139/18 144/5 151/1 152/13 171/8 171/8 171/9 171/22 172/5 173/7 180/7 188/19 190/2 191/23 196/1 204/4 205/10 205/13 205/15 205/16 228/12 234/7 236/2
them [64] 7/19 8/9 13/24 18/4 18/5 20/9 22/6 22/16 43/1 44/25 45/13 49/6 52/16 61/21 61/22 61/23 73/19 74/13 78/2 78/12 79/13 80/1 87/17 88/20 90/2 90/14 90/15 91/19 92/4 93/3 95/15 114/3 116/9 133/17 133/20 141/2 141/20 142/12 143/4 144/1 144/2 144/4 155/4 172/22 174/23 179/11 179/25 189/4 190/19 190/22 191/6 191/23 193/16 193/23 195/25 198/14 198/21 201/8 203/19 204/3 215/7 228/8 240/9 241/8
thematic [52] 20/25 22/12 22/18 24/11 30/25 78/21 84/7 84/12 128/9 129/5 129/11 129/24 131/23 133/19 166/21 175/20 184/22 206/10 206/12 206/20 220/8 220/11 220/15 220/19 220/22 221/1 221/6 221/12 221/20 222/17 224/21 224/24 225/5 225/7 225/18 226/18 232/17 235/1 235/5 235/9 235/13 235/16 236/17 236/20 236/23 237/11 237/16 244/24 245/2 245/4 245/8 251/21
theme [11] 23/18 24/20 24/22 54/16 144/21 175/24 177/5 177/11 177/20 183/6 238/10
themes [4] 24/19 147/16 176/22 215/13
themselves [8] 10/21 39/18 79/21 96/23 112/19 126/18 171/1 179/25
then [132] 2/6 2/8 2/9 3/13 4/20 5/12 6/5 9/15 10/10 10/24 15/22 16/5 20/10 20/11 21/20 22/19 22/20 23/4 23/8 24/8 24/13 25/14 26/11 27/17 30/5 33/7 36/4 36/16 36/22 37/15 38/3 39/8 40/19 41/11 42/25 42/25 45/15 47/11 50/24 54/1 54/17 55/3 55/7 58/17 58/18 58/18 59/19 61/16 66/1 66/15 67/9 67/12 75/21 83/5 88/17 91/6 98/16 100/5 100/8 104/7 106/8 109/3 112/5 116/19 118/9 120/7 133/21 136/16 137/22 138/3 138/14 139/8 139/10 141/9 142/20 143/17 144/19 144/20 146/14 150/16 153/9 153/13 154/9 154/10 155/22 155/25 159/5 163/17 163/20 166/18 167/17 170/5 170/8 171/3 173/9 174/16 175/3 179/17 182/1 185/5 198/23 202/5 204/23 205/11 205/24 206/21 206/23 206/23 206/24 208/14 210/1 212/16 214/1 215/25 220/20 223/5 223/24 224/12 226/20 231/8 236/6 237/9 238/23 241/10 241/22 242/8 242/21 244/4 250/7 252/7 252/9 252/24
there [396]
there's [14] 56/20 70/8 78/1 108/7 109/11 113/16 201/3 205/19 205/20 215/23 229/14 235/2 235/2 239/24
therefore [27] 25/6 38/7 79/24 81/17 87/13 87/25 124/22 125/19 128/15 129/4 131/11 135/21 142/6 143/16 145/4 151/15 153/4 156/14 161/2 169/1 197/3 204/21 205/16 211/19 222/1 226/23 227/6
these [48] 14/6 21/4 21/21 23/17 24/9 25/23 27/8 31/1 38/8 47/2 47/8 47/14 92/5 107/7 115/3 122/7 126/7 126/12 127/23 130/6 132/25 141/23 145/7 148/20 150/2 160/22 171/24 172/22 173/4 182/16 185/8 195/22 196/2 196/5 196/13 198/21 202/14 204/24 207/23 208/7 214/2 214/17 215/5 224/23 247/1 249/23 253/7 253/7
these June [1] 21/4
they [190] 3/23 3/23 8/10 8/17 8/18 8/19 9/19 10/5 10/5 11/4 14/5 14/22 16/20 18/6 18/22 20/8 20/21 23/2 23/5 24/17 26/24 27/7 29/4 32/13 36/10 36/25 37/2 37/14 39/3 39/11 39/16 39/17 41/4 41/9 42/2 42/8 42/24 45/10 45/11 45/12 46/20 49/7 49/10 49/12 49/13 49/24 49/25 50/1 50/3 53/22 54/4 54/6 54/7 54/18 58/13 66/22 67/5 72/3 74/21 75/3 77/21 78/4 78/5 78/11 78/14 79/13 79/14 79/21 79/21 79/25 79/25 80/13 81/10 88/19 92/24 93/13 94/2 96/22 96/22 96/23 102/11 104/22 104/23 110/7 112/19 113/5 113/6 113/6 113/7 114/5 117/9 122/22 125/24 127/19 129/12 129/25 133/10 133/10 133/11 133/12 133/18 134/25 137/13 137/20 138/18 141/18 141/19 144/16 145/10 146/1 147/20 147/24 150/25 150/25 151/12 156/10 157/3 158/4 159/5 159/18 160/25 161/8 161/10 161/11 161/14 162/24 164/12 164/13 168/21 168/23 171/9 172/7 172/7 172/10 172/10 172/11 172/18 172/19 172/20 174/15 174/15 174/16 177/14 181/3 187/23 187/24 189/23 190/8 190/11 190/11 190/14 191/6 191/7 191/9 191/23 193/11 198/23 199/3 199/10 199/24 199/25 204/10 204/25 205/2 205/8 205/16 205/17 206/19 214/4 214/23 214/23 216/8 216/9 218/11 222/15 228/8 232/12 236/1 237/7 237/7 241/9 242/17 242/17 244/1 249/15 249/25 250/4 252/6 254/17 254/23
thing [9] 16/8 58/15 59/14 82/2 130/8 184/6 189/21 201/17 239/14
things [26] 14/15 22/23 33/7 54/3 74/21 78/17 79/13 93/23 94/8 97/3 97/7 103/11 107/18 112/20 140/18 148/21 148/24 148/24 150/18 154/4 172/23 173/16 206/18 206/23 232/11 235/23
think [199] 1/19 2/11 3/17 4/22 5/20 13/5 15/6 18/2 20/4 20/5 20/5 20/17 21/12 22/2 22/24 23/25 26/7 31/5 31/6 31/20 32/25 33/1 33/12 34/24 35/14 35/18 36/9 36/15 37/11 38/19 38/20 38/21 40/12 40/13 40/13 40/21 42/19 42/20 42/20 44/5 51/12 52/8 56/6 56/12 56/15 56/25 57/23 58/25 59/10 59/19 61/8 63/8 67/25 69/14 70/7 70/18 73/6 73/17 74/24 75/9 76/6 76/15 76/18 76/18 79/3 82/8 87/24 88/12 88/15 88/22 89/21 89/21 91/2 91/2 91/3 91/4 91/9 91/12 91/17 94/3 94/16 95/4 95/12 101/25 101/25 102/6 102/6 102/17 103/18 103/20 106/1 112/23 113/16 113/18 114/4 114/8 116/17 117/20 118/19 123/17 125/1 128/2 129/20 129/20 129/22 131/9 132/2 133/4 133/4 133/4 133/5 133/5 134/23 135/3 138/5 138/6 138/25 139/15 140/4 141/16 141/25 142/11 142/14 143/2 143/22 144/23 148/7 149/16 149/19 152/19 152/22 154/3 154/3 157/10 158/9 159/1 159/15 160/3 160/14 160/17 161/6 161/18 162/25 164/13 164/17 166/5 167/25 169/18 169/25 171/6 171/11 172/6 173/12 176/22 178/20 179/17 185/1 186/15 186/16 189/22 190/14 190/18 191/21 191/24 193/15 194/2 194/3 195/13 199/9 201/13 202/8 202/18 202/19 202/23 206/9 206/11 212/9 219/21 222/22 222/22 224/24 227/2 231/3 232/19 235/12 238/14 239/14 242/10 244/3 244/7 245/21 246/18 247/18 251/15 253/15 254/1 254/2 254/2 255/8
thinking [4] 158/4

T

thinking... [3] 159/25 160/2 160/4
third [14] 57/4 149/17 150/17 151/17 152/4 152/4 152/19 158/7 158/21 170/3 188/19 189/22 199/5 237/25
thirds [1] 106/16
THIRLWALL [4] 60/5 247/13 256/6 256/11
this [354]
thorough [2] 161/14 239/1
those [114] 6/22 8/25 9/12 9/22 10/2 10/7 13/5 20/14 20/16 20/23 20/25 23/5 23/16 27/9 27/10 28/18 29/3 29/16 30/16 30/18 31/11 36/14 37/3 37/13 40/21 41/8 42/8 47/16 47/17 48/8 52/15 52/17 59/3 59/16 59/20 63/11 64/12 64/18 64/20 64/21 67/8 74/11 74/14 74/20 75/3 76/17 77/24 78/15 79/12 79/23 81/14 81/20 81/21 87/24 88/4 89/23 89/23 89/25 90/14 91/21 93/4 93/6 93/23 97/2 100/10 103/10 106/7 106/8 115/13 116/22 120/1 121/11 122/1 124/24 126/25 127/16 131/2 132/7 141/10 145/20 145/24 147/19 151/20 152/2 154/20 161/16 162/4 162/24 169/1 172/2 173/16 176/19 177/10 181/2 189/17 190/17 193/21 193/25 196/23 197/4 197/5 197/5 205/12 205/21 207/1 210/22 211/20 219/12 234/11 241/6 244/16 248/16 253/8 254/16
though [5] 8/10 48/5 51/18 124/24 236/22
thought [30] 68/9 70/6 77/14 80/20 81/2 84/25 88/16 113/14 117/10 126/7 142/25 155/13 155/15 163/10 171/20 173/16 187/25 191/16 197/14 197/15 201/25 202/21 204/6 234/23 235/4 238/25 239/10 242/13 247/2 254/21
thoughts [2] 87/4 253/13
thread [4] 85/20 85/22 178/24 182/25
three [18] 3/8 30/21 50/11 89/13 134/25 146/10 146/13 150/9 150/9 152/6 152/8 154/3 154/11 154/13 157/23 162/16 189/5 243/13
three days [1] 50/11
three months [1] 3/8
three months' [1] 89/13
through [96] 2/6 6/24 10/5 10/14 18/24 19/12 39/23 43/18 55/10 60/14 79/13 81/7 86/24 87/11 87/15 88/3 89/13 94/4 95/17 97/24 98/4 104/16 105/6 105/15 113/4 113/9 113/10 113/19 114/16 117/5 117/6 118/7 124/6 130/25 135/19 139/11 139/11 139/15 141/22 146/13 147/2 147/3 151/9 152/18 152/19 153/21 156/8 156/22 156/23 165/20 168/1 168/24 169/10 172/3 172/9 172/16 173/5 173/14 173/20 179/1 180/18 182/2 182/12 182/13 182/21 182/24 184/2 184/21 185/20 186/11 187/14 187/24 188/2 189/1 200/19 204/18 204/20 205/14 205/19 206/8 206/21 219/3 222/11 224/14 226/13 228/15 238/11 241/20 241/21 242/8 249/24 252/7 253/24 254/3 254/5 254/24
throughout [1] 111/23
tiers [1] 165/6
time [182] 2/19 2/23 5/1 5/2 5/24 7/15 9/21 10/12 11/18 13/7 14/19 15/5 15/19 15/21 17/23 18/7 23/22 29/14 29/18 30/1 31/5 31/9 31/21 31/24 31/25 33/10 34/16 35/5 35/9 36/7 36/10 37/19 39/20 41/23 41/25 42/25 44/6 44/8 44/19 46/3 47/19 48/18 53/11 53/18 56/2 57/20 58/13 58/15 59/5 59/10 59/13 59/15 59/23 61/13 64/2 64/20 66/2 66/15 69/21 69/23 70/2 70/4 70/6 70/7 70/11 71/9 72/5 72/8 72/10 73/2 73/6 73/9 73/12 74/3 75/16 76/4 76/21 77/10 78/19 79/5 79/18 79/19 79/20 79/22 79/22 80/4 80/5 81/25 82/5 82/25 82/25 83/10 83/13 83/16 85/12 86/1 87/4 92/14 92/23 94/1 96/9 96/14 103/21 124/2 124/25 126/11 127/10 128/2 128/21 129/7 129/22 130/1 130/18 137/1 140/5 140/22 141/14 142/25 143/24 147/1 148/20 149/10 150/13 150/14 150/19 154/21 156/9 156/9 156/16 157/4 158/17 158/23 159/9 159/21 159/22 159/24 160/4 162/8 162/15 163/5 165/12 166/23 167/1 167/10 167/19 168/18 168/25 171/5 171/17 173/1 173/9 173/15 173/18 174/17 176/4 178/12 178/20 179/4 179/6 182/23 193/22 194/18 195/25 196/3 196/9 200/24 206/4 206/21 222/2 224/3 224/14 226/13 227/16 228/14 233/2 233/7 233/10 234/5 236/8 243/13 243/19 252/4
timeframes [1] 241/15
timeline [2] 64/22 80/3
timely [3] 131/2 181/20 206/8
times [3] 32/1 60/15 83/25
timewise [1] 231/22
timing [2] 106/11 188/21
title [13] 65/15 80/4 81/1 81/23 88/8 88/17 90/3 90/18 92/19 101/23 102/18 102/24 209/9
today [12] 97/4 126/12 137/2 138/10 156/14 159/22 221/6 223/1 224/8 227/18 240/16 247/19
today's [1] 70/12
together [17] 9/9 9/11 153/5 154/11 162/7 178/25 180/12 190/22 192/9 192/9 196/5 196/14 198/17 198/21 198/22 199/3 200/14
told [33] 20/3 36/20 41/16 61/20 79/1 79/2 82/24 123/1 129/1 136/10 148/4 156/5 157/19 164/20 165/9 166/3 166/24 167/24 168/8 169/6 169/15 178/22 181/3 183/25 187/14 202/10 203/19 216/14 232/7 241/1 241/5 249/13 254/15
told in [1] 241/1
tomorrow [2] 191/14 255/14
Tony [1] 122/22
too [8] 68/1 82/10 113/2 113/2 116/13 122/22 134/22 218/9
took [20] 3/1 13/1 13/8 33/12 50/12 52/3 84/20 88/2 124/1 146/13 165/19 166/22 176/13 186/18 200/7 202/4 202/5 225/25 240/9 254/3
top [10] 4/10 28/3 79/23 105/19 108/23 110/21 118/2 120/17 149/17 230/19
topic [5] 63/15 104/9 134/3 173/25 175/6
topics [1] 107/7
touch [2] 51/3 51/7
towards [3] 91/16 91/16 234/21
Townsend [14] 1/5 1/7 1/9 1/14 41/14 48/13 60/8 62/5 105/1 117/20 123/19 131/3 205/11 256/3
traceability [1] 205/20
track [1] 76/5
tracking [1] 119/3
trained [2] 8/14 45/16
training [8] 63/23 63/24 94/8 94/9 94/10 139/13 139/17 139/19
trajectory [2] 97/5 115/21
transcript [4] 186/9 186/10 187/12 202/17
transfer [2] 55/25 131/12
transfers [1] 191/9
transfusion [1] 67/13
transitional [2] 3/2 3/5
translate [1] 172/9
transparency [2] 31/12 205/20
transparent [1] 161/9
transposed [1] 37/15
treated [3] 165/4 202/12 237/12
treatment [4] 104/3 138/3 145/16 145/17
tree [15] 109/13 109/17 110/8 111/23 112/11 116/18 116/23 117/2 248/22 249/2 249/4 249/6 249/16 249/21 250/1
trend [1] 144/21
triangulated [1] 218/15
tricks [1] 209/17
tried [8] 46/19 58/18 58/18 76/24 115/23 146/23 177/25 212/9
triggered [1] 138/14
triggers [1] 137/25
triplet [8] 32/6 32/10 36/20 41/4 55/6 56/16 57/1 57/4
triplets [8] 32/14 36/2 36/21 36/21 48/15 54/22 55/8 207/11
triumvirate [1] 8/13
trouble [1] 197/10
true [7] 1/16 37/20 63/12 79/6 88/10 172/6 173/16
truly [1] 87/20
Trust [46] 5/21 28/11 29/4 29/14 30/4 46/19 72/14 73/2 73/9 74/1 75/12 75/20 76/20 88/10 92/14 95/8 104/14 109/14 111/13 111/14 118/3 119/18 121/2 124/7 125/5 125/21 126/25 127/6 127/9 133/13 134/11 135/6 135/13 135/20 137/6 170/10 170/14 214/9 216/24 217/23 217/25 220/1 223/12 240/18 241/11 246/20
Trust's [2] 125/24 134/23
truth [1] 161/1
try [17] 36/16 36/17 58/19 77/3 85/6 101/17 107/21 125/17

T

try... [9] 127/17 129/21 148/13 167/14 168/10 169/25 170/5 226/9 244/8
trying [13] 30/13 67/24 81/20 115/13 123/6 132/9 138/19 146/24 153/22 157/15 194/2 199/22 251/2
Tuesday [1] 255/17
turn [13] 31/13 44/21 47/1 56/23 57/5 75/4 96/1 136/1 155/1 200/16 203/22 203/24 234/17
turnaround [1] 201/11
turning [1] 9/15
twice [2] 4/21 70/4
Twin [1] 155/4
two [39] 32/14 36/1 36/21 36/21 36/24 39/3 41/22 44/12 54/6 55/17 60/8 82/25 83/8 93/20 106/16 108/3 108/6 121/14 122/1 122/7 126/19 126/25 127/23 132/4 139/17 162/12 162/16 162/23 175/14 185/1 188/18 189/20 193/25 194/1 210/15 211/14 217/6 225/14 244/2
two years [1] 139/17
two-thirds [1] 106/16
type [4] 73/14 75/14 146/24 147/10
types [2] 143/25 210/15
typically [1] 236/6

U

ultimate [2] 103/4 159/5
ultimately [3] 76/2 222/9 236/12
unacceptable [2] 242/17 243/10
unascertained [1] 223/19
unaware [3] 52/13 52/20 52/22
uncomfortable [1] 33/4
unconsidered [1] 227/11
undecided [1] 229/15
under [22] 24/11 66/20 84/10 84/14 93/7 100/12 110/23 135/22 137/14 146/10 146/17 147/8 147/9 147/12 148/17 153/6 157/10 157/19 213/8 214/15 221/11 227/8
underlined [1] 238/1
underlying [4] 15/2 15/8 16/2 19/21
underneath [1] 67/12
understand [72] 4/9 15/20 25/1 25/13 28/23 30/13 33/23 37/11 41/12 42/15 42/22 46/11 46/19 47/18 54/11 68/13 72/17 77/5 77/12 80/8 83/9 84/20 87/20 91/24 92/7 94/17 95/2 95/5 95/21 96/12 100/3 100/5 102/5 104/14 108/3 109/22 111/7 115/7 115/13 115/15 115/18 123/7 123/10 128/10 129/21 132/9 137/22 138/13 138/19 142/8 142/15 143/4 146/20 146/24 153/3 157/15 160/19 165/13 170/5 171/2 174/5 191/22 193/11 195/8 196/1 196/6 196/11 205/6 227/12 244/9 248/2 250/15
understanding [40] 15/17 26/19 29/2 29/21 31/7 41/18 44/6 88/12 93/15 106/4 112/25 113/4 113/13 113/20 114/9 115/5 116/22 123/18 145/8 146/25 149/8 150/4 154/12 160/23 167/19 168/25 169/5 182/11 182/21 194/17 195/9 195/11 195/13 201/19 225/17 226/17 233/10 234/6 240/17 245/17
understands [1] 138/17
understood [29] 15/13 23/16 23/19 25/11 35/25 42/17 87/12 111/13 139/8 147/24 165/15 165/17 175/14 183/19 185/18 185/23 186/5 192/5 204/8 207/13 207/17 211/15 211/16 234/9 240/1 245/18 246/18 248/21 252/5
undertake [4] 34/18 44/15 188/11 240/1
undertaken [4] 5/3 161/14 162/3 235/17
undertaking [2] 29/15 68/22
underwent [1] 170/21
undoubtedly [1] 200/9
unexpected [17] 33/25 50/7 52/10 55/20 93/10 105/23 115/20 137/2 138/11 144/5 144/11 144/13 145/14 155/11 174/13 175/25 222/10
unexpectedly [2] 137/10 177/17
unexplained [7] 50/8 52/11 137/19 138/12 153/15 155/14 222/10
unfair [1] 179/17
unfortunately [5] 44/18 115/21 154/9 220/7 238/6
unhealthy [1] 178/21
unintended [3] 137/3 138/11 174/13
unintentionally [1] 213/21
unit [98] 2/17 3/20 7/11 7/16 9/17 9/24 12/20 13/3 13/7 16/7 16/16 16/22 19/20 21/1 21/18 22/8 23/14 28/12 28/17 30/7 30/18 32/7 32/12 33/5 33/10 34/5 34/23 36/4 36/22 42/4 42/23 44/1 44/9 46/11 47/20 50/8 67/19 81/6 81/13 84/5 87/17 95/15 95/16 98/25 99/7 99/12 105/24 117/1 118/4 119/19 119/22 121/8 124/2 124/12 124/21 124/25 125/19 126/23 127/13 132/13 133/2 133/6 134/8 140/23 141/3 141/18 141/20 142/10 142/21 143/3 152/9 160/13 160/15 160/24 164/4 165/15 167/3 167/21 168/12 170/10 170/11 171/20 172/4 173/11 185/4 185/7 188/23 189/10 189/13 189/24 198/24 202/21 204/23 211/17 246/25 247/8 253/4 253/11
unit's [2] 140/7 162/2
units [4] 6/17 7/4 7/13 14/10
unjust [2] 203/7 203/13
unless [3] 50/4 103/1 228/14
unlikely [5] 116/8 199/16 222/5 223/2 229/17
unnecessary [2] 136/23 138/7
unpick [1] 101/23
unpleasant [1] 91/14
unreasonable [1] 199/1
unsupervised [1] 33/5
until [12] 5/2 12/9 30/15 44/9 132/24 142/21 149/3 175/9 180/18 219/7 255/13 255/16
until February 2016 [1] 142/21
until June [1] 132/24
untoward [2] 204/23 241/3
Untowards [1] 234/15
untrue [1] 94/9
unusual [3] 35/6 152/25 250/17
unwell [1] 55/6
up [71] 4/3 4/6 8/1 9/23 10/10 10/13 13/10 17/5 17/22 19/8 20/22 25/25 43/5 49/5 49/20 50/19 51/4 60/25 84/15 85/10 85/22 89/18 89/25 90/2 90/10 90/14 93/18 94/10 95/17 96/7 104/13 105/24 107/7 112/20 120/17 130/25 133/9 133/18 133/20 133/21 142/2 142/21 147/18 153/23 157/9 158/8 169/22 174/22 183/1 185/20 193/5 193/6 203/24 204/20 205/12 205/14 205/24 207/12 219/13 222/4 222/8 222/20 223/25 224/19 226/15 232/6 234/12 236/24 239/2 242/14 242/24
updated [5] 103/16 103/19 104/18 112/8 112/9
updates [2] 112/5 241/22
upon [24] 67/18 75/14 77/19 81/12 81/14 83/20 91/23 96/11 107/18 117/7 124/16 124/17 128/6 133/12 134/23 148/3 156/14 158/20 172/13 179/4 179/7 188/5 190/19 199/3
ups [1] 50/3
upstream [1] 148/7
urgency [1] 39/15
urgent [33] 2/12 2/14 3/18 4/11 5/20 6/15 11/16 11/24 23/6 25/5 25/21 25/23 26/5 26/7 26/10 28/4 37/21 48/7 57/23 58/16 59/11 60/1 67/18 67/23 67/23 95/17 117/22 119/6 121/15 123/13 133/7 205/9 238/3
urgently [2] 239/6 251/18
us [52] 4/4 47/3 73/1 77/5 77/12 77/16 78/16 79/1 79/2 80/8 81/6 82/3 82/24 83/24 84/1 84/23 91/24 96/12 102/4 109/12 111/7 123/17 125/7 136/10 142/24 143/10 145/17 146/20 150/6 155/20 156/5 157/5 157/19 160/7 160/18 161/4 166/24 169/15 169/23 174/23 184/15 202/10 205/6 209/17 232/7 238/5 238/23 239/9 240/6 241/5 243/25 249/13
use [23] 96/25 99/21 109/20 111/23 112/1 116/17 126/21 137/2 138/9 139/20 141/17 143/22 144/9 145/12 173/22 190/24 203/13 203/15 204/9 205/3 221/9 235/15 235/18
used [14] 50/2 50/3 58/13 73/15 83/25 100/21 100/23 110/11 110/18 113/12 116/24 118/1 147/5 160/6
useful [1] 148/10
users [1] 8/7
using [4] 111/22 127/17 139/11 150/3
usual [2] 165/13 251/13
usually [1] 11/11
utilise [1] 204/23
utilising [1] 204/3
UVC [1] 223/6

V

vague [2] 11/20 27/20
valid [3] 129/18 162/25 204/7
validated [1] 129/4
validating [1] 77/24
value [1] 200/14
variation [1] 197/11

V

varied [2] 67/16 68/9
variety [2] 80/12 171/23
various [2] 105/6 111/21
venue [2] 51/10 51/11
verbal [4] 69/14 70/12 70/18 133/10
verbalised [1] 70/21
verbally [1] 133/18
version [2] 97/23 161/1
very [122] 5/20 5/21 5/25 5/25 8/13 14/4 16/7 17/1 21/10 25/7 26/8 27/20 31/9 32/13 32/25 33/6 33/7 34/12 36/2 36/8 36/24 36/24 42/1 44/3 46/1 46/1 46/2 50/20 51/7 51/16 51/23 52/17 54/2 54/4 57/1 58/2 58/3 60/6 62/5 67/16 73/4 74/9 75/9 77/7 78/22 78/22 85/1 85/20 87/15 87/15 88/2 91/14 92/23 93/9 93/10 95/25 96/17 102/12 102/20 102/21 103/6 105/19 106/1 107/17 108/13 114/18 115/16 115/25 118/22 120/7 128/2 128/25 130/2 131/25 132/5 132/10 132/25 148/21 149/9 151/7 151/8 157/3 159/24 161/9 161/10 161/13 163/9 166/23 167/10 167/17 167/20 173/25 174/18 174/19 177/23 178/21 181/6 184/17 190/25 191/1 200/5 201/10 203/18 203/18 206/18 215/25 216/1 223/2 224/23 225/12 229/17 232/23 245/22 247/21 249/12 254/9 254/10 254/12 254/17 255/10 255/10 255/12
via [2] 146/10 173/8
view [31] 27/10 45/15 90/8 90/9 91/20 101/21 113/21 115/9 124/20 124/25 125/17 129/25 137/23 139/6 140/21 141/22 171/9 171/22 172/5 172/11 173/11 173/15 174/19 175/1 176/8 177/6 202/22 203/21 237/10 247/6 254/25
views [1] 197/5
visible [1] 85/7
visit [5] 7/3 7/5 166/23 169/14 170/19
visited [1] 7/11
voice [7] 70/17 132/13 133/17 192/18 205/15 205/16 206/6
voiced [5] 195/23 195/24 201/9 207/23 207/25
volume [1] 164/18

W

wait [3] 175/13 217/8 220/19
waited [1] 42/19
waiting [2] 43/4 229/20
want [26] 11/21 96/7 96/19 96/23 99/21 100/2 100/3 100/5 123/19 124/10 128/9 145/16 179/1 188/5 203/24 207/12 207/13 209/19 210/10 219/24 222/19 250/11 251/4 254/22 255/2 255/9
wanted [11] 29/4 46/3 49/5 50/6 92/7 148/23 148/24 190/11 190/11 201/20 201/22
wanting [5] 40/22 62/3 201/7 201/7 201/8
ward [13] 3/8 7/4 11/11 19/20 38/14 39/7 41/16 44/14 57/24 75/11 113/11 132/12 148/11
wards [6] 5/22 5/22 7/5 7/6 54/7 147/23
warrant [1] 201/25
was [990]
was February/March 2016 [1] 245/9
was June [1] 38/1
was May 2016 [1] 2/11
was sent [1] 47/9
wasn't [66] 7/9 12/11 16/9 16/11 19/1 22/14 22/21 23/2 27/21 29/13 30/15 31/24 31/25 34/13 35/5 35/12 35/14 37/8 37/16 37/25 40/3 40/15 44/10 47/19 48/19 49/21 51/16 51/20 52/24 56/17 66/25 69/13 70/5 81/18 91/17 133/23 140/11 142/3 145/8 158/22 159/25 160/4 160/5 160/12 160/24 161/6 161/16 163/5 173/1 173/3 179/3 179/12 180/6 189/2 190/13 202/19 218/12 230/10 230/10 231/20 234/9 237/19 237/21 237/23 237/24 255/4
wave [1] 212/25
way [64] 25/16 65/5 72/2 72/4 72/6 73/19 76/16 86/2 97/24 105/2 105/15 106/16 107/25 108/5 108/13 114/14 116/18 116/24 118/7 126/14 127/13 136/15 139/6 142/15 144/16 144/20 145/25 148/17 148/22 149/9 156/6 158/18 159/9 159/25 160/2 160/5 161/20 164/14 164/14 166/12 173/21 181/4 181/20 182/24 190/15 191/23 196/8 196/12 199/10 206/14 206/19 209/24 211/7 213/19 223/10 228/20 229/22 230/12 230/13 237/12 237/15 252/20 255/4 255/5
ways [5] 73/15 94/6 108/6 120/21 172/19
we [504]
we'll [3] 106/10 106/13 170/4
wealth [1] 171/23
week [9] 7/9 40/14 41/2 43/16 43/23 43/24 68/18 136/3 248/24
weekend [5] 34/19 41/4 41/13 41/15 42/12
weekly [3] 68/16 165/23 218/7
weeks [4] 7/14 14/3 196/10 201/18
weighted [1] 82/10
welcome [1] 75/3
well [137] 6/3 12/14 13/19 14/14 16/13 24/5 26/2 27/7 29/19 29/23 39/2 43/13 44/20 50/2 51/13 51/14 53/16 53/23 54/4 55/7 56/9 56/22 58/18 61/18 63/19 64/21 67/15 68/8 70/3 73/24 74/1 74/18 75/7 76/22 77/18 78/5 78/6 81/9 85/1 86/15 88/13 93/20 95/22 95/24 97/4 97/17 97/22 99/21 104/16 105/14 106/10 110/2 112/4 113/22 114/18 114/23 115/5 123/12 123/16 127/4 127/6 127/8 128/25 129/19 130/14 130/18 132/4 133/25 134/1 136/18 137/16 140/1 141/19 144/25 145/2 145/8 146/3 147/16 147/24 147/25 151/10 154/23 158/24 160/17 167/23 168/4 168/5 168/12 169/25 170/8 171/3 171/8 173/1 174/19 174/25 176/25 180/8 180/11 181/1 182/4 184/8 184/11 188/17 188/21 190/16 196/2 202/6 210/4 210/18 211/7 212/16 214/20 215/24 218/20 218/22 219/18 222/9 223/16 225/1 229/12 233/18 236/23 237/10 238/6 238/19 238/20 239/23 242/11 243/11 243/18 244/4 245/10 245/11 246/7 253/15 254/2 254/22
well-established [1] 210/18
went [24] 29/18 29/19 36/12 36/13 36/16 42/4 42/22 42/25 44/9 50/24 54/17 61/16 61/23 89/22 91/25 133/9 154/9 181/12 185/10 205/12 205/18 206/21 221/14 226/19
were [309]
weren't [11] 21/13 23/2 35/10 41/7 49/25 58/12 106/7 119/9 151/12 160/25 162/25
what [277]
what's [8] 10/17 20/2 22/6 78/3 170/16 220/18 225/12 229/16
whatever [5] 11/14 12/7 90/17 97/15 240/4
whatsoever [2] 27/21 230/6
when [106] 2/3 2/5 2/15 3/1 3/25 3/25 10/3 10/17 13/1 13/8 13/9 13/14 13/17 14/4 15/3 18/5 20/14 20/21 28/15 30/9 30/21 30/23 30/24 35/9 39/10 40/25 41/3 41/15 42/6 42/14 51/18 51/19 53/9 54/17 54/23 59/13 61/16 64/21 66/18 66/19 70/18 71/1 73/13 75/6 75/18 77/10 77/21 80/2 83/12 88/2 91/13 93/14 94/19 101/1 101/1 105/10 107/23 112/2 112/4 112/7 112/11 112/18 116/8 116/25 117/15 120/3 122/15 123/7 126/7 128/18 135/9 136/6 139/21 140/10 141/15 143/16 145/20 156/12 160/14 166/24 167/4 173/9 173/13 173/13 176/12 178/22 179/4 179/6 179/15 182/19 183/24 195/11 195/13 205/11 206/20 208/23 214/21 221/24 227/11 228/6 235/22 242/2 242/18 247/22 248/25 250/17
where [48] 11/1 24/17 28/13 29/7 33/20 36/18 44/22 51/10 51/10 60/10 65/2 75/11 84/14 87/10 89/12 100/8 118/5 120/1 126/15 132/6 134/1 137/19 138/1 139/7 145/3 151/24 156/4 157/11 161/10 170/5 170/23 180/15 190/1 195/23 199/24 200/25 201/6 202/1 207/24 208/21 221/15 228/8 228/11 229/14 244/24 245/19 246/20 246/20
whereas [1] 185/2
whereby [1] 91/24
whether [39] 12/6 16/5 16/20 17/9 24/23 24/23 27/3 43/7 90/13 93/6 96/20 101/21 107/11 107/13 107/14 111/24 113/14 115/18 115/21 123/6 124/4 129/1 131/15 138/20 140/2 155/12 158/13 198/9 221/16 228/7 229/15 232/24 235/16 240/21 240/21 245/23 246/9 246/13 247/5
which [128] 2/3 4/22 6/20 10/14 11/8 13/9 14/15 16/2 16/7 20/20 24/12 30/6 35/7 35/22 35/25 39/21 42/24

W

which... [111] 47/2 48/25 49/2 54/15 54/25 55/9 58/14 58/15 61/4 61/5 61/11 63/11 66/6 68/9 68/16 71/13 73/25 74/11 76/20 78/6 81/3 86/7 86/9 87/1 88/18 89/10 92/14 97/24 98/5 102/10 103/16 104/1 104/23 108/1 108/10 108/14 108/16 109/13 109/18 109/19 112/20 116/5 119/22 121/8 122/6 124/11 126/17 126/20 128/4 131/23 132/6 133/7 134/13 137/24 140/2 145/1 146/1 146/5 149/17 152/19 153/21 154/7 155/17 158/21 161/3 163/2 163/10 164/16 169/18 169/23 170/13 170/17 170/20 176/3 176/15 176/15 176/23 180/6 180/9 181/23 183/24 185/25 191/6 192/9 193/12 202/6 210/16 217/15 218/6 220/5 221/14 221/15 225/10 227/7 227/9 230/9 230/13 232/4 232/17 232/19 232/21 233/21 234/20 234/20 239/25 240/16 240/19 248/23 250/10 251/6 252/25

whichever [1] 186/21

while [5] 35/17 43/3 100/25 218/11 252/24

whilst [6] 6/2 46/18 64/4 78/13 110/14 196/10

who [87] 2/20 2/22 4/12 4/16 4/18 6/5 6/5 6/6 6/11 6/12 11/13 11/17 12/23 18/21 32/23 35/16 36/4 36/22 46/22 60/17 60/21 62/15 66/9 67/4 67/5 67/9 67/11 67/21 67/22 68/6 69/12 74/2 75/19 77/2 87/3 93/14 93/15 93/17 100/15 101/8 110/6 122/22 126/9 127/11 131/4 131/5 131/9 135/8 137/4 142/16 142/17 145/20 147/19 154/23 158/10 158/10 159/8 161/23 162/19 166/10 170/16 170/24 173/6 174/11 174/22 178/8 178/11 181/15 186/13 186/20 192/8 202/13 213/17 217/16 217/22 219/17 226/4 230/3 234/10 235/4 238/15 241/5 241/10 243/21 244/2 249/14 252/10

who's [1] 246/25

whoever [2] 12/12 122/24

whole [1] 180/11

whose [6] 31/19 73/21 111/11 149/14 158/6 210/12

why [60] 16/19 18/16 19/3 19/23 19/24 20/3 20/3 21/12 26/4 27/17 29/10 29/10 30/13 37/3 37/14 37/16 41/9 41/12 42/8 42/9 46/11 54/11 73/17 76/6 77/16 79/7 81/23 96/12 101/7 118/20 123/23 125/1 126/14 127/6 127/8 127/8 128/10 130/12 130/19 132/9 146/20 149/7 150/3 150/6 156/15 176/20 188/16 204/10 206/17 209/21 211/12 213/23 214/7 214/8 215/8 231/12 231/13 238/19 239/9 253/15

widely [3] 73/8 74/4 196/15

wider [6] 10/22 28/11 118/3 119/18 121/2 205/22

will [101] 13/9 55/7 61/20 62/8 63/11 64/21 69/19 75/12 75/13 77/3 80/2 83/24 84/6 84/16 85/22 85/23 86/24 89/12 90/21 94/1 95/3 95/4 96/2 96/6 97/9 97/25 98/4 98/8 98/12 98/15 98/16 100/11 105/5 105/11 105/14 107/25 108/2 108/14 109/9 112/4 117/16 118/6 118/14 118/19 118/20 118/23 120/1 120/9 120/19 122/8 122/16 123/25 124/3 124/8 124/17 127/22 131/3 134/1 139/15 143/13 144/17 146/3 147/6 148/7 149/12 149/16 152/11 159/17 159/18 166/21 169/13 170/5 171/1 172/16 175/8 177/3 178/20 183/23 184/16 185/13 190/6 191/4 191/13 194/6 197/9 213/25 217/9 219/16 220/10 227/13 230/20 230/23 231/10 236/13 239/23 240/13 240/15 243/2 245/6 251/15 255/13

Williams [12] 65/18 66/11 68/16 95/4 189/3 191/12 191/13 192/4 192/14 192/15 192/16 192/18

Williams' [1] 191/18

wise [1] 10/24

withdrawal [2] 89/3 91/21

within [64] 2/18 3/21 6/17 6/17 7/4 14/10 14/10 14/15 14/17 15/10 16/8 22/25 23/20 24/1 24/1 25/12 25/14 25/23 28/12 28/20 30/17 33/12 37/22 48/1 48/7 48/22 49/4 49/10 50/23 54/16 67/19 75/22 79/2 92/21 95/8 96/21 96/21 98/14 117/1 118/4 119/19 119/22 121/7 124/12 125/9 125/15 125/21 132/14 135/2 138/18 142/17 145/12 151/22 152/12 154/22 157/2 158/19 160/22 168/20 172/1 179/24 184/9 212/11 244/20

without [9] 76/23 86/7 86/16 86/21 87/13 98/21 124/13 133/18 233/14

witness [16] 31/15 53/5 62/14 63/3 96/8 132/11 174/2 189/7 191/14 191/15 194/17 224/9 229/23 231/10 244/5 244/6

witnesses [2] 160/20 243/21

women [21] 13/18 14/13 14/21 15/11 20/12 23/17 50/21 68/3 95/12 119/7 119/15 121/6 132/21 132/23 133/24 166/3 166/14 169/10 181/12 181/14 182/5

Women's [1] 3/21

won't [2] 199/13 206/19

wonder [7] 8/8 47/3 60/7 62/19 118/17 175/6 243/20

wondered [1] 41/9

WOODS [5] 217/11 217/14 243/20 247/14 256/10

word [6] 29/10 29/11 100/14 203/2 203/14 216/11

wording [9] 28/9 28/13 29/6 29/7 122/9 123/20 151/23 152/2 185/9

words [7] 56/23 99/21 110/18 137/2 184/15 203/13 253/7

work [34] 2/3 8/2 8/9 8/16 9/9 46/19 48/6 67/2 68/13 68/21 72/19 73/5 73/7 76/5 77/22 78/1 80/13 85/17 87/11 87/15 87/23 98/15 100/7 105/15 118/7 118/15 141/15 143/3 148/17 153/23 170/22 178/13 191/3 191/6

work-around [1] 78/1

worked [8] 2/5 8/15 35/18 65/2 68/8 78/14 85/1 192/23

workforce [6] 8/6 9/2 11/6 13/6 13/7 54/15

working [17] 7/1 7/9 31/2 42/12 43/25 47/19 47/20 68/7 84/24 118/20 131/6 159/3 159/7 170/14 170/24 200/14 204/2

works [3] 47/5 108/6 142/15

world [3] 70/12 82/6 216/14

worried [1] 56/22

worry [3] 41/17 183/18 249/20

worse [2] 56/23 57/6

worst [1] 109/7

worth [1] 89/13

would [452]

wouldn't [39] 31/21 56/13 72/1 77/18 90/14 101/17 103/4 125/25 127/8 127/9 128/25 131/12 136/18 139/1 142/4 142/5 144/7 147/8 148/1 166/18 168/16 169/6 201/21 206/14 211/5 216/14 226/23 229/19 235/6 236/16 237/15 237/17 239/16 240/7 241/8 244/19 251/20 254/22 255/2

write [2] 53/9 240/14

writing [5] 53/11 53/22 94/13 139/13 252/1

written [9] 1/20 54/19 54/19 56/7 63/10 69/13 70/13 226/25 228/21

wrong [8] 25/13 137/13 167/20 171/7 171/12 171/20 194/9 203/2

wrote [3] 54/23 195/12 195/13

Y

year [10] 37/19 37/20 37/25 37/25 52/11 63/4 63/6 64/24 93/17 93/17

year-on-year [1] 93/17

years [6] 66/1 71/10 87/22 117/25 139/17 248/7

yes [314]

yesterday [1] 220/8

you [1165]

you've [1] 111/25

Young [1] 170/4

younger [1] 46/17

your [162] 1/13 1/17 1/23 2/2 2/2 2/18 3/6 4/10 4/21 4/23 6/1 7/4 9/7 9/8 11/16 13/9 13/15 14/10 14/15 14/17 15/16 18/5 18/9 19/5 19/8 19/11 19/20 19/25 20/10 22/25 25/10 26/11 28/2 28/20 28/21 28/21 29/11 29/21 30/22 31/15 31/17 31/20 37/7 39/19 44/22 45/1 45/15 46/24 48/1 48/18 49/24 51/18 51/23 53/5 53/21 55/23 56/2 57/11 57/18 62/4 62/24 63/12 63/16 63/23 64/16 64/23 66/13 67/21 68/24 69/23 70/22 72/9 72/17 72/21 74/5 75/5 76/16 77/6 77/11 77/11 77/16 79/2 79/3 79/4 83/1 84/23 85/20 86/11 89/14 92/14 92/15 93/7 96/8 101/20 103/3 106/13 107/3 107/4 116/9 120/3 122/25 130/15 131/6 132/11 140/5 142/17 143/10 143/11 143/19 146/5 146/7 146/21 148/3 149/22

Y

your... [48] 150/3 158/16 160/7 161/16 161/21 163/16 166/24 169/5 169/19 169/23 173/11 173/15 174/2 176/8 177/6 179/12 181/2 181/18 182/9 184/15 186/3 188/9 189/7 193/15 193/19 194/8 194/17 194/17 195/5 200/17 203/22 203/23 205/3 206/1 214/14 214/18 217/20 220/7 226/9 235/12 237/9 242/1 242/1 245/21 247/22 250/25 251/13 253/19

yourself [5] 51/11 168/8 168/17 211/5 211/25