

Thursday, 12 December 2024

(9.30 am)

DR ALAN FLETCHER (affirmed)

Questions by MS BROWN

LADY JUSTICE THIRLWALL: Thank you very much, Dr Fletcher. Thanks for beaming in this morning.

Ms Brown.

MS BROWN: If you could please give your full name?

A. My name is Dr Alan Keith Fletcher.

Q. Dr Fletcher, you have provided two statements to the Inquiry, one dated 8 March and a supplemental statement dated 6 December 2024. Are those statements true to the best of your knowledge and belief?

A. They are.

Q. Just dealing first with your qualifications and your current role, you are a Fellow of the Royal College of Physicians and of the Royal College of Emergency Medicine, you are currently a Consultant in emergency medicine and acute general internal medicine at the Sheffield Teaching Hospitals NHS Foundation Trust and since 1 March 2019, you have been the National Medical Examiner for England and Wales, which as from 9 September this year is a statutory position, and I believe you perform your roles as a National Medical Examiner alongside your clinical role with approximately

1

with the role of the Medical Examiner, obviously those who are doing the job on the ground, and I think you have to some extent, but just summarising what a Medical Examiner will be doing, please.

A. Yes, thank you. The summary really is to ensure that an independent person reviews the documents and circumstances of every -- every person that who has died in England and Wales whose death is not subject to Coronial investigation. And the purpose of that is to ensure that all deaths receive an independent scrutiny to ensure that three principal questions are answered: the first is what is the cause of death and to ensure that it is accurately recorded. The second is whether the case needs to be referred to a Coroner and to ensure that in a timely and accurate way, if necessary, and the third is it establish whether there are any clinical governance concerns that need a further review or look at.

Q. Thank you, and I am going to if I may in a minute work through those but just dealing first with your point about independence. In what sense is a Medical Examiner independent? Can you just explain the safeguards that are in place to ensure that there is true independence between the review of the death and the initial doctor who will have certified death?

3

60% of your time being devoted to the role of the

National Medical Examiner; is that correct?

A. Yes, it is.

Q. Turning then to your role as National Medical Examiner, you address this in paragraph 3 of your main statement. How would you briefly define your role as the National Medical Examiner?

A. Thank you. My role is to provide the national leadership for the Medical Examiner system components of the reformed processes of death certification that were introduced from a statutory basis from 9 September of this year. Before that, I was the lead and assisted with the design and implementation in the non-statutory phase of the Medical Examiner system which is ostensibly to review the causes of death and the circumstances of all those -- all deaths in England and Wales that are not investigated by a Coroner.

Q. Just to pick up, you covered it but just so that we are entirely clear, you cover Wales; the Medical Examiner system covers Wales but not Northern Ireland or Scotland?

A. Correct, it covers the areas that mirror Coroner responsibilities in England and Wales but not Scotland and Northern Ireland.

Q. At paragraph 7 of your statement, you deal

2

A. Thank you. There are lots of layers of independence that are incorporated into the system. In the non-statutory phase, the evolution of the process meant that for the best part of six years, over a million deaths were scrutinised by doctors who were always independent of the case and that is one way in which independence is safeguarded, as set out now in the statutory regulations.

Q. Sorry to interrupt. But independent of the case, you are meaning they had no -- didn't treat that patient at any point?

A. Correct, yes.

Q. But what about independence from the hospital or knowledge of the doctors and so on? I think you are going to come on to that.

A. Yes, I am. And that is also set out in good practice guidelines as well as which now must be adhered to from a statutory perspective, that there must be no conflict of interest for the Independent Medical Examiner reviewing a case, it is such as the world of medicine that acquaintances are made and people know one another and it is a matter of professional responsibility.

One of the benefits of the system ensures that there is a team of medical examiners to enable in any

4

1 one office to ensure that if there is a potential
2 conflict there are opportunities to discuss, to escalate
3 to pass the case on to a colleague, and if necessary,
4 seek advice from regional colleagues and, if necessary,
5 me as the National Medical Examiner.

6 **Q.** So just in very practical terms, a death that
7 occurs on a neonatal unit in a hospital, the doctor who
8 takes the role of the Medical Examiner, they could not
9 be employed by that hospital?

10 **A.** Now, that's not quite right. The way that,
11 from a pragmatic perspective, employment has to -- this
12 was a policy decision taken by the Department of Health
13 and Social Care -- that Medical Examiners and their
14 officers would be hosted within acute hospitals --
15 within the NHS and that's what the regulations
16 stipulate. Employment does not necessarily mean the
17 same thing as a reporting mechanism.

18 The reporting of outcomes, deaths, their reviews
19 and scrutiny is passed through the regional structure
20 and through to me as the National Medical Examiner.

21 **Q.** So would you ever have a situation where it
22 would be one of the fellow doctors working on the same
23 unit who would be the Medical Examiner for another
24 doctor working within that unit?

25 **A.** It is -- it is on, I cannot imagine

5

1 Just dealing with the third of those, the clinical
2 governance concerns. What really is meant in practical
3 terms by clinical governance concerns?

4 **A.** There is such a range. If I may, I can
5 explain that.

6 The Medical Examiner process is a little unique in
7 any local hospital Mortality Review process in that it
8 considers the whole of the patient's journey and for
9 example a patient who is admitted from home, who's had
10 contact with primary care, ambulance services, local
11 authority care for example then in an emergency
12 department or a different, a different department
13 transferring even to another hospital as is often the
14 case for neonates as well, the whole of the journey is
15 considered and along that process if there are any
16 issues that are flagged as unexpected events or
17 acquisition of complications or problems that occurred
18 during that patient's journey, then those would register
19 as matters that would, having been detected, would be
20 passed on for review as clinical governance concerns.

21 There may be a parallel referral to a Coroner also
22 if there is reason to suspect that those concerns caused
23 or contributed to the death of that person, but they are
24 not necessarily linked; there can be differences,
25 a complaint about long waiting times may not have

7

1 a situation where neonatology Medical Examiners -- and
2 we have some -- would scrutinise the death of a baby
3 that occurred on their unit. That is not appropriate
4 and they would not do so.

5 They would pass that to a colleague and if
6 necessary one of those Medical Examiners might be, for
7 example, a GP or another doctor from a different Trust
8 who is employed, for their sessional basis, to work in
9 that hospital, but that would be an independent person
10 to review things.

11 **Q.** When you say it wouldn't be appropriate, it
12 would be clear to them that if that situation occurred
13 and they were asked to review a death, it's clear to
14 them not just as a matter of their own conscience but it
15 would be clear to them that that is something they would
16 not be able to deal with and they would have to pass to
17 someone else?

18 **A.** That would not fit with the guidelines, the
19 guidance we provide to say you must be independent of
20 the conflicts and colleagues and relationships that
21 inevitably would, would arise.

22 **Q.** And you set out the questions, the three
23 questions: what did the patient die from? Does the
24 death need reporting to the Coroner, and are there
25 clinical governance concerns?

6

1 influenced death for example but nevertheless is
2 a concern.

3 **Q.** So, for example, obviously we are focused on
4 a neonatal unit; if there was a concern that a baby was
5 being -- had either been referred to a unit that didn't
6 have the relevant level of specialty or was being
7 transferred between units or to another unit
8 inappropriately, that would come within governance
9 concerns?

10 **A.** It would. I can recall, if I may, an example
11 of a case where -- that's not relevant, not directly
12 linked to this Inquiry -- where the care of a child who
13 had been transferred to a paediatric critical care unit
14 from a district hospital, the care at the tertiary
15 centre was exemplary and it never, looking at the care
16 at the district hospital before that child was
17 transferred, led to concerns being raised.

18 In fact, I -- by the parents, most significantly
19 and I am sure you are going to come on to that --

20 **Q.** Yes. Just staying though with the raising of
21 a clinical governance concern. What about if there was
22 a concern regarding staffing, that there's concern that
23 there may have been inadvertent negligent harm caused by
24 a staff member or, of course, deliberate harm?

25 **A.** Well, there are now different -- these are

8

1 different kinds of clinical governance concerns as
 2 opposed to a complication of treatment for example.
 3 I understand exactly what you mean and there are
 4 examples of cases where staff members from a ward have
 5 raised concerns about the lack of supervision of junior
 6 staff or the lack of Consultant involvement in cases,
 7 that, that register as a governance concern and those
 8 would absolutely be included as part of the remit of
 9 concern raising.

10 **Q.** So one's got to a situation where the Medical
 11 Examiner, either through reading the notes or talking to
 12 the doctor concerned or through speaking to the parents
 13 has raised a clinical governance concern. Where does it
 14 go from there? How is it followed up in particular?

15 **A.** Yes, thank you. As I stated in the statement,
 16 in my statement the role the Medical Examiner is to
 17 detect an issue and pass it on. It's not our role to
 18 investigate that because we neither have the resources
 19 nor the scope or jurisdiction to do so.

20 What happens to a clinical governance depends on
 21 local arrangements and the circumstances of -- of the
 22 right destination.

23 As part of the good practice guidance we provided
 24 some guidance about the places where concerns could be
 25 raised and there are tiers of escalation. They may, for

9

1 investigating, but is there any follow-up to see was
 2 anything done with that concern?

3 **A.** Yes, thank you. If I may break that down
 4 a little. The first point is very well made and what
 5 about -- this is -- what of the recurrent or frequent
 6 numbers of concerns that arise from different Medical
 7 Examiners, who, as you say, they work shifts.

8 In those circumstances, the -- what we have --
 9 there is the constant of the Medical Examiner Officer in
 10 the office who are a kind of glue to keep, keep a review
 11 of the whole of the practice that's going on and,
 12 therefore, frequent consistent problems that arise are
 13 noticeable by that, through the Medical Examiner office.

14 Each office has a lead Medical Examiner and in my
 15 guidance, I have requested that all Medical Examiner
 16 officers must conduct review meetings, consider the
 17 cases that they -- and concerns that they have,
 18 opportunities to detect patterns, trends, themes.

19 The next tier is, what happens if those are raised
 20 and the problem keeps happening? And in those
 21 circumstances, again the escalation is set out in my
 22 guidance, that all the Medical Examiner officers are
 23 supported to escalate those to regional colleagues who
 24 have direct access to regional, their regional
 25 counterparts, directors of nursing, regional medical

11

1 example, be appropriate to raise to the -- if it is
 2 extremely local, to a local nurse ward manager or
 3 ensuring that the incident is reported through an
 4 incident reporting system framework.

5 In other circumstances, if the concern is immediate
 6 and serious then there ought to be a -- there is
 7 a direct link to senior members of the Executive.

8 Also there is the parallel route of ensuring that
 9 the Coroner is notified and a Coroner has the
 10 opportunity to, if necessary, escalate that to officers
 11 to investigate including police if necessary.

12 **Q.** Because of course the situation could arise
 13 where a number of concerns arise, none of which are
 14 serious or considered serious enough in the first
 15 instance to go to the Coroner or maybe to be referred
 16 out to the regional Medical Examiner but are necessarily
 17 concerns and really the issue is in that case, were you
 18 to have different Medical Examiners, all of whom are
 19 working several shifts a week, so that that may occur,
 20 different Medical Examiners, who all raise a concern
 21 that go back to the hospital, is there any mechanism
 22 where the Medical Examiner unit would think, "Oh, we
 23 have raised these number of concerns and nothing seems
 24 to have happened."

25 Is there a -- I appreciate you are not

10

1 directors and to me. I would expect those to be
 2 notified.

3 In fact, in the last reporting that we had for the
 4 quarter, there was an example cited of an apparent
 5 cluster of child deaths that were noticed by the Medical
 6 Examiner office, escalated and investigations followed.

7 There is no formal requirement for feedback about
 8 those investigations and this is something that I --
 9 I grappled with early on. One of the important aspects
 10 of the Medical Examiner system is that it's trusted as
 11 a place where people can raise concerns and if necessary
 12 will raise them on their behalf.

13 If we require feedback from other investigators,
 14 then there is the risk that the Medical Examiner office
 15 is seen to police the system and that's not our role.
 16 We can't -- there is no statutory remit to do so and
 17 I prefer -- the more informal feedback and the learning
 18 that follows, we request it but we can't demand it.

19 **Q.** Just to follow up on a few points there. In
 20 terms of, you have referred to meetings that were being
 21 held to see if similar situations were arising. Is
 22 there a system where any decision, made by the Medical
 23 Officer/Medical Examiner, is recorded so that someone
 24 can say, "Of the deaths that we have reviewed, five have
 25 been referred back for a clinical governance problem to

12

1 X hospital."

2 Is it as systematic as that or does it depend on
3 a meeting and these things having been sort of
4 organically noticed?

5 **A.** There has to be the organic approach, partly
6 to be able to respond quickly to noticeable clusters of
7 events. For example, if there were post-operative
8 infections arising frequently and unexpectedly from
9 a particular ward or a procedure, I would expect that to
10 be noticed and acted upon directly as soon as it became
11 obvious rather than wait for a meeting.

12 There is a systematic approach to -- to reviewing
13 data and information and that reflects the quarterly
14 reporting that I request and have done since 2020.

15 That is systematic, but not thematic. There is
16 an important difference of how that is structured within
17 the constraints of what we have.

18 The quarterly reporting is reviewed by the -- my
19 regional colleagues in a tiered way and considered
20 nationally at the Medical Examiner Oversight Group.
21 Patterns, trends, deviations from baselines are all part
22 of that, that analysis and review.

23 **Q.** The other thing I wanted to ask you about was
24 you referred to the Medical Officer. Is that someone
25 who actually has medical training, any clinical

13

1 bereaved families. But my understanding is it would be
2 sometimes the Medical Officer that would make contact
3 and as a member of the public if someone was to
4 telephone and say, "I was a Medical Officer", a large
5 majority of the public I suspect would interpret that as
6 meaning they have a medical qualification?

7 **A.** So the title is a Medical Examiner Officer and
8 I would, I would say that part of the discussion of the
9 introduction of that conversation, which is sensitive
10 and complex, is their role and responsibility is always
11 clearly described to the member of the public, the
12 bereaved person they are discussing with.

13 I don't -- I am not aware of issues here.

14 In the same way that when Coroner's Officers,
15 because it is always Coroner's Officers practically that
16 speak to family members, there is no confusion that it
17 is the Coroner that they are speaking to.

18 **Q.** Just turning on then to having laid out the
19 three questions, you talk about the steps that the
20 Medical Examiner would take and one of those is the
21 medical note review. I just wanted to ask you about
22 that.

23 What they are required to do is a proportionate
24 review of relevant medical notes and I just wanted to
25 understand who is it that decides what is proportionate

15

1 training?

2 **A.** The Medical Examiner officers are definitely
3 trained to do their role. They come from a range of
4 backgrounds and that actually is -- I celebrate this
5 because what they bring is a host of skills and
6 knowledge from different areas -- most of them have
7 a clinical background. Some of them are former
8 Coroner's Officers for example as well, but ultimately
9 there is a professional development strategy, a clear
10 job description that requires analytical skills,
11 clinical skills, personal skills in interacting with
12 doctors and bereaved people and that inevitably requires
13 some clinical knowledge.

14 **Q.** But they don't have any -- it's not
15 a requirement they have a clinical qualification, they
16 don't have to be a nurse or a doctor or do they?

17 **A.** No, we have a range. They do not have to be
18 because it isn't defined, their role is not defined in
19 statute.

20 Their delegated functions are undertaken at the
21 request, where appropriate, by a Medical Examiner but if
22 they are not able to do so then the default is that it's
23 the Medical Examiner's responsibility.

24 **Q.** Because just considering the situation we are
25 going to come on in a moment to the contact with the

14

1 and, looking very specifically at neonatal deaths, how
2 the view is taken. Obviously there's situations where
3 the obstetric notes as well as the neonatal notes would
4 be relevant and how that assessment is made of the
5 extent of notes that would be looked at.

6 **A.** Thank you. The reason to include the word
7 "proportionate" is because that in some cases it is not
8 necessary to try and to attempt a forensic review of
9 a lifetime's medical records and one will appreciate
10 that this includes all deaths of all people of all ages
11 and there are some patients whose sets of records run to
12 thousands and thousands of pages.

13 It would be wholly unreasonable to expect a review,
14 going back to the 1960s, of records for somebody who has
15 clearly died from a natural cause in a natural way at
16 the end of a long life and the person who decides what
17 is required is the Medical Examiner applying their
18 clinical judgment when they review that case.

19 For cases in neonatal units, most cases, if I may
20 say, the records are relatively concise. Some babies
21 have a protracted stay and have extensive records, I do
22 appreciate, and those will take longer.

23 Along that journey there are, there are sideways
24 directions to review proportionate elements of medical
25 investigations, for example, or observation charts and

16

1 focus in on the some of the aspects that occur along
 2 that patient's journey.
 3 I -- in one of the learning sessions that
 4 I authored originally to describe how to do, to do the
 5 work, I describe this as a sort of like reading
 6 a person's records a bit like one reads -- reads a book.
 7 You start with the last illness as a logical place to
 8 commence and review, read the pages and subconsciously
 9 have those three questions in mind: what is the cause of
 10 death? Does this case need to be notified to a Coroner
 11 and are there any issues arising?

12 So if there is something that crops up like, let's
 13 say, an unexpected collapse or a sudden drop in blood
 14 sugar, that prompted a flurry of activity and concern,
 15 that would always attract attention as you go through
 16 the journey.

17 You mentioned obstetric records and one of the
 18 issues here is that the power that the Medical Examiner
 19 has under the regulations is via the Access to
 20 Healthcare Records Amendment 1990 that permits review of
 21 the deceased person's records.

22 The obstetric records pertain to a live person for
 23 whom consent would be required to review those.

24 I am comfortable with Medical Examiners requesting
 25 consent from, from people. However, this is an

17

1 prompt insulin and C-peptide measurements would always
 2 flag as an issue of concern. That's regardless of
 3 a patient being a neonate.

4 Medical Examiners are aware of the investigations
 5 and issues that have arisen historically and I am minded
 6 of the case of Colin Norris in Leeds, a nurse who was
 7 tried for the concern of having administered insulin to
 8 elderly patients, and the case of Bridget Bock is a case
 9 in point that led to a criminal proceedings. There are
 10 other examples of insulin being administered.

11 So Medical Examiners are generally aware of this as
 12 an issue. I would expect hypoglycaemia to always prompt
 13 concern and, "Uh-oh, what's this going on?"

14 I am open, I am open to any recommendations about
 15 specific matters from this Inquiry, of course, and would
 16 just -- would just say that we are currently preparing
 17 some joint learning and updating the Good Practice
 18 Guideline Series Guidance that I provide about neonatal
 19 and child deaths.

20 I have commissioned my colleagues and neonatal
 21 Medical Examiners to do this and I am sure that that
 22 could be incorporated or may well be incorporated
 23 because it's in association with the British Association
 24 for Perinatal Medicine as well.

25 **Q.** Moving on. Thank you. Moving on from the

19

1 extremely sensitive and difficult time for parents and
 2 if it's got to the stage where there is concern to
 3 review obstetric records, I would have expected this to
 4 already have been passed to others; the clinical
 5 governance, the Child Death Review process and/or the
 6 Coroner that would consider those aspects.

7 **Q.** Dr Fletcher, you are I'm sure aware that one
 8 of the issues that has arisen in this case, not in fact
 9 in terms of the babies that in fact died, but one of the
 10 issues is harm being caused by insulin and I am just
 11 wondering whether there is any specific guidance that's
 12 given to Medical Examiners that if they see, when
 13 dealing with a neonatal death, reference to insulin
 14 results whether that is automatically something that
 15 they should investigate and ask to see results if the
 16 results aren't apparent from the notes in front of them,
 17 or whether that indeed should be something in the light
 18 of what this Inquiry has heard?

19 **A.** Well, thank you. Yes, I -- again, this is
 20 a matter that I have considered carefully. One, I have
 21 to be cautious about providing examples of specific
 22 matters to look out for because the list could be
 23 exhaustive and overwhelming.

24 My observations are that unexpected hypoglycaemia,
 25 the drop in blood sugar that insulin -- that would

18

1 examination of the notes, the next step is the
 2 interaction with the attending doctor.

3 Can you just explain that. Will that always be
 4 speaking to just one doctor or if there were concerns,
 5 would you speak to for example the resident doctor who
 6 had been involved in the care? What's the extent of
 7 that interaction?

8 **A.** Thank you. The interaction is with the -- the
 9 requirement is that the Medical Examiner and/or Officer
 10 must speak to the attending practitioner and that is the
 11 person who would be completing a medical certificate of
 12 cause of death if it was appropriate to do so.

13 That varies according to every location. It could
 14 be a senior GP, it could be the Consultant
 15 neonatologist, or paediatrician or it could be a junior
 16 doctor on unit. The interaction is along the lines of,
 17 "Tell us about the case."

18 **Q.** And this is a face-to-face or over the
 19 telephone?

20 **A.** Or telephone, yes, or in the case of remote
 21 interaction for example with a busy GP surgery it might
 22 be recorded as a last entry in the medical records for
 23 example, "My thoughts about the case are ... and this is
 24 the proposed cause of death."

25 So it's what -- it is about a cause of death and to

20

1 ask if there are any concerns that you have.

2 **Q.** So there will always be an actual
3 conversation, will there, as opposed to an exchange of
4 emails presuming --

5 **A.** For inpatients, for inpatients almost always
6 a telephone or a face-to-face interaction.

7 **Q.** In the case we are dealing with, all the
8 babies who died where the resuscitation involved
9 a Consultant paediatrician being called, a paediatrician
10 with some expertise in neonatology and in terms of the
11 expertise of the Medical Examiner, they are drawn from
12 a range of specialties. So you could have a GP,
13 a dermatologist, an orthopaedic surgeon discussing with
14 the Consultant paediatrician the cause of death.

15 And how effective is that going to be in terms of
16 scrutiny when the disparity of expertise could be vast?

17 **A.** Yes, it's a really good question and 1 million
18 cases later it turns out that it's okay and the reason
19 it's okay is because the emphasis is slightly different.
20 It is just looking at things through a different lens.

21 Medical Examiners look at the -- are trained to
22 look at the generic process of care and there are plenty
23 of aspects that are common to all cases. All the cases
24 involve a human being in the hospital setting where
25 there is, for example, observations, or unexpected

21

1 happen? Can you explain that to me?"

2 **Q.** Do you consider or has it been considered
3 whether specifically in terms of neonatal deaths, which
4 is obviously a particular specialty even of paediatrics,
5 that that is one area where Medical Examiners should
6 call in an expert as an exception to the general rule?

7 **A.** Oh, first of all, we make it clear that if
8 there is advice to be -- that's required then calling
9 a colleague is always an appropriate thing to do.

10 In due course, I, this is -- the knowledge and
11 expertise of Medical Examiners is growing. It's -- they
12 will, in a year, review 2,000 deaths and we are, we have
13 been at an early stage; their experience is maturing.

14 I think it's fair to say that the knowledge and
15 experience of paediatric and neonatal deaths will be
16 increasing as well, albeit these are relatively rare
17 events that, in the wider complexion of cases that are
18 not notified to the Coroner who are -- that are neonatal
19 deaths is a small number and more concentrated in
20 certain units, they can, they can and will call
21 colleagues.

22 As we get further, I think there will be
23 an opportunity for wider expertise amongst Medical
24 Examiners. But we don't have the funding or resource or
25 capacity to provide a full network yet of neonatal --

23

1 events. They are generic. They occur in every aspect
2 of care.

3 And in the same way that a Medical Examiner who is
4 a -- it sounds like I am singling out specialists and
5 it's not fair to do that -- but the example would be
6 that a Medical Examiner who is a GP may not have
7 specialist knowledge of the complex haematological
8 oncology patient who is an adult, or a neuro-surgical
9 case and in those circumstances the way that -- the
10 subject matter expert is the Consultant paediatrician,
11 the neonatologist, because they were there and we always
12 say, "This is your case, this is your patient."

13 And there is a trajectory of learning and
14 improvement of knowledge and skills as we go along
15 acquiring information about, "Oh, okay, that's --
16 I understand where you are with the cause of death
17 here."

18 How we may refine that and word it differently on
19 the certificate is the Medical Examiner's expertise, as
20 is knowing the Notification of Deaths Regulations 2019
21 inside out. So it is a different perspective.

22 And the final point on that is that the Medical
23 Examiner, who is not a specialist in the unit, can ask
24 the naive but really important question and it's
25 actually, it is a useful challenge to say, "Why did that

22

1 **Q.** Because of course a Medical Examiner will
2 generally do that alongside their other role. So
3 although, as you say, Medical Examiners, the number of
4 deaths there they are dealing with is going up all the
5 time. An individual Medical Examiner may only work
6 maybe one shift a week and may come across a neonatal
7 death once a year if that; they are very infrequent and
8 it is whether, in those infrequent cases, they have the
9 expertise to be able to know for example when something
10 is truly unexpected or whether a response to
11 resuscitation is unusual. Not to have the expertise but
12 even to have the relevant expertise to ask the right
13 questions?

14 **A.** Yes, thank you. I understand the challenge,
15 and I would -- I would expect a Medical Examiner who is
16 confronted with a case like this of -- well, any
17 unexpected death of a neonate I am almost sure would
18 always prompt, "This doesn't sound like it's for us,
19 this sounds like it is for others to investigate."

20 But if they were uncertain, the structure locally
21 and if necessary regionally provides the opportunity
22 to -- to obtain further advice and expertise from
23 independent people as well as the clinicians directly
24 involved with the care.

25 **Q.** Thank you. Just staying with training for

24

1 a moment. You will be familiar, I am sure, with the
 2 recommendation from the Clothier Inquiry that the
 3 actions of Beverley Allitt were to heighten awareness,
 4 in all those caring for children, of the possibility of
 5 malevolent intervention as a cause of unexplained
 6 clinical events and I am just wondering if that specific
 7 recommendation is part of the training for all Medical
 8 Examiners so that, when they consider any case that
 9 possibility is, as a matter of course, considered
 10 because we know, in the events of this case, that many
 11 people spoke about not being able to think the
 12 unthinkable and, clearly, a Medical Examiner, it's very
 13 key that they do and I am curious as to what extent
 14 that's incorporated in their training?

15 **A.** Yes, thank you. Well, it is in the first line
 16 of their e-learning, of the training.

17 As you will be aware from the statement the
 18 training is both e-learning, face to face continued, on
 19 the job and CPD coordinated by the Royal College of
 20 Pathologists, as the lead College. In the first line of
 21 the e-learning, Medical Examiners are reminded that
 22 their role had the germination from the murders
 23 committed by Harold Shipman, the issues at Morecambe
 24 Bay, Gosport War Memorial Hospital --

25 **HEARING MANAGER:** My Lady, I'm sorry to interrupt,
 26

1 training, and my own included, is that -- is the
 2 requirement for safeguarding training to be undertaken.
 3 It's mandatory training.

4 **LADY JUSTICE THIRLWALL:** I am very sorry to
 5 interrupt you, Dr Fletcher, but there seems to be
 6 a problem with the live transcript. So we will just
 7 wait to see what the problem is.

8 *(Pause for technical issue)*

9 **LADY JUSTICE THIRLWALL:** Has everyone got the
 10 "testing, testing" message? I am the only one who
 11 hasn't, so we can restart.

12 **MS BROWN:** Sorry, Dr Fletcher, you were just
 13 dealing with safeguarding, if there is anything you want
 14 to add where you were in your answer?

15 **A.** Yes, thank you. So first just to reiterate
 16 that Medical Examiners must comply with mandatory
 17 training requirements which include safeguarding,
 18 including of children and young people, the second is
 19 that whilst safeguarding is for everyone employed in the
 20 NHS, the responsibility for raising safeguarding
 21 concerns for a neonate where there may be harm, or an
 22 adult for that matter, I would normally expect that to
 23 be raised by the treating clinical team after
 24 a discussion if it was raised.

25 So my -- my preference would be for -- after

27

1 can we take a two-minute break?

2 **LADY JUSTICE THIRLWALL:** We will just take two
 3 minutes.

4 Sorry, Dr Fletcher, if you wouldn't mind just
 5 staying there, we will just pause.

6 *(Technical pause)*

7 **LADY JUSTICE THIRLWALL:** We are ready to restart.
 8 Thank you. Ms Brown.

9 **MS BROWN:** Thank you. Dr Fletcher, just the final
 10 issue on training then is regarding safeguarding
 11 training. Again, we know from the facts of this case
 12 that safeguarding was not picked up as an issue; even
 13 though there were concerns raised, no one saw this as
 14 a safeguarding issue, even when harm -- the potential of
 15 harm was noticed. "Safeguarding" isn't a word that
 16 appears in some of the materials that you have provided
 17 us with and I am just wondering whether there is
 18 sufficient training of Medical Examiners that, if they
 19 think there may be a situation of potential harm being
 20 caused, whether in terms of referral to the LADO, those
 21 sort of safeguarding measures are, again, part of the
 22 Medical Examiner's training or checklist, so to speak?

23 **A.** Yes, thank you. I think that's -- that's
 24 a very reasonable point, and I have reflected on that as
 25 well. The first point is that, as part of all mandatory

26

1 discussion for Medical Examiners to say: have you raised
 2 a safeguarding concern for this case? And are you going
 3 to do so?

4 I suppose it's aligned to are you going -- I think
 5 this case needs to be notified to the Coroner, are you
 6 going to do so? And if the answer is no, well the --
 7 what we will do is say, "Well, we will do it instead
 8 then".

9 I am open to any advice or recommendations about
 10 specific lists because whilst I can see the disadvantage
 11 of duplicating a referral, it's probably better that
 12 somebody does it more than once if necessary in my mind.

13 **Q.** At least the question is asked as to whether
 14 there has or has not been a safeguarding referral?

15 **A.** If that was -- if it's appropriate to the
 16 case, of course.

17 **Q.** If we can move on then to a different topic,
 18 interaction with the bereaved family because that as you
 19 have explained and set out in your statement is very
 20 much at the heart of the Medical Examiner's role.

21 Obviously, the Medical Examiner's role takes place
 22 very shortly after the death in the five days and in
 23 terms of a neonatal death sometimes the mother will be,
 24 potentially having had a caesarean, in hospital herself.

25 I just would like your views on, if you could give your

28

1 views, on how that works in practice; the interaction
2 with a family specifically who have just lost a baby in
3 a neonatal unit?

4 **A.** Yes, thank you. Look, the first thing to say
5 is that each case is unique. Every death and every
6 family and every bereaved person has -- has always had
7 a different experience. In terms of the approach,
8 timing is everything and choosing the right time to call
9 somebody to discuss the loss of a baby is -- is subject
10 to a value judgment partly on the part of the person
11 making the call but also needs to be respectful, that if
12 traumatic events have occurred in the middle of the
13 night calling somebody who is exhausted and acutely
14 bereaved at 8 o'clock in the morning four hours later
15 would be wholly inappropriate.

16 So the way this is approached is if this is in
17 a hospital setting, then liaising with the key worker,
18 liaising and offering the opportunity and also most
19 importantly the opportunity not to have a call if that
20 is requested is fully respected.

21 The --

22 **Q.** I'm sorry just to interrupt, who will be
23 making this call because obviously there is the Medical
24 Officer for the Medical Examiner or the Medical Examiner
25 themselves, obviously the person making this contact,

29

1 seeking their opinion on it, if necessary explaining it,
2 and to ask the question: do you have any concerns?

3 **Q.** Just thinking that through again in this case
4 the fact there were Families who didn't have that
5 opportunity to discuss and later had concerns, is there
6 a problem that a family in the first stages of grief
7 feel they have in fact lost an opportunity if they are
8 not in a position to respond within those first days,
9 then the Medical Examiner process is shut and they feel
10 that they haven't had the opportunity to express their
11 concerns, can they come back with concerns, how's that
12 dealt with?

13 **A.** Yes, that is always on offer at the conclusion
14 of a call and the requirements for the Medical
15 Examiner's involvement is as you stated earlier at the
16 very early stages of this process, so that cases get
17 notified to Coroners quickly if necessary and that
18 funerals can occur. We have similar situations for
19 urgent cases, some parents want to take their baby home
20 and others may have faith or cultural reasons that they
21 want an urgent funeral, for example.

22 I think it's important to remind the Inquiry that
23 the Medical Examiner system is not one -- is not
24 a single part, the only safeguard for these processes.
25 There are other opportunities for review, for reflection

31

1 whether it's direct or through a bereavement nurse are
2 two of the key issues?

3 **A.** So the requirements, a policy decision taken
4 by the government at the time has been that the Medical
5 Examiner or the Medical Examiner under a delegated
6 authority will make the call to the -- to the bereaved
7 person.

8 **Q.** That is the Medical Examiner, that is the
9 Medical Examiner Officer who?

10 **A.** Yes, either Medical Examiner or Medical
11 Examiner Officer. I think it is important to recognise
12 that this is not done routinely in every case because if
13 through the initial review of records and/or the
14 interaction of the clinician, that the case has been
15 notified to a Coroner there is no need for that
16 conversation to garner their views or thoughts because
17 there has been taken already to the next stage and those
18 can be explained by key workers and Coroners Officers.

19 If everything has appeared to be okay, and those --
20 in those cases after a medical certificate has been
21 completed and there has been interaction with an
22 attending practitioner, at that point, there is
23 an opportunity to have a sensitive call and offer the
24 opportunity to discuss the death of their baby. And
25 that would centre on the proposed causes of death

30

1 and opportunities of concern raising.

2 So whilst that's not, I am not seeking to dismiss
3 the responsibility that an acutely bereaved person may
4 not be thinking clearly at the time of a call, we will
5 do the best we can at the time and understand that
6 sometimes issues can be raised later and we do have
7 that -- I can recall cases of where bereaved relatives
8 have contacted the Medical Examiner Office down the
9 line, even weeks down, and said: do you know, I have
10 been thinking about this, I have had a call with you,
11 and that's what -- we are accustomed to it in those rare
12 occasions. It is rare.

13 **Q.** In that situation, you would follow the same
14 process of referring it to a Regional Medical Examiner
15 or back to the Trust depending on the concern that was
16 raised, if the parent came later down the line to speak
17 to you?

18 **A.** Yes. Yes, I think it's really important that
19 the Medical Examiners and Officers are not, not
20 a bereaved person's advocate but they must listen and
21 register the concerns. And, I mean, there are -- it's
22 discussing with the bereaved person what -- how they
23 would like to take matters forward as well, because it
24 takes courage to raise a concern and to feel that your
25 voice is heard. The Medical Examiner system -- and

32

1 I have done it myself -- will say: listen, you don't
2 have -- if you don't want to raise this concern
3 personally, I will raise it for you. I will take this
4 forward.

5 In other circumstances, the families feel -- if
6 correctly signposted may well raise the concern
7 themselves. It depends on the case and it depends on
8 the individual and respecting family wishes.

9 But in any circumstances, if there's -- if there's
10 a concern raised that might require Coroner notification
11 even if it's weeks down the line, that's still
12 appropriate, and Medical Examiners know it.

13 **Q.** Just finally with this issue, just to be
14 clear. The contact, would that normally be directly
15 between the Medical Examiner or Medical Examiners Office
16 and the individual parent or would one always go via,
17 for example, a bereavement nurse or a key worker or does
18 it vary?

19 **A.** The -- the requirement according to the
20 statute is that there is an interaction with the parents
21 and along the journey of refining practices and
22 guidelines, I took advice from clinicians,
23 practitioners, Medical Examiners, officers and
24 especially parents.

25 And the -- there is a -- there is a peculiarly
33

1 of the system, experience of Medical Examiner Officers,
2 Medical Examiners and processes discussing with
3 colleagues in neonates in obstetrics and paediatrics,
4 the opportunities -- refining processes and learning
5 about how these interactions may occur locally because
6 everywhere is a little different, means that we have our
7 experience of interacting with bereaved parents of
8 neonates is less than the million cases of older ones.

9 We have had, as part of my guidelines, monitoring
10 effectiveness of the system includes recommendations for
11 obtaining feedback and surveys and there are lots of
12 different ways in which that can be obtained locally
13 including with partners.

14 **Q.** Is there a joined-up process between those who
15 are experts on bereavement and who generally talk in
16 terms of having a key worker, a bereavement nurse and
17 having one point of contact and the Medical Examiner --
18 I understand what you say about the Medical Examiner
19 speaking directly to the parents, but the point is does
20 that go through a conduit or does someone literally
21 receive a call, an unexpected call, from a Medical
22 Examiner?

23 **A.** Well, that can happen, but the way in which --
24 collaborative working and communication is paramount and
25 I could set that out in the guidelines and that's
35

1 characteristically medical issue that -- that we as
2 doctors often think we know best for our parent patients
3 and their families and where I settled with this is the
4 powerful message I got from parents, bereaved parents
5 and those representing them that why -- that they wanted
6 the opportunity to speak directly to a Medical Examiner
7 or Officer.

8 I have, there were concerns raised by those
9 involved in the Child Death Review process that this
10 would be duplicative, intrusive and difficult.

11 In practice, that doesn't -- that's not the case
12 and we have learnt from experience. I feel this was
13 a perceived risk rather than an actual one.

14 **Q.** Have there been reviews -- obviously it is
15 a relatively new process, but have reviews been done of
16 feedback from those who have been involved in the
17 process?

18 **A.** We -- from a -- from a paediatric and neonatal
19 cases, the feedbacks are -- are recent because they --
20 they were the later additions to including the
21 development of the Medical Examiner system.
22 Understandably, the larger numbers of adult deaths
23 attracted in terms of simple numbers and establishing
24 offices and experience were the logical place to start
25 and as experience grew, and I think this was a positive
34

1 supported in all aspects of the Child Death Review
2 contact guidelines. The key worker is an ideally placed
3 person to make the introductions, I have no issue with
4 that whatsoever.

5 The most -- the valuable learning we have had from
6 interactions with bereaved people is that it helps
7 enormously if they are prepared to receive a call. That
8 could be on a ward or from a general practice or
9 wherever it may be to say: this is what happens after
10 death because this is a -- it's -- one hopes almost that
11 it's a once in a lifetime experience, I don't mean just
12 for neonatal bereaved parents, but it is an infrequent
13 event, it's acute, it's raw, it's complicated. Every
14 circumstances is a little different, each requirement.

15 So guiding people through that process in the new
16 statutory reforms, if they are prepared that a Medical
17 Examiner or Officer will be calling you, you don't have
18 to speak to them if you don't want to, but they will
19 have that. You will be expected to receive a call.
20 That's the best way to preface it.

21 **Q.** If I could turn now to the referral to the
22 Coroner and referral to the police. In what
23 circumstances will a case be referred to a Coroner,
24 first of all, before we turn to the police?

25 **A.** I -- the -- it is ingrained as part of the
36

1 Medical Examiner role and training to know when the
2 notification of death criteria are fulfilled. The
3 Inquiry will be aware of the beautifully crafted words
4 of those -- those regulations which cannot cater for
5 every, every scenario and Medical Examiners are not
6 lawyers.

7 However, their experience of knowing when their
8 cases need to be notified, if there is reason to suspect
9 based on some tangible fact of evidence, then it becomes
10 a decision for the Coroner to make their independent
11 judicial decision of whether section 1 of the Coroners
12 and Justice Act is invoked.

13 So they know how to do it and they will fulfil the
14 criteria as set out in those regulations.

15 **Q.** In the Countess of Chester, at the time there
16 was a convention that all child deaths would be referred
17 initially to the Coroner and I am just wondering
18 although there wouldn't necessarily be an investigation
19 by the Coroner, but they would be initially referred to
20 the Coroner. Just briefly, how does the -- does that
21 bypass the Medical Examiner or can you explain how the
22 Medical Examiner nevertheless goes on to scrutinise the
23 death?

24 **A.** Okay. No, thank you, I like this question
25 because it's actually really helpful to -- to -- this,

37

1 if any guidance, is given to Medical Examiners about
2 when they should be themselves referring matters to the
3 police? Or would they always refer that on to someone
4 else, would there be a situation where the Medical
5 Examiner would say: this I think needs to be referred to
6 the police? And what guidance they are given to help
7 them?

8 **A.** Plainly, if I may say, notification to police
9 is a highly significant step for any healthcare
10 professional to make, if it's -- if they are concerned
11 about criminal activity being conducted in -- in the
12 environment of a hospital by members of staff.

13 I would expect that to be a multi-agency decision.

14 I would expect the concern to be recognised by
15 a Medical Examiner including a need to notify a --
16 notify the police, and that that would be best handled
17 either or both by -- it would be by the requesting of
18 the senior management team of the hospital and the
19 environment in which the activity had occurred and via
20 notification of the Coroner.

21 I am minded of the advice given to me now retired
22 Senior Coroner for South Yorkshire West who used to say,
23 "Tell me about these cases because I have got 1,000
24 officers in blue uniforms who I can instruct to
25 investigate if I need to" and the logical route is via

39

1 some Coroners, including clearly the Cheshire Coroner,
2 requested that all child deaths are notified to their
3 office and that came from a good place, it was because
4 they wanted to take a view of all of those cases.

5 The -- the downside of it is that it became
6 a routine matter and what the Medical Examiner system
7 provides is ensuring that the right cases are notified
8 to a Coroner, including the correct child and neonatal
9 deaths, and that unnecessary notifications, because
10 there were, were not undertaken.

11 These are complex areas and what the Coroner
12 depends on is accurate information. The safeguard that
13 the Medical Examiner system provides is that the Medical
14 Examiner's thoughts, reviews, issues are conveyed to the
15 Coroner, alongside the refined and clear notification
16 made by the attending practitioner.

17 That way the Coroner can make a -- make a properly
18 informed decision on the cases that they are notified.

19 If one were to dilute that by referring all cases,
20 I fear that that the correct attention may not be
21 focused in the right way on the right cases.

22 **Q.** Moving from referral to the Coroner to
23 referral to the police. We know in this case that there
24 was very significant delay even when there were concerns
25 about referring matters to the police. What guidance,

38

1 the -- via the Coroner.

2 We -- we also have as part of the scenario based
3 trainings, it isn't specifically concerning a neonatal
4 case but it -- in another example where criminal
5 activity was -- was alleged that notification of the
6 police is covered in that training scenario.

7 **Q.** Just going back to the history of the origins
8 of the Medical Examiner system. You have referred to
9 and you set out in your statement that they were
10 introduced of course as a result of Dame Janet Smith's
11 recommendations following the murders of Shipman and so
12 coming out of a report that was published in July 2003.

13 You say in your statement that you consider that
14 the Medical Examiner system would have prevented or
15 stopped earlier the events that occurred at the Countess
16 of Chester relating to Letby. That inevitably calls
17 into question whether the scheme has taken too long to
18 be implemented because if a scheme was envisaged in 2003
19 and we have got events that happened in 2015/16 and this
20 system would have prevented it or at least reduced the
21 numbers of deaths, the question is: why wasn't it
22 brought in earlier?

23 **A.** Yes, thank you. That's a -- that is
24 a terrible thing to have to consider and I'm sure that
25 the parents of -- of the babies in this case are -- it

40

1 would be very difficult to hear that -- that -- my view
2 and my evidence that the a correctly functioning Medical
3 Examiner system would make it extremely difficult for
4 one of those steps, a proportionate review, the
5 interaction with an attending clinician or conversation
6 with families, to fail to detect a problem at an early
7 stage.

8 I suppose one can never say never in -- as one
9 never does in medicine. But I -- the safeguards, I --
10 I refer the conversation with family members, for
11 example, as "the Shipman question", because that was
12 the -- the evidence that Dame Janet Smith heard from
13 family members who said: well, I would have said it was
14 really odd because my mum was really well the day
15 before, she was playing golf. And in those
16 circumstances that kind of level of concern is an alarm
17 bell for every Medical Examiner.

18 Why hasn't it happened earlier? I have set out
19 some of that history in my statement and really, the
20 introduction of this has -- is for government and
21 Department of Health and Social Care to discuss with
22 you.

23 My -- my perspective is that we have got this over
24 a line after what is a period personally of 17 years of
25 effort and persistence, and I am pleased -- I am very

41

1 processes avoiding duplication and is supportive,
2 sharing information, openness, transparency, promoting
3 what I consider -- well, part of the reason that I am
4 here, what I said at the start is that to tell the
5 truth, the whole truth and nothing but the truth is
6 a really good way to practise medicine.

7 **Q.** Whilst we are dealing with the CDOP process,
8 one of the issues that arose in this case was that
9 deaths were -- went to different panels depending on
10 where the baby's Family lived. Just in terms of
11 geography and patterns, it's correct, is it, that the
12 Medical Examiners in the case of a number of deaths all
13 occurring in one hospital would all go to the same
14 Medical Examiner's Office, so that wouldn't be a problem
15 in terms of the method, those patterns would be picked
16 up?

17 **A.** Yes, a problem on a unit in that -- in that
18 environment would always be picked up by a Medical
19 Examiner Office, that Medical Examiner Office.

20 **Q.** I am correct, am I, that because although the
21 Medical Examiners may deal only one shift, for example,
22 per week because it's within an office, a pattern would
23 be -- you would be confident that a pattern would be
24 spotted?

25 **A.** I --

43

1 proud and pleased that we have reached a stage where we
2 can offer the opportunity for early detection and
3 notification.

4 And I -- I have seen first hand how the system also
5 provides a degree of deterrence knowing that somebody
6 else is going to be looking at cases.

7 **Q.** Just a few more questions, Dr Fletcher.

8 There is a suggestion, again you deal with this in
9 your statement, that there is a danger that there's an
10 overcrowded regulated space in terms of child deaths.
11 We have got the Child Death Overview Panel in case of
12 a sudden death, the SUDIc process, PRUDIC in Wales.

13 What are your views on that?

14 **A.** Thank you. Yes, my view is that it is
15 crowded, I think it is crowded for adults too, actually,
16 the establishment of the various arm's-length bodies and
17 different ways in which things are looked at. I see the
18 positives that, look, reviewing things from different
19 perspectives at different points involving different
20 agencies brings in itself a safety net. I am not the
21 correct person to comment on the efficacy of the Child
22 Death Review process, of course.

23 What I would like to do is to ensure that the
24 Medical Examiner system as it becomes increasingly
25 established and mature is complementary to those

42

1 **Q.** Well, there is mechanisms aimed to pick up
2 patterns, I should say?

3 **A.** Yes, thank you. Yes, I consider that there
4 are appropriate safeguards and safety nets, yes.

5 **Q.** Dr Fletcher, if I can just end by referring
6 you to paragraph 105 of your statement, because
7 that's -- that is where just very briefly you talk
8 through what the scenario of where there is a death or
9 a series of deaths in a neonatal ward and how the
10 Medical Examiner system, as you say, operating at its
11 best would operate and I wondered if it would be helpful
12 for you briefly to set that out?

13 **A.** Okay. Yes. Thank you.

14 I think the first thing to say, and it is relevant
15 to the Inquiry is that the Sudden and Unexpected Death
16 of a baby in a neonatal unit is an outstanding and
17 remarkable matter. So in of itself I would expect that
18 occurrence to generate a level a heightened sense of
19 concern about what happened, what led up to it, what the
20 response was, and why it happened, even though those
21 questions may not be answerable by the Medical Examiner
22 at the time.

23 And so the process would involve the review of
24 records after notification to the office, a -- an
25 extremely low threshold for notifying the Coroner in

44

1 that case, and the interaction with an attending
2 practitioner would include: what happened? What was
3 your -- what do you think happened? And it wouldn't
4 necessarily -- the views of the attending practitioner
5 may be that that that leads to, "Well, I'm not sure, but
6 I think this is a possibility." Well, the heightened --
7 the naive question of the Medical Examiner or Officer
8 would lead to: well, you know, are there any other
9 possibilities? The most likely is what you might need
10 for completing a medical certificate.

11 And actually ask what do the family -- what have
12 the family been told? Because that is a really useful
13 question. Are you expected, what are they expecting?

14 If on that journey there are any concerns this goes
15 to, this gets escalated. This is -- there is a binary
16 approach of, well, surely this is a matter for the
17 Coroner and isn't this a Joint Agency Response case
18 where you would follow the Child Death Review process,
19 it is not for me as a Medical Examiner to require you to
20 do this, but here is a prompt.

21 If even despite all of that we get through the
22 holes of this particular Swiss cheese where there is
23 an interaction with a family member and one is met with
24 a response, for example: "I don't understand what
25 happened. I'm -- I just don't get -- we were told

45

1 from ...

2 **LADY JUSTICE THIRLWALL:** Mr Skelton.

3 Questions by MR SKELTON

4 **MR SKELTON:** Dr Fletcher, I ask questions on behalf
5 of one of the Family groups.

6 I don't know if you have had the opportunity to
7 follow some of the evidence given to the Inquiry during
8 the last three months?

9 **A.** I have had some opportunity and I have had
10 some -- some updates and briefings from colleagues
11 because as you might imagine other things have been
12 quite busy.

13 **Q.** Of course. Very early on evidence was given
14 by Dr Joanna Garstang.

15 **A.** Yes.

16 **Q.** Were you able to follow that?

17 **A.** I have followed that, thank you.

18 **Q.** Thank you.

19 There were a couple of points that she raises that
20 I would just like to put to you just to see what your
21 response is?

22 **A.** Of course.

23 **Q.** My Lady, just for your reference the two
24 points come from paragraphs 2.8 and 4.2 in her statement
25 to this Inquiry.

47

1 everything was fine", a comment like that would -- would
2 and should lead to a the brakes being applied in the
3 nicest -- in the most sensitive way possible to say:
4 I think we need to take a further look at that given the
5 light of your concern and we will take this one away and
6 discuss with a team, others, the review process, the key
7 worker and Coroner and we will get back to you.

8 I mean, at the end of this, this is -- this is
9 a tragic and desperately sensitive matter. In my
10 experience, bereaved people, including bereaved parents,
11 want to know what happened and they want the truth and
12 they want it as quickly as possible and they may -- even
13 having an apology is worthwhile and I'm okay, as Medical
14 Examiners and Officers, providing that apology saying:
15 I'm sorry this has happened to you.

16 Ultimately that is something that's familiar to --
17 whether it's older people or neonates. I have an eldest
18 daughter in hospital at the moment recovering from
19 surgery. I don't think it makes any difference in the
20 nicest possible way whether you are interacting with
21 a person who is a parent of a child who is days old,
22 years old, 20 years old or 60 years old. The feeling is
23 the same.

24 **MS BROWN:** Yes, thank you very much, Dr Fletcher.

25 There are, I believe, just some further questions

46

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

2 **MR SKELTON:** The first point is really about
3 variability and the point she makes is that the Medical
4 Examiner system is not yet being used for child deaths
5 in all areas of England and I wondered what your
6 response to this was?

7 **A.** Well, I -- I think matters have moved on. And
8 that was from Dr Garstang's statement and evidence, in
9 the nicest way, the -- it is correct that at the time of
10 my statement not every death of children and neonates
11 were being considered by Medical Examiners.

12 Since 9 September the statutory regulations mandate
13 that all deaths must be considered by Medical Examiners
14 or a Coroner and so from 9 September, every death of
15 every child and every neonate are being reviewed, either
16 by a direct referral to a Coroner or by a Medical
17 Examiner. So now statutory requirement we are doing
18 this.

19 **Q.** Thank you. The second point that she makes
20 and I will just quote the sentence if it helps:

21 "The Medical Examiner system could help provide
22 an additional safety net but many Medical Examiners know
23 little about the SUDiC, JAR or child deaths so may not
24 have the expertise to recognise when to intervene."

25 I wonder -- if I may, I am going to take you

48

1 through some of the guidelines that you have issued on
2 this issue. I wonder if that is something of concern,
3 that it may be that some of your Medical Examiners don't
4 in fact understand the process that should occur?

5 **A.** Yes, thank you, I think that is a reasonable
6 question. The guidelines clearly reference my -- my
7 good practice guidelines published for the commencement
8 of the statutory system, because they had to be
9 refreshed, obviously since the new process has been
10 established, reference to Child Death Review process,
11 the mandatory requirement to engage with it and ensure
12 the criteria because it is linked as part of guidelines
13 and the Good Practice Series papers, which were
14 published in association after careful consultation with
15 colleagues who were engaged in the Child Death Review
16 process.

17 Further to that, and I recognise the anxieties and
18 concerns about this, I had already requested three --
19 there are three Medical Examiners, two of whom are
20 neonatologists, one is a paediatric pathologist, to
21 liaise with the British Association for Perinatal
22 Medicine and work to do two things, to -- well three
23 things: one is to work with the BAPM on updated guidance
24 on -- for their colleagues, the second is to update the
25 Good Practice Series document, for child and neonatal

49

1 look up a separate set of guidelines and processes and
2 teach themselves in effect, whereas I was going to
3 invite you to consider whether or not your guidelines
4 including the flowcharts in the Royal College of
5 Pathologists guidelines need to include the SUDIc
6 process directly because it actually takes through
7 various steps in a child's investigation which the
8 Medical Examiner needs to know about?

9 **A.** Yes, thank you. I think -- I think that's,
10 that's helpful I think that is a helpful observation and
11 I will -- as I have explained, we have got some steps
12 here to improve and educate and inform.

13 So there are lots -- there are plenty of ways that
14 that can be done and I think that kind of -- that kind
15 of suggestion will be very helpful. So there are ways
16 in which we can do this and we are --

17 **Q.** As a Medical Examiner yourself are you
18 familiar with the SUDIc process? In other words, the
19 fact that with a Sudden Infant Death, as Dr Garstang at
20 least explained it, within 24 hours the Joint Agency
21 Response must be initiated, the police involved, the
22 Consultants spoken to, et cetera, et cetera.

23 Are you aware of that and in your area as far as
24 you were concerned is that how it works?

25 **A.** Yes, I don't -- I am aware of it, yes, I do

51

1 deaths from 2022 to improve that and bring it more into
2 focus, especially in the light of this Inquiry; and the
3 third is to create a specific e-learning module with the
4 BAPM that is -- that works across agencies because
5 I think that it cuts both ways. I think neonatologists
6 and paediatricians need to know what the Medical
7 Examiner system is about as well. It's not just
8 a one-way traffic.

9 That being a learning module is in development and
10 I am hoping that I will be able to update the Inquiry as
11 we go forward that that's ready and I can mandate --
12 I will mandate that that is -- must be completed by all
13 Medical Examiners and officers.

14 **Q.** I think, Dr Fletcher, you probably pre-empted
15 a lot of the questions I was going to ask about the
16 detail of that.

17 **A.** Right.

18 **Q.** Because one of the features it may be thought
19 of the guidelines that you have issued recently is that
20 it cross-refers to the SUDIc, the statutory process, but
21 doesn't actually tell the person reading the guideline
22 had it actually is, so it is going to require the
23 Medical Examiner --

24 **A.** Yes.

25 **Q.** -- if they are particularly diligent to go and

50

1 know that.

2 I know that I should explain that I have for
3 obvious reasons relinquished my responsibilities to
4 scrutinising individual cases locally as a Medical
5 Examiner because I would be accountable to myself for my
6 actions and that hardly seems appropriate.

7 But during the 21,000 cases I have reviewed over
8 the -- over a decade and a bit, that included child
9 deaths and I can recall the interactions with
10 a designated doctor who coordinated the Joint Agency
11 Responses for children and neonates who had died
12 unexpectedly and suddenly. So yes, I am aware of it.
13 I have a hesitation about trespassing into territory for
14 Medical Examiners where they do not need to become
15 directly closely involved.

16 It -- that's not, that's not a -- that's not
17 a refusal to include information and update. It is
18 recognising that the Medical Examiner has no part to
19 play in the Joint Agency Response themselves. They are
20 not a direct component. They can provide information
21 and support but they are not responsible for the -- the
22 Child Death Review process, or even the CDOP, weeks,
23 months, later.

24 I think we also need to bear in mind that
25 regulations are there to protect and one of the things

52

1 that I observe is that if -- just assuming that things
2 are going to work well everywhere as a result of
3 regulations is -- is misguided because there are
4 undoubtedly beacons of excellent practice and then there
5 has to be the reasonable common denominator that ensures
6 that everything is protected and follows appropriate
7 paths.

8 You are describing that to me ensuring that we make
9 sure that everybody knows and I am okay with that.

10 **Q.** Within the Joint Agency Response process that
11 Dr Garstang sets out in the table in her statement,
12 there isn't a role at all, it seems, for the Medical
13 Examiner and first of all, that seems to be concordant
14 with what you have just said; in other words, that
15 process is a statutory process that occurs completely
16 separately from the Examiner system.

17 But bearing in mind your earlier responses to
18 Ms Brown, is there a danger that some in some localities
19 they will think it is the Medical Examiner's
20 responsibility to do this investigation, and in others
21 the Medical Examiner will think it is the SUDIc process
22 and again you have that variability with
23 responsibilities falling between stools?

24 **A.** Yes, I think that's a really good question.
25 I don't think there is a risk that the Child Death

53

1 They are overlapping lenses that are looking at the
2 same issue, a family and a deceased child, but from
3 slightly different perspectives and we need to make sure
4 we get that right.

5 **Q.** Already with the Coronial system the Medical
6 Examiner is well aware that there are certain cases that
7 must go to the Coroner?

8 **A.** Correct.

9 **Q.** So is there a similar degree of awareness that
10 is required for the Medical Examiner to say: actually,
11 this is a case that requires the SUDIc process, because
12 in fact the SUDIc process, to be fair to the Medical
13 Examiners, is a much more detailed multi-factoral system
14 than you can provide?

15 **A.** Absolutely. Yes.

16 **Q.** So might it be that the Medical Examiner needs
17 to do the assessment: this is not for me, this is for
18 others, I need to check that's gone on because this is
19 a SUDIc case, just as you might do for a Coronial case?

20 **A.** Yes, and I think it -- I think that is
21 reasonable and in my earlier answers I explained that
22 the point at which a Sudden or Unexpected Death of
23 a child I would expect Medical Examiners to ensure --
24 ask the question of the attending practitioner, the
25 paediatrician or neonatologist that the case is being

55

1 Review process will assume the Medical Examiner is
2 undertaking an investigation, I don't think that --
3 I think that would be unlikely because the process has
4 been well-established without Medical Examiner
5 involvement for several years.

6 The reason plainly that the Medical Examiner's role
7 is not listed as a mandatory component of the SUDIc
8 process, the Joint Agency Response, is because that
9 statutory guidance predates -- that statute became
10 apparent in 2018 and here we are six years later, having
11 just established the statutory role of the Medical
12 Examiner.

13 There is a need for an update, I believe, and that
14 provides us with the opportunity.

15 I have always felt that there is a risk in any
16 systems where somebody else is expecting somebody else
17 to do something and in the end nobody does it and that's
18 not -- that is the worst of all worlds.

19 I think that -- it's my view that there is the
20 layers of care and fierce devotion to this process means
21 that the chance of that happening are remote to say the
22 least and for child and neonatal deaths I -- I think --
23 I believe strongly that the strength and guidance that
24 we provide, the education and training, will cement and
25 clarify the roles and responsibilities here.

54

1 referred through to the SUDIc process.

2 And I can -- and this discussion will cement that
3 view in future guidance and training.

4 **Q.** Can I ask you about the point that Ms Brown
5 raised briefly and you talk about in your statement,
6 particularly at paragraph 123 about this particular case
7 Lucy Letby. And you express a degree of confidence, if
8 I may say so, that the Medical Examiner system would
9 have picked up a concern or the issue of Lucy Letby,
10 just as you say I think in relation to Harold Shipman,
11 and you refer of course to the three questions that
12 would be asked and the three steps that would be carried
13 out.

14 Can I just test that with you?

15 **A.** Yes, of course.

16 **Q.** Have you gone through sort of the algorithm of
17 applying the three questions and the three steps to come
18 to that conclusion and if so, could you explain it?
19 First of all, what did the patient die from? That may
20 have elicited a partial view from some of the
21 paediatricians in some cases they had an idea of what
22 the child may have died from, in others they couldn't
23 find an explanation but they were trying to investigate
24 things internally or through the Coronial system? Does
25 the death need reporting to the Coroner? That is

56

1 relatively straightforward as a question. Many cases
2 were but some cases weren't.

3 Are there any clinical governance concerns? Well,
4 to some extent there were but they certainly weren't
5 articulated even between the Consultants themselves, let
6 alone with third parties.

7 So do you think those questions are going to be
8 sufficient?

9 **A.** Yes. The -- the obvious challenge would be
10 would this detect the first case? And for the case, for
11 the extent of the activity of Harold Shipman and
12 Beverley Allitt and others I think that when an
13 unexpected event occurs in a hospital, or outside of
14 hospital for that matter, by and large the first natural
15 response of caring human beings and especially
16 healthcare professionals is not to wonder if something
17 bad happened, has something terrible gone on?

18 And this is actually quite, must be quite difficult
19 for the Inquiry and the Families to hear, but it may be
20 the case that the first time that something happens it
21 is not recognised as an obvious case of malicious harm
22 having occurred. But the next one and if necessary, and
23 if it happened the one after, must raise concerns as
24 a signal that things are not right.

25 And these three questions would, because the kind

57

1 Do you think that open question in the context of
2 a child's death is good enough? I don't mean that
3 critically but do you think it should be: is there
4 a concern that this child may have been harmed? Can
5 it -- does it need to be more pointed in order to put
6 the clinician or member of staff on the spot a bit more?

7 **A.** If I may say, I think that the tragedies that
8 have unfolded, be they at Morecambe Bay, East Kent or in
9 this case are enough of -- enough for Medical Examiners,
10 who are, I reiterate, attuned to these sorts of issues,
11 being able to ask the question in that way without it
12 feeling like an inquisition.

13 Now, there are similarities, if I may say, with
14 Medical Examiners who have detected issues with
15 competence and probity about their colleagues and that
16 could be somebody who they work alongside in their unit.

17 I know that those -- those concerns have been
18 raised by, by colleagues to Medical Examiners, who for
19 quite good reasons the clinicians may have wished to
20 keep their head below the parapet but the Medical
21 Examiner said: that is okay, I will take that one for
22 you, I won't reflect specifically that you have
23 imparted -- quote you verbatim, but raising the concern
24 still within their remit.

25 **Q.** I understand that and that makes sense and you

59

1 of question that: we have had the second case that you
2 have had in your unit, this is odd, I mean it's just
3 asking that naive question, how can this be? You have
4 gone weeks, months, without anything and then suddenly
5 this is the case ... that's the interaction with the
6 attending practitioners. The unexpected events that
7 defied explanation would stand out in the records and be
8 notified to a Coroner.

9 And then, finally, that conversation with family
10 members that says: this is, this is just so unusual ...
11 that together collectively they would -- it would --
12 I find it unconscionable that a correctly functioning
13 office would -- that that would escape attention and not
14 lead to escalation and investigation.

15 **Q.** Just testing that a little bit, if I may, just
16 in terms of asking questions. I think when Ms Brown
17 asked you the questions: what would the Medical Examiner
18 ask, you said: they would say tell us about the case or
19 do you have any concerns.

20 Those are obviously good, open questions designed
21 to elicit any thoughts, but obviously as we know from
22 this Inquiry there's an immense degree of professional
23 reticence and personal reticence for clinicians
24 articulating the unthinkable, which could be
25 a suspicious of deliberate harm.

58

1 are sort of working from the hypothesis of the perfect
2 Medical Examiner who asks the right questions, but it is
3 not clear that that question or that type of question
4 would in fact be asked from the guidelines and I wonder
5 if it does need to be asked: is there a safeguarding
6 concern, is there a concern this child may have been
7 harmed and that needs to be part of the every day
8 practice, not just the practice of the good examiner?

9 **A.** And that is a fair question and observation
10 and I am -- I'm -- I'm -- in giving my responses I would
11 not wish to appear that I am defending not doing so.

12 I'm open to the suggestions and your questions have
13 opened my mind to that -- to consider whether that's
14 required and I am comfortable with that.

15 **Q.** Can I ask you lastly about the specialist
16 question, which is something you consider in your
17 statement. In medicine obviously there are multiple
18 specialties, you are an emergency specialist, there are
19 many, many different sub specialties. But paediatrics
20 in some respects is different from a standard specialty
21 in that firstly that the physiology of a child is
22 different, particularly a neonate and secondly there is
23 a vulnerability attaching to a child which doesn't
24 always attach to an adult although, you know, there are
25 vulnerabilities in a hospital setting. There are of

60

1 course specialist pathologists that deal with children
2 and there are safeguarding specialists that deal with
3 children in a hospital setting.

4 Do you think, bearing in mind this Inquiry's -- the
5 events that are the subject of this Inquiry, and the
6 fact that the paediatrics -- there is something
7 different about paediatrics that actually there is
8 a case for having Medical Examiners with a degree of
9 specialism to deal with neonates because they may not
10 necessarily know to ask the right questions if they
11 don't have that specialist knowledge?

12 **A.** Yes, thank you.

13 I understand the question and it is -- it was
14 discussed and debated and a policy decision taken by
15 DHSC that Medical Examiners apply to all specialties.

16 I have -- I have a slight issue, I am trained to
17 look after children too as an emergency physician, that
18 children are uniquely special in and different because
19 we are all human beings and we suffer issues with our
20 health in similar ways, diagnoses get missed, the wrong
21 medicines get given, people get overlooked, they wait
22 for treatment, there is a delay in recognition of
23 sepsis, there may be accidents or incidents that happen
24 in hospital or at home that lead to concerns and they
25 are documented. Unexpected clinical events like

61

1 a professional matter. It is -- it is set out in GMC
2 Good Medical Practice guidelines.

3 There is -- it's -- at the end of it all every
4 specialty could make a case for having a unique Medical
5 Examiner specific to their specialty. And that is
6 neither practical nor appropriate because it's -- this
7 is a -- this is a system that covers all deaths in
8 England and Wales and is learning and maturing even as
9 we speak. My last quarter returns showed that Medical
10 Examiners were scrutinising the deaths of 576 children
11 and neonates. That's -- that's getting on for just over
12 50% of all cases and I am comfortable.

13 I'm happy to look at further developments down the
14 line, I think that's an evolution. There is a process
15 here we will learn, we will adapt and change because not
16 everything is set as it is now.

17 **Q.** Thank you. Lastly, Dr Fletcher, you have been
18 in post now for many years and there's obviously
19 sometimes a tension between the employee in the
20 Department of Health and their ability to get things
21 done because of financing and the political will and so
22 on, but are there any relevant recommendations or
23 improvements to the system within which you work that
24 you would like to see this Inquiry recommend?

25 **A.** Thank you. That's a wonderful question for me

63

1 hypoglycaemia or a cardiac arrest happen to every
2 patient, group of patients.

3 And I also take issue that vulnerability is -- is
4 unique to children. It is definitely not. Patients who
5 are unconscious through injury or medical intervention
6 are good examples of people who are utterly vulnerable,
7 similarly people who cannot -- who have got learning
8 disabilities or are adults that way are in a vulnerable
9 position, those who have no family members or people to
10 advocate for them are especially vulnerable. The
11 homeless are very vulnerable.

12 It is the holistic approach that Medical Examiners
13 take that equip them with that wider base of knowledge
14 that actually means that they are very well placed to
15 ask the -- the reasonable questions and consider these
16 cases.

17 The important point though is that the opportunity
18 is there to seek advice and asking the question whether
19 that's advice about a legal issue, picking up the phone
20 and speaking to the Coroner is one way.

21 Asking about medical specialty expertise is
22 something that Medical Examiners do all the time. There
23 may be a paediatrician or a neonatologist in the team of
24 Medical Examiners, for example, and similarly, knowing
25 the limits of one's professional boundaries is

62

1 to try and potentially end my evidence on.

2 I think the important next stages are going to be
3 about consolidation and we have been going for three
4 months now, we need some learning in the statutory phase
5 of this, of course.

6 One of the things that will -- that will help us
7 a lot will be the digitisation of the medical
8 certification process. I mean that because whilst we
9 are dependent on a paper-based system in the modern era
10 it inevitably creates administrative and bureaucratic
11 distractions from what is the core function of the
12 Medical Examiner system which we have discussed at
13 length in this evidence.

14 So I suppose my -- my primary wish will be for --
15 for consolidation, understanding what -- what has
16 happened since the advent of the statutory system across
17 England and Wales for all deaths, including children and
18 neonates. The second point is to establish the
19 digitisation of the process. And the third will be to
20 evaluate the effectiveness of the Medical Examiner
21 system and the death certifications as a whole which are
22 for the Government to undertake.

23 **Q.** I understand that, and sorry to push you
24 again, but those things I understand are already
25 happening and you want them to happen. Is there

64

1 something else, something that isn't happening which you
2 want to happen ideally?

3 **A.** No.

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

5 Questions by LADY JUSTICE THIRLWALL

6 **LADY JUSTICE THIRLWALL:** Thank you, Mr Skelton.

7 If I can just go back a little bit in your

8 evidence, if I may, Dr Fletcher. You were saying that
9 you recently commissioned up-to-date guidance for
10 neonatal deaths for Medical Examiners. Can I just ask
11 what the timeline is for that? When did you start that
12 exercise?

13 **A.** I made the request earlier this year. I can't
14 recall exactly when, I think it was probably around
15 April/May time. And it was -- it was timely because it
16 coincided with contact being made by the
17 British Association for Perinatal Medicine and through
18 a discussion with the president and her colleague.

19 I suggested that we work together to collaborate to
20 make this guidance. It's -- I asked my -- I asked
21 a colleague Lead Medical Examiner who is a neonatologist
22 who kindly agreed to undertake that and I suggested that
23 he work collaboratively with another Lead Medical
24 Examiner who is a forensic -- paediatric pathologist and
25 subsequently involving another one.

65

1 particularly helpful to the Inquiry and I hope helpful
2 to you, if there's a deadline, as it were?

3 **A.** I can see that, my Lady. My hesitation is
4 because as the national lead for the e-learning for
5 Medical Examiners, there is -- there is a quality
6 assurance and editorial process for any e-learning that
7 always takes three months. It's --

8 **LADY JUSTICE THIRLWALL:** Why does it take
9 three months, do you think?

10 **A.** Why, why indeed? I recall asking the same
11 question in November 2009 when I first started the work
12 and the reason is that whilst content is -- the content
13 is for the authors, which would be for my colleagues --

14 **LADY JUSTICE THIRLWALL:** Yes.

15 **A.** -- there has to be an instructional design
16 process that is to make this -- it's simply
17 a publication of a -- of a document or a slideshow. It
18 has to be constructed in an appropriate instructional
19 design manner according to the Health Education England
20 standards, they are the ones that are responsible for
21 this work.

22 It goes through quality assurance processes,
23 queries, peer reviews and editorial actions.

24 **LADY JUSTICE THIRLWALL:** The peer reviewing --
25 sorry to cut across you, but the reviewing, who is that

67

1 Their focus, quite rightly, with the advent of the
2 statutory system has been getting where we need to;
3 there has been an enormous amount of work, my Lady, in
4 getting the system ready for statutory augmentation.

5 I understand that my colleagues are working on that
6 now the updating guidance and things.

7 **LADY JUSTICE THIRLWALL:** Yes, all right, and when
8 do they think it is going to be ready?

9 **A.** I don't know for sure. I -- before -- before
10 coming, as you might imagine, I asked the question.

11 **LADY JUSTICE THIRLWALL:** I thought you might have
12 checked, yes.

13 **A.** And they said: there is a lot going on, we are
14 on it, and I'll keep you updated.

15 I -- this is a prompt to revisit that question and
16 ask, I am hoping that this will be ready in the early
17 part of 2025.

18 **LADY JUSTICE THIRLWALL:** Right. So it started
19 about eight months ago and now for reasons that you have
20 explained well, it hasn't progressed all that far by the
21 sound of it.

22 So if we might expect and you have said very kindly
23 that you will send it to us but it would be enormously
24 helpful if it could come before the end of February,
25 even if it is the very end of February, that would be

66

1 done by? The other subject matter experts?

2 **A.** Yes, the way this -- we would put this through
3 both subject matter experts, so enabling the, in this
4 case, British Association for Perinatal Medicine to
5 comment and the Royal College of Pathologists Medical
6 Examiner Committee members who provide oversight of
7 content and ultimately me as the lead editor.

8 **LADY JUSTICE THIRLWALL:** So presumably all those
9 things could be done. That could be front-loaded,
10 couldn't it, so that the then -- the later -- I don't
11 want to use "bureaucratic", but the process steps could
12 be taken rather more swiftly, couldn't they?

13 **A.** Thank you, my Lady, and I -- your authority
14 will probably enable me to -- to do what I can to
15 accelerate the process. I won't of course specifically
16 say that you have -- that you have asked the question.

17 **LADY JUSTICE THIRLWALL:** That won't be a secret,
18 everyone knows I have asked the question so, yes, they
19 will know that.

20 **A.** Indeed.

21 **LADY JUSTICE THIRLWALL:** And there are others who
22 come after you who may want to help on that.

23 **A.** Indeed, and I am -- I'm comfortable absolutely
24 with accelerating this as far as we can. The practical
25 delivery of this in time I'm afraid I cannot give you

68

1 that assurance that it will be ready by the end of
 2 February, I apologise.

3 **LADY JUSTICE THIRLWALL:** No, I wasn't expecting you
 4 to be able to give that, it is just the actual getting
 5 the material ready seemed to me an essential first step.

6 Thank you. Just I think one other matter.

7 Just a swift question about the Medical Examiner
 8 Officer and presumably they have some sort of script
 9 that they would use, obviously I would imagine they are
 10 trained to be empathetic, et cetera. But one hears
 11 about confusion that can or is said to have arisen in
 12 relation to physician associates who are not physicians
 13 and I suppose a concern might be is that a Medical
 14 Examiner Officer just needs to make it clear at the
 15 beginning that: I am the Officer of the Medical Examiner
 16 as the Coroner's Officers do, and I presume that's
 17 something that's just made crystal clear right at the
 18 beginning so a parent knows who they are talking to?

19 **A.** Yes, thank you, my Lady. Yes, it is.

20 It's absolutely part of the training. There are
 21 core, modules, core modules for Medical Examiner
 22 Officers that include just that, a template if you like,
 23 a script.

24 **LADY JUSTICE THIRLWALL:** Yes.

25 **A.** And part of that is to be absolutely explicit

69

1 **LADY JUSTICE THIRLWALL:** Yes, it is just one of the
 2 scenarios I am trying to see how you might improve the
 3 situation. But that's a different --

4 **A.** It is a difficult one because each case is
 5 individual, unique, and it depends on the confidence in
 6 which people are proposing a cause of death.

7 I have had cases personally where there was concern
 8 raised about the cause of death of a child and the --
 9 there is a triangle here. There is the triangle of the
 10 attending practitioner, the Medical Examiner and the
 11 Coroner as well and there are situations where to our
 12 surprise a Coroner declines to take a case for
 13 investigation and the same sort -- it is the same
 14 scenario that plays out, this is covered at length in
 15 the training, so I think there are parallels, if I may
 16 say.

17 In those circumstances, we advocate picking up the
 18 phone and speaking to the Coroner and asking -- and
 19 challenging the question: I know you think this, you
 20 have said that you declined to investigate. Can you
 21 just explain to me why, it helps my learning, because
 22 sometimes there are some sensitivities here about
 23 challenging that kind of authority.

24 Asking the question like that, saying: why -- what
 25 was it about this? Were you told this? But what about

71

1 that the case, the death, the child has been reviewed by
 2 a Medical Examiner and therefore clarifying their
 3 Officer status at the start and explaining that the
 4 Medical Examiner has reviewed the records and consulted
 5 with -- with others.

6 So it's all part of the script, yes. Thank you.

7 **LADY JUSTICE THIRLWALL:** Thanks.

8 Then one final thing which is if you would just
 9 consider this scenario and we are looking at, you know,
 10 what could be done to stop what's happened in this case
 11 happening again.

12 You have made the point about first, second, third
 13 and well made, if I may say so. What about the
 14 situation where a very young baby, a neonate, dies
 15 suddenly and apparently unexpectedly, but the treating
 16 clinician believes that there is an explanation and as
 17 you say they are the subject matter expert and the
 18 Medical Examiner, who may or may not -- probably not --
 19 have a neonatal background. I suppose the situation
 20 could arise, could it, in fact probably would arise,
 21 that the Medical Examiner would accept the view of the
 22 paediatrician on cause of death, you know, after
 23 a discussion?

24 **A.** (Nods). Is that possible? Yes, it is
 25 possible, my Lady, it is.

70

1 this aspect of the case? And sometimes Coroners will
 2 say: I didn't know that. I wasn't told that. That's
 3 a good point ...

4 Nothing is lost through that conversation. In the
 5 case of an expressly confident neonatologist saying,
 6 "I believe this is perfectly explainable and natural",
 7 I -- I agree with you, my Lady, that there is, there is
 8 the possibility that the Medical Examiner would accept
 9 that view and say "okay". But if it happened again
 10 I think that would be different.

11 **LADY JUSTICE THIRLWALL:** Yes. Anybody want to ask
 12 anything arising out of my questions?

13 No. Thank you. Dr Fletcher, we are very grateful
 14 to you for making yourself available today, it is clear
 15 from what you said earlier that this is a very difficult
 16 time for you and your family and so repeated and renewed
 17 thanks for being here and we wish your daughter as
 18 speedy a recovery as is possible.

19 Thank you very much indeed.

20 **A.** Thank you very much.

21 **LADY JUSTICE THIRLWALL:** You are free to switch us
 22 off now.

23 I am grateful to the shorthand writer for sitting
 24 through that navigating the various difficulties so we
 25 will come back into court at a quarter to 12.

72

1 (11.27 am)

2 (A short break)

3 (11.45 am)

4 **MR CARR:** My, Lady we now turn to look again at
5 evidence from the RCPCH, if I can call please
6 Professor Stephen Turner.

7 PROFESSOR STEPHEN TURNER (sworn)

8 **LADY JUSTICE THIRLWALL:** Do sit down,

9 Professor Turner. Mr Carr.

10 Questions by MR CARR

11 **MR CARR:** My Lady, thank you. If we can start
12 please with your full name.

13 **A.** Yes, I am Stephen William Turner.

14 **Q.** You have prepared a short witness statement
15 dated 2 December 2024?

16 **A.** Yes.

17 **Q.** The contents of that statement are true to the
18 best of your knowledge and belief?

19 **A.** Yes.

20 **Q.** Before I start with my questions, I understand
21 there is a statement that you would like to make.

22 **A.** Yes. Thank you. I would like to make a --
23 pass on my personal condolences and sympathies to the
24 Families on behalf of the College. I apologise to you,
25 the Families, for the role that we played. It delayed

73

1 statement that we have from Mr Okunnu on it?

2 **A.** Thank you, yes.

3 **Q.** If we can start, please, with a brief summary
4 of the Royal College. It is a charity?

5 **A.** Yes.

6 **Q.** Its objectives are set out in its
7 Royal Charter?

8 **A.** Yes.

9 **Q.** Amongst the objectives are the aims of raising
10 the standard of medical care provided to children?

11 **A.** Yes.

12 **Q.** Advancing education of the public and medical
13 practitioners in child health and protection of
14 children?

15 **A.** Yes.

16 **Q.** It is a membership organisation with over
17 22,000 members?

18 **A.** Yes.

19 **Q.** All of your members are child health
20 professionals?

21 **A.** Yes.

22 **Q.** The vast majority of those are paediatricians
23 based in the UK

24 **A.** That is correct.

25 **Q.** One of the significant roles of the RCPCH is

75

1 you finding out what happened to your children.

2 I also apologise to our members, the paediatricians
3 at the Countess of Chester. We didn't behave as we
4 should have done towards you and the College and myself
5 are determined and have learnt from the mistakes that
6 have been made. Thank you.

7 **Q.** You gave evidence today in your capacity as
8 the current President of the RCPCH?

9 **A.** Yes.

10 **Q.** So far as your professional background, you
11 are a Consultant paediatrician at the Royal Aberdeen
12 Children's Hospital?

13 **A.** Yes.

14 **Q.** And your statement, which is short, the effect
15 of it is to confirm that you have read the much
16 lengthier statements prepared by Robert Okunnu?

17 **A.** Yes.

18 **Q.** He is the Chief Executive Officer of the
19 RCPCH?

20 **A.** That is correct.

21 **Q.** He has prepared statements which address the
22 Invited Review that was carried out in 2016?

23 **A.** Yes.

24 **Q.** And I am going to be asking you a number of
25 questions about that review and the evidence, the

74

1 in its provision of education?

2 **A.** Yes.

3 **Q.** The College sets the exam, the MRCPCH, which
4 is a mandatory part of the training pathway for doctors
5 who want to become paediatricians?

6 **A.** That is correct.

7 **Q.** If we can turn then to look at the Invited
8 Review service and what I am going to do before we look
9 at aspects of the review of the Countess of Chester
10 Hospital is to look at the structure. So the principles
11 of Invited Reviews, as was the case in 2016.

12 We are going to go to the guide, please, it's
13 INQ0010214. We can see this is the first page. This
14 was a document published by the RCPCH setting out the
15 principles that applied to Invited Reviews.

16 **A.** Yes.

17 **Q.** This is dated August 2016, but its terms were
18 broadly similar to the predecessor document?

19 **A.** Yes.

20 **Q.** If we turn, please, to page 4 of that
21 document, we have there definitions and it's
22 paragraph 2.2 at the top the page that we are concerned
23 with because it was a service review that was carried
24 out at the Countess of Chester.

25 And the definition of a service review is as

76

1 stated:

2 "An invitation to visit and comment upon a current
3 service. This may be the whole paediatric service or
4 a specific element such as safeguarding, neonates or
5 emergency care. It will include meeting the
6 paediatricians, nurses, managers and others who have
7 links with the service. The Terms of Reference will
8 usually be rooted in the quality, safety and efficiency
9 of that service."

10 It was that sort of service review as defined in
11 the terms that I have just read out that was intended to
12 be provided to the Countess of Chester?

13 **A.** Yes.

14 **Q.** In broad -- broader terms, Invited Reviews are
15 not, are they, a regulatory process?

16 **A.** You are correct.

17 **Q.** It's not a forensic investigation?

18 **A.** Correct.

19 **Q.** It's a peer review which assesses how
20 a service complies with standards?

21 **A.** Yes.

22 **Q.** That's what it should be?

23 **A.** That is correct.

24 **Q.** If we go forward, please, to page 9 of this
25 document. And we look at paragraph 8. 1, under the

77

1 of the Terms of Reference?

2 **A.** Yes, that is correct.

3 **Q.** In the case of the Countess of Chester, that
4 did not occur, did it?

5 **A.** That did not occur. This guideline was not
6 followed in the Countess of Chester.

7 **Q.** The RCPCH accepts, as it should have, that
8 there should be clinical input both as to the decision
9 whether an Invited Review should go ahead --

10 **A.** Correct, yes, we regret that.

11 **Q.** -- and as to the Terms of Reference?

12 **A.** Correct.

13 **Q.** Would that particularly be the case here
14 because this was from the outset an unusual request for
15 an Invited Review given it involved consideration of
16 an increase in death?

17 **A.** Yes, I mean this -- this review went wrong
18 from the start and it -- it was unusual. Looking back,
19 it -- it certainly was unusual from the information we
20 have now.

21 **Q.** Say that last bit again?

22 **A.** So, yes, it was an unusual request and
23 unfortunately the due process that we have in this
24 document here wasn't followed.

25 **Q.** And as well as the absence of clinical input

79

1 heading "Process -- Main Review", we can see there it's
2 describing part of the process for an Invited Review;
3 once the clinical adviser has agreed for the College to
4 proceed with an IR, an early pre-review visit may be
5 proposed to familiarise the College representatives with
6 the relevant individuals, issues and arrangement of
7 services on site."

8 Then if we look at 8.2 before I ask my questions on
9 this:

10 "Following agreement to proceed, the review manager
11 works with the client and clinical adviser or lead
12 reviewer to clearly define the issues requiring the
13 Invited Review."

14 Then there are a few more subparagraphs including
15 discussing and agreeing the Terms of Reference.

16 Now, clinical adviser and lead reviewer, they are
17 both clinician roles?

18 **A.** That is correct.

19 **Q.** We have heard evidence from the clinical
20 adviser at the time, that was Dr David Shortland.

21 Two points emerged from the sections of the
22 guidance that I just read: firstly, the guide envisages,
23 doesn't it, involvement from clinicians, either the
24 clinical adviser and/or the lead reviewer, in the
25 decision to proceed with a review and in the formation

78

1 there was no pre-review visit, was there?

2 **A.** There was not.

3 **Q.** Now, again, given the nature of the review
4 that was being requested, considerations of an increase
5 in neonatal death with unexplained deaths, that would be
6 an example of a review which called for a pre-review
7 visit?

8 **A.** It -- it could do, yes.

9 **Q.** The benefit of the pre-review visit is that it
10 would give an opportunity to either the clinical adviser
11 or the clinical lead to discuss the nature of the issues
12 to be covered by the review visit?

13 **A.** Yes, that would be the purpose of the
14 pre-review visit or contact, yes.

15 **Q.** One of the observations made in Mr Okunnu's
16 statement is the lack of an escalation policy for
17 Invited Reviews in 2016. There is now an escalation
18 policy and we will look at that later in your evidence.

19 But even looking within this guide, there are
20 aspects of it which deal with what to do when concerns
21 arise. If we can start, please, page 7. Under the
22 heading in the second half of page 6 "Where serious
23 concerns are raised" we see at 6.1:

24 "If issues of patient safety are raised at any
25 time, the reviewers will advise the clients immediately

80

1 and discuss what urgent action should be taken, if any.

2 "If there are concerns about an individual's
3 practice, for example, the client may want to consider
4 restriction of the doctor's practice as set out in the
5 guidance for MHPS England and NCAS or equivalent."

6 Then at 6.2:

7 "The College maintains good working relations with
8 NCAS and the GMC and may discuss anonymously or
9 specifically any issues relating to an individual doctor
10 to establish that it is appropriate for the College to
11 act in this capacity.

12 "Depending upon the issues under review, the
13 College may recommend to a referring client that NCAS or
14 the GMC is a more appropriate body to approach."

15 So within this section of the guidance, as it
16 applied at the time, there is an indication of some of
17 the steps that might be taken where concerns arise?

18 **A.** Yes, there are some, yes.

19 **Q.** If we look, please, at page 8, there is at
20 paragraphs 7.5, the subparagraph 7.5, a list of category
21 of cases that the College would not take on for an
22 Invited Review. We see that the third subparagraph is
23 where the expected scope includes behavioural
24 misconduct, bullying, harassment or possible mental
25 health concerns and criminal conduct would obviously be

81

1 suggests that the review should be completed unless
2 advised to the contrary, advised to the contrary by
3 whom?

4 **A.** So if -- sorry, I don't understand the
5 question "advice to the contrary". So, for example,
6 when the Review Team arrived for example if they heard
7 advice that would suggest that there had been
8 misbehaviour then yes, I think -- yes, the -- the review
9 should have been halted then. That was a missed
10 opportunity to stop the review.

11 **Q.** Well, what appears to be suggested here is
12 that if you arrive so looking at 7.7, okay:

13 "If any of the issues listed in 7.5 come to light
14 during an IR, the review should be completed in relation
15 to its original remit, unless advised to the contrary in
16 order to avoid prejudicing other investigations by
17 a public authority or regulator."

18 Now, what appears to be suggested there is that if
19 an issue arises and we looked at 7.5, so if, for
20 instance, an issue of criminal conduct arises, there are
21 two options: either you continue with the review in
22 relation to the original remit or you stop if advised
23 not to continue with the review because it might
24 prejudice other investigations by a public authority or
25 regulator?

83

1 an extreme form of what is listed there?

2 **A.** Mmm.

3 **Q.** Then at page 9, please, paragraph 7.7 at the
4 top, it deals with the approach that ought to be taken
5 where any of the issues at paragraph 7.5 arise during
6 the visit.

7 **A.** Mm-hm.

8 **Q.** So what appears to be -- and correct me if
9 I am wrong -- the process that's envisaged here there is
10 a clear category of case that the College would not take
11 on for a review, if you are at a review and it becomes
12 apparent that it is one of those categories of case and
13 there was a process to be followed?

14 **A.** That is correct.

15 **Q.** Now, at paragraph 7.7, what is provided for is
16 as follows:

17 "The review should be completed in relation to its
18 original remit unless advised to the contrary in order
19 to avoid prejudicing other investigations by a public
20 authority or regulator."

21 If I pause there. The advice to the contrary, who
22 would that come from?

23 **A.** Sorry, can you repeat the question? I didn't
24 hear.

25 **Q.** The advice from the contrary, so where it

82

1 **A.** Yes.

2 **Q.** So it is suggesting --

3 **A.** Yes, I agree.

4 **Q.** -- a fork and what I am asking, if you know
5 the answer, is where that advice to the contrary would
6 come from?

7 **A.** I don't know. It's, the -- the text that is
8 provided to be interpreted by subjectively but I --
9 I don't know.

10 **Q.** Well, one interpretation is that the Review
11 Team could seek advice from the Invited Review board to
12 consider whether or not they ought to continue?

13 **A.** Sorry. Yes.

14 **Q.** In circumstances where the review is going to
15 continue, the second sentence states:

16 "Clear scope boundaries should be agreed before
17 further work takes place in order to avoid prejudicing
18 other investigations."

19 And what appears to be envisaged there is where
20 concerns arise, if you are not going to stop, so you are
21 not advised to stop to avoid prejudicing other
22 investigations by a public authority or regulator, and
23 you continue, you need to have those boundaries in place
24 to avoid the sort of prejudice --

25 **A.** Yes.

84

1 Q. -- from occurring?

2 A. Yes, I agree that's what it says, yes.

3 Q. So whilst there is no formal escalation policy
4 as such standalone document, we have seen from page 7
5 the circumstances in which concerns may be raised. We
6 see here at paragraph 7.7 where concerns are raised, the
7 steps that need to be taken and the considerations that
8 need to be borne in mind.

9 Then finally looking at the guide, if we go forward
10 please to page 13, and there are two parts of this page
11 that I want to take you to. The top paragraph on that
12 page which is paragraph 9.7, the sentence that commences
13 on the top line:

14 "If during a review or follow-up period the College
15 deems that action taken in response to concerns or
16 recommendations is insufficient to mitigate safety
17 concerns, the Invited Review Programme Board reserves
18 the right to authorise further action which may include
19 reporting the findings directly to the appropriate
20 regulatory or commissioning authority."

21 So this is another example, isn't it, of steps that
22 the RCPCH can take to escalate concerns?

23 A. Yes, that is.

24 Q. At paragraph 10.1, which deals with
25 confidentiality, the point that is made there is:

85

1 agreed. From the point of the initial contact between
2 the Countess of Chester Hospital and the Royal College
3 to the point of the Terms of Reference being agreed, and
4 those are the amended Terms of Reference, it's a period
5 of about two weeks, isn't it, 28 June 2016 to
6 12 July 2016?

7 A. Yes.

8 Q. Mr Okunnu in his statement, it's paragraph 53,
9 about seven lines down he comments:

10 "From the RCPCH's perspective in 2024 the proposals
11 in terms of reference of the Invited Review at the
12 Countess of Chester Hospital were compiled more quickly
13 than usual. It can take up to 10 weeks to draft and
14 agree Terms of Reference."

15 A. Mmm.

16 Q. So we are looking here at about a fifth of
17 that period?

18 A. Yes, yes.

19 Q. But you agree with what Mr Okunnu says there
20 about that time?

21 A. I do.

22 Q. But it doesn't need, does it, the
23 qualification from a perspective in 2024? For an
24 Invited Review, particularly one that was unusual such
25 as this one, the considerations of an increase in

87

1 "The College will not disclose to the public, or
2 any individual not directly involved, any details of the
3 review or its involvement without the permission of the
4 Medical Director, Chief Executive, or authorised
5 representative of the client unless there is an
6 overriding reason, for example urgent safety concerns
7 where the regulator and/or Commission must be notified
8 and/or public interest."

9 A. Yes.

10 Q. So that's another example of an escalatory
11 step that can be taken?

12 A. Yes.

13 Q. So whilst it's right to say that there wasn't
14 a standalone escalation policy as there is now, within
15 the guide to Invited Reviews at the time, there were
16 steps that could be taken or that should be taken where
17 concerns arose during a review?

18 A. Yes.

19 Q. If we move away -- we can take this down now,
20 please, thank you. If we move away from the guidance
21 and begin to look at the Invited Review of the Countess
22 of Chester Hospital. The first issue I want to consider
23 is the Terms of Reference and agreement of the Terms of
24 Reference.

25 If we can address the speed with which they were

86

1 mortality two weeks is just too short?

2 A. I agree.

3 Q. It's particularly too short where it's being
4 agreed by a review manager, a non-clinician without
5 clinical input?

6 A. Yes, I agree.

7 Q. If we can consider the Terms of Reference
8 themselves, please. It's INQ0009591. These were the
9 Terms of Reference as agreed and I want to look at,
10 please, the fourth bullet point in the middle of the
11 page which requires or states as follows:

12 "To consider concerns about the neonatal unit with
13 specific reference to: are there any identifiable common
14 factors or failings that might in part or in whole
15 explain the apparent increase in mortality in 2015 and
16 2016?"

17 Now, there are a number of different elements to
18 that particular term of reference. Do you agree that in
19 order to address that properly as part of a review, it
20 would be necessary for the Review Team to consider and
21 determine whether there's an increase in mortality given
22 the suggestion here it's an apparent increase in
23 mortality?

24 A. Yes.

25 Q. In respect of individual deaths, the Review

88

1 Team would need to consider in those individual cases
 2 what are the factors that caused or contributed to the
 3 death?
 4 **A.** Yes.
 5 **Q.** They would need to consider whether there were
 6 failings contributing to deaths?
 7 **A.** Yes.
 8 **Q.** Once they have considered causative factors or
 9 contributory factors to deaths and whether there are any
 10 failings, they would then need to carry out
 11 an assessment of whether there is commonality between
 12 those factors or failings?
 13 **A.** Yes.
 14 **Q.** Now, that exercise is well beyond the scope of
 15 an Invited Review as we looked at it at the start of
 16 your questions, isn't it?
 17 **A.** I agree, yes.
 18 **Q.** We know from the notes of the interview that
 19 the very first day the review visit, 1 September, the
 20 very first meeting of the review visit with Ian Harvey
 21 and Alison Kelly, the first thing that is recorded in
 22 the notes is David Milligan, the lead reviewer saying
 23 "we may not be able to explore the detail of the
 24 deaths"?
 25 **A.** Yes.

89

1 communicated to the hospital?
 2 **A.** I believe that to be the case, yes.
 3 **Q.** If we can turn now -- we can take that down,
 4 thank you very much.
 5 If we can turn now to the sharing of information
 6 with and amongst the reviewers. Sue Eardley, who was
 7 a review manager, she has given evidence to the Inquiry
 8 and her evidence was that she was told ahead of the
 9 review visit that there were concerns about the
 10 association of a member of staff and the deaths at the
 11 hospital.
 12 She did not have a recollection of sharing those
 13 concerns with other members of the team but she accepts
 14 that she should have done so?
 15 **A.** Yes.
 16 **Q.** That is quite right, isn't it, a review
 17 manager receiving evidence like that should share it?
 18 **A.** Absolutely, yes, that should have been shared
 19 with the team.
 20 **Q.** David Milligan and Alex Mancini's evidence --
 21 David Milligan by way of his witness statement,
 22 Alex Mancini gave evidence to the Inquiry -- is that
 23 they had identified a correlation between Letby and the
 24 deaths from the documents that they had but they were
 25 not aware of suspicions or concerns at the Countess of

91

1 **Q.** That's because such exploration is unsuitable
 2 for an Invited Review?
 3 **A.** That is correct.
 4 **Q.** The report ultimately compiled does not
 5 identify, does it, any common factors or failings
 6 responsible for deaths?
 7 **A.** That is correct.
 8 **Q.** Now, in light of all of that, was this a Term
 9 of Reference that was doomed to failure from the outset?
 10 **A.** Yes.
 11 **Q.** Is it a Term of Reference that should never
 12 have been agreed?
 13 **A.** I agree, it -- it should never have been
 14 agreed.
 15 **Q.** Was the agreement of this Term of Reference
 16 a missed opportunity to appreciate that what the
 17 hospital needed, what it required was an investigation
 18 into the cause of deaths which was something that
 19 couldn't be delivered by the RCPCH by way of an Invited
 20 Review?
 21 **A.** Yes.
 22 **Q.** If there had been discussion, if there had
 23 been clinical involvement, is it likely that the fact
 24 the RCPCH weren't the appropriate body to deliver on
 25 that kind of Term of Reference, that would have been

90

1 Chester Hospital that the Countess of Chester Hospital
 2 had, the evidence of Ms McLaughlan and Mr Stewart, the
 3 remaining members the Review Team, was to the effect
 4 that they were unaware of any concerns about Letby prior
 5 to arriving at the hospital for the visit.
 6 Now, as you have explained, any concerns should be
 7 shared with the whole team and discussed amongst the
 8 team?
 9 **A.** Yes.
 10 **Q.** And that would provide a further opportunity,
 11 would it, in that forum for discussion by the team ahead
 12 of a visit to consider whether an Invited Review was
 13 appropriate, an appropriate means of addressing and
 14 investigating those concerns?
 15 **A.** Yes, I agree.
 16 **Q.** So looking at the issues that we have
 17 considered so far, all of which are focused on the
 18 period leading up to the review visit. It is a fair
 19 summary, isn't it that there should have been
 20 involvement of the clinicians, either clinical adviser
 21 or lead reviewer, in the decision as to whether to
 22 undertake a review in the first place?
 23 **A.** Yes.
 24 **Q.** A pre-visit to the hospital to understand and
 25 explore the issues calling for a review?

92

1 A. That would have been helpful.
 2 Q. Involvement of the clinicians in determining
 3 the Terms of Reference?
 4 A. Yes.
 5 Q. In those circumstances that full Term of
 6 Reference wouldn't have been agreed?
 7 A. I -- I agree with you.
 8 Q. A sharing of the concerns at the Countess of
 9 Chester Hospital which were communicated to Sue Eardley,
 10 a sharing of those concerns with everybody in the Review
 11 Team?
 12 A. (Nods)
 13 Q. Now, had all of that occurred, it's likely,
 14 isn't it, that the Invited Review wouldn't have gone
 15 ahead at all?
 16 A. That is correct.
 17 Q. Now, in terms of what happened during the
 18 review visit, we know from the notes and from the
 19 evidence that we have obtained that the concerns
 20 relating to Letby dominated the first two interviews on
 21 the first day of the visit, so the interview with
 22 Ian Harvey and Alison Kelly, and then the interview with
 23 Stephen Brearey and Ravi Jayaram?
 24 A. Yes.
 25 Q. What we can see from the notes is that the

93

1 A. That is correct.
 2 Q. Paragraph 85 of Mr Okunnu's statement, reads:
 3 "We do not know why the Invited Review team did not
 4 stop the review after learning this information ..."
 5 That is a reference to the interviews with
 6 Dr Brearey and Dr Jayaram.
 7 "... but we note that in a feedback session at the
 8 end of the second day, the reviewer David Milligan said.
 9 "'We considered aborting the review and starting
 10 again', but the Terms of Reference indicated it is
 11 important to get the background."
 12 Now, is it the RCPCH's view that the Invited Review
 13 should have been aborted when those concerns were raised
 14 with the team at the beginning of day one of the visit?
 15 A. Yes, it is.
 16 Q. When considering aborting the review, there
 17 was a failure by the team, wasn't there, to seek advice
 18 from the Invited Review board at the RCPCH?
 19 A. Yes.
 20 Q. And not only was there a failure to abort so
 21 that the review continued, there is no evidence, is
 22 there, in the notes or elsewhere of consideration of or
 23 implementation of clear scope boundaries to avoid
 24 prejudicing future investigations as required by the
 25 Invited Review guide?

95

1 Review Team were told that there were concerns?
 2 A. (Nods)
 3 Q. They were told that there was a correlation
 4 between Letby and the deaths and that that correlation,
 5 as it were, followed Letby so when she was moved from
 6 night shifts to day shifts the collapses changed from
 7 night to day, and when she was removed from the shift,
 8 the collapses ceased?
 9 A. Yes.
 10 Q. They were told that the deaths and collapses
 11 were unexpected/unexplained?
 12 A. Yes, yes.
 13 Q. We know from the notes that we have of the
 14 review and the evidence that Ms Eardley gave to the
 15 Inquiry that the Review Team during the lunch break
 16 discussed amongst themselves different forms of
 17 deliberate harm that might explain the deaths?
 18 A. Yes.
 19 Q. There is evidence, isn't there, suggesting
 20 that there was a discussion amongst the Review Team as
 21 to whether or not they should abort the review on day
 22 one?
 23 A. That is correct.
 24 Q. But we don't have a contemporaneous record of
 25 that discussion?

94

1 A. You are correct.
 2 Q. If there had been consideration of clear scope
 3 boundaries, then a very obvious clear scope boundary
 4 would have been: we had best not interview Letby who's
 5 not even listed as one of our interviewees?
 6 A. I agree.
 7 Q. Instead, what appears to have occurred is the
 8 concerns emerging so clearly during the first day of the
 9 visit, a decision to continue with the visit in the
 10 review, that not only are there no clear scope
 11 boundaries but the decision is made to add Letby to the
 12 list of interviewees.
 13 What is the position of the RCPCH as to the
 14 appropriateness of interviewing Lucy Letby?
 15 A. Lucy Letby should not have been interviewed by
 16 our Review Team.
 17 Q. It's clear, isn't it, because in paragraph 88
 18 of Mr Okunnu's statement we have again the reference to
 19 the view of the RCPCH in 2023 and it describes it as
 20 being highly unusual that Lucy Letby was interviewed.
 21 But one, you don't need the benefit of hindsight to
 22 arrive at that conclusion, do you?
 23 A. I agree.
 24 Q. As you have indicated it's not simply that it
 25 was highly unusual; it was wrong and it should not have

96

1 happened?

2 **A.** I agree.

3 **Q.** If we can get up, please, the text messages
4 that Letby sent on the evening following day one of the
5 review, it is INQ0000569, and it should be page 34 of
6 that document.

7 **LADY JUSTICE THIRLWALL:** Don't worry, I think it
8 will be enlarged a bit.

9 **A.** Thank goodness for that.

10 **MR CARR:** It is 18:14, is what I am looking at, it
11 should be page 34/37. Yes.

12 **LADY JUSTICE THIRLWALL:** 18:14 on 1 September.

13 **MR CARR:** Yes, thank you. It is slightly different
14 to mine but I can see the entry there, is it entry 1274.

15 So this is a text message or a Facebook message
16 that was sent by Letby to somebody else. It follows the
17 interview that she had with Claire McLaughlan and
18 Alex Mancini earlier in the day.

19 You can see what she writes:

20 "Thank you for your help. The team members were
21 nice. They didn't ask much about the babies. It was
22 more about the unit as a whole et cetera. In brief, it
23 looks as though there is the potential for this to go
24 further over a long period of time. H ..."

25 That is likely a reference to Hayley Cooper, it's
97

1 such a tip-off?

2 **A.** That would have been wholly inappropriate.

3 **Q.** Dealing now, please, with the issue of
4 escalation. We looked at the entries in the 2016
5 guidance, although there wasn't a standalone escalation
6 process we looked that there were different points
7 within the guidance which gave the RCPCH power to
8 escalate and address circumstances in which escalation
9 might be appropriate. It's right to say that, isn't it,
10 that nowhere in the notes of the review visit the
11 correspondence following it or the report itself is
12 their advice to escalate the concerns of criminality,
13 deliberate harm by Letby to the police?

14 **A.** That is correct.

15 **Q.** No advice to escalate to the Local Authority
16 Designated Officer?

17 **A.** That is correct.

18 **Q.** In his witness statement, Graham Stewart, one
19 of the reviewers states that he provided verbal feedback
20 that included that any concerns of criminality should be
21 addressed by involving the police. But we don't see
22 that documented in the notes, do we?

23 **A.** That is correct.

24 **Q.** Mr Okunnu's statement, at paragraph 127.3,
25 page 50:

99

1 just disappeared, but what it says at the bottom is:

2 "H thinks we need to look at taking out a grievance
3 case."

4 Then the next entry: 18:33, it is entry 1281:

5 "The report will take a minimum of six weeks with
6 a preliminary tomorrow. They off the record told me
7 they think an investigation into the deaths will be
8 a recommendation and I need to prepare myself that as
9 I would play a big part in that overdue to being
10 a common factor and it could take several months."

11 Thank you, we can take that down. There was also
12 evidence from Hayley Cooper, the Union rep, that the
13 interviewers queried with her whether Letby knew what
14 she was being accused of.

15 Now, we know that an investigation into the deaths
16 as described in those messages was exactly what was
17 recommended by the RCPCH, wasn't it?

18 **A.** Mm-hm yes.

19 **Q.** It's important to state that the interviewers
20 both of them, Alex Mancini and Claire McLaughlan dispute
21 having any off-the-record discussion with Letby.

22 If such a discussion had occurred and if Letby had
23 effectively been tipped off that there would be a large
24 investigation in which she would be playing a big part,
25 what is the RCPCH's view as to the appropriateness of
98

1 "There is no evidence that RCPCH shared the report
2 or its findings and recommendations with any external
3 scrutiny bodies, regulators, the police or other
4 authorised individuals for consideration after the
5 Invited Review was completed in 2016. We do not know
6 why the concerns were not escalated with external
7 investigations and whether any consideration about this
8 was given at the time in light of the serious allegation
9 that had been made about Lucy Letby during the review."

10 So does it follow from that, Professor Turner, that
11 the RCPCH accepts that the hospital should have been
12 positively advised to report these concerns to the
13 police?

14 **A.** Yes.

15 **Q.** Given the sections of the 2016 Invited Review
16 guide that I have taken you to, is it accepted that
17 going to the police is something that the RCPCH could
18 have done itself particularly if the hospital did not?

19 **A.** That would have been an option, yes.

20 **Q.** The circumstance in which it would have been
21 appropriate to exercise that option would have been, for
22 instance, if the hospital had been told to go to the
23 police and they did not or they were reluctant to do so?

24 **A.** I agree.

25 **Q.** So one way or another, acting appropriately,

100

1 the police would have been informed of these concerns
2 following the review, had a proper procedure been
3 followed either by the hospital directly on advice from
4 the RCPCH or by the RCPCH?

5 **A.** Yes.

6 **Q.** If we can look, please, now at the feedback
7 letter which followed very shortly after the review
8 dated 5 September 2016, it's INQ0009611, page 2 of this
9 document, please.

10 Under the heading "Action Required -- HR
11 investigation", the second sentence:

12 "Our understanding is that an allegation has been
13 made and therefore a process of investigation needs to
14 be put in place which sets out the nature of the
15 allegation and the process you will follow to
16 investigate it."

17 The reference to an allegation there is a reference
18 to the allegation of deliberate harm resulting in the
19 deaths of babies?

20 **A.** Yes.

21 **Q.** Does the RCPCH accept that recommending an HR
22 investigation into allegations of murder was wrong and
23 inappropriate?

24 **A.** Yes, we do.

25 **Q.** Thank you, we can take that down, please.

101

1 **Q.** So the analysis that we see there would not
2 have -- would not have been included?

3 **A.** Correct.

4 **Q.** The RCPCH accepts, doesn't it, that its Review
5 Team did not have the capability to be carrying out that
6 type of analysis entered into?

7 **A.** That's correct, we accept that.

8 **Q.** As to the decision to produce two reports, the
9 rationale is explained in the cover letter from
10 Mr Shortland when the reports were sent and we see that
11 at INQ0009620. It is the second paragraph on this page
12 where it reads:

13 "Aware of the personnel issues. We have provided
14 two reports: one including full details of actions taken
15 and one omitting the confidential HR issues."

16 Now, just pausing there. The issues omitted -- and
17 I have asked you this question in respect of the
18 immediate follow-up letter, but the issues omitted are
19 not HR issues, are they?

20 **A.** I agree.

21 **Q.** They shouldn't have been described as such?

22 **A.** I agree.

23 **Q.** Now, in the course of the evidence, and indeed
24 at the time but subsequent to the report, there have
25 been a number of references to the dissemination version

103

1 If we can deal with the reports, and there were
2 two reports produced, a dissemination version and what
3 was called a confidential version, the confidential
4 version dealing with the issues that had been raised
5 about Letby at the review.

6 Now, it was accepted by Ms Eardley in her evidence
7 that in the confidential report which dealt with the
8 Letby issues, "It was wrongly attributed to the
9 Consultants that they had described their concerns as
10 a gut feeling".

11 You have seen the transcripts of Ms Eardley's
12 evidence, haven't you?

13 **A.** Yes.

14 **Q.** The confidential report describes, doesn't it,
15 the Consultants having a subjective view with no
16 evidence or history to support it?

17 **A.** Yes.

18 **Q.** Now, again, if we think to the clear scope
19 boundaries that ought to have been contemplated and
20 implemented if the review -- if the reviewers decided to
21 continue that review, notwithstanding the concerns
22 raised, one of the clear scope boundaries would be: we
23 are not in a position to be assessing and reporting on
24 evidence of criminality?

25 **A.** That is correct.

102

1 of the report as a redacted report, but to be clear, it
2 wasn't a redacted report in the sense that somebody who
3 picked up the dissemination copy would look at it and
4 could see that sections had been redacted, so there
5 weren't kind of black marks like you sometimes see in
6 a redacted document?

7 **A.** That's correct.

8 **Q.** Indeed if we look at this letter, if you look
9 in the top right corner, we can see there is those white
10 boxes with "I&S" in them where certain information has
11 been redacted from this document?

12 **A.** Yes.

13 **Q.** But what happened in the dissemination version
14 was that the sections dealing with the concerns in
15 respect of Letby, they were just completely removed?

16 **A.** Yes.

17 **Q.** So anybody picking up the dissemination report
18 and reading it, they would have no clue that it wasn't
19 a full and complete report?

20 **A.** That is correct.

21 **Q.** There was nothing to indicate that information
22 had been removed?

23 **A.** That is correct.

24 **Q.** So there was a real risk, wasn't there, that
25 anybody considering the dissemination report, both the

104

1 health professionals to whom it was disseminated in the
2 hospital but also third parties, a real risk that they
3 would be misled into thinking that the dissemination
4 report was a comprehensive account of the issues that
5 arose during the Royal College's visit?

6 **A.** I agree with you.

7 **Q.** What we know occurred subsequently is that in
8 early 2017 the Countess of Chester came to publish
9 a report, it was the dissemination version of the
10 report?

11 **A.** Yes.

12 **Q.** They came to share that report with a number
13 of third parties. But again, for the most part, it was
14 the dissemination version that was shared with external
15 agencies?

16 **A.** Yes.

17 **Q.** Now, even if there are circumstances where
18 there are issues which might be considered sensitive or
19 it might be considered warrant redaction, given the
20 potential if information is completely removed for
21 recipients to be misled, shouldn't it be made clear on
22 the face of a dissemination version that it is exactly
23 that; it is a dissemination version and information has
24 been removed or withheld?

25 **A.** Yes, I agree with you.

105

1 a report where there's an overriding reason to do so?

2 **A.** Yes, I agree.

3 **Q.** And in light of the concerns that had been
4 raised at the visit, this was exactly the sort of case
5 that might give rise to those overriding reasons?

6 **A.** I agree that this case might, might give rise
7 to such a scenario, yes.

8 **Q.** So it was wrong, wasn't it, to give that
9 reassurance to the Countess of Chester?

10 **A.** Yes.

11 **Q.** Can I turn now, please, to information sharing
12 with the Invited Review board.

13 One of the points made by Mr Okunnu in his
14 statement, it's paragraph 127.2 at page 50, he states:

15 "There is no evidence that the board of trustees or
16 any other senior group was comprehensively briefed by
17 Sue Eardley or the clinical lead Dr David Shortland
18 about the issues raised during the Invited Review and
19 the implications of them."

20 At paragraph 128 of his statement, page 51:

21 "We consider that the ability of the RCPCH's board
22 and other senior bodies to conduct their oversight
23 functions was hampered because they were not
24 sufficiently sighted on the level and seriousness of the
25 concerns that the Countess of Chester Hospital review

107

1 **Q.** Now, in terms of who the full version of the
2 report ought to have been shared with, does the RCPCH
3 consider that the paediatricians at the Countess of
4 Chester Hospital, those raising the concerns that were
5 removed, that they should have seen the full version and
6 not the dissemination version?

7 **A.** I agree, I believe they should have seen the
8 full version.

9 **Q.** When it comes to the report being shared with
10 external bodies, particularly if they are external
11 bodies who are concerned about issues at the hospital,
12 should it be the full version or the dissemination
13 version which is shared with them?

14 **A.** I -- I think for the majority that would be
15 the full version.

16 **Q.** Now, looking at this letter, the cover letter
17 to the report, 28 November, and in the paragraph that
18 has been highlighted, the final sentence of that
19 paragraph states:

20 "It remains your report though and we will not
21 distribute or share it more widely without your
22 permission."

23 Now, again, that is contrary to the guidance we
24 have looked at, isn't it, because the guidance we have
25 looked at gave the Royal College the right to disclose

106

1 entailed."

2 One of the reasons suggested by Mr Okunnu as to why
3 this was the case was because of the confidential nature
4 of Invited Reviews.

5 **A.** Right, yes.

6 **Q.** So the question is this: did the
7 confidentiality of Invited Reviews prevent a report, or
8 the concerns arising from a review visit, being shared
9 with the RCPCH board?

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

11 **Q.** Well, if it did, that would be a significant
12 shortcoming in the ability of the board to provide
13 oversight if they don't know what is going on during
14 Invited Reviews?

15 **A.** Yes, I -- I agree with you.

16 **Q.** If I can deal now to the role of the sharing
17 or notification of information to families concerned.

18 Now, part of the review visit did include
19 a discussion with two patient representatives. But what
20 we know from the review, from the documents that were
21 obtained and by the reports written, including
22 appendix 4, is that there was considerable consideration
23 of medical reports, Morbidity and Mortality Meetings,
24 postmortem reports of a significant number of children
25 for the purposes of the review?

108

1 A. Yes.

2 Q. Now, what is the RCPCH's position on obtaining
3 consent or ensuring that the client has obtained the
4 consent of families before sensitive medical records and
5 reports are provided to its reviewers?

6 A. We presume that the healthcare organisation
7 has the appropriate permissions in place.

8 Q. Are there -- were there at the time or have
9 there been implemented since any steps in place to
10 ensure that your clients are discharging their duty of
11 candour when instructing you and are ensuring that
12 permission is obtained?

13 A. I -- I don't know. What I will say is that we
14 as a healthcare or as a Invited Review service wouldn't
15 be party to contact details.

16 As part of duty of candour it wouldn't be right for
17 us to have contact, confidential details of parents and
18 families with which to disseminate results of a report
19 like this.

20 Q. Yes, the question or part of the question is
21 aimed at what steps are taken to ensure that families
22 are aware that sensitive medical records of their loved
23 ones are being sent to reviewers.

24 Now, one suggestion that was made by Ms Eardley in
25 her evidence is that it could be made a term of the

109

1 matrix, don't we, of the types of concerns and how
2 significant those concerns would be divided into:
3 concerns, serious concerns, immediate risk.

4 Amongst the examples of immediate risk, in the
5 third box on the page, the box at the bottom of the page
6 are significant safeguarding concerns.

7 Would it be the case that the concerns that were
8 raised at the Countess of Chester review would or should
9 fall within that category of significant safeguarding
10 concerns, immediate risk issue?

11 A. Yes, absolutely.

12 Q. It would require, wouldn't it, the Review Team
13 to recognise the concern as both a safeguarding one and
14 a significant one?

15 A. Yes.

16 Q. If we turn to page 14 of this document,
17 appendix 2, we can see -- we might need to zoom in --
18 yes, the box for immediate risk, which sets out the
19 steps that ought to be taken, which include adjourning
20 the review, which is one of the issues that we looked at
21 in respect of the Countess of Chester and in the
22 paragraph that follows, steps of escalation including
23 escalation to external bodies?

24 A. Yes.

25 Q. Thank you. We can take that down.

111

1 contract for the purposes of an Invited Review that the
2 client has discharged or complied with its duty of
3 candour?

4 A. That, that could be the case.

5 Q. But it sounds like it's not currently the
6 case, it's not currently part of a contractual term or
7 any requirement on the client to ensure --

8 A. I am not aware that it is. But that might be,
9 that might be my ignorance.

10 LADY JUSTICE THIRLWALL: So that's something that
11 could be checked, isn't it?

12 A. That's something that can be checked, yes,
13 my Lady.

14 LADY JUSTICE THIRLWALL: Thank you.

15 MR CARR: I referred, when we were looking at the
16 2016 guide, to the fact that there is now a escalation
17 process and that's a standalone escalation process.
18 That's one of the changes that has been introduced
19 following a review of the Invited Review at Countess of
20 Chester amongst other reviews?

21 A. That is correct. There have been a series of
22 changes and this escalation policy is one of them.

23 Q. If we can look, please, at that escalation
24 policy. It's INQ0012813, and if we look at the appendix
25 which is at page 13. Here we have essentially a risk

110

1 So in addition to this escalation policy, what are
2 the other significant differences between the review
3 process as it exists now and the review process in 2016?

4 A. Thank you. So following on from the Countess
5 of Chester we had an external review of the Invited
6 Review service called the Crisp Report, which I believe
7 you've heard of previously.

8 It made 86 recommendations. I will not go into all
9 of them.

10 Briefly, we have heard about the escalation policy
11 which has changed. If I go through the timeline of
12 commissioning the review, we now have a process whereby
13 it's not just the clinical lead who makes the decision
14 when to proceed with Invited Review; it's a team of two
15 clinicians and two members of staff and they go through
16 a pro forma which explores reasons why we might and
17 might not. So that's one new thing that has come in
18 upfront, if you will, in the natural journey of a review
19 and at that stage the review might be declined.

20 Then the second main area -- I have covered the
21 initial context, we have covered the escalation
22 policy -- the Terms of Reference which we have talked
23 about. Now they are substantially different. The first
24 thing that is different is that the Terms of Reference
25 are agreed by the healthcare organisation, the College

112

1 and also the Invited Review team and it's important that
2 we include those individuals.

3 **Q.** So the entire team?

4 **A.** For the entire team. And the second aspect of
5 the Terms of Reference which has been brought in is
6 following on from the discussion we have had we make it
7 clear that the healthcare organisation is obligated to
8 meet concerns that we believe are of high concern by
9 a given date and up front in the Terms of Reference we
10 make it clear that if we are not satisfied with the
11 timeliness and completeness of the healthcare
12 organisation's response we will go to the appropriate
13 regulator. And we have actually done this in the -- in
14 the last year or so.

15 **Q.** The focus of much of my questions has been on
16 the issues and shortcomings, recognised shortcomings of
17 the Invited Review at the Countess of Chester Hospital
18 in 2016.

19 But of the service more broadly, what do you
20 consider the benefits of the review process to be to the
21 College and to the clients when properly performed?

22 **A.** Yes, thank you. So -- so I think generally
23 the purpose of an Invited Review is for a healthcare
24 organisation, which recognises it has a problem, to
25 invite a professional, external, independent, peer

113

1 We will look at three documents. If we can start
2 at INQ0012734 and we will want to go to -- this is
3 an email chain -- we will want to go to page 4 first.

4 At the second half of that page, and it goes on
5 into the next page, is an email from Stephen Brearey to
6 the RCPCH President at the time Professor Modi, dated
7 5 February 2018. That final paragraph on the page:

8 "I do have a number of concerns regarding the way
9 the college responded to our concerns, particularly
10 after the invited review report was submitted to the
11 Trust. The modified report, which did not include any
12 of our concerns, was utilised by the Trust to follow
13 a plan that gave us all considerable patient safety
14 concerns and was a stressful time for all of us.

15 "It is quite possible that if the college had
16 intervened at that stage and provided support to its
17 members (the consultant body) ..."

18 We need to go over to the next page, thank you:

19 "... then the police investigation might have
20 started earlier. The affected parents were also given
21 information by the Trust in January 2017 regarding the
22 report which was later different to the information
23 given in May 2017."

24 The final paragraph there deals with the lack of
25 more positive support.

115

1 review group to come in and to help them improve their
2 service with a focus on patient safety.

3 So the benefits to patients are that there is
4 a focus on patient safety and the staff who were looking
5 after them will gain by reflecting on their practice, by
6 receiving education.

7 The Review Team themselves will learn from their
8 review and will feed that back to the service and so the
9 Review Team itself does benefit from doing Invited
10 Review because nothing's perfect and each review further
11 improves the service that we deliver.

12 **Q.** Thank you. I have one more topic for you,
13 which is moving slightly away from the Invited Review
14 service.

15 The Invited Reviews are carried out for clients,
16 for clients who are contracting which is usually Medical
17 Director as we have heard. But as you explained at the
18 beginning, the RCPCH is a membership organisation. Your
19 members are paediatricians and the paediatricians at the
20 Countess of Chester Hospital, who were raising concerns
21 with the Review Team, were members of your organisation.

22 What I would like you to look at and to reflect
23 upon is the support that was provided to your members,
24 the paediatricians at the hospital, following the
25 Invited Review.

114

1 What are your reflections on the concerns that are
2 raised there as to the support provided by the College
3 to its members?

4 **A.** I am very sorry that we behaved that way.

5 I think that we could and should have been more
6 responsive. We should and could have listened more
7 carefully to their concerns.

8 **Q.** If we look at the initial reply, so it's
9 page 3 of this document, the initial reply from
10 Professor Modi, it's the same date,
11 8 February 1800 hours.

12 In the second half of her response:

13 "You will appreciate that we do not have authority
14 over what actions are taken by Trusts as a result of our
15 reviews. Did you have something specific in mind when
16 you referred to 'supported by the college in a more
17 positive way'? Please do be aware that given this is
18 now a police investigation it would not be appropriate
19 for us to intervene."

20 Now, would you accept that's perhaps not the most
21 supportive response in the context of the issues that
22 had just been raised by Dr Brearey?

23 **A.** I agree with you.

24 **Q.** We see at page 2 of this document, at the
25 bottom of the page is Dr Brearey's email, and the third

116

1 paragraph from the bottom starting, "Secondly ..." he is
2 highlighting in particular there the issue of the two
3 versions of the report and the fact that you have one,
4 the dissemination version, which just has large chunks
5 completely missing.

6 **A.** Yes.

7 **Q.** We can take that down now, please. The next
8 document, INQ0012733.

9 At page 4 of this document, we see this is a little
10 later in the year. It's the email at the bottom of the
11 page, 4 July 2018, an email from Dr Brearey and the
12 concern that he is raising here is in relation to press
13 cuttings which were being circulated by the
14 Royal College to its membership and those press
15 clippings suggest that the review led to the police
16 investigation and that's something that Dr Brearey
17 wanted to set right, isn't it?

18 **A.** Absolutely. Dr Brearey's understandably very
19 cross when he is writing this letter.

20 **Q.** He emphasises again that he and his colleagues
21 feel let down and this string of communication led to
22 a meeting, didn't it, between the College and Dr Brearey
23 and another doctor from the Countess of Chester?

24 **A.** It did, yes.

25 **Q.** That's the final document we will look at.

117

1 investigation into Lucy Letby was ongoing. But my ...

2 I would speak to the members. I would listen to
3 the members and understand their perspective. That
4 would be the very first thing that I would do in terms
5 of practical engagement with members.

6 **Q.** Would you ensure that the report, even if it
7 didn't explore concerns raised in detail, and that was
8 dealt with in a separate document that the report
9 somewhere made the point that there are concerns falling
10 outside the Terms of Reference that have been followed
11 up in an alternative document?

12 **A.** If, if that's what we agreed was necessary
13 absolutely. So, for example, if you suggest
14 a supplement or an appendix to the report that we
15 issued, that, that would be an option.

16 **MR CARR:** Professor Turner, thank you for answering
17 my questions. My Lady, those are all my questions.

18 I know there are -- no, I am told there are no
19 further questions so that's it for this witness.

20 **LADY JUSTICE THIRLWALL:** Thank you very much,
21 Mr Carr. Professor Turner, thank you very much indeed
22 for coming to give your evidence. It has been very
23 helpful. You are now free to go.

24 **A.** Thank you very much. Thank you.

25 **LADY JUSTICE THIRLWALL:** Mr Carr, can we take the

119

1 It's INQ0012742. This is a note of a meeting,

2 12 July 2019, between the doctors and the RCPCH.

3 If we look at page 2 of this document, please. We
4 see outlined there, from the third paragraph onwards,
5 some of the particular concerns that were raised in
6 relation to the RCPCH's role and the concerns that we
7 see emerging are similar to some of those we have
8 covered: it's the creation of two reports and the fact
9 that one of those wasn't shared with the paediatricians.

10 In the current escalation document, there is
11 still -- forgive me, not the escalation document -- in
12 the more recent review, Invited Review policy document,
13 there is still provision that allows for issues that
14 emerge during an Invited Review to be dealt with in
15 a letter separate from a report?

16 **A.** Yes.

17 **Q.** So how would, today, the RCPCH deal with this
18 very same issue that was a cause of concern for
19 Dr Brearey and the paediatricians of issues arising
20 during a review and then not being documented in the
21 report?

22 **A.** Sure. So should this happen now, I think the
23 first thing I would do, I would get legal advice as to
24 what I was and wasn't able to do. Because it might
25 be -- let's just imagine that the legal enquiry, the

118

1 full hour for lunch or should we start earlier?

2 **MR CARR:** I would propose a slightly shorter lunch,
3 maybe 45 minutes.

4 **LADY JUSTICE THIRLWALL:** Shall we say 10 to 2? So
5 we will rise now and start at 10 to 2.

6 (1.05 pm)

7 (The luncheon adjournment)

8 (1.50 pm)

9 **LADY JUSTICE THIRLWALL:** Mr Carr.

10 **MR CARR:** My Lady, the next witness is Dr Kingdon,
11 who will be giving evidence focusing on Part C and
12 before I call her, in respect of the RCPCH evidence on
13 Part B, we have heard evidence from a number of members
14 the Review Team. The Inquiry has --

15 **LADY JUSTICE THIRLWALL:** Do sit down, Dr Kingdon.

16 **MR CARR:** Forgive me, the Inquiry has also obtained
17 witness statements from David Milligan who was the lead
18 reviewer, Graham Stewart, who was the neonatologist and
19 who was a part of the Review Team, neither of them were
20 called to give evidence for health reasons.

21 We will be uploading their statements as well as
22 a statement from Professor Neena Modi who was President
23 of the RCPCH at the time and addresses her comments on
24 2016 Invited Review.

25 We will be uploading those statements in due

120

1 course.
 2 If I can now call Dr Kingdon.
 3 **LADY JUSTICE THIRLWALL:** Do come forward.
 4 DR CAMILLA KINGDON
 5 **LADY JUSTICE THIRLWALL:** Thank you, do sit down.
 6 Questions by MR CARR
 7 **MR CARR:** If we can start, please, with your full
 8 name?
 9 **A.** My name is Camilla Clare Kingdon.
 10 **Q.** Before we turn to your statement, I understand
 11 that you want to address the Inquiry?
 12 **A.** Thank you.
 13 I've been a paediatrician and neonatologist for
 14 over 30 years and particularly as a neonatologist have
 15 cared for families who have lost their babies and their
 16 grief is unfathomable and unimaginable and I just wanted
 17 to say how very, very sorry I am to the parents of the
 18 babies who lost their lives at the Countess of Chester
 19 Hospital.
 20 Thank you.
 21 **Q.** Now, you have made a statement for the
 22 purposes of this Inquiry dated 25 March 2024, haven't
 23 you?
 24 **A.** I did.
 25 **Q.** You can confirm that the contents of that

121

1 **Q.** You were responsible in that role for training
 2 over 1,000 postgraduate trainees in paediatrics?
 3 **A.** Yes.
 4 **Q.** You were also the past President of the
 5 Royal College of Paediatrics and Child Health?
 6 **A.** I was.
 7 **Q.** May 2021 to March 2024?
 8 **A.** Yes.
 9 **Q.** Prior to that you were Vice President for just
 10 under three years?
 11 **A.** That's correct.
 12 **Q.** Turning to your evidence at paragraph 7, you
 13 state that you make your statement on behalf of the
 14 members of the RCPCH?
 15 **A.** Yes.
 16 **Q.** At paragraph 8 you explain that you have had
 17 input in preparing the statement from a number of RCPCH
 18 officers?
 19 **A.** Yes.
 20 **Q.** To be clear, those officers are working
 21 paediatricians?
 22 **A.** Yes, they are.
 23 **Q.** So in preparing your statement and giving your
 24 evidence today you are drawing on that wealth of
 25 knowledge and experience?

123

1 statement are true to your best knowledge and belief?
 2 **A.** It is, yes.
 3 **Q.** The statement addresses principally issues
 4 relevant to C of the Inquiry's Terms of Reference?
 5 **A.** Yes.
 6 **Q.** I am going to ask you a number of questions on
 7 both points raised in your statement and some issues not
 8 raised in your statement but which you may be able to
 9 assist upon.
 10 Before I do, if I can summarise your professional
 11 background. You just commented a few moments ago you
 12 have been working in paediatrics for over 30 years and
 13 you started working in paediatrics in 1992?
 14 **A.** Yes.
 15 **Q.** You became a Consultant paediatrician in 2000?
 16 **A.** Yes.
 17 **Q.** Your clinical speciality is neonatology?
 18 **A.** Yes, it is.
 19 **Q.** You have a particular special interest in
 20 neonatal nutrition?
 21 **A.** Yes.
 22 **Q.** Of potentially particular relevance to your
 23 evidence between 2014 and 2018, you were the head of the
 24 London School of Paediatrics?
 25 **A.** Yes, I was.

122

1 **A.** I am.
 2 **Q.** So far as your statement you cover three broad
 3 topics. The first, governance and management structures
 4 in keeping children safe; the second, professional
 5 regulation; the third, regulation of senior managers?
 6 **A.** Yes.
 7 **Q.** I am going to go through each of those in
 8 turn, starting with governance and management
 9 structures.
 10 The point that you make at paragraph 9 of your
 11 statement, it's page 3, is that mechanisms for
 12 overseeing patient safety and the quality of care are
 13 not restricted just to governance and management, but
 14 there's a number of additional external bodies?
 15 **A.** Yes.
 16 **Q.** Do you have in mind there with reference to
 17 external bodies NHS England, CQC, professional
 18 regulators?
 19 **A.** Yes.
 20 **Q.** The final sentence of paragraph 9 states:
 21 "The system of oversight both within hospitals and
 22 for external bodies is overlapping and, in the RCPCH's
 23 view, sometimes lacking coherence and clarity."
 24 Are you able to elaborate upon that, please?
 25 **A.** So it -- it can at times as a front line

124

1 clinician feel bewildering as to who -- where guidance
2 is coming from and which organisations and structures
3 you are answering to in terms of regulation and
4 governance.

5 So, you know, there are, there are -- we have
6 NHS England, we have the Department of Health and Social
7 Care, then there is the CQC.

8 As a doctor I have my regulator, the
9 General Medical Council and so on and so the landscape
10 is complicated and often guidance is -- is overlapping
11 and there's a lack of clarity as a result of that.

12 **Q.** Can there be circumstances where there's also
13 a degree of duplication so an issue that you need to
14 raise with one body, that same issue needs to be raised
15 with other bodies as well?

16 **A.** Yes. So it's true that sometimes we are
17 reporting data, the same data, but through different
18 channels to different organisations that perhaps have
19 different regulatory activities.

20 **Q.** We will come back to data and systems of
21 regulation later in your evidence.

22 On this section, in paragraph 10 of your statement,
23 you state that:

24 "In respect of hospital governance and management,
25 the RCPCH consider that the structures in place are more
125

1 organisations you touch upon it but you are talking
2 about NHS organisations, NHS Trusts?

3 **A.** I apologise. Yes, I am. Yes.

4 **Q.** In your view are you able to help us with what
5 distinguishes the Trust, who -- do you get that culture
6 right or do have a proactive culture and the ones who
7 are more reactive and fire-fighting?

8 **A.** On a very practical level, it is often down to
9 time, adequate staffing, adequate resourcing. Because
10 to create a culture that asks front line clinical staff,
11 you know nurses, doctors, the whole professional team,
12 to take time to think about and reporting early warning
13 signs around the potential for harm to be done to
14 patients, that -- that genuinely requires some headspace
15 that you cannot expect of staff when they are working in
16 rotas that are half filled or where there is just a lack
17 of resource to undertake these kind of activities.

18 **Q.** You go on in your statement, it's
19 paragraph 11, you observe that there's no standardised
20 national mandate on how to ensure that effective
21 hospital governance or management structures are in
22 place to prevent harm.

23 Now, what would the kind of mandate you are
24 referring to here, what would that look like? In your
25 previous answer you identified the difference between
127

1 focused on reacting to concerns raised through incident
2 reporting, than proactively creating and supporting
3 a culture, system and process that prevent harm and
4 ensure quality of care."

5 So is the point you are making there that whilst
6 there are systems that tell you what to do when
7 something goes wrong, there is not as much attention
8 given to having systems in place that prevent things
9 from going wrong in the first place?

10 **A.** I think that is true, although that is
11 a generalisation.

12 There are certainly some organisations where there
13 is huge attention placed on the culture around promoting
14 safety, and a curiosity about picking up early warning
15 signs and signals.

16 So it is true that in many, many very busy acute
17 Trusts it -- it is -- concerns are flagged once there's
18 a problem.

19 But I have certainly seen it done in other
20 organisations, other acute Trusts where -- where the
21 culture is different, where actually signals can be
22 picked up at a much earlier stage, where the culture
23 encourages that kind of curious questioning about early
24 warning signals.

25 **Q.** To be clear when you said there are some
126

1 hospitals who have a good culture and those who are
2 struggling and more reactive being about time and
3 resources. So if there was a national mandate, what
4 kind of things would it cover?

5 **A.** Well, I think NHS England has published
6 something that we call PSIRF which stands for the
7 Patient Safety Incident Reporting Framework. Actually,
8 that's a framework that can be a really helpful vehicle
9 for just creating opportunities to think about themes
10 around early warning signs as I have been describing.

11 So you can -- you can have a framework but unless
12 you have got staff with time and expertise, you know,
13 who have had some training about actually how to use
14 these frameworks, you know, how to look at hospitals
15 have systems whereby they report encourage staff to
16 report near misses or indeed incidents and some
17 organisations call those Datix, other call them IR-1s,
18 there's various names they give them, but let's call
19 them incident reporting systems.

20 All hospitals have that, but how you encouraged
21 your staff to use those reporting systems, there are
22 thresholds you might suggest to them, so some
23 organisations will say to their staff: we want you to
24 report everything that you have noticed that isn't quite
25 right or where you think we as a clinical service can
128

1 learn from. Whereas others will be saying to their
2 staff: we don't want you to report unless you have had
3 a discussion before because this might look bad for the
4 organisation.

5 So it's how you equip your clinical teams to use
6 the frameworks that exist and give them the -- both the
7 time and the wherewithal to do that meaningfully.

8 **Q.** So on that example, so that we understand, the
9 thresholds for reporting generally is left to the Trust
10 to decide on a Trust by Trust basis. There are
11 obviously certain incidents that have to be reported?

12 **A.** Of course.

13 **Q.** But outside of that, you are saying -- well,
14 you will see different thresholds applied by different
15 Trusts?

16 **A.** Yes.

17 **Q.** Are you suggesting that where that threshold
18 is set is one of the factors or is a factor which might
19 tell you something about the culture of safety in
20 a particular Trust?

21 **A.** I would say that, yes.

22 **Q.** So when you talk about a national mandate, for
23 instance, it could apply a standard across all Trusts?

24 **A.** I think technically the answer to that
25 question is probably yes. But I don't know how you

129

1 you have got one factor conditions."

2 Next sentence:

3 "We have outlined behaviours that might help boards
4 focus more effectively."

5 The next sentence:

6 "We have also set out how different leadership
7 approaches contribute to delivering major system
8 change."

9 Then the fourth sentence on what appears to be the
10 fourth factor:

11 "Finally we have shown how person-centred and
12 team-centred leadership may influence the ways in which
13 teams work together."

14 Now, what do you consider to be the significant or
15 important takeaways from this piece of work, this
16 document?

17 **A.** I think my reading of this paper points to the
18 kinds of -- essentially the culture that you would hope
19 hospital board, the senior Executive Team in the
20 hospital would set because that then filters down to
21 behaviours and practices across the entire organisation.

22 And what I mean by that is if your board and your
23 senior Executive Team are accessible, are making a point
24 of getting out and about interacting with front line
25 clinical staff, asking simple questions like, you know:

131

1 mandate a culture.

2 **Q.** If we address, please, your reference to the
3 paper by Fulop & Ramsay. Because in the context of
4 culture, one of the things that you consider in your
5 statement is the role of management leadership and the
6 impact that that can have on a culture?

7 **A.** Yes.

8 **Q.** The reference is INQ0012274. And this is
9 a paper on governance and leadership, under the heading
10 "Improving Quality and Safety in Healthcare".

11 It is a document that you have cited in your
12 witness evidence. Is the importance of this document
13 that it identifies and explores the role that governance
14 and leadership can have in improving quality in
15 healthcare, improving a safety culture?

16 **A.** Yes.

17 **Q.** If we can look at the summary of conclusions
18 at page 32.

19 Now, it's obviously a long document, this is
20 page 26 of the narrative and this paragraph here brings
21 together the conclusions. What appears to be identified
22 is about five lines down, the authors say:

23 "We have described conditions that might help to
24 ensure that performance measures, targets and regulatory
25 activities support rather than hinder organisations so

130

1 what worries -- what is worrying you at the moment?

2 What could we be doing better? What are you observing
3 that are some issues, you know, what's your top patient
4 safety concern at the moment?

5 Open questions like that that allow front line
6 clinical -- particularly clinical staff an open
7 opportunity to report from the front line about what
8 they are seeing and they are worried about. If you can
9 create that style of leadership, that promotes those --
10 that sort of soft intelligence that allows you to detect
11 concerning areas early and create a culture of openness
12 where staff are free to speak up and feel heard.

13 **Q.** If we look at the next page then, page 27,
14 which has box 6 and again summarises some of the lessons
15 to be learned and we see they are divided into macro
16 level, meso level and micro level.

17 Your previous answer I think focuses on meso level
18 systems and organisations and micro level clinical teams
19 and that is where you see this work being important?

20 **A.** Yes.

21 **Q.** If we go to the start of this document,
22 please, page 7, under paragraph 2.1:

23 "The role of governance and leadership in quality
24 and safety."

25 This is the first page of the text of the document.

132

1 The paragraphs there identify the central role played by
2 governance and leadership in the actions and inactions
3 relating to quality of care and patient safety. It
4 notes that:

5 "That has been repeatedly identified by Inquiries
6 and investigations into major organisational failings."

7 It picks up in particular on the 2002 Inquiry into
8 paediatric heart surgery at Bristol Royal Infirmary, the
9 final paragraph on the page refers to the Mid
10 Staffordshire NHS Foundation Trust investigation and
11 then right on the last line, the Morecambe Bay Maternity
12 Services.

13 In your view, or the view of your members, is there
14 a problem in healthcare in implementing and complying
15 with recommendations made by Public Inquiries?

16 **A.** I -- I think it's true that if you look at the
17 various Public Inquiries we have had that the
18 recommendations tend to follow very, very similar
19 themes. So I think the answer to your question is
20 I would agree that there's a problem with implementing
21 the recommendations.

22 **Q.** Would you make any recommendation to ensure
23 that recommendations made by Inquiries are implemented,
24 for instance should there be an Inquiries Unit to
25 implement and monitor compliance with --

133

1 are you able to help us with what that fundamental
2 problem might be?

3 **A.** I think the honest answer is that it's very
4 complex. But a significant problem is lack of resource
5 and particularly lack of workforce and that's
6 particularly true in my specialty. But I think it's
7 fair to say it's true across the National Health
8 Service.

9 **Q.** Yes, resources is one of the issues that you
10 touch upon and we are going to come to that specifically
11 in a few moments. In paragraph 12 of your statement you
12 make the point that whilst hospital organisations are
13 likely to have appropriate governance in place on paper
14 to support patient safety and quality care, you have
15 identified or the RCPCH has identified five elements
16 that it is considered must be in place in practice on
17 a consistent basis to meet those aims.

18 Now, is the inference that should be drawn there
19 that having the appropriate governance in place on paper
20 and actually delivering patient safety can be quite
21 different things?

22 **A.** So the inference there is that the structures
23 are there to deliver on patient -- on patient safety.
24 So the theory -- the theory is correct, the structures
25 are correct. It's the process of implementation that

135

1 **A.** Sorry, I'm afraid I missed the first bit of
2 your question?

3 **Q.** What I am interested in is whether you
4 consider there ought to be steps taken to ensure that
5 when recommendations are made by Inquiries, Public
6 Inquiries, they are followed and they are complied with?

7 **A.** Yes, of course they should be complied with.

8 **Q.** Now in particular, do you consider there
9 should be an Inquiries Unit to ensure that
10 recommendations made by Inquiries are implemented and to
11 monitor their implementation?

12 **A.** The answer to that question has to be yes.

13 But if I may, it does beg the question as to
14 whether there is some underlying problems that mean that
15 these, the various Inquiry recommendations, there is
16 a problem with implementing them because I -- I know
17 I speak on behalf of our members and I am sure this is
18 true across the entire healthcare workforce, people come
19 to work largely to do a really good job and to care for
20 their patients. So if there is a problem implementing
21 what are really important and salient recommendations
22 from, you know, key Inquiries, then there's a more
23 fundamental problem.

24 **Q.** Do you know what that is or you are simply
25 identifying that there is a more fundamental problem or

134

1 needs more attention.

2 **Q.** So having the appropriate structures on paper
3 is just really the first step?

4 **A.** Exactly.

5 **Q.** Now, the five elements that have been
6 identified are: resource, appropriate data matrix,
7 an established safety culture, appropriate lines of
8 accountability and timely response; and action when
9 concerns are raised.

10 If we look at the first of those, resources. You
11 have already touched on that in your answer, both
12 addressing implementation of Inquiry recommendations and
13 also thresholds for noting or reporting concerns, the
14 point that you make in your statement are that hospital
15 services are under immense financial pressure?

16 **A.** Yes.

17 **Q.** And as a public service that is something that
18 we would all be familiar with but the particular theme
19 that emerges in your evidence is in circumstances where
20 there are financial stresses, the problem for children's
21 services is that they are not prioritised?

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

23 **Q.** You give as an example NHS England's 2023
24 Annual Operational Planning Guidance, which focuses
25 mainly on systems for adults?

136

1 A. Yes.

2 Q. The point that you make is that where the
3 performance of a hospital is going to be examined
4 against essentially national standards which are
5 focusing on adult outcomes, it's not surprising if
6 within hospitals children's services aren't viewed as
7 a priority because they are not prioritised in national
8 standards?

9 A. That's correct.

10 Q. To read directly from your statement, at
11 paragraph 18, you write:

12 "... the RCPCH observes that in general the focus
13 in hospitals, and central decision-making and
14 prioritisation by NHS England and Government, is on
15 adult focused indicators, such as cancer care waiting
16 time standards, predominantly higher volume low
17 complexity elective care for adults, and waiting times
18 in A&E."

19 A. Yes.

20 Q. So is the point that in circumstances where
21 you are dealing with limited resources, if children's
22 services aren't included, or targets which are not
23 specific to children aren't included, in national and
24 local standards, it's easy for them not to receive
25 resources and to be, as you describe it, deprioritised?

137

1 deprioritisation of children and young people in current
2 health policy."

3 In your view is this record high waiting list, is
4 this an example of a lack of resources and a lack of
5 focus on child outcomes with the result that children's
6 services are deprioritised?

7 A. Yes.

8 Q. Okay, we can take that down, please. Thank
9 you.

10 Another example of the consequences of a lack of
11 resource is addressed at paragraph 19 of your statement,
12 where you refer to the significant workforce restraints,
13 particularly in children's services and a decline
14 year-on-year in neonatal nurse staffing.

15 Again, is that, as far as you are concerned,
16 a resource issue?

17 A. Yes.

18 Q. These are problems that you consider are
19 likely to increase, that is the impact and consequences
20 of under-resourcing, at paragraph 17 of your statement
21 seven lines down, you say:

22 "The RCPCH considers that current demands from the
23 rising volume and complexity of health needs of children
24 already exceeds the workforce in place to provide care
25 and future demands on children's services is likely to

139

1 A. Correct.

2 Q. As to the impact of that, you describe and the
3 document reference is INQ0012295, and this is an RCPCH
4 publication from May 2023, and here we can see the
5 headline:

6 "Record High: over 400,000 children waiting for
7 treatment amidst child health crisis".

8 This statement, this page going into the next page,
9 that's your statement, isn't it?

10 A. Yes, yes, it is.

11 Q. It is a statement in your name?

12 A. Yes.

13 Q. Going back to the first page and looking at
14 the bottom, I think this supports the observation that
15 you make between focusing on adult outcomes sometimes at
16 the expense of the child outcomes you say:

17 "We have seen considerable progress made in
18 shrinking the adult backlog but the children's list
19 continues to rise at an unprecedented rate. Our
20 children are not being prioritised."

21 A. Yes.

22 Q. Over the page, page 2 of this document, the
23 final paragraph, you express on behalf of the RCPCH, and
24 this was a statement made whilst you were President:

25 "The RCPCH is deeply concerned with the

138

1 increase further as children are surviving with more
2 medical complexity from advances in medicines and
3 treatments."

4 A. Yes.

5 Q. If we can turn, please, to how this has
6 an impact in particular on issues of safety, quality of
7 care and safeguarding issues. What you say at
8 paragraph 15 of your statement, page 5, eight lines
9 down:

10 "RCPCH members generally agree that hospital
11 management are supportive of patient safety initiatives
12 and will support clinicians to escalate concerns about
13 safety. However, it is more difficult to secure
14 management support if there is a financial implication
15 associated with taking forward an action to prevent harm
16 or respond to a patient safety concern for example
17 making changes to the clinical environment or recruiting
18 additional staff."

19 Now, firstly, are you able to give examples of why
20 you or your members believe management support is
21 lacking if preventing harm incurs a cost?

22 A. Well, this -- I mean, this can play out in
23 a number of different ways. I suppose firstly more
24 broadly if we are talking about creating an environment
25 which encourages the reporting of near misses and

140

1 opportunities to learn from patient safety examples, you
 2 need -- you need staff to take a lead for that. That
 3 requires time in people's job plans or you may need to
 4 recruit a nurse who is going to particularly focus on
 5 governance and patient safety and in other words not be
 6 clinically facing for a proportion of his or her working
 7 life.

8 I mean, that represents a cost pressure. Making
 9 the case for that can be very, very difficult
 10 particularly in an environment where there are
 11 significant financial constraints.

12 So that's on a kind of specific patient safety
 13 level. But there are too many examples of where
 14 a member of staff might go on maternity leave, the post
 15 is frozen, gaps arise, the opportunity is seen to -- it
 16 appears that the Trust see it as an opportunity to for
 17 some months not fill that gap because there is some
 18 money to be saved and those sorts of stories we hear
 19 around the country and across the clinical workforce.

20 And when you have got a workforce that's already
 21 working at maximum capacity actually it really matters
 22 if just one or two people are off sick or on maternity
 23 leave or have left and months drag by before they are
 24 replaced and that does compromise care.

25 Particularly our nursing staff are already working

141

1 But if we are talking about creating a culture
 2 where you are looking for early warning signs, where you
 3 want to sort of embed that in the way you work, that is
 4 in other words not just being reactive to -- to safety
 5 concerns, then that's an entirely different endeavour
 6 and that does require people with time and head space to
 7 do justice to that programme of work.

8 **Q.** There are two proposals which are made in your
 9 witness statement, two measures that the RCPCH put
 10 forward. The first, ring-fenced funding to meet safety
 11 and quality needs in neonatal units and presumably the
 12 reason for ring-fenced funding is because of the issues
 13 that we have identified which was deprioritisation of
 14 children's services when they are not included in
 15 national targets?

16 **A.** Yes.

17 **Q.** The second is the appointment of a Neonatal
 18 Safety Champion and can you explain what that role is,
 19 where that person would work and what they would be
 20 doing, what difference they would make, what is
 21 a Neonatal Safety Champion?

22 **A.** So the Neonatal Safety Champion was
 23 a recommendation from NHS England in response to one of
 24 the Inquiries -- forgive me, I can't remember which, one
 25 of the maternity -- it links in with Maternity Safety

143

1 at -- at extremely stretched capacities and in an
 2 intensive care environment on neonatal units nurses
 3 already look after two patients rather than one patient
 4 which is what you expect in any other intensive care
 5 environment.

6 So actually it doesn't take many gaps in your
 7 staffing complement for that generally to translate into
 8 a patient safety issue.

9 **Q.** Particularly on the issue of management not
 10 being supportive, where there is a financial implication
 11 with safety measures, how widespread is that view
 12 amongst your membership that they won't get management
 13 support if that patient safety measure required is going
 14 to cost money?

15 **A.** That's very widespread.

16 **Q.** Does that mindset mean in practice that your
 17 members won't raise patient safety and safeguarding
 18 issues that cost money because they know it's going to
 19 be marked against a cost, there's not going to be the
 20 management support for it?

21 **A.** I think, I think I -- I wouldn't go so far as
 22 to say that because I think genuinely a paediatric nurse
 23 or doctor who was deeply concerned about a patient
 24 safety issue of course they would -- they would -- they
 25 would flag it.

142

1 Champions, so it will have been one the maternity safety
 2 Inquiries. And the role of the Neonatal Safety
 3 Champion, as I understand it -- well, as I know it
 4 exists, is a member of staff of a level of seniority who
 5 has an ability to access members of the board,
 6 particularly the board Non-Exec Director who has -- who
 7 is named for paediatric and neonatal safety and so has
 8 a clear channel of communication and essentially the
 9 Neonatal Safety Champion would be someone within the
 10 clinical arena who is aware of -- who has got time to
 11 understand where the safety issues are, focus on them,
 12 look for themes and then have clear escalation pathways
 13 to the NED, the Non-Exec Director on the board who's
 14 named for safety -- maternity and neonatal safety.

15 **Q.** So it would be an additional role for
 16 a clinician working in a hospital?

17 **A.** Yes.

18 **Q.** It would give them access to -- easy access
 19 and clearly defined access to the board --

20 **A.** Yes, and access to data and, you know, the
 21 metrics to be able to do the job thoroughly.

22 **Q.** With a specific mandate on safety --

23 **A.** Yes.

24 **Q.** -- within neonatal care.

25 If we move now to the second element required to

144

1 support patient safety and quality of care, that is data
2 and metrics. At paragraph 21 of your statement, you
3 address that data collection and we have already touched
4 upon this in your evidence.

5 Data in respect of reporting incidents focuses on
6 measuring past harm and what you propose in your
7 statement is consideration of data and metrics that can
8 be helpful in assessing present safety or future safety.

9 Now, in this context in your statement you cite the
10 Manchester Patient Safety Framework Tool and that is at
11 INQ00122766. Earlier in your evidence you refer to
12 PSIRF, has PSIRF replaced --

13 A. Yes, I think the Manchester Patient Safety
14 Framework was an example of a framework but PSIRF, as
15 I understand it, is an overarching framework that
16 probably supersedes the Manchester one.

17 Q. Does it do a similar job?

18 A. Yes, yes.

19 Q. So if you can help us to understand what this
20 framework is. We need to look first, please, at page 2
21 and at the bottom it's difficult to see on the screen.
22 Well, there we go.

23 So the third section "Evaluation sheet sample" and
24 we can see there are a number of measures there with
25 rankings A, B, C, D, E.

145

1 organisations that have a mature approach to patient
2 safety, it starts as I think I have already mentioned
3 with having really encouraging staff to have a very low
4 threshold to complete incident reporting, incident
5 reports, basically. And then the self-reporting
6 exercise is essentially -- usually takes the form of
7 a monthly meeting where all reports are looked at and
8 themes are derived.

9 And within patient safety incidents there are some
10 very common themes. In paediatrics and the neonatal
11 world probably the commonest theme are medication errors
12 as an example. So you may well put out a theme around
13 medication errors. The idea then would be to dig into
14 that theme to really understand, you know, what is going
15 on, why is it that we have got this problem with, you
16 know, whatever it is around administering medicines to
17 children?

18 Then the critical question is: what's the learning?
19 What do we take away from this and what are we going to
20 do differently going forward?

21 So that is quite a sophisticated mature
22 conversation with some actions that then need to be
23 followed up on.

24 That is where I have seen it that would be for me
25 that, you know, number E, that would be the mature,

147

1 We will look at what those ranks mean in a moment
2 but effectively what this tool appears to propose or to
3 comprise is essentially self-evaluation completed by
4 staff --

5 A. That's correct.

6 Q. -- in a hospital. They would fill out this
7 section.

8 If we look at page 4, they would rank each of those
9 categories A, B, C, D, E, and that reflects a spectrum
10 from A, pathological -- why do we need to waste our time
11 on patient safety issues? -- to E, what's described as
12 generative: managing patient safety is an integral part
13 of everything we do.

14 So E is closer to what you described earlier in
15 your evidence of Trusts who are proactive and have
16 a good safety culture?

17 A. Yes.

18 Q. B is what you see in some other Trusts who
19 were much more reactive?

20 A. Yes.

21 Q. Now, when a self-evaluation tool like this is
22 completed, what happens, why do you consider that that's
23 a helpful data point for assessing present and future
24 risks as opposed to past incidents?

25 A. Well, I -- where I have seen it work well in

146

1 ideal way in which self-assessment becomes the
2 opportunity for developing a safer system.

3 Q. Yes, so is the emphasis there on it becomes
4 an opportunity because simply having an evaluation
5 probably isn't going to move you towards category E
6 alone, it's just going to tell you what your staff
7 think, but if you want to move towards category E then
8 one of the first steps might be self evaluation to see
9 where realistically you are?

10 A. Yes.

11 Q. But that begs the question of where the
12 hospital is and where they want to go?

13 A. Absolutely.

14 Q. Are there other tools or measures that you
15 would recommend that would help with assessing data that
16 tells you about safety in the present or safety in the
17 future beyond self-evaluation?

18 A. Well, there are other metrics that one can
19 draw on to assess whether how your service is
20 benchmarking, for instance against other equivalent
21 similar services. So this -- this mode of, this is
22 reacting to incident reports and self-assessment. But
23 there are other ways in which one can develop an
24 objective sense of how your service fits in against
25 similar services nationally.

148

1 **Q.** In your statement when dealing with data and
2 metrics you refer to three different programmes, two of
3 those, as I understand it, are national audit programmes
4 so we have got the National Neonatal Audit Programme,
5 NNAP, and that's operated by the RCPCH?

6 **A.** Yes.

7 **Q.** We have then got the National Maternity and
8 Perinatal Audit, the NMPA, which is led by the
9 Royal College of Obstetricians and Gynaecologists but
10 the RCPCH also contribute towards that and at
11 paragraph 24 you deal with the Perinatal Mortality
12 Review Tool.

13 Now, in broad terms can you set out what those
14 tools do and your recommendation for more information
15 sharing amongst those tools?

16 **A.** So I -- if I begin with the NNAP, the National
17 Neonatal Audit Programme, this is an audit programme
18 that derives its data from an electronic database that
19 every neonatal unit in the country inputs into -- well,
20 they did up until about just over a year ago.

21 But when -- so NNAP essentially pulls data from
22 a platform that is called BadgerNet which up until about
23 a year ago every single neonatal unit in the country was
24 entering their data into and it derives -- it's an audit
25 programme that then reports every three months, so

149

1 **A.** The data doesn't, yes.

2 So some Trusts would double-enter their data so
3 some poor soul at midnight each night has to enter
4 manually into the Badger system in order to produce the
5 NNAP return but actually many Trusts can't spare
6 somebody to do that and if they have now got
7 an electronic health record they won't be completing
8 their audit collection for NNAP. So that's that is
9 a very serious missed opportunity now because NNAP
10 really, really has got an opportunity to be a lever for
11 improvement.

12 **Q.** Has a solution been identified for how to work
13 with BadgerNet records?

14 **A.** No.

15 **LADY JUSTICE THIRLWALL:** Was the problem identified
16 before?

17 **A.** Yes.

18 **LADY JUSTICE THIRLWALL:** So it was foreseeable,
19 foreseen and still --

20 **A.** It was. I mean there are many databases that
21 don't speak to these electronic health records but
22 because of course there is a national move to move away
23 from paper notes to electronic records, that has been
24 prioritised over the --

25 **LADY JUSTICE THIRLWALL:** The data collection.

151

1 there's a rapid, you know, response time and turnaround
2 time for clinicians to be able to interrogate the
3 database in order to be able to see where my neonatal
4 unit fits compared to other neonatal units, or in fact
5 the whole country.

6 It reports around 10 outcome measures which are --
7 which are everything from mortality to, you know, how
8 well we are establishing breastfeeding rates to are
9 parents present on Consultant ward rounds? There are
10 a range of outcomes that are reported through that audit
11 programme and there's a very high level of clinician
12 buy-in so it is a trusted resource.

13 Because it reports every three months it actually
14 genuinely can, you know -- again if you have got
15 a service that's interested in how it's performing or
16 maybe worried about how it's performing, this is
17 a programme that they can go to in real-time to
18 understand actually how well or not they are doing.

19 I am caveating it slightly because with the rollout
20 of electronic health records across the NHS, many Trusts
21 are having to abandon the BadgerNet platform because it
22 doesn't speak to the electronic health -- speak as in
23 a computer IT sense speak to the BadgerNet programme.

24 So --

25 **Q.** So they are unable to upload their data to ...

150

1 **A.** -- smaller local audit programme.

2 **LADY JUSTICE THIRLWALL:** Yes.

3 **MR CARR:** What is likely to happen? Is NNAP going
4 to -- is it likely to be abandoned or is it going to
5 have to be adjusted so it can read electronic ...

6 **A.** It would be a disaster if it was abandoned.
7 There is -- there are fixes but there needs to be --
8 somebody needs to prioritise it and create -- find some
9 fundings to create a patch. But the problem is because
10 there are numerous electronic health records being
11 bought by NHS Trusts, it is not like it is a single
12 electronic health record that needs to devise a single
13 patch to speak to this BadgerNet platform. This is
14 going to have to be done piecemeal across many systems.

15 **Q.** NMPA, the National Maternity and Perinatal
16 Audit, does that do a similar thing, but ...

17 **A.** Yes, I mean, in the neonatal world we don't
18 tend to use that nearly as much because it is much more
19 maternity-focused. But of course the Royal College of
20 Obstetric and Gynaecology are of course collecting data
21 around newborn outcomes because that informs our
22 practice. That is not actually a tool that we as
23 paediatricians will be using in practice.

24 **Q.** One of the issues that you identify both in
25 respect of these audit tools but also more generally is

152

1 data flow between maternity and neonatal services being
2 inadequate. You make the point as between these two
3 tools but, as I understand it, you also make the same
4 point in terms of in hospital, so maternity data not
5 being transferred or made available to neonates and you
6 recommend that there are appropriate links between the
7 two.

8 Now in practical terms, what is it that you would
9 propose? Is it not just a case of handing over the
10 records from one unit to another?

11 **A.** Well, so for instance NMPA, which is the
12 second audit programme that we have mentioned there --
13 actually, if that was a maturer audit programme, that
14 actually could fulfil precisely that outcome. So
15 because we don't want to separate mothers from babies,
16 we want to be able to think about them holistically and
17 if you really, really want to improve care both for term
18 babies but particularly preterm babies, you do need to
19 look at them as a single entity. So actually NMPA, and
20 the reason why we as the Royal College of Paediatrics
21 and Child Health are so invested in NMPA, is because
22 we -- we value that cohesive data collection and would
23 like to see it become as mature as the Neonatal Audit
24 Programme is or was until recently.

25 **Q.** So when you are talking about data sharing
153

1 pregnancy give rise to a live birth. It then stops at
2 28 days. So NNAP goes on throughout the neonatal
3 admission but PMRT will stop at 28 days.

4 **Q.** It sounds as if it gives you more information
5 that that is relevant to mortality?

6 **A.** Yes, and thinking much more around the causes.
7 So that interacts much more with the pregnancy and
8 outcomes very early on in life.

9 **Q.** Staying with then data and metrics and
10 although not touched upon in your statement, there are
11 a number of different organisations to whom deaths have
12 to be reported. MBRRACE PMRT collects information the
13 Child Death Overview Panel. What's the view of the
14 RCPCH as to these parallel reporting obligations?

15 **A.** So with respect to death, we have -- we have
16 a requirement to report to our Child Death Overview
17 Panel, so that is CDOP, we also have a requirement to
18 fill out PMRT which feeds into MBRRACE which is the
19 maternity death and confidential Inquiry database.

20 They -- so when a baby dies one is inputting
21 information to both those systems. They are asking --
22 of course they are both curious about the death but they
23 are asking very different questions, some of which you
24 can sort of see a bit of relationship but they kind of
25 diverge off into different directions.
155

1 between maternity and neonatal, it is for the purpose of
2 analysing for these sorts of tools rather than actual
3 clinical care being given to patients?

4 **A.** Yes. And I have to say on the positive side
5 these electronic health records that Trusts are rolling
6 out actually are allowing mothers and babies' notes to
7 be closely linked. Certainly as a neonatologist, I can
8 interrogate in a huge amount of detail any one of my
9 patient's mother's notes. So that is an advantage of
10 these electronic health records.

11 **Q.** So easier at a micro level but problems at
12 a macro level --

13 **A.** Yes.

14 **Q.** -- because of the auditing systems?

15 **A.** Yes.

16 **Q.** Finally the PMRT, the Perinatal Mortality
17 Review Tool, what does that do that NNAP doesn't do and
18 what do you see as the significance of --

19 **A.** Well, so PMRT only looks at death whereas NNAP
20 is looking at mortality but also quality of care across
21 a number of parameters. So of course analysis of death
22 gives us a lot of learning opportunities. So yes, it is
23 a really important tool but it's addressing a different
24 set of questions. PMRT looks at essentially 20 weeks
25 gestation through up until 28 days of life, should the
154

1 It would be much more efficient if somehow they
2 were aligned. But they are funded separately. You
3 know, the CDOPs are funded by local government and they
4 report their death data into the National Child
5 Mortality Database, whereas PMRT is part of MBRRACE, it
6 is much more of a research tool. It was set up as
7 a research tool. It's entirely different to the CDOP
8 process which is a statutory process.

9 So they are not at all well aligned and hence
10 the -- you know, the need for dual reporting.

11 **Q.** Does the RCPCH consider that there is
12 inefficiency in having to report the same thing in many
13 different ways?

14 **A.** Yes.

15 **Q.** In respect of the Child Death Overview Panel,
16 are there any particular observations that you have as
17 to the benefits and working of that system?

18 **A.** So the Child Death Overview Panels have been
19 in existence for some years now and of course the
20 healthcare landscape has changed a lot in that time and
21 I am thinking particularly of the introduction of
22 integrated care systems.

23 So the geography, what would be ideal is if each
24 integrated care system had one CDOP process. Because if
25 we really want -- if we believe in the integration of
156

1 other healthcare systems, and actually at RCPCH we
 2 really do believe that integration is a really important
 3 tool for improving child health outcomes because
 4 understanding children in your geography, in your place,
 5 allows you to think about them in a unique way and
 6 understand how you can improve children's health and
 7 wellbeing.

8 So what would be ideal would be if the CDOPs, you
 9 know, literally linked directly to an integrated care
 10 system and spoke really closely to it but we -- we
 11 haven't got into that place yet because the ICS came
 12 into being after the CDOPs were set up.

13 **Q.** Thank you.

14 If we can move to your third element,
 15 an established safety culture.

16 At the end of your paragraph 25, you state:

17 "The RCPCH has concerns that patient safety
 18 policies are not being implemented effectively because
 19 safety culture is not always embedded in hospitals."

20 What are the barriers to embedding safety culture,
 21 is it the point that you have already made in respect of
 22 resources or are there additional barriers?

23 **A.** I -- it is partly resources but we also know
 24 that in places there may be racism, there may be
 25 bullying and undermining, and these are all barriers to

157

1 **A.** Yes.

2 **Q.** The key part of it, it seems -- but tell me if
 3 I am wrong -- is page 2, the second paragraph, when
 4 looking at assessing culture, there is reference there
 5 to second sentence:

6 "Within the MatNeoSIP programme in England
 7 a comprehensive safety culture, SCORE, Safety,
 8 Communication, Organisational Reliability, Engagement
 9 survey took place across all maternity and neonatal
 10 services between 2017 and 2018. There were plans in
 11 place to repeat these surveys."

12 So that looks again like some form of
 13 self-evaluation tool to assess culture.

14 Is this the reason that you have cited this
 15 document?

16 **A.** Yes. I mean, I think it's the document in
 17 totality which is essentially suggesting a number of
 18 different tools. I mean, they mention for instance
 19 trainee feedback surveys which is another really
 20 valuable way of getting insight into your kind of
 21 services, culture and so on. Trainees who rotate around
 22 the region and don't have a vested interest necessarily
 23 in your service are often much freer to speak up so they
 24 provide a very important kind of resource to kind of
 25 illuminate areas where perhaps you might need to focus

159

1 people essentially having psychological safety to be
 2 enabled to speak up about, you know, the kinds of unsafe
 3 practice they might be observing in their day-to-day
 4 clinical practice.

5 **Q.** So toxic work environments essentially?

6 **A.** Yes.

7 **Q.** You have referenced in this section of your
 8 evidence at your paragraph 26 the British Association of
 9 Perinatal Medicine guidance to support service Leaders.
 10 We can get up the document if necessary, but that
 11 appears to be another essentially self-evaluation tool,
 12 the SCORE system.

13 Is that similar to the Manchester Patient
 14 Framework, but just with a different focus -- a similar
 15 tool but a different focus?

16 **A.** I believe so. I'm afraid I would have to look
 17 at it, but --

18 **Q.** We can get up the document you have
 19 referenced, it is INQ0012282. What you describe in your
 20 statement is that:

21 "The British Association for Perinatal Medicine has
 22 developed guidance to support service leaders and
 23 healthcare professionals to understand and evaluate its
 24 culture in neonatal care ..."

25 Then you have cited this document?

158

1 attention on improving culture.

2 So I think the totality of this document is just
 3 about providing ways in which services might be able to
 4 assess their workplace culture.

5 **Q.** For completeness, so you have referred to
 6 trainee feedback surveys which is on that page. We also
 7 see in the paragraph that follows robust reporting
 8 mechanisms. If we go to the final page of that
 9 document, page 3, it describes in -- forgive me, page --
 10 the final page of the text, page 3, second paragraph
 11 refers to specific scales to examine interprofessional
 12 working?

13 **A.** Yes.

14 **Q.** So it's all of the measures described in this
 15 which you think can assist in improving safety?

16 **A.** Yes.

17 **Q.** When you describe then in your statement at
 18 paragraph 26, that front line healthcare staff could be
 19 made more aware of these tools, it's all the different
 20 tools in here that you are saying should be communicated
 21 or should be within the awareness of front line
 22 healthcare staff?

23 **A.** Yes.

24 **Q.** Now, you conclude this section by commenting
 25 that the RCPCH are supporting BAPM with a call for the

160

1 appointment of a national Neonatal Safety Champion to
2 work alongside the champions for obstetrics and
3 midwifery.

4 Now, does it follow from that that there were
5 already Safety Champions for obstetrics and midwifery,
6 National Safety Champions for obstetrics and midwifery?

7 **A.** My understanding is that they are -- well, the
8 last time I -- my understanding is that the two -- the
9 Chief Midwife and the National Clinical Director for
10 women's are acting as co-National Maternity Safety
11 Champions.

12 **Q.** Are these different to the Neonatal Safety
13 Champions that you described earlier --

14 **A.** They would be, yes.

15 **Q.** -- which would work within hospitals and have
16 access to boards?

17 **A.** Yes, so that would be within every
18 organisation you would have that.

19 **Q.** So this is a single national --

20 **A.** Correct, yes.

21 **Q.** What would they do, what would they achieve?

22 **A.** Well, that national oversight would allow, you
23 know, all Trusts to feed into a single -- a single
24 person. I think also a Neonatal Safety Champion working
25 closely with the Maternity Safety Champions actually

161

1 **Q.** So can you elaborate on what they would do and
2 how that would help to address the lack of clarity on
3 managing risks emanating from the paediatric department?

4 **A.** So yes, we have advocated for a named
5 Non-Executive Director on every acute Trust board as
6 well as a named member of every Integrated Care Board --
7 sorry, a named lead for children on every Integrated
8 Care Board.

9 And this is because we have seen so many examples
10 of where children and babies essentially slip between
11 the cracks and so unless somebody is speaking up for
12 thinking about children, they often get forgotten or
13 deprioritised. I think, you know, there is
14 an assumption that children are generally healthy and
15 well and don't need the kind of level of focus that we
16 know they do.

17 I think particularly as the landscape around the
18 kind of care we are delivering for children in this
19 country is changing, and complexity of care is
20 increasing as not only is it risky but actually these
21 children deserve a profile that is on a par with adults.

22 **Q.** Again, to be clear, this would be different to
23 a Neonatal Safety Champion?

24 **A.** Well, ideally you want somebody who speaks up
25 for all children. I don't think we would -- we

163

1 start providing that kind of more comprehensive thinking
2 around the continuum of maternity and newborn care and
3 the safe delivery of that care and it means also that
4 the baby doesn't get forgotten. Because so often -- and
5 I do understand this. And many of our maternity
6 inquiries, the focus has been very much on the mother
7 for very, very good reasons.

8 But the -- it is often forgotten that there is
9 a baby and particularly if that baby has been born early
10 that actually they have very specific needs and safety
11 issues are paramount. So it's just about, I guess,
12 parity of mother and baby and keeping the baby central
13 to the safety message.

14 **Q.** If we look, please, at your fourth element,
15 "Appropriate lines of accountability up to Board level".
16 The point that you make here is that your members are
17 confident using existing mechanisms to escalate safety
18 and risk concerns within paediatric departments but
19 where there is a lack of clarity is how that risk is
20 going to be managed and beyond the paediatric department
21 and the reporting responsibilities to board level.

22 What is recommended it appears to address this, is
23 a children's lead at the highest level of every NHS
24 organisation?

25 **A.** Yes.

162

1 definitely wanted. So, for instance, my own Trust
2 the -- the -- that person reporting to board level would
3 be speaking on behalf of all children and babies.
4 I don't think we are necessarily suggesting duplication
5 of roles -- but that person needs to be clear that they
6 are responsible for articulating the safety concerns of
7 babies and children because they may be in different
8 departments.

9 **Q.** Your fifth element, which is related to your
10 fourth element, is timely response and action when
11 concerns are raised. So the fourth element was
12 appropriate lines of accountability.

13 You reference there the lack of clarity when safety
14 concerns are raised by paediatricians. In your fifth
15 element, you describe the fact -- and this is your
16 paragraph 30 -- that where safety and risk issues are
17 raised by paediatricians, there is rarely communication
18 back to describe what actions are being taken or what
19 the timelines are, there is a lack of clarity about
20 who's responsible for responding to concerns?

21 **A.** (Nods)

22 **Q.** You identify that there is no national
23 standard setting out when patient safety concerns should
24 be responded to, in what time or in a timely and
25 proportionate manner. Is that a recommendation proposal

164

1 that you on behalf of the RCPCH make?

2 **A.** It is, and if we had the structures in place,
3 along the lines of a clearly named board level member
4 speaking, you know, with a remit for children and
5 children's safety, then that would be the obvious
6 vehicle to try and deliver on clarity around escalation
7 of concerns for children in an organisation and a kind
8 of reporting back mechanism.

9 **Q.** So what you are -- what you would be proposing
10 is a national standard which identifies that where risks
11 or concerns are raised by paediatricians, this is the
12 person who should deal with it, this is the time frame
13 in which it should be dealt with and communicated back
14 to the paediatrician?

15 **A.** Yes.

16 **Q.** You identify and explain that the system as it
17 is at present with a lack of response, that can
18 undermine the confidence that a paediatric department
19 has?

20 **A.** Yes.

21 **Q.** That deals with your five elements in respect
22 of governance and management structures.

23 There are two further points you deal with in your
24 statement, the first is professional regulation and what
25 you identify is that there are a significant number of

165

1 patient safety and they seek to influence standards and
2 with their external legitimacy they exert what is
3 described as regulatory influence on provider
4 organisations?

5 **A.** (Nods)

6 **Q.** Now, if we can go to the conclusion of this
7 paper, please, at page 8., it is on the right of the
8 page, that there are two broad points that are made, one
9 the regulatory system in -- of the NHS has evolved, so
10 it's not been created by design, and it is suggested
11 that it is not fully understood, even by professional
12 regulators and it's very difficult -- impossible is the
13 word used -- for the general public to navigate the
14 system and that there is a suggestion that the overall
15 impact of the regulatory system hinders its
16 effectiveness.

17 Now, this appears to be a point that you are
18 echoing in your statement. What is the position of the
19 RCPCH in respect of professional regulation and what
20 proposals do you make?

21 **A.** Well, I mean, regulation is important so we
22 are not suggesting that isn't the case. But I think
23 when you have such a kind of I guess bewildering
24 landscape and actually since this paper has been
25 published, I think there already it's now inaccurate

167

1 different regulatory organisations or organisations with
2 regulatory influence.

3 Do you have those paragraphs?

4 **A.** Yes, sorry.

5 **Q.** Paragraphs 31 to 33. In particular you cite
6 a paper from the BMJ, it is INQ0012289, the title is.

7 "Patient safety regulation in the NHS: mapping the
8 regulatory landscape of healthcare."

9 It has the useful chart if we can go to it, please,
10 it is page 5 of the document. If we can rotate it, if
11 that's possible. There we go. This sets out what this
12 paper identifies and you have cited in your statement
13 the 126 organisations exerting some regulatory influence
14 in the NHS.

15 **A.** Yes.

16 **Q.** Now, as acknowledged in the paper,
17 a significant number of these bodies are not regulators.

18 So, for instance, we can see there is a section, there
19 is a box underneath the word "Trust" in the middle
20 "Royal Colleges" and your organisation, the RCPCH, would
21 not consider itself a regulator?

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

23 **Q.** But the point made in this paper is that there
24 can be organisations that have regulatory influence
25 because they are concerned, as the RCPCH is, with

166

1 because other groups have superseded some of them, so
2 (inaudible) my world is now Maternity and Neonatal
3 Safety Inspectorate which is a group of -- branch of
4 CQC, it's constantly evolving and I think we -- in
5 a perfect world, it requires somebody or a body to have
6 a fresh look at it all and try and create some clarity
7 because and almost certainly there will be some
8 redundancy or overlap within these numerous structures.

9 I think for the --

10 **Q.** I think the -- forgive me, sorry, carry on?

11 **A.** I think for the individual clinician or group
12 of clinicians who may be worried about safety in their
13 own environment it is -- it is perfectly conceivable
14 they really wouldn't know where to go to for help.

15 **Q.** So the concern is confusion on the part of the
16 professionals who have to use these regulators. Is
17 their concern that the number of bodies in that
18 confusion means that you are at risk of having issues
19 fall through the cracks?

20 **A.** Yes.

21 **Q.** Is the proposal that there should be
22 consideration of harmonisation and improving
23 efficiency --

24 **A.** Yes.

25 **Q.** -- of the regulatory landscape.

168

1 We can take that down. Thank you.
 2 Regulation of senior managers. You deal with this
 3 at paragraphs 34 and 35 of your statement. You identify
 4 that the RCPCH has already expressed support for
 5 regulation of NHS managers. It did so in response to
 6 the Inquiry -- the Northern Ireland Inquiry into
 7 hyponatraemia-related deaths, INQ0012287. It is a joint
 8 response by a number of organisations as we can see
 9 there from the first page, and it is page 15 of that
 10 document.

11 As I understand it, it's under 5.1, specific
 12 recommendations. In response to Recommendation 55, it
 13 says we agree -- Recommendation 55 is that:

14 "Trust Chairs and Non-Executive Board Members
 15 should be trained to scrutinise the performance of
 16 Executive Directors particularly in relation to patient
 17 safety objectives."

18 The response is:

19 "We agree this recommendation is a starting point
 20 but strongly advise that new models of regulations and
 21 accountability to assess the performance of medical
 22 managers and Trusts should be developed."

23 So that is the section that you are citing in your
 24 statement; is that right?

25 **A.** Yes.

169

1 because we do think there is value in thinking about
 2 this very carefully.

3 **Q.** Moving away from your statement, and I am
 4 getting towards the end of my questions now.

5 I want to address first the issue of safeguarding
 6 and particularly given your experience that you have in
 7 teaching paediatricians. A feature that has emerged
 8 from the evidence that the Inquiry has heard is that
 9 whilst there is safeguarding guidance Working Together
 10 to Safeguard Children, statutory guidance, there was not
 11 a referral to the Local Authority Designated Officer as
 12 soon as possible concerns of deliberate harm were
 13 suspected and even when the RCPCH reviewers went in,
 14 obviously included some experienced paediatricians, this
 15 issue of safeguarding guidelines, referral to the Local
 16 Authority Designated Officer, does not did not seem to
 17 be engaged with.

18 What is the level of understanding of raising
 19 safeguarding concerns amongst paediatricians when those
 20 concerns relate to fellow members of staff?

21 **A.** So safeguarding is a core activity for all
 22 paediatricians and all paediatricians and children's --
 23 anyone working directly with children have to undertake
 24 what is called Level 3 Child Protection Training and
 25 there is a curriculum that's been developed and that is

171

1 **Q.** The RCPCH's position is that there ought to be
 2 regulation of NHS managers?

3 **A.** We -- we don't have an established position as
 4 such. We -- in light of Justice O'Hara's findings, we
 5 were supportive of it but that, but there is an active
 6 consultation happening at the moment and we will be
 7 contributing our viewpoints to that.

8 **Q.** Does the RCPCH have a view as to the impact
 9 that regulation of managers would have on patient
 10 safety?

11 **A.** I think our view is that, you know, doctors
 12 and nurses are regulated. And because -- as the health
 13 service has developed into a very complex ecosystem, we
 14 now know that our managers who are not nurses and
 15 doctors actually are making really key decisions for
 16 instance around resource allocation and so on that are
 17 as germane to patient safety as the kinds of decisions
 18 I might make as a clinician and therefore it does seem
 19 anomalous that they are not regulated. But we also
 20 recognise that doctors and nurses have clear training
 21 pathways and the opportunities to regulate possibly are
 22 clearer and more straightforward.

23 So, you know, I don't think we are pretending that
 24 this is a straightforward outcome to achieve but it
 25 certainly, we will be participating in the consultation

170

1 actually mandated by every Trust and we are required to,
 2 you know, revalidate it every three years.

3 So -- but the-- this case having highlighted the
 4 deficiencies and people's understanding of the role of
 5 the Local Authority Designated Officer in looking at our
 6 Level 3 Safeguarding Training, actually that is not
 7 referred to. So it is the case that for most
 8 paediatricians, they will actually not have heard of
 9 a Local Authority Designated Officer.

10 **Q.** So hitherto, that wasn't -- that didn't form
 11 part of the Level 3 training?

12 **A.** That's correct. And unless you were a named
 13 doctor for child protection, in which case you would
 14 undertake Level 4 Child Protection Training, or
 15 a designated doctor, which is Level 5 Child Protection
 16 training, there the role of the LADO is part of the
 17 training but that is a small subset of paediatricians.

18 **Q.** Yes. So that is a deficiency on the
 19 training --

20 **A.** It is.

21 **Q.** -- because the statutory guidance makes clear
 22 it should be read by everybody working in healthcare
 23 with children. Has that now changed, has that
 24 deficiency been addressed?

25 **A.** It hasn't changed yet but it -- it will.

172

1 Q. When?

2 A. Well, as -- I -- I will take that away and
3 action it with the College as soon as possible.

4 **LADY JUSTICE THIRLWALL:** Perhaps you could give us
5 an update on that when that's been done?

6 A. We can, yes.

7 **MR CARR:** A related issue, and again it arises from
8 statutory guidance, Working Together to Safeguard
9 Children, although there are also local guides on it,
10 Sudden Unexpected Death in Childhood, so SUDiC
11 guidelines. There seems to be or seemed to be at the
12 time at least a level of confusion as to whether those
13 guidelines applied to sudden deaths in hospital rather
14 than in the community.

15 Again, what is your understanding as to the
16 teaching of when SUDiC guidelines apply, if they should
17 apply in hospitals, and has that changed as a result of
18 the events at the Countess of Chester?

19 A. So it -- I think it's true to say that up
20 until very recently the teaching and our curriculum has
21 not highlighted Sudden Death in Infancy and Childhood
22 well enough. That has been remedied because we have
23 an outcomes-based curriculum which is very easy to
24 update, so that has been updated.

25 That's not enough. So we are now actively working
173

1 rather than the other or would that be left to the
2 Coroner?

3 A. I think -- I mean, all doctors know -- should
4 know the difference between a forensic postmortem and
5 a standard postmortem. Truthfully in the neonatal
6 world, I have not come across that specifically. But
7 that -- the crucial step in any postmortem discussion is
8 around having the conversation with either the Coroner
9 or the pathologist around what the clinical question is.

10 So I am not trying to hedge your question. Because
11 I -- I probably wouldn't use the word "forensic". But
12 that doesn't mean that if I have got some very specific
13 questions that I wouldn't be on the phone discussing it
14 with the person performing the postmortem so that they
15 know what the clinical uncertainty is.

16 Q. So where there are particular concerns, direct
17 communications between the neonatologist and the
18 pathologist is something that should in your view occur?

19 A. Absolutely.

20 Q. The final question that I have, please, is in
21 respect of leadership training. So the RCPCH plays
22 an important role in educating paediatricians. Within
23 neonatal units, within paediatrics, there are clinicians
24 who will rise to take up leadership roles.

25 Does the RCPCH provide specific training for those
175

1 with e-learning for health, which is an online learning
2 platform, NHS learning platform, to create an online
3 resource, and as a College, we will be providing
4 a bespoke course.

5 Q. What support and/or training is given to
6 paediatricians or guidance as to their communications
7 with Coroners? Is that something that forms part of
8 their training, the duty to communicate fully with
9 Coroners, raising concerns with Coroners and
10 communicating with pathologists, how does that feed into
11 the training?

12 A. It's certainly part of the neonatal
13 sub specialty curriculum. Neonatology is a specialty
14 that deals with a lot of death and so it is -- so we
15 have a requirement, for instance, for our trainees to
16 attend postmortems, be familiar with and have undertaken
17 the full completion of the recording and reporting of
18 death including interaction with the Medical Examiner,
19 thresholds, speaking to the Coroner; that is absolutely
20 part of neonatal training.

21 Q. Would you expect neonatologists to know the
22 difference between a forensic postmortem and
23 a non-forensic perinatal postmortem, is that something
24 that you would anticipate neonatologists knowing the
25 difference between and knowing when to request one
174

1 roles and are there any recommendations that you would
2 make in respect of the approach to training for
3 leadership?

4 A. Our new curriculum now has formalised
5 leadership as one of the learning -- it is a core
6 curriculum outcome for anyone completing training to the
7 level of a Consultant paediatrician.

8 And there is a whole kind of sub-curriculum that
9 goes with that. For paediatricians who wish and take on
10 formal leadership roles we offer a variety of resources
11 and have an ongoing continuum, you know webinar -- type
12 leadership professional development series and then in
13 addition most Trusts will put on leadership development
14 programmes and then we signpost to organisations like
15 the Faculty of Medical Leadership and Management who
16 have, you know, very -- very expensive but very good
17 courses.

18 Q. The courses are very expensive?

19 A. Yes.

20 Q. Are they funded by the Trust or are they
21 funded by the individual?

22 A. Well, all Consultants will have a study leave
23 budget, but my experience is most of these courses are
24 way in excess of your annual budget so yes, most people
25 end up paying for themselves.
176

1 **MR CARR:** Dr Kingdon, thank you for answering my
 2 questions.
 3 My Lady, those are all the questions I have.
 4 **LADY JUSTICE THIRLWALL:** I think we have got
 5 questions from Mr Skelton first off.
 6 Questions by MR SKELTON
 7 **MR SKELTON:** Dr Kingdon, I ask questions on behalf
 8 of one of the Family groups. Can I just ask you
 9 a little bit more about the SUDiC process, if I may?
 10 **A.** Yes.
 11 **Q.** It might help if I have on screen INQ0016484,
 12 can I ask you these questions with both your hats on, so
 13 your Consultant neonatology hat and your past President
 14 of the Royal College hat, if I may?
 15 **A.** Of course.
 16 **Q.** So this is the guidance I think which was --
 17 is from your hospital although I think it was October 21
 18 to October 24, so it may in fact have been superseded
 19 recently but I think it is still probably
 20 representative. If we go to page 3. It will probably
 21 have to be expanded a bit but if we expand the top --
 22 that is it -- left, you can see the notification process
 23 which now includes the Medical Examiner system?
 24 **A.** Yes.
 25 **Q.** And down at the bottom left there is the

177

1 deteriorate --
 2 **Q.** Without it being expected, and die?
 3 **A.** That's not an uncommon scenario on a neonatal
 4 unit. Preterm babies can deteriorate very suddenly and
 5 it may be that you don't get the explanation until for
 6 instance potentially a blood culture result comes back
 7 which may be after death. So it's not uncommon to have
 8 an unexpected death on a neonatal unit.
 9 **Q.** So the scenario in this case is that the
 10 children were stable and not expected to suffer
 11 collapses or deteriorations and then they didn't respond
 12 appropriately to resuscitation, which caused alarm on
 13 the part of the paediatric team for obvious reasons.
 14 So can I just be clear, is that not the type of
 15 scenario that you would envisage falling within the
 16 SUDiC criteria?
 17 **A.** I wouldn't, no.
 18 **Q.** You would not?
 19 **A.** It's -- it -- but for a baby to be on
 20 a neonatal unit they are -- they are not normal healthy
 21 babies. So -- so and we know that, for instance,
 22 infection, a nasty complication of prematurity in
 23 relation -- in relation to the gut, can strike very,
 24 very suddenly and lead to unexpected death. So the --
 25 we -- we would always discuss with the Medical Examiner.

179

1 unexpected child death aspect, if you can move it down
 2 and the Joint Agency Response or JAR which we have heard
 3 a lot about. Can you see that? I appreciate it is
 4 quite small, bottom left?
 5 **A.** Yes.
 6 **LADY JUSTICE THIRLWALL:** Bottom right, I think.
 7 **MR SKELTON:** Sorry, bottom right. Sorry.
 8 Now, I don't know whether you were here this
 9 morning for the evidence of Dr Fletcher?
 10 **A.** No, I'm afraid I wasn't.
 11 **Q.** Is it your understanding that the Medical
 12 Examiner process can run in parallel with the Joint
 13 Agency Response or are they separate and one takes
 14 precedence?
 15 **A.** My understanding is that both are both well,
 16 they run in parallel.
 17 **Q.** So a child -- so many of the children as you
 18 know suddenly deteriorated at the hospital --
 19 **A.** Yes.
 20 **Q.** -- without medical explanation, so on the face
 21 of it they would meet the criteria or at least one of
 22 the criteria for JAR, a Joint Agency Response; is that
 23 right from your perspective?
 24 **A.** As a -- if I am answering as a neonatologist,
 25 so if these are babies on a neonatal unit who suddenly

178

1 I am afraid I don't know how often the JAR would be
 2 activated in a preterm baby that had collapsed on
 3 a neonatal unit.
 4 **Q.** Dr Garstang who gave evidence who works in
 5 Birmingham and is also a safeguarding Professor --
 6 **A.** Yes.
 7 **Q.** -- she said that in her jurisdiction, if I can
 8 call it that, the SUDiC process would be triggered
 9 automatically for a death of a child in hospital because
 10 you need to do every -- a belt and braces investigations
 11 for every child no matter whether you -- no matter what
 12 their background and it involves -- without judgment it
 13 involves a multi-agency approach and you can rapidly
 14 presumably rule out foul play and things like that, but
 15 it is from the start that process needs to be triggered
 16 and followed through. Dr Brearey, the lead
 17 neonatologist at the Countess of Chester, didn't take
 18 that approach. Dr Subhedar in Liverpool and Alder Hey
 19 didn't take that approach.
 20 So it is clear there is quite an inconsistency of
 21 view. It may be felt that in the context of this
 22 Inquiry that the Dr Garstang approach is the safest
 23 approach?
 24 **A.** That might be -- might well be correct.
 25 I don't know if Dr Garstang is referring to a neonatal

180

1 unit, she may be talking about death within Birmingham
 2 Children's Hospital which doesn't have a neonatal unit.
 3 **Q.** So as far as you are concerned, you would not
 4 see it as being appropriate, would you, to trigger?
 5 **A.** I am not saying it is not appropriate I. Am
 6 saying I am not surprised the other people you mentioned
 7 wouldn't have thought of activating it.
 8 **Q.** It may be felt that it is something that ought
 9 to be changed --
 10 **A.** It may well be.
 11 **Q.** -- that children that die in hospital, and
 12 even neonates who are by definition very small and very
 13 unwell, still need to have that form of investigation in
 14 order to exclude causes of death which wouldn't
 15 otherwise be identified including foul play; do you
 16 understand that?
 17 **A.** Oh, of course I do, yes.
 18 **Q.** The existing guidance, both I think the joint
 19 guidance that Baroness Kennedy was involved in, which
 20 involved your College and the Royal College of
 21 Pathologists and the national guidance that the Cabinet
 22 Office produced on the CDOP, Child Death Overview,
 23 doesn't make that presently clear either that children
 24 have to be investigated under JAR or SUDIc if they die
 25 in hospital or particularly neonates who suddenly die

181

1 Medical Examiners is definitely a step in the right
 2 direction because it's another clinician that one can
 3 speak to about a cause of death, but the world of
 4 neonatology is very specialised now and I think most of
 5 our Medical Examiners are adult trained clinicians. So
 6 to expect them to have the kind of degree of knowledge
 7 and for me as a neonatologist to be able to have the
 8 kind of detailed conversation, you know, when I am
 9 really troubled about what could have happened that
 10 triggered this child's death I think is expecting quite
 11 a lot of -- of clinicians who are dealing with all
 12 deaths in a busy, you know, general hospital.

13 So I think in a perfect world an advance on the
 14 current Medical Examiner system might be to have
 15 regional either Neonatal Medical Examiners or at least
 16 Paediatric Medical Examiners so people with specific
 17 training around death in childhood or death in the
 18 newborn period.

19 **Q.** Dr Fletcher, the Chief Medical Examiner --
 20 **A.** Yes.
 21 **Q.** -- this morning I asked him some questions
 22 about the need for a Paediatric or Neonatal Medical
 23 Examiner, a specialism on the basis that there are
 24 physiological differences with children which don't
 25 appear in adults and also there are safeguarding

183

1 unexpectedly.
 2 Is that something that needs to be considered by
 3 the two Colleges and/or HMG?
 4 **A.** Well the -- the joint, the Kennedy guidelines,
 5 as they are called, actually are out of date and --
 6 **Q.** Yes.
 7 **A.** -- in need of updating and if this sounds like
 8 a topic that would be perfect for a focused piece of
 9 work and collective thinking about -- about, you know,
 10 that would be something that could be undertaken in
 11 the -- in the update, although there isn't a plan or
 12 funding to do the update as things currently stand.
 13 **Q.** If the SUDIc process doesn't apply and the
 14 benefits of the SUDIc process are obvious, it is a joint
 15 response?
 16 **A.** Yes.
 17 **Q.** It involves a degree of independence, it
 18 involves other organisations externally like the police
 19 or the Coroner, but if that doesn't apply how would the
 20 existing processes of death investigation that you apply
 21 say in your own hospital pick up concerns about foul
 22 play unless somebody stepped up and, as it were,
 23 whistleblow?
 24 **A.** So I think it can be difficult and quite
 25 frustrating. So at the moment, the advent of the

182

1 vulnerability issues. Could you explain your own
 2 justifications for having a specialist Medical Examiner?
 3 **A.** Well, I suppose it goes back to my -- you
 4 know, when you were speaking to me about sudden death on
 5 the neonatal unit. The signs that can lead up to
 6 a catastrophic collapse in a newborn can be very, very
 7 subtle. And so it -- one not infrequently can be in
 8 a situation where a baby has collapsed very
 9 unexpectedly, where you have got some suspicions about
 10 what might be might have led to that death, but you are
 11 really wanting to you are look at it in more detail. It
 12 might be that you actually want to get the Coroner
 13 involved but maybe the Coroner's threshold wherever you
 14 are working, the threshold to react and take on the case
 15 is not quite -- isn't aligned with yours.

16 So to be able to have a Medical Examiner who has
 17 got that degree of appreciation, I think it's quite
 18 a tall ask of somebody who's probably predominantly
 19 looking at death in frail elderly people and so on.

20 So I think there would be huge mileage to having
 21 people with particular expertise within child health.

22 In my own organisation we have one Medical Examiner
 23 who is a paediatrician but if it is a day that she is
 24 not rostered to work, we don't have access to that level
 25 of expertise.

184

1 Q. One of the counterarguments I think
 2 Dr Fletcher put was that there are lots of medical
 3 specialties, cardiology, neurology, orthopedics and all
 4 sorts and people die from all sorts of complex medical
 5 reasons which require specialist knowledge?
 6 A. Yes.
 7 Q. The generalist Medical Examiner will be well
 8 aware that there is a need for specialist input to their
 9 investigation. Why can't they obtain that input from
 10 a neonatologist or a paediatrician, why do they need to
 11 have a specialist knowledge themselves?
 12 A. Because -- well, I would argue it is because
 13 I am talking about 20% of the population, I am not
 14 talking about cardiology, you know, which is
 15 a specialty, I am talking about the complexity of all
 16 diseases in children.
 17 I mean, we train for eight years to become
 18 paediatricians. I think it's -- it -- you have got
 19 to be able to understand everything from a, you know
 20 22/23 week gestation preterm baby and all the
 21 complexities of that all the way up to a 17 year old.
 22 I think, with the greatest respect to the National
 23 Medical Examiner, that is a very tall ask of a Medical
 24 Examiner and I think we really, really want to
 25 understand child death and understand when it needs, for
 185

1 in practice, it doesn't go down. We don't tend to go
 2 down the JAR/SUDIc approach. I think, you know, we
 3 recognise that sometimes we can't explain why small
 4 babies die, we have a suspicion. A lot of the
 5 investigations we do with small babies are
 6 problematical, so, you know, you might be considering
 7 sepsis as a cause for a baby's sudden collapse but
 8 actually, you know, when you have got a 600-gram baby,
 9 the volume of blood, you have sent the laboratory to
 10 look for signs of sepsis may have been inadequate so you
 11 are left with not the full picture of investigations.
 12 I'm afraid it is -- it is not uncommon for there to
 13 be a degree of clinical uncertainty as to the precise
 14 reason why a particular baby collapsed and died.
 15 Q. I understand that --
 16 A. But it is usually in the context of a very at
 17 risk situation.
 18 Q. I understand that. The difficulty is in the
 19 context of this Inquiry that that very uncertainty
 20 creates an opportunity for those that want to kill
 21 a child without it being spotted. Obviously some of the
 22 children were injected with air, some of them with
 23 insulin, and that was not picked up by any of the
 24 investigative processes while the babies were being
 25 looked at internally in the hospital or indeed in the
 187

1 instance, escalation to the Coroner, we do need to have
 2 resources that allow us to have those kind of
 3 conversations.
 4 Q. You have mentioned escalation to the Coroner.
 5 What is, as far as you are concerned, the threshold when
 6 a neonate dies in a hospital setting for getting the
 7 Coroner involved?
 8 A. Well, from the -- from the clinical
 9 perspective, the threshold is you can't explain you --
 10 actually can't think of what the cause of death was.
 11 For me, that would be the trigger to have a conversation
 12 with the Coroner.
 13 It depends on the Coroner you speak to. Some will
 14 -- you know, one you will end up having a conversation
 15 with, explain what your clinical question is and they
 16 will undertake to look at the case. But there will be
 17 others that are of the view: well, preterm babies die
 18 and put prematurity as the cause of death.
 19 Q. Going back to the SUDIc criteria. I focused
 20 on the unexpected death but the death without medical
 21 explanation, would that also trigger a SUDIc process?
 22 Not only was it unexpected but immediate analysis
 23 doesn't provide an explanation for why the child has
 24 died medically?
 25 A. Certainly in -- in the -- as things currently
 186

1 Coronial system.
 2 So I am trying to understand how that can be
 3 stopped using the existing mechanisms, the Medical
 4 Examiner, the SUDIc process or the Coroner, and it does
 5 certainly require paediatricians such as yourself to
 6 engage those systems, doesn't it? So the criteria need
 7 to be satisfactory for that?
 8 A. Yes. I -- I agree. And, I mean, it might be
 9 that we need to rethink with the Medical Examiners the
 10 Coroners, the SUDIc guidelines, how, you know, what the
 11 triggers would be for us to activate all three of those
 12 or where the Medical Examiner alone is, you know the
 13 single person that we discuss the case with.
 14 Q. The second issue I would like to ask you about
 15 is just support for the paediatrician who has concerns.
 16 As you may know independently it appears several of the
 17 senior paediatricians and possibly some of the junior
 18 paediatricians started to suspect there was some form of
 19 harm taking place at the hospital but they were very
 20 isolated at least for a period of time and I wonder if
 21 there is a role for the Royal College supporting the
 22 paediatrician who finds themselves in that situation.
 23 So someone that needs advice on what to do and the
 24 reason that support might be required is that it is now
 25 infamously known that the whistleblower may suffer huge
 188

1 consequences personally and professionally for raising
2 concerns and the Speak Out process is very valuable but
3 hasn't necessarily provided the support that some
4 doctors have needed in order to get themselves heard.

5 I wonder if there should be some advice given to
6 your members on a helpline, what to do if you have
7 concerns, who to contact, and the support that could be
8 provided and associated with that?

9 **A.** As a membership organisation I -- I -- I can
10 see that we would, could should have a role in this.
11 I -- I would struggle to imagine how a Royal College
12 would for instance offer a hotline that was available
13 24 hours a day. I don't think, well -- Royal Colleges
14 don't have the resources for that kind of activity.

15 I do slightly beg to differ on -- I do think the
16 Freedom to Speak Up Guardians and the Guardian of Safe
17 Working, which is the member of -- every acute Trust has
18 a Guardian of Safe Working for trainees, junior doctors,
19 to escalate concerns to. Where they work effectively
20 they are an incredibly valuable resource and they do
21 provide confidential -- they are a confidential resource
22 and certainly in organisations that take Speak Up
23 seriously, the Freedom to Speak Up Guardians have direct
24 reporting to board level.

25 My own sense is that these things are best dealt
189

1 know, for instance, that when it comes to workforce
2 planning, planning for expansion in the child health
3 workforce is often on the back burner.

4 There are often assumptions made that because for
5 instance our national birth rate is stable now that that
6 means that actually attention focuses on the
7 ever-increasing number of frail elderly in the
8 population and that has meant that the degree of
9 attention that I think needs to be paid on children and
10 babies isn't there. Advances in medical care mean that
11 we are looking after more and more vulnerable newborn
12 babies, babies are surviving what were previously not
13 survivable conditions so the complexity of the work and
14 the care we deliver is rising exponentially and
15 resources and focus hasn't kept up with that.

16 So -- and I think many of my responses around
17 safety champions and reporting to the board directly
18 come from a place of -- come from a place of sensing
19 that actually -- Bliss, the baby charity, talk about
20 "weigh less, worth less" and I am afraid on the ground
21 it feels like that. Just because you have got a small
22 baby in an incubator that somehow they don't need -- why
23 would a critically ill baby need its own nurse in an
24 intensive care unit, whereas on a children's intensive
25 care unit or an adult intensive care unit it would be
191

1 with locally. But I am not saying that as
2 a Royal College we couldn't be there to signpost people
3 to resources, you know, because it is perfectly possible
4 for an individual doctor to literally not know who to
5 turn to for help and I think Royal Colleges do
6 understand the landscape better.

7 **Q.** I think that's the issue, certainly it is
8 clear the Speak Up policy will work if it is implemented
9 effectively with robust internal governance, et cetera.
10 It's just the advice to those who find themselves in a
11 very isolated situation internally who are nevertheless
12 in need of help?

13 **A.** Yes. Yes.

14 **Q.** Thank you. Lastly, an open question. You
15 have been asked a lot about your thoughts on future
16 changes and you have talked about data and you have
17 talked about various other things. Are there any other
18 aspects of other policies or governance relevant to this
19 Inquiry that you would like to identify as being in need
20 of change?

21 **A.** I think it probably comes back to a theme that
22 we endlessly go on about at the Royal College of
23 Paediatrics and Child Health which is around the
24 importance of children and babies in the thinking and
25 the priority setting of the NHS and each Trust. We
190

1 entirely unacceptable not to have one-to-one nursing.
2 Yet in neonatal intensive care units we almost never get
3 one-to-one nursing and that is because it is simply not
4 seen as a priority or they are just little. So of
5 course a nurse could look after two critically ill
6 newborn babies and their traumatised parents.

7 So in relation to -- this is an ongoing battle that
8 we have around the importance of seeing these as human
9 beings that are just as worthy of attention and resource
10 as any other members of the population.

11 **MR SKELTON:** Thank you.

12 **LADY JUSTICE THIRLWALL:** Thank you, Mr Skelton.
13 Ms Scolding.

14 Questions by MS SCOLDING

15 **MS SCOLDING:** Dr Kingdon, you know who I am, so
16 I have just got a couple of rounding up questions for
17 you about some of the issues that have been raised by
18 Mr Skelton and Mr Carr. The first one is about capital
19 funding for neonatal units. One of the things that's
20 come out very strongly in the evidence is that in effect
21 the neonatal unit at the Countess of Chester was
22 literally "out of sight, out of mind", both inadequate
23 in terms of the accommodation it had, and also far away
24 from the rest of the hospital, or so it was perceived.

25 Is that something which is uncommon or common in
192

1 respect of neonatal units and does that vary depending
2 upon whether one is looking at a Level 3 unit, a Level 2
3 unit or a Level 1 unit?

4 **A.** It's not uncommon. It's a slight sort of
5 quirk inasmuch as neonatal units have to be co-located
6 with maternity services so they are not invariably not
7 co-located with paediatric services.

8 **Q.** Yes.

9 **A.** And there's something about the fact that they
10 are separate that means they are often forgotten. And
11 I think that's particularly true out of hours, and
12 I think, you know, as neonatal doctors and nurses, we
13 are obsessed with hand washing and hygiene and we tend
14 to restrict visiting, so I guess we don't exactly
15 welcome people because our patients are very vulnerable
16 so we -- so they are often these isolated little units
17 with locked doors because you can't have access to just
18 anybody and so they are "out of sight, out of mind".

19 **Q.** Right. In respect of capital funding, are
20 there any current proposals? I know the RCPCH has made
21 various proposals in needs of expanding cot numbers in
22 the UK generally and/or aligning cot numbers with the
23 regional units. Has there been any promise from
24 NHS England or is there any prospect of any capital
25 funding in order to expand units where appropriate

193

1 that during the course of this Inquiry, mainly that the
2 Countess of Chester Hospital didn't need the BAPM
3 standards, but that in reality no other hospital in the
4 relevant locality met the BAPM standards. Is that still
5 the picture across the picture, that very few versions
6 meet the British Association of Perinatal Medicine
7 standards for staffing?

8 **A.** Certainly if you are thinking -- depends what
9 level you are talking about. For intensive care, yes,
10 absolutely.

11 **Q.** None of them do?

12 **A.** I don't think any do.

13 **Q.** Right. Okay.

14 **A.** Which is -- that is one-to-one nursing for
15 every intensive care baby, no.

16 **Q.** No.

17 Okay, can I ask in respect of the NHS published a
18 Workforce Plan last year in 2023, did that include any
19 enhanced roles either for paediatricians or for nursing
20 staff with the paediatric or neonatal speciality?

21 **A.** No. There was 0% increase in children's
22 nurses planned.

23 **Q.** Okay. Can I also ask: one of the more recent
24 introductions has been introduction of Martha's Rule
25 which I think the Royal College has welcomed in respect

195

1 and/or upgrade units when they are old and in need of
2 some better facilities and equipment?

3 **A.** There, there -- the caveat to that is that you
4 haven't got staff to open more cots, it is pointless
5 having any more cots. So because we have never achieved
6 the British Association of Perinatal Nursing standards,
7 I would have anxieties about brave ambitions to open
8 many more cots because you can't put babies into them.

9 I have to say the advent of the neonatal ODNs --
10 Organisational Delivery Networks -- of which there are
11 now ten across England, and there are similar structures
12 in Scotland and Wales and Northern Ireland, has come
13 with funding and so in the last less than five years
14 there has been an injection of capital, this is since
15 the Ockenden review and Kirkup review, so linked to
16 maternity inquiries. And so there have been more
17 resources made available and some attempt to think
18 across networks and around where care is best delivered
19 and sort of the streamlining of what we call, you know,
20 Level 3 which is the intensive care Level 2, which is
21 the local neonatal unit and Level 1, you know, the kind
22 of the way the networks are structured. Attention has
23 been -- more attention has been given to that.

24 **Q.** You have mentioned the BAPM standards in the
25 answer to that question and we have heard a lot about

194

1 of openness and candour.

2 Can you tell us what the Royal College's slight
3 concern is about the operation of Martha's Rule?
4 I mean, obviously Martha herself was a child, she
5 I think was 12 or 13.

6 What the -- what the implications are for the
7 implementation of Martha's Rule in respect of paediatric
8 care?

9 **LADY JUSTICE THIRLWALL:** Neonatal care.

10 **MS SCOLDING:** And neonatal care in particular?

11 **A.** So Martha's Rule essentially is the
12 opportunity for a concerned family member or patient,
13 but in our world family member, to request a speedy
14 second clinical opinion. So this is not a form of
15 second opinion. It is: I am really worried about my
16 child who isn't as well, nobody is listening to my
17 concerns on the ward. I would like somebody to come in
18 essentially with a fresh pair of eyes.

19 So in an adult setting, the way Trusts are
20 delivering on Martha's Rule is essentially using their
21 Critical Care Outreach Teams to visit the bedside and
22 undertake that fresh pair of eyes review.

23 That's extremely difficult to deliver in both
24 either a paediatric and certainly in a neonatal -- on
25 the postnatal ward setting because you can't expect an

196

1 adult critical care nurse, for instance, to come to the
2 bedside of a three-day old baby and deliver a clinical
3 review. So there are major issues with delivering on
4 Martha's Rule for children's services across the
5 totality and particularly in a newborn setting.

6 **Q.** How could that particular problem be solved,
7 in particular as obviously the rule was invented because
8 of the death of a child in an acute setting?

9 **A.** So currently the three different approaches
10 are being piloted for children's services. And actually
11 the three models are quite interesting, I am sure you
12 don't want to go into the details here. And they have
13 been given an opportunity to report back as to whether
14 they were effective or not.

15 But you are essentially dealing with, you know,
16 significant workforce constraints. We have only got
17 less than 20 paediatric intensive care units in the
18 entire country so there is no way this can be delivered
19 by Paediatric Critical Care Outreach Teams except
20 potentially over a phone where you can phone your local
21 paediatric intensive care and have a conversation over
22 the phone and they potentially send a team round to
23 assess the child, but that seems a -- that has major
24 resource implications.

25 So I think in all my conversations with the Patient
197

1 **LADY JUSTICE THIRLWALL:** Dr Kingdon, just if I can
2 ask you about a couple of the matters you were being
3 asked about by Mr Skelton, in particular.

4 You were describing the differing approaches of
5 Coroners to the information that you might give them
6 over the telephone as to whether there is to be a
7 Coroner's investigation. I assume that is what you were
8 describing?

9 **A.** Yes.

10 **LADY JUSTICE THIRLWALL:** I think you said it
11 depends on the Coroner's threshold.

12 **A.** Yes.

13 **LADY JUSTICE THIRLWALL:** I think what you
14 described, I want to make sure I have understood this
15 correctly, would be a conversation between you or
16 another doctor in your unit with the Coroner who was not
17 really interested in how a very premature or how
18 a premature baby had died and so it would end up being
19 resolved as: premature baby died from being premature.

20 **A.** (Nods)

21 **LADY JUSTICE THIRLWALL:** Which seems quite
22 unsatisfactory. But would that conclusion be come to
23 without a postmortem or would there be a postmortem and
24 then that discussion?

25 **A.** So it would be -- that conclusion would be
199

1 Safety Commissioner and other senior people at
2 NHS England, there is a recognition that this is
3 extremely difficult to deliver in children. But we have
4 to test out ways in which we can potentially make it
5 work.

6 **Q.** Okay. There's been a number of discussions
7 amongst the paediatricians who have come to give
8 evidence in Part B about the fact that they were having
9 to do the vast majority of their kind of worry time,
10 thinking time, outside of their sessional time. In
11 other words, they were doing it in their own time. Is
12 that something which is common across the board in
13 respect of paediatricians or is that something that was
14 particularly unusual at the Countess of Chester, that
15 the time that they were given for kind of oversight
16 time, guidance time, thinking time, training time, was
17 woefully insufficient for the work they actually had to
18 undertake in those respects?

19 **A.** That is ubiquitous.

20 **MS SCOLDING:** Thank you I have no further questions
21 my Lady.

22 **LADY JUSTICE THIRLWALL:** Thank you very much,
23 Ms Scolding.

24 **MS SCOLDING:** Thank you.

25 Questions by LADY JUSTICE THIRLWALL
198

1 come to without a postmortem.

2 **LADY JUSTICE THIRLWALL:** Without, yes?

3 **A.** It's, it's -- we always counsel families about
4 the value of a postmortem and in fact, you know, I am
5 very fortunate where I work, sometimes the pathologists
6 are happy to come and talk to families as well. But it
7 is true that the uptake of hospital postmortems is very
8 low in our practice.

9 And so if you then -- so if you can't encourage the
10 parents to consent to a hospital postmortem, and the
11 Coroner doesn't agree that it's met the threshold for
12 a Coroner's postmortem, you are left in a situation
13 where you actually don't have another means to formally
14 explore, you know, the clinical questions you might have
15 to really understand why a baby might have died.

16 **LADY JUSTICE THIRLWALL:** And I suppose -- perhaps
17 I shouldn't suppose, but in that situation, I am
18 assuming there is no even remote possibility that there
19 may have been foul play in that situation?

20 **A.** Truthfully that isn't something that we
21 typically think about inasmuch as the babies we look
22 after have only ever been in hospital, so although as
23 paediatricians we think a lot about safeguarding it's
24 usually in the context of coming through the front door
25 of A&E.

200

1 **LADY JUSTICE THIRLWALL:** Yes.
 2 **A.** So, yes, you are right, the threshold to think
 3 about harm is not, you know, very high.
 4 **LADY JUSTICE THIRLWALL:** Yes, understood. And you
 5 are at the Evelina I picked up from the various
 6 documents we have looked at?
 7 **A.** Yes.
 8 **LADY JUSTICE THIRLWALL:** I am assuming is that
 9 a Level 3 or a Level 4.
 10 **A.** Level 3.
 11 **LADY JUSTICE THIRLWALL:** So how many cots have you
 12 got?
 13 **A.** We have 20 intensive care, 12 high dependency
 14 and 15 low dependency beds.
 15 **LADY JUSTICE THIRLWALL:** Thank you. And I am
 16 assuming then that babies come from sort of all round --
 17 **A.** Yes.
 18 **LADY JUSTICE THIRLWALL:** -- London and wherever
 19 else?
 20 **A.** Yes.
 21 **LADY JUSTICE THIRLWALL:** Am I right to assume this
 22 has sort of been said, but since I have got you here and
 23 I wasn't expecting to, are the babies as a general rule
 24 overall more sick babies than those in a Level 2, than
 25 those in Level 1. Obviously it sort of rather depends
 201

1 babies that are dying, I don't want to give you the idea
 2 that preterm babies die as frequently as -- so we on
 3 average will have between three and seven deaths a month
 4 but then we are seeing a subset of extremely ill babies.
 5 The numbers would be much lower in another Level 3 unit,
 6 for instance, that didn't have --
 7 **LADY JUSTICE THIRLWALL:** That complexity.
 8 **A.** -- cardiac or the other complexity.
 9 **LADY JUSTICE THIRLWALL:** Then presumably lower in
 10 a Level 2 as a general rule?
 11 **A.** It would be usual -- the less intensive care
 12 they are delivering, it should be more and more unusual
 13 to have maybe more than one death a month or even fewer
 14 than that.
 15 **LADY JUSTICE THIRLWALL:** Yes. Thank you, that is
 16 very helpful.
 17 Now, you were asked some questions about the
 18 regulation of senior managers and in your statement you
 19 suggested we might like to ask some other people what
 20 their views were about it but I understand from the
 21 evidence you have just given that the College is going
 22 to be making its submission in relation to the
 23 consultation.
 24 **A.** (Nods)
 25 **LADY JUSTICE THIRLWALL:** Now, without wanting to
 203

1 where the baby comes -- at what stage the baby comes
 2 into you but assuming it's in the very, very early
 3 stages of life, do you have the sicker babies than
 4 a Level 2 would have?
 5 **A.** Oh, yes, there are very strict rules about
 6 what a Level 2 unit -- what kind of baby a Level 2 unit
 7 can look after and when they need to refer the baby out.
 8 In a perfect world, we have -- the mother is
 9 identified as having a difficult pregnancy and the
 10 mother will deliver with us. But of course nature
 11 doesn't always work like that and so if a mother does
 12 end up delivering at a Level 2 unit or a Level 1 unit
 13 then we have a Regional Transport Service that brings
 14 the baby in to us.
 15 **LADY JUSTICE THIRLWALL:** Yes. Thank you.
 16 One question which you touched on without giving
 17 any numbers, but you mentioned that you deal a lot of
 18 death in your unit. So are you able to say, is there
 19 a sort of general level of the number of deaths that
 20 there might be in your unit over the course of a year?
 21 **A.** Yes. It obviously varies.
 22 **LADY JUSTICE THIRLWALL:** Of course.
 23 **A.** Where I work we have a lot of babies with
 24 complex congenital cardiac disease, complex other
 25 congenital anomalies and so these are not just preterm
 202

1 tread on toes, it would be helpful if -- what is the
 2 deadline for the consultation? I have just forgotten
 3 it.
 4 **A.** It is end of February.
 5 **LADY JUSTICE THIRLWALL:** End of February. Thank
 6 you. That might work out quite well in terms of timing.
 7 I wonder whether consideration could be given to
 8 providing the Inquiry with the broad thrust of your
 9 views as they have been developed by that stage.
 10 **A.** Yes.
 11 **LADY JUSTICE THIRLWALL:** I don't want to take you
 12 by surprise but I am just flagging it and then obviously
 13 the legal team will have a look at it but I hope it is
 14 nothing too controversial to suggest that you might want
 15 to send that to the Inquiry.
 16 **A.** Yes.
 17 **LADY JUSTICE THIRLWALL:** Since you are obviously in
 18 the process of developing your thinking in a way that
 19 perhaps hadn't been anticipated.
 20 **A.** Yes.
 21 **LADY JUSTICE THIRLWALL:** Thank you. Those are all
 22 my questions, anybody want to ask anything else? No.
 23 In that case, Dr Kingdon, thank you very much
 24 indeed for coming and you are free to go.
 25 We will take a break now and start again at quarter
 204

1 past 4.

2 (3.59 pm)

3 (A short break)

4 (4.15 pm)

5 LADY JUSTICE THIRLWALL: Mr Bershadski.

6 MR BERSHADSKI: Yes, if I could please call

7 Mr Newman, my Lady.

8 LADY JUSTICE THIRLWALL: Mr Newman, do come

9 forward.

10 MR TONY NEWMAN (sworn)

11 Questions by MR BERSHADSKI

12 LADY JUSTICE THIRLWALL: Do sit down, Mr Newman.

13 I'm sorry you have had a longer wait than you were

14 probably told to expect but I had assumed that you would

15 rather give your evidence today.

16 A. Yes, please, if that is okay.

17 LADY JUSTICE THIRLWALL: Of course it is, yes,

18 thank you. Now, Mr Bershadski.

19 Questions by MR BERSHADSKI

20 MR BERSHADSKI: Could you confirm your full name

21 for the Inquiry please.

22 A. Tony Michael Newman.

23 Q. Mr Newman, is it right that you have made two

24 statements for the Inquiry, the first dated 3 June 2024

25 and the second dated 1 November 2024?

205

1 the Employer Link Service?

2 A. So the Employer Link Service was established

3 from the Francis Inquiry into the Mid Staffs health

4 failings and the primary purpose of the service is to

5 develop relationships with employers, to do with

6 anything to do with their professional regulator, but

7 predominantly fitness to practise.

8 And one of the key functions of the service is that

9 we offer an advice service to employers to call if they

10 have got any emerging concerns, to have a discussion

11 about what the regulator would like to see in terms of

12 local action or whether it needs to be referred to the

13 regulator or it doesn't meet the threshold for referral.

14 Q. And you explain in your first statement at

15 paragraph 4 that when you receive a call, you speak to

16 somebody who rings you up, there are three basic options

17 you have at the conclusion of the call, and that's the

18 first is to advise them to make a referral to the NMC,

19 the second is to advise them not to make a referral and

20 the third is to advise to investigate or manage locally,

21 is that correct?

22 A. That's correct. That's how the advice service

23 was initially established with those three outcomes.

24 Q. Broadly speaking, what are the criteria for

25 giving somebody advice to refer?

207

1 A. That's correct.

2 Q. Are those statements true and accurate to the

3 best of your knowledge and belief?

4 A. Yes, they are.

5 Q. If we could just start off with a bit of

6 background, Mr Newman. Is it right that you worked for

7 33 years for the Post Office?

8 A. That's right.

9 Q. And that you have a Masters in Security and

10 Risk Management?

11 A. That's right.

12 Q. You initially joined the NMC in April 2015; is

13 that correct?

14 A. That's correct.

15 Q. You were first a senior project manager, but

16 were then promoted to the position of adviser in the

17 Employer Link Service, a regulation adviser in the

18 Employer Link Service?

19 A. A regulation adviser, that's correct.

20 Q. That was in May 2016, is that correct?

21 A. Yes, that's correct.

22 Q. And is it right that you still hold that

23 position today?

24 A. Yes, I do.

25 Q. Could you just briefly describe the purpose of

206

1 A. So it would be based on the seriousness of the

2 allegation, first and foremost, and then we would

3 explore some information about the response of the

4 individual, whether it's a nurse, a midwife or a nursing

5 associate, to understand if they have developed or shown

6 any insight, if they have reflected on the concern and

7 whether if needed whether they strengthen their

8 practice.

9 So we would consider all of those aspects in

10 providing the advice as to whether it needs to be

11 referred or not.

12 Q. Is it right that one of the important

13 consequences of advising an organisation to make

14 a referral to the NMC is that that triggers the power of

15 the NMC to ensure that, for example, a nurse who poses

16 a risk to patient safety isn't able to work?

17 A. Yes, we can restrict their practice initially

18 at a very early stage while the investigation is

19 ongoing. That's referred to as an interim order.

20 We could remove them from the register while the

21 investigation continues or we could allow them to carry

22 on practising but with some form of restriction.

23 Q. Is it correct that all of those powers that

24 you have just outlined they are only available to you if

25 they -- once there has been a referral, is that correct?

208

1 **A.** Absolutely, yes, that's correct.
 2 **Q.** So it follows from that, does it, that if no
 3 referral is made then the NMC doesn't have any power to
 4 take any of those steps?
 5 **A.** We don't have any statutory powers, that's
 6 correct.
 7 **Q.** Is it correct that therefore the decisions
 8 that the NMC makes, including that initial decision
 9 about what advice to give, they are potentially hugely
 10 important in protecting patients?
 11 **A.** Definitely, yes. I mean, there are some
 12 serious allegations that come through the advice line
 13 service and there are some really low-level calls that
 14 we receive where it doesn't meet the threshold.
 15 **Q.** If we could just cover some background first
 16 to the call that you had with Alison Kelly.
 17 Is it right that you received an email from
 18 Alison Kelly at the Countess of Chester Hospital on
 19 4 July asking to have a call with you because she was
 20 aware that somebody else she knew had spoken to you and
 21 found a call very useful?
 22 **A.** Yes. So part of the initial purpose of the
 23 service was to reach out to all of the directors and
 24 nursing across every single NHS Trust in England in the
 25 first year, so that we made contact with all of them to
 209

1 that the Trust has seen a rise in mortality of babies on
 2 the neonatal unit, is that right?
 3 **A.** That's right.
 4 **Q.** Did you make any enquiry when told that as to
 5 the extent of the rise in the mortality?
 6 **A.** I would have asked if there's any reason for
 7 that rise.
 8 **Q.** So you would have only asked for the reason in
 9 the rise, but not the extent of the rise; so you didn't
 10 know, for example, what was a normal or average
 11 mortality rate and what the mortality rate had become?
 12 **A.** No, no numbers were quoted.
 13 **Q.** Just to understand that. Did you ask and not
 14 receive an answer, or did you not ask at all about how
 15 great the increase was?
 16 **A.** It's probably unlikely I asked that question.
 17 **Q.** Can you just explain why that would be. It
 18 would seem that if somebody's told you there's been
 19 an increase in deaths that one of the potential
 20 follow-up questions is, "Well, what do you mean?"
 21 **A.** I would have asked what that meant, but
 22 I wouldn't have asked specifically for numbers or
 23 averages or what that meant in terms of what is normal
 24 and what is unusual. I probably wouldn't have gone into
 25 that level of detail at that time.
 211

1 make them aware of what the service was.
 2 And I visited -- I can't remember the name of the
 3 Trust -- but I visited another Trust that operates on
 4 the same site and that particular Director of Nursing
 5 found the meeting so useful that she wrote to all the
 6 surrounding Trusts, which is where Alison Kelly picked
 7 up that email and made contact with us.
 8 **Q.** Thank you. If we then go on to discuss the
 9 call that you had with Alison Kelly on 6 July. If we
 10 could just put up, please -- the best note that we have
 11 of that is an email that you wrote on the same day
 12 summarising the phone call to Alison Kelly and that's
 13 INQ0002965, and if we go straight to page 4.
 14 Now, is it correct that this version that we see on
 15 the screen in front of us is a version of, firstly,
 16 an email that you typed up but then with some
 17 corrections that Alison Kelly made to it two days later?
 18 **A.** That's right, she made some minor corrections.
 19 **Q.** So where we see strikeouts and yellow, those
 20 are Alison Kelly's corrections, is that right?
 21 **A.** That's right, yes.
 22 **Q.** Now, if we just go through this note. We have
 23 essentially a series of bullet points which summarise
 24 the discussion, which, for some reason, appear as
 25 question marks in this version. You are told by her
 210

1 **Q.** Is this sort of issue, an increase in deaths,
 2 would it be fair to say that that's probably at the top
 3 end of the sort of spectrum of potential seriousness of
 4 the kinds of concerns that would come through to you on
 5 the Employer Link Service?
 6 **A.** Potentially. It really does depend on the
 7 cause and the reasons. It could have been something
 8 that's completely innocent, it could be something
 9 obviously we now know is a lot more sinister.
 10 It would depend on, really, the -- I mean we can
 11 only investigate individuals. So if there is a specific
 12 allegation or information that says an individual could
 13 have caused deliberate harm that would be at the highest
 14 level of concern for us.
 15 **Q.** Yes. Well, let's carry on going through the
 16 list. So the second point is you are told that each
 17 death has been the subject of a clinical team case
 18 review, the third point is reviews have produced no
 19 evidence as to a lack of competence by individuals or
 20 the team and the fourth point is that further analysis
 21 has identified one registrant that has been present at
 22 nearly all these incidents and, fifthly, some clinicians
 23 are concerned that the registrant may present a serious
 24 risk to public safety, although no evidence is available
 25 at this time.
 212

1 Now, taking those five points together, is that not
2 precisely the sort of potential concern that you have
3 just identified in your previous answer, which is that
4 there may be a connection between deaths and an
5 individual?

6 **A.** Yes, but the way it was positioned was that
7 there was one person, the initial analysis had
8 identified that there was one person, which is
9 Lucy Letby, that was just present at all of these
10 particular incidents.

11 **Q.** Yes.

12 **A.** Not all, but nearly all and that, as a result
13 of that, her presence, some clinicians were concerned.

14 **Q.** Yes.

15 **A.** And that was the level of the information.

16 There wasn't -- there was never an allegation that
17 she could be causing deliberate harm or that there was
18 serious negligence. It was simply the facts that were
19 presented in the first four bullet points.

20 **Q.** Well, if we just unpack that a little bit.

21 What you recorded in that fifth bullet point is
22 that some clinicians are concerned that the registrant
23 may present a serious risk to public safety and, at the
24 same time, you are being told that there is no evidence
25 as to a lack of competence.

213

1 then you are allowed to operate the advice line service
2 on your own and I think this, this could even have been
3 the first. It was definitely one of the first or second
4 calls that I ever took.

5 So it was my uncertainty as to the level of risk at
6 the time which probably caused me to follow up in
7 writing.

8 **Q.** Do you think that you were affected in how you
9 dealt with this call by the fact that it was so early on
10 in your time in this role?

11 **A.** I think so. I did actually follow it up with
12 a conversation with a colleague that had just joined the
13 team at the same time that I knew was a very experienced
14 lawyer in the Fitness to Practise directorate and I ran
15 exactly the same information past him and he basically
16 said that he agreed with the advice and that, at the
17 moment, without any evidence or any further information
18 to suggest that she does pose a risk the advice would be
19 to manage locally or investigate further.

20 **Q.** So just to be clear. You had already come to
21 the view that the appropriate response was to advise to
22 manage locally --

23 **A.** (Nods)

24 **Q.** -- because that's the advice you gave straight
25 away on that call and then you subsequently had the

215

1 So putting those two things together, isn't the
2 obvious inference that in effect some clinicians think
3 she may be killing babies?

4 **A.** Yes, which is why I took the time to actually
5 record the conversation, which in the eight years I have
6 been doing this job, I've never done since because
7 I just really wanted to establish in writing exactly
8 what I was told during that call.

9 **Q.** Had you ever taken that step prior to?

10 **A.** No.

11 **Q.** So it's the only time in your entire time with
12 the Employer Link Service, which is around eight
13 years --

14 **A.** That I have done that.

15 **Q.** -- eight and a half years, that you've ever
16 done this?

17 **A.** Correct.

18 **Q.** Wouldn't that suggest that this is at the very
19 top of the level of concern in terms of calls that you
20 receive over your whole career in this service?

21 **A.** It crossed my mind, which is obviously why
22 I followed it up in writing.

23 At the time, I think this was probably only the
24 second call that I ever took on the advice line. So
25 there is quite a intensive three-month induction and

214

1 correctness of that advice, as you saw it, confirmed by
2 a colleague?

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

4 **Q.** Okay. Can you just explain to us, given that
5 this is at the top level of seriousness, why is it that
6 you didn't take the most serious action, which would be:
7 make a referral to us because that would trigger our
8 powers to keep the public safe?

9 **A.** Because -- and it was confirmed at both the
10 meeting and afterwards which we refer to as a peer
11 review and benchmarking, which is another part of the
12 governance process -- it would have just gone into our
13 screening stage and just sat there because of the lack
14 of information or evidence.

15 We wouldn't be able to take any action. We
16 wouldn't be able to consider it for an interim order
17 without further information or evidence of deliberate
18 harm. So we were in a really difficult situation
19 whereby if we advised to refer and there wasn't enough
20 information or evidence to provide that advice, we would
21 know full well that it would just sit in our screening
22 section without any action having been taken.

23 **Q.** Is it really right that an allegation by --

24 well, the clinicians that you were told about that had
25 these concerns, were you told that they were Consultants

216

1 because the Inquiry has heard evidence from people who
2 were on this call that you were told that they were
3 Consultants?

4 **A.** I wasn't told they were Consultants at the
5 time.

6 **Q.** Are you sure you are able to recall
7 a telephone call?

8 **A.** I probably would have put "consultants."

9 **Q.** Okay.

10 **LADY JUSTICE THIRLWALL:** I think you had put "the
11 Trust", hadn't you?

12 **A.** Oh, I put "the Trust", yes.

13 **LADY JUSTICE THIRLWALL:** And that was corrected to
14 "some clinicians".

15 **A.** It was corrected to "clinicians", yes.

16 I can't recall if it was specifically mentioned
17 that they were Consultants. The suggestion is that
18 I put "the Trust", it's managers in general.

19 **MR BERSHADSKI:** Yes. So surely a concern that's
20 raised with you of such gravity isn't one that the NMC
21 would or should allow to sit in a screening process
22 without any action being taken?

23 **A.** Well, there wasn't an allegation. There was
24 not an allegation that Lucy Letby caused deliberate harm
25 or even through gross negligence caused the death of

217

1 reads, if we include Alison Kelly's corrections:

2 "The Executive Team are due to meet today
3 6 July 2016 to decide if this registrant will be
4 reported to the police to investigate."

5 I mean, you have got one registrant who is present
6 at nearly all deaths, some clinicians are concerned that
7 she presents a serious risk to the public. Mortality
8 has increased and they are considering referring that
9 person to the police. What could all of that together
10 be other than an allegation of deliberate harm?

11 **A.** The suggestion is there, but there was never
12 any mention of that during the call.

13 **Q.** Well, isn't it an allegation from those
14 clinicians who consider that she poses a serious risk of
15 harm? It's a suggestion.

16 **A.** It's suggestion, yes, without any evidence to
17 support it or additional information that would allow me
18 to make a decision to refer.

19 **Q.** So is it the lack of what you see as
20 additional evidence or of particular evidence that drew
21 you to the feeling that it wasn't an allegation rather
22 than the fact that the allegation is not made itself if
23 you see what I mean?

24 **A.** It is both. There was no allegation and there
25 was no evidence to support.

219

1 these babies.

2 Looking back at it now, it seemed like it was an
3 initial enquiry to maybe test the waters with the
4 regulator because we'd just introduced this service
5 where you could have this pre-referral discussion and
6 obviously knowing Alison Kelly's evidence, you know,
7 information was withheld at the call.

8 **Q.** Yes. But you have just agreed that the
9 essence of what you have been told is that there is
10 a concern that a nurse is killing babies and it's not
11 due to incompetence. So, how does that square with the
12 suggestion that there are no allegations being made?

13 I mean, in fact, it's a very serious allegation that's
14 being made, isn't it?

15 **A.** There was no allegation made on the call.
16 Alison never said to me, "We suspect she could be
17 deliberately harming babies." Had she said that, that
18 would have set off all sorts of alarm bells and we
19 probably would have said, even with a lack of evidence
20 because we would recommend that they contact the police,
21 we would recommend a referral at that time so that we
22 could contact the police.

23 But there was never any suggestion that she caused
24 deliberate harm in that call.

25 **Q.** Well, if we look at your last bullet point, it
218

1 **Q.** What evidence would you expect at this stage
2 of deliberate harm by a nurse before you would consider
3 advising to refer?

4 **A.** Information or evidence that she could have
5 caused harm that could have resulted in death,
6 witnesses, that would be the type of information and
7 evidence we would look for.

8 **Q.** Well, she clearly could have caused harm
9 because she is present at nearly all deaths and there
10 has been an increase in deaths and some clinicians think
11 it is her and they are considering referring her to the
12 police.

13 So clearly that first part of your test is met that
14 it could be her, isn't it?

15 **A.** Yes.

16 **Q.** So are we then left with just the lack of eye
17 witnesses?

18 **A.** The lack of evidence that will allow us to
19 take action, yes.

20 **Q.** Well, how are you in a position to judge
21 whether there is evidence against her or not if there
22 hasn't been an investigation yet at this stage?

23 **A.** That was why the advice was to investigate
24 first.

25 **Q.** But doesn't that mean that there isn't any
220

1 power to stop her in the interim period from continuing
2 to practise and therefore possibly to harm more babies?
3 If you don't make a referral at this stage and you just
4 wait until a local investigation?

5 **A.** Sorry, can you repeat the question?

6 **Q.** Well, doesn't the approach of "investigate
7 locally first" mean that there isn't an ability to stop
8 the person from working whilst that investigation is
9 going on and therefore potentially harming more babies?

10 **A.** With -- with most local investigations you
11 would expect some sort of restriction on practice while
12 the investigation is ongoing.

13 **Q.** But how would such a restriction on practice
14 in a local Trust prevent that person from potentially
15 working as a bank nurse, an additional shift at another
16 Trust or leaving the Trust altogether and working
17 elsewhere?

18 **A.** It would be a real trigger point if they left
19 employment for that organisation. We would probably ask
20 them to refer because they lose their ability to manage
21 the situation locally to investigate without the
22 registrant being present. There's opportunities to work
23 bank or agency, we would expect the Trust to try and
24 restrict that practice as well. There is a lot of
25 emphasis on local resolution and local investigation.

221

1 through all the case records, et cetera?

2 **A.** So the emphasis was put on the Trust
3 investigation.

4 **Q.** But I go back to that point. How is it
5 adequate to put the emphasis on a local Trust
6 investigation when you don't know how well equipped they
7 are, how objective they are, how qualified they are to
8 undertake investigation of that seriousness? How does
9 it accord with patient safety to rely on such a huge
10 unknown?

11 **A.** Even if we did recommend that a referral comes
12 into the NMC we would wait until the Trust had concluded
13 their investigation, without knowing the quality of the
14 investigation, we would wait for them to provide us with
15 information and evidence that was achieved through the
16 local investigation and obtained through the local
17 investigation.

18 So I understand what you are saying, how can we
19 leave the burden or responsibility down to NHS Trusts?
20 But that's simply the way it was then and it still is,
21 to a certain extent, but we provide Trusts with a lot
22 more advice and guidance about what we consider to be
23 a really good robust local investigation and all the
24 things you need to consider. But at the time that just
25 simply wasn't there.

223

1 **Q.** Is it not entirely misplaced to rely on
2 a local investigation when you have got such hugely
3 serious allegations being made because you don't know
4 what kind of local investigation it would be, how well
5 equipped people are at the Trust to undertake a local
6 investigation, you have got no idea of those sort of
7 matters, do you?

8 **A.** No and at the time, we didn't to be fair, no.
9 We didn't have any idea about the quality of the local
10 investigations.

11 **Q.** I think in opening statements to the Inquiry,
12 counsel for the NMC suggested that the key priority of
13 the NMC is the protection of patients?

14 **A.** (Nods)

15 **Q.** Is it not entirely contrary to that to not in
16 such a serious situation advise to refer to the NMC so
17 that it can immediately consider restricting that person
18 from practising?

19 **A.** Well, the key aspects of the Nursing and
20 Midwifery Council is to protect the public but in order
21 to do that we need clear information and evidence to
22 restrict someone's practice.

23 **Q.** Well, have you done anything here to go and
24 obtain that evidence like saying: well, somebody needs
25 to meet with you immediately to look at rotas, to go

222

1 **Q.** Well, do you think if there is any possibility
2 that this would still be the outcome today, is that
3 a gap in the NMC's ability or processes to protect
4 patient safety?

5 **A.** If we had a call like this today, the actions
6 would be very different.

7 **Q.** Well, let's turn to that issue, if I may.
8 I think you are aware that the Inquiry was provided with
9 a document from the Employer Link Service team which
10 suggested in essence that the actions today would not be
11 any different. You are aware of that, aren't you?

12 **A.** Yes, I am, yes.

13 **Q.** You have looked at that document in
14 preparation for giving your evidence today?

15 **A.** I did.

16 **Q.** That's right?

17 **A.** Yes.

18 **Q.** That document references you by name --

19 **A.** Yes.

20 **Q.** -- doesn't it?

21 **A.** Yes.

22 **Q.** Were you shown that document setting out
23 concerns before it was circulated?

24 **A.** Yes, I was. But I didn't contribute towards
25 it. I understood that when the initial statement by the

224

1 NMC was read out in the first week of the Inquiry the
2 team had some concerns about some of the remarks in the
3 statement suggesting a criticism of the team and how we
4 reacted.

5 I think what we were trying to suggest in that
6 statement -- and I didn't contribute towards the
7 statement because it conflicted somewhat with my own
8 personal statement, but obviously I was bound by the
9 confidentiality of the Inquiry so I couldn't disclose
10 that -- it was -- it was that the decision would still
11 be the same, but what I am trying to suggest is the
12 actions would be different.

13 **Q.** When you say the decision would be the same,
14 that's the decision to advise investigate locally rather
15 than advise to refer?

16 **A.** Yes.

17 **Q.** So that is what we are really concerned with,
18 because as we discussed previously, it's the advice to
19 refer which allows the NMC to protect the public?

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

21 **Q.** So the very essence of the decision would
22 still be the same today?

23 **A.** It would, because we didn't have the evidence
24 to support any restriction of their practice or to even
25 recommend a referral to the NMC?

225

1 can't recall, was there any suggestion by either
2 Alison Kelly or Sue Hodgkinson that these clinicians
3 were -- didn't genuinely believe that there was a risk
4 that this person was deliberately doing this?

5 **A.** So I wasn't made aware Sue Hodgkinson was on
6 the call. Had I been aware, I would have recorded it in
7 the notes, because it's not unusual for someone else to
8 be joining the call which we always allow.

9 Sorry, could you just repeat the question?

10 **Q.** Well, was it ever suggested to you -- let me
11 put it this way: did Alison Kelly give any opinion of
12 her own as to the motivations of the clinicians that
13 were raising these serious concerns?

14 **A.** No.

15 **Q.** She simply said: there are clinicians who have
16 serious concerns?

17 **A.** She said they had concerns.

18 **Q.** Okay. Do you think that it is a serious gap
19 in the NMC's screening seriousness guidance that it
20 requires specific evidence of an act before advising to
21 refer in a situation like this because specific evidence
22 might not be available until you conduct the
23 investigation, do you see what I am saying?

24 **A.** I see what you are saying but equally we got
25 a lot of allegations from employees and members of the

227

1 **Q.** Again when you say "we didn't have the
2 evidence", is it correct to say that what you mean is
3 you didn't have eyewitness evidence?

4 **A.** Eyewitness evidence, or clinical notes that
5 suggested that that individual was the person
6 responsible for causing harm, whether it was deliberate,
7 or accidental, or negligence. It's a combination, but
8 essentially eyewitnesses is the most powerful evidence.

9 **Q.** Was the notion that you required eyewitness
10 evidence before advising somebody to make a referral
11 where there is a suspicion of killing babies, is that
12 something that you were trained on, that particular
13 types of evidence were required or was it contained in
14 any particular guidance document that you were applying?

15 **A.** It would be in the screening seriousness
16 guidance that we had available at the time.

17 **Q.** In the screening seriousness?

18 **A.** Yes. So it's what evidence does the screening
19 team need to have available to consider it for an
20 interim order which is an immediate restriction on
21 someone's practice. So we would base our advice and
22 decision using that as well.

23 **Q.** Was there any suggestion in this call by
24 Alison Kelly or anybody else on the call because
25 Sue Hodgkinson says she was also on this call which you

226

1 public that could be serious on face value and we can't
2 restrict every nurse's practice based upon
3 a straightforward allegation. We need evidence to do
4 that.

5 **LADY JUSTICE THIRLWALL:** I think we have perhaps
6 explored that sufficiently now.

7 **MR BERSHADSKI:** Yes.

8 **LADY JUSTICE THIRLWALL:** Can I just ask something
9 before you leave it. You mentioned a number of times
10 a local investigation and I just can't quite see where
11 that's recorded here. There is reference to the police
12 report and a subsequent action and then another advice
13 call.

14 **A.** So it would have been provided verbally on the
15 call and then when I record it on our system, I would
16 record the outcome of that advice which was to
17 investigate locally first.

18 **LADY JUSTICE THIRLWALL:** So it is not in the
19 emails, it is not that I have missed it.

20 All right, thank you.

21 **A.** No, it doesn't appear so, no.

22 **MR BERSHADSKI:** Just to follow up on that if I may,
23 my Lady.

24 Why would that not be included within your email
25 summary?

228

1 **A.** I don't know. It's not something that, as
 2 I have said earlier, I have ever done in the eight and
 3 a half years I have been doing this job since -- and
 4 I suppose it would have been useful right at the bottom
 5 would be -- to summarise my advice would be to
 6 investigate locally. That would have been useful, yes.

7 **Q.** Now, you mentioned that you discussed this
 8 call with somebody in the Fitness to Practise Team. Was
 9 that on the same day as the call took place?

10 **A.** It was directly after the call.

11 **Q.** Is it right that your advice also went through
 12 a benchmarking process?

13 **A.** Yes. So first of all, it goes through what we
 14 call a peer review process which is other regulation
 15 advisers looking at the details of the call and either
 16 agreeing with the advice or challenging the advice.
 17 So it went through peer review initially, which is
 18 with the team and they agreed with the advice. Then it
 19 goes as part of the governance process to what we call
 20 a benchmarking meeting, which also includes senior
 21 lawyers within the screening team and they again agreed
 22 with the advice.

23 **Q.** So would you have been present during that
 24 benchmarking process?

25 **A.** Present during both meetings, yes.

229

1 three weeks after that.

2 **Q.** You receive an answer -- if we can go to
 3 page 1 of the same document that is on the screen. You
 4 receive an answer from Alison Kelly on 31 August; is
 5 that right?

6 **A.** Yes.

7 **Q.** And she tells -- she says to you that we
 8 undertook a thorough internal review, nothing of
 9 significance was identified. You are told also that
 10 following discussion with our board and on receiving
 11 views from our clinicians the step was taken to place
 12 Lucy Letby on non-clinical duties working in a corporate
 13 team.

14 Is that the first time that you were told that some
 15 step had been taken to remove Lucy Letby from clinical
 16 duties?

17 **A.** From recollection, yes.

18 **Q.** Now, is it right that at the initial call on
 19 6 July you didn't give any advice to Alison Kelly around
 20 removing Lucy Letby from clinical duties?

21 **A.** That's right.

22 **Q.** But you were told that she was on leave --

23 **A.** Yes.

24 **Q.** -- during that initial call but presumably you
 25 didn't know when she would be returning from leave?

231

1 **Q.** Were any clinicians or people with a clinical
 2 background also present at the benchmarking process?

3 **A.** So in our team at the time there was an ex-NMC
 4 registrant, she may well actually have had NMC
 5 registration at the time and that was the only clinical
 6 person that was on the call at the time that I am aware
 7 of.

8 **Q.** So somebody probably who had a nursing
 9 background?

10 **A.** A nursing and midwifery background, if
 11 I recall.

12 **Q.** And midwifery, yes, thank you.

13 Is it right that you chase Alison Kelly for an
 14 update about this issue on 23 August?

15 **A.** That's right, yes, I think it was the day
 16 after the benchmarking meeting I took an action to
 17 follow up with Alison Kelly.

18 **Q.** Why did it take that period of time, so it's
 19 around a month and a half, why did it take that period
 20 of time before you chased for an update?

21 **A.** I think it is just the structure of our
 22 governance. So the peer review I think took place
 23 a week after the call and these are all scheduled well
 24 in advance for the whole year and then the benchmarking
 25 would have followed I think probably another two or

230

1 **A.** No.

2 **Q.** Now, would it have been possible for you to
 3 give general advice of that nature in how to manage the
 4 concern at the time?

5 **A.** We probably would do now because of our
 6 strength and guidance on good local investigations, but
 7 at the time that wasn't available. So it would have
 8 been very unlikely I would have been allowed to give
 9 that type of advice.

10 **Q.** Well, you did advise her to inform you of any
 11 action that was taken regarding the police?

12 **A.** Yes.

13 **Q.** So there wasn't anything stopping you giving
 14 general sensible advice?

15 **A.** There's nothing stopping me, no.

16 **Q.** No. Is it just something that you didn't
 17 think about at the time?

18 **A.** I don't -- as I said, I don't think we had the
 19 guidance in place. I mean, about a year later we
 20 introduced the new Fitness to Practise Strategy which
 21 put a lot of emphasis on local resolution and it was at
 22 that point that employers were starting to contact us to
 23 say: well, what do you mean by a good local
 24 investigation, which prompted us to spend a couple of
 25 years on putting together some best practice guidance.

232

1 So it just wasn't something we considered at the
2 time.

3 **Q.** So by 31 August, you now know that Lucy Letby
4 has been placed on non-clinical duties as a result of
5 these clinicians continuing to have their concerns and
6 that further reviews were going to be conducted. Should
7 that not have prompted at that stage a concern on your
8 part: well, this issue hasn't been resolved, there is
9 still a risk that she could go and be, if not doing
10 shifts at this Trust, doing shifts at another Trust and
11 therefore we need to get a referral in to prevent that
12 risk from happening?

13 **A.** So it looked at the time as if the Trust were
14 taking the right steps to protect any future risk by
15 removing her from clinical duty and it's often a good
16 thing to do to remove people from their role so it
17 doesn't influence or affect a good local investigation.
18 So that would seem quite a natural step to remove her
19 from clinical duties while investigations are ongoing
20 and manage the risk.

21 **Q.** But again that doesn't remove the risk in any
22 other location, does it?

23 **A.** No. It -- I probably would expect the Trust
24 to tell us if they thought this individual was working
25 locally as an agency nurse or on another Trust Bank

233

1 They had commissioned a review, an independent
2 review and following the initial feedback that there was
3 no immediate risk to patient safety.

4 **Q.** So you can't recall being given any more
5 detail than what's contained in that note, is that
6 right?

7 **A.** It's very unlikely I was given any more
8 detail. I probably would have tried to capture
9 everything that was discussed even if it's a summary.

10 **Q.** As far as you were aware, the clinicians that
11 had raised concerns still had those concerns?

12 **A.** Yes, they were still there.

13 **Q.** So did you at any point, whether on the
14 previous occasions that we have discussed, 6 July, the
15 email correspondence in August, did you ask for, "Well,
16 why is it that the Consultants are saying this?"

17 **A.** I would have asked the question. But the
18 information obviously wasn't forthcoming because I would
19 have made a note of that either in the initial call or
20 at the meeting that was held a few months later.

21 Now we would probably explore the context more, you
22 know, the culture. Often maternity departments have
23 a multi-disciplinary team cultural issue with doctors
24 and nurses, the midwives. We probably would explore
25 that now. But, no, I didn't at the time ask

235

1 service and if they knew that they probably would
2 restrict her practice at the time as well.

3 **Q.** Okay, but you don't tell them to alert you?

4 **A.** No.

5 **Q.** As to any such development?

6 **A.** We ask the question now and it could be my
7 inexperience at the time as to why I didn't ask it at
8 that point.

9 **Q.** Now, the next conversation that you have is
10 when you attend a meeting -- thank you, that document
11 can come down off the screen now -- with Alison Kelly
12 and Sue Hodgkinson on 29 November; is that right?

13 **A.** That's correct.

14 **Q.** If we go to that, INQ0002447, page 6. We can
15 see that's the second item in your note of the meeting.
16 We discussed in detail the issues from the advice line
17 call conversation in July. Were you given more detail
18 at this point as to the nature of the allegations
19 against Lucy Letby or why the clinicians had the
20 concerns they did?

21 **A.** No. It looks as if I was told that the
22 neonatal unit had been downgraded, obviously that would
23 have restricted a number of children they were caring
24 for because of the increase in mortality so that was new
25 information.

234

1 specifically what their concern was other than ... But
2 then there was no information to suggest anything at the
3 time.

4 **Q.** Do you think looking back on it that you
5 should have done?

6 **A.** Yes, and I would now given the same call.

7 **Q.** The reason you would now, is that because of
8 updated guidance that is in place or is it because of
9 your experience?

10 **A.** It's a combination of both. We've
11 strengthened the service. There's a lot more detail
12 taken on the calls now. Obviously I am a lot more
13 experienced, I have had eight and a half years worth of
14 advice line calls.

15 The relationship with the Trusts also has been
16 strengthened significantly, which allows -- we have got
17 a really good working relationship with all my Directors
18 of Nursing, so if they have got concerns I know that
19 they would be able to call me and talk about
20 confidential matters, open and honestly, when looking
21 for advice.

22 So it's a combination of all those factors.

23 **Q.** Is it right that fundamentally the process
24 hasn't changed significantly from July 2016 to now? So
25 for example you have given some examples that you can

236

1 now input more data and more coding regarding
2 conversations that you have. I mean, that doesn't
3 change the nature of the advice you give, does it?

4 **A.** No, but we explore a lot more detail. We ask
5 a lot more information about the individual, their
6 response to the concern. We explore context, you know,
7 "What were the staffing levels? What's the equipment
8 like? What's the culture like?"

9 And we would look for much more evidence of local
10 resolution in terms of what did their
11 investigator/investigation uncover? What action has
12 been taken?

13 So the actual fundamental principles of the service
14 remain the same, but we explore an awful lot more and
15 probe for a lot more information on today's calls than
16 we did at that time.

17 **Q.** Is there any different evidential threshold
18 for allegations like this now compared to back then?

19 **A.** No.

20 **Q.** I'm going to ask you a few questions now about
21 a different topic, about interim orders.

22 I appreciate that after the 29 November 2016
23 conversation you weren't involved because after that
24 I think it's right that the adviser system was split by
25 region such that this no longer fell within your remit?

237

1 decision as to whether in fact to impose an interim
2 order.

3 So this is a little bit further through the
4 process. This is actually when we get a referral into
5 the NMC that that particular --

6 **Q.** Yes.

7 **A.** -- part of the process is invoked.

8 If you want my personal opinion, we have always
9 said if the police are involved we would advise to refer
10 because it allows us to open up our statutory powers and
11 gain information from the police throughout the course
12 of their investigation. If we didn't have a referral,
13 we would have to wait for the conclusion of the police
14 investigation and obviously any potential risks wouldn't
15 be identified and we wouldn't be able to manage those
16 risks.

17 So if there's police involvement, we would at the
18 time and probably still to this day would recommend
19 a referral comes in really quickly.

20 **MR BERSHADSKI:** My Lady, those are my questions for
21 Mr Newman.

22 **LADY JUSTICE THIRLWALL:** And no one else wants to
23 ask any questions, I don't think, and I have no
24 questions for you, Mr Newman. So thank you very much
25 for coming and you are now free to go.

239

1 **A.** That's right. So at the time there was just
2 six regulations advisers. We were just reaching out to
3 whoever came back with a response to our initial letter,
4 inviting them to a meeting to explain the service.

5 And then when we -- as the team grew we were
6 specifically assigned regional areas. So I moved to the
7 Midlands.

8 **Q.** Yes.

9 **A.** And someone else took responsibility for that.

10 **Q.** Now, an interim order or the NMC didn't apply
11 for an interim order in respect of Lucy Letby until
12 after she'd been charged with an offence and in its
13 opening statement on behalf of the NMC it was said that
14 the arrest could have been sufficient to justify
15 an interim order application.

16 What is your view about whether it's appropriate to
17 wait until an arrest has been made of an individual in
18 this sort of circumstance before applying for an interim
19 order given that it might take a long time before, for
20 example, the police reach that stage?

21 **A.** Yes. So this is not my area of speciality.
22 There is a screening, Seriousness Screening team that
23 look at the nature of the allegations, the seriousness
24 of the allegations and if it's considered for an interim
25 order it goes to an independent panel who will make the

238

1 **A.** Thank you.

2 **LADY JUSTICE THIRLWALL:** Mr Bershadski, that
3 concludes the evidence --

4 **MR BERSHADSKI:** It does.

5 **LADY JUSTICE THIRLWALL:** -- for this week.

6 So we are going to adjourn now and I think our next
7 day of sitting is --

8 **MR BERSHADSKI:** I am told it's not until 7 January.

9 **LADY JUSTICE THIRLWALL:** 7 January, thank you very
10 much indeed. And are we starting at 10 o'clock that
11 day? Yes, so 10 o'clock on 7 January.

12 I hope you all have something of a break, thank you
13 all very much and we will see you in the New Year.

14 **(5.02 pm)**

15 (The Inquiry adjourned until 10.00 am
16 on Tuesday, 7 January 2025)

17

18

19

20

21

22

23

24

25

240

I N D E X

1		
2		
3	DR ALAN FLETCHER (affirmed)	1
4	Questions by MS BROWN	1
5	Questions by MR SKELTON	47
6	Questions by LADY JUSTICE THIRLWALL	65
7	PROFESSOR STEPHEN TURNER (sworn)	73
8	Questions by MR CARR	73
9	DR CAMILLA KINGDON	121
10	Questions by MR CARR	121
11	Questions by MR SKELTON	177
12	Questions by MS SCOLDING	192
13	Questions by LADY JUSTICE THIRLWALL	198
14	MR TONY NEWMAN (sworn)	205
15	Questions by MR BERSHADSKI	205
16	Questions by MR BERSHADSKI	205

17
18
19
20
21
22
23
24
25

<p>HEARING MANAGER: [1] 25/25</p> <p>LADY JUSTICE THIRLWALL: [81] 1/5 26/2 26/7 27/4 27/9 47/2 48/1 65/6 66/7 66/11 66/18 67/8 67/14 67/24 68/8 68/17 68/21 69/3 69/24 70/7 71/1 72/11 72/21 73/8 97/7 97/12 110/10 110/14 119/20 119/25 120/4 120/9 120/15 121/3 121/5 151/15 151/18 151/25 152/2 173/4 177/4 178/6 192/12 196/9 198/22 199/1 199/10 199/13 199/21 200/2 200/16 201/1 201/4 201/8 201/11 201/15 201/18 201/21 202/15 202/22 203/7 203/9 203/15 203/25 204/5 204/11 204/17 204/21 205/5 205/8 205/12 205/17 217/10 217/13 228/5 228/8 228/18 239/22 240/2 240/5 240/9</p> <p>MR BERSHADSKI: [8] 205/6 205/20 217/19 228/7 228/22 239/20 240/4 240/8</p> <p>MR CARR: [13] 73/4 73/11 97/10 97/13 110/15 119/16 120/2 120/10 120/16 121/7 152/3 173/7 177/1</p> <p>MR SKELTON: [6] 47/4 48/2 65/4 177/7 178/7 192/11</p> <p>MS BROWN: [4] 1/8 26/9 27/12 46/24</p> <p>MS SCOLDING: [4] 192/15 196/10 198/20 198/24</p>	<p>1,000 [2] 39/23 123/2 1.05 pm [1] 120/6 1.50 pm [1] 120/8 10 [4] 120/4 120/5 125/22 150/6 10 o'clock [2] 240/10 240/11 20.00 [1] 240/15 10.1 [1] 85/24 105 [1] 44/6 11 [1] 127/19 11.27 [1] 73/1 11.45 [1] 73/3 12 [4] 72/25 135/11 196/5 201/13 12 December 2024 [1] 1/1 12 July 2016 [1] 87/6 12 July 2019 [1] 118/2 123 [1] 56/6 126 [1] 166/13 127.2 [1] 107/14 127.3 [1] 99/24 1274 [1] 97/14 128 [1] 107/20 1281 [1] 98/4 13 [3] 85/10 110/25 196/5 14 [1] 111/16 15 [3] 140/8 169/9 201/14 16 [1] 40/19 17 [2] 139/20 185/21 17 years [1] 41/24 18 [1] 137/11 18:14 [2] 97/10 97/12 18:33 [1] 98/4 19 [1] 139/11 1960s [1] 16/14 1990 [1] 17/20 1992 [1] 122/13 1s [1] 128/17</p>	<p>87/5 87/6 88/16 99/4 100/5 100/15 101/8 110/16 112/3 113/18 120/24 219/3 236/24 237/22 2017 [4] 105/8 115/21 115/23 159/10 2018 [5] 54/10 115/7 117/11 122/23 159/10 2019 [3] 1/21 22/20 118/2 2020 [1] 13/14 2021 [1] 123/7 2022 [1] 50/1 2023 [4] 96/19 136/23 138/4 195/18 2024 [9] 1/1 1/12 73/15 87/10 87/23 121/22 123/7 205/24 205/25 2025 [2] 66/17 240/16 21 [2] 145/2 177/17 21,000 [1] 52/7 22,000 [1] 75/17 22/23 [1] 185/20 23 [1] 185/20 23 August [1] 230/14 24 [2] 149/11 177/18 24 hours [2] 51/20 189/13 25 [1] 157/16 25 March 2024 [1] 121/22 26 [3] 130/20 158/8 160/18 27 [1] 132/13 28 [3] 154/25 155/2 155/3 28 June 2016 [1] 87/5 28 November [1] 106/17 29 November [1] 234/12 29 November 2016 [1] 237/22</p>	<p>4 4 July [1] 209/19 4 July 2018 [1] 117/11 4.15 pm [1] 205/4 4.2 [1] 47/24 400,000 [1] 138/6 45 minutes [1] 120/3</p> <p>5 5 February 2018 [1] 115/7 5 September 2016 [1] 101/8 5.02 pm [1] 240/14 5.1 [1] 169/11 50 [3] 63/12 99/25 107/14 51 [1] 107/20 53 [1] 87/8 55 [2] 169/12 169/13 576 [1] 63/10</p> <p>6 6 December 2024 [1] 1/12 6 July [3] 210/9 231/19 235/14 6 July 2016 [1] 219/3 6.1 [1] 80/23 6.2 [1] 81/6 60 [1] 2/1 60 years [1] 46/22</p> <p>7 7 January [3] 240/8 240/9 240/11 7 January 2025 [1] 240/16 7.5 [5] 81/20 81/20 82/5 83/13 83/19 7.7 [4] 82/3 82/15 83/12 85/6</p>	<p>Aberdeen [1] 74/11 ability [7] 63/20 107/21 108/12 144/5 221/7 221/20 224/3 able [31] 6/16 13/6 14/22 24/9 25/11 47/16 50/10 59/11 69/4 89/23 118/24 122/8 124/24 127/4 135/1 140/19 144/21 150/2 150/3 153/16 160/3 183/7 184/16 185/19 202/18 208/16 216/15 216/16 217/6 236/19 239/15 aborn [2] 94/21 95/20 aborted [1] 95/13 aborting [2] 95/9 95/16 about [158] 3/21 4/13 7/25 8/21 9/5 9/24 11/5 12/7 13/23 15/19 15/21 18/21 19/14 19/18 20/17 20/23 20/25 22/15 25/11 28/9 32/10 35/5 35/18 38/25 39/1 39/11 39/23 44/19 48/2 48/23 49/18 50/7 50/15 51/8 52/13 56/4 56/5 56/6 58/18 59/15 60/15 61/7 62/19 62/21 64/3 66/19 69/7 69/11 70/12 70/13 71/8 71/22 71/25 71/25 74/25 81/2 87/5 87/9 87/16 87/20 88/12 91/9 92/4 97/21 97/22 100/7 100/9 102/5 106/11 107/18 112/10 112/23 126/14 126/23 127/2 127/12 128/2 128/9 128/13 129/19 129/22 130/22 131/24 132/7 132/8 140/12 140/24 142/23 143/1 148/16 149/20 149/22 150/16 153/16 153/25 155/22 157/5 158/2 160/3 162/11 163/12 164/19 168/12 171/1 177/9 178/3 181/1 182/9 182/9 182/21 183/3 183/9 183/22 184/4 184/9 185/13 185/14 185/15 188/14 190/15 190/16 190/17 190/22 191/19 192/17 192/18 193/9 194/7 194/25 195/9 196/3 196/15 198/8 199/2 199/3 200/3 200/21 200/23 201/3 202/5 203/17 203/20</p>
<p>'supported [1] 116/16</p> <p>'We [1] 95/9</p> <p>1 1 March 2019 [1] 1/21 1 million [1] 21/17 1 November 2024 [1] 205/25 1 September [2] 89/19 97/12</p>	<p>2 2 December 2024 [1] 73/15 2,000 [1] 23/12 2.1 [1] 132/22 2.2 [1] 76/22 2.8 [1] 47/24 20 [4] 154/24 185/13 197/17 201/13 20 years [1] 46/22 2000 [1] 122/15 2002 [1] 133/7 2003 [2] 40/12 40/18 2009 [1] 67/11 2014 [1] 122/23 2015 [2] 88/15 206/12 2015/16 [1] 40/19 2016 [18] 74/22 76/11 76/17 80/17</p>	<p>3 3 June 2024 [1] 205/24 3.59 pm [1] 205/2 30 [1] 164/16 30 years [2] 121/14 122/12 31 [1] 166/5 31 August [2] 231/4 233/3 32 [1] 130/18 33 [1] 166/5 33 years [1] 206/7 34 [2] 97/5 169/3 35 [1] 169/3 37 [1] 97/11</p>	<p>8 8 February 1800 hours [1] 116/11 8 March [1] 1/11 8 o'clock [1] 29/14 8.2 [1] 78/8 85 [1] 95/2 86 [1] 112/8 88 [1] 96/17</p> <p>9 9 September [4] 1/23 2/11 48/12 48/14 9.30 [1] 1/2 9.7 [1] 85/12</p> <p>A abandon [1] 150/21 abandoned [2] 152/4 152/6</p>	<p>142/23 143/1 148/16 149/20 149/22 150/16 153/16 153/25 155/22 157/5 158/2 160/3 162/11 163/12 164/19 168/12 171/1 177/9 178/3 181/1 182/9 182/9 182/21 183/3 183/9 183/22 184/4 184/9 185/13 185/14 185/15 188/14 190/15 190/16 190/17 190/22 191/19 192/17 192/18 193/9 194/7 194/25 195/9 196/3 196/15 198/8 199/2 199/3 200/3 200/21 200/23 201/3 202/5 203/17 203/20</p>

A				
<p>about... [16] 207/11 208/3 209/9 211/14 216/24 222/9 223/22 225/2 230/14 232/17 232/19 236/19 237/5 237/20 237/21 238/16</p> <p>absence [1] 79/25</p> <p>absolutely [14] 9/8 55/15 68/23 69/20 69/25 91/18 111/11 117/18 119/13 148/13 174/19 175/19 195/10 209/1</p> <p>accelerate [1] 68/15</p> <p>accelerating [1] 68/24</p> <p>accept [5] 70/21 72/8 101/21 103/7 116/20</p> <p>accepted [2] 100/16 102/6</p> <p>accepts [4] 79/7 91/13 100/11 103/4</p> <p>access [10] 11/24 17/19 144/5 144/18 144/18 144/19 144/20 161/16 184/24 193/17</p> <p>accessible [1] 131/23</p> <p>accidental [1] 226/7</p> <p>accidents [1] 61/23</p> <p>accommodation [1] 192/23</p> <p>accord [1] 223/9</p> <p>according [3] 20/13 33/19 67/19</p> <p>account [1] 105/4</p> <p>accountability [4] 136/8 162/15 164/12 169/21</p> <p>accountable [1] 52/5</p> <p>accurate [3] 3/15 38/12 206/2</p> <p>accurately [1] 3/13</p> <p>accused [1] 98/14</p> <p>accustomed [1] 32/11</p> <p>achieve [2] 161/21 170/24</p> <p>achieved [2] 194/5 223/15</p> <p>acknowledged [1] 166/16</p> <p>acquaintances [1] 4/21</p> <p>acquiring [1] 22/15</p> <p>acquisition [1] 7/17</p> <p>across [20] 24/6 50/4 64/16 67/25 129/23 131/21 134/18 135/7 141/19 150/20 152/14 154/20 159/9 175/6 194/11 194/18 195/5</p>	<p>197/4 198/12 209/24</p> <p>act [3] 37/12 81/11 227/20</p> <p>acted [1] 13/10</p> <p>acting [2] 100/25 161/10</p> <p>action [18] 81/1 85/15 85/18 101/10 136/8 140/15 164/10 173/3 207/12 216/6 216/15 216/22 217/22 220/19 228/12 230/16 232/11 237/11</p> <p>actions [11] 25/3 52/6 67/23 103/14 116/14 133/2 147/22 164/18 224/5 224/10 225/12</p> <p>activate [1] 188/11</p> <p>activated [1] 180/2</p> <p>activating [1] 181/7</p> <p>active [1] 170/5</p> <p>actively [1] 173/25</p> <p>activities [3] 125/19 127/17 130/25</p> <p>activity [7] 17/14 39/11 39/19 40/5 57/11 171/21 189/14</p> <p>actual [5] 21/2 34/13 69/4 154/2 237/13</p> <p>actually [50] 13/25 14/4 22/25 37/25 42/15 45/11 50/21 50/22 51/6 55/10 57/18 61/7 62/14 113/13 126/21 128/7 128/13 135/20 141/21 142/6 150/13 150/18 151/5 152/22 153/13 153/14 153/19 154/6 157/1 161/25 162/10 163/20 167/24 170/15 172/1 172/6 172/8 182/5 184/12 186/10 187/8 191/6 191/19 197/10 198/17 200/13 214/4 215/11 230/4 239/4</p> <p>acute [8] 1/19 5/14 36/13 126/16 126/20 163/5 189/17 197/8</p> <p>acutely [2] 29/13 32/3</p> <p>adapt [1] 63/15</p> <p>add [2] 27/14 96/11</p> <p>addition [2] 112/1 176/13</p> <p>additional [8] 48/22 124/14 140/18 144/15 157/22 219/17 219/20 221/15</p> <p>additions [1] 34/20</p> <p>address [11] 2/5 74/21 86/25 88/19</p>	<p>99/8 121/11 130/2 145/3 162/22 163/2 171/5</p> <p>addressed [3] 99/21 139/11 172/24</p> <p>addresses [2] 120/23 122/3</p> <p>addressing [3] 92/13 136/12 154/23</p> <p>adequate [3] 127/9 127/9 223/5</p> <p>adhered [1] 4/17</p> <p>adjourn [1] 240/6</p> <p>adjourned [1] 240/15</p> <p>adjourning [1] 111/19</p> <p>adjournment [1] 120/7</p> <p>adjusted [1] 152/5</p> <p>administered [2] 19/7 19/10</p> <p>administering [1] 147/16</p> <p>administrative [1] 64/10</p> <p>admission [1] 155/3</p> <p>admitted [1] 7/9</p> <p>adult [12] 22/8 27/22 34/22 60/24 137/5 137/15 138/15 138/18 183/5 191/25 196/19 197/1</p> <p>adults [6] 42/15 62/8 136/25 137/17 163/21 183/25</p> <p>advance [2] 183/13 230/24</p> <p>advances [2] 140/2 191/10</p> <p>Advancing [1] 75/12</p> <p>advantage [1] 154/9</p> <p>advent [4] 64/16 66/1 182/25 194/9</p> <p>advice [55] 5/4 23/8 24/22 28/9 33/22 39/21 62/18 62/19 82/21 82/25 83/5 83/7 84/5 84/11 95/17 99/12 99/15 101/3 118/23 188/23 189/5 190/10 207/9 207/22 207/25 208/10 209/9 209/12 214/24 215/1 215/16 215/18 215/24 216/1 216/20 220/23 223/22 225/18 226/21 228/12 228/16 229/5 229/11 229/16 229/16 229/18 229/22 231/19 232/3 232/9 232/14 234/16 236/14 236/21 237/3</p> <p>advise [11] 80/25 169/20 207/18 207/19</p>	<p>207/20 215/21 222/16 225/14 225/15 232/10 239/9</p> <p>advised [8] 82/18 83/2 83/2 83/15 83/22 84/21 100/12 216/19</p> <p>adviser [11] 78/3 78/11 78/16 78/20 78/24 80/10 92/20 206/16 206/17 206/19 237/24</p> <p>advisers [2] 229/15 238/2</p> <p>advising [4] 208/13 220/3 226/10 227/20</p> <p>advocate [3] 32/20 62/10 71/17</p> <p>advocated [1] 163/4</p> <p>affect [1] 233/17</p> <p>affected [2] 115/20 215/8</p> <p>affirmed [2] 1/3 241/3</p> <p>afraid [7] 68/25 134/1 158/16 178/10 180/1 187/12 191/20</p> <p>after [31] 27/23 27/25 28/22 30/20 36/9 41/24 44/24 49/14 57/23 61/17 68/22 70/22 95/4 100/4 101/7 114/5 115/10 142/3 157/12 179/7 191/11 192/5 200/22 202/7 229/10 230/16 230/23 231/1 237/22 237/23 238/12</p> <p>afterwards [1] 216/10</p> <p>again [29] 11/21 18/19 26/11 26/21 31/3 42/8 53/22 64/24 70/11 72/9 73/4 79/21 80/3 96/18 102/18 105/13 106/23 117/20 132/14 139/15 150/14 159/12 163/22 173/7 173/15 204/25 226/1 229/21 233/21</p> <p>again' [1] 95/10</p> <p>against [6] 137/4 142/19 148/20 148/24 220/21 234/19</p> <p>agencies [3] 42/20 50/4 105/15</p> <p>agency [13] 39/13 45/17 51/20 52/10 52/19 53/10 54/8 178/2 178/13 178/22 180/13 221/23 233/25</p> <p>ages [1] 16/10</p> <p>ago [4] 66/19 122/11 149/20 149/23</p> <p>agree [31] 72/7 84/3</p>	<p>85/2 87/14 87/19 88/2 88/6 88/18 89/17 90/13 92/15 93/7 96/6 96/23 97/2 100/24 103/20 103/22 105/6 105/25 106/7 107/2 107/6 108/15 116/23 133/20 140/10 169/13 169/19 188/8 200/11</p> <p>agreed [16] 65/22 78/3 84/16 87/1 87/3 88/4 88/9 90/12 90/14 93/6 112/25 119/12 215/16 218/8 229/18 229/21</p> <p>agreeing [2] 78/15 229/16</p> <p>agreement [3] 78/10 86/23 90/15</p> <p>ahead [4] 79/9 91/8 92/11 93/15</p> <p>aimed [2] 44/1 109/21</p> <p>aims [2] 75/9 135/17</p> <p>air [1] 187/22</p> <p>ALAN [3] 1/3 1/9 241/3</p> <p>alarm [3] 41/16 179/12 218/18</p> <p>albeit [1] 23/16</p> <p>Alder [1] 180/18</p> <p>Alder Hey [1] 180/18</p> <p>alert [1] 234/3</p> <p>Alex [4] 91/20 91/22 97/18 98/20</p> <p>Alex Mancini [3] 91/22 97/18 98/20</p> <p>algorithm [1] 56/16</p> <p>aligned [4] 28/4 156/2 156/9 184/15</p> <p>aligning [1] 193/22</p> <p>Alison [20] 89/21 93/22 209/16 209/18 210/6 210/9 210/12 210/17 210/20 218/6 218/16 219/1 226/24 227/2 227/11 230/13 230/17 231/4 231/19 234/11</p> <p>Alison Kelly [16] 89/21 93/22 209/16 209/18 210/6 210/9 210/12 210/17 226/24 227/2 227/11 230/13 230/17 231/4 231/19 234/11</p> <p>Alison Kelly's [3] 210/20 218/6 219/1</p> <p>all [106] 2/16 2/16 3/10 10/18 10/20 11/15 11/22 13/21 16/10 16/10 16/10 21/7 21/23 21/23 23/7 24/4 25/4 25/7 26/25</p>

A	already [17] 18/4 30/17 49/18 55/5 64/24 136/11 139/24 141/20 141/25 142/3 145/3 147/2 157/21 161/5 167/25 169/4 215/20 also [41] 4/16 7/21 10/8 29/11 29/18 40/2 42/4 52/24 62/3 74/2 98/11 105/2 113/1 115/20 120/16 123/4 125/12 131/6 136/13 149/10 152/25 153/3 154/20 155/17 157/23 160/6 161/24 162/3 170/19 173/9 180/5 183/25 186/21 192/23 195/23 226/25 229/11 229/20 230/2 231/9 236/15 alternative [1] 119/11 although [12] 24/3 37/18 43/20 60/24 99/5 126/10 155/10 173/9 177/17 182/11 200/22 212/24 altogether [1] 221/16 always [26] 4/6 15/10 15/15 17/15 19/1 19/12 20/3 21/2 21/5 22/11 23/9 24/18 29/6 31/13 33/16 39/3 43/18 54/15 60/24 67/7 157/19 179/25 200/3 202/11 227/8 239/8 am [95] 1/2 3/19 4/16 8/19 15/13 17/24 18/10 19/5 19/14 19/14 19/21 22/4 24/17 25/1 25/6 25/13 26/17 27/4 27/10 28/9 32/2 37/17 39/21 41/25 41/25 42/20 43/3 43/20 43/20 48/25 50/10 51/25 52/12 53/9 60/10 60/11 60/14 61/16 63/12 66/16 68/23 69/15 71/2 72/23 73/1 73/3 73/13 74/24 76/8 82/9 84/4 97/10 110/8 116/4 119/18 121/17 122/6 124/1 124/7 127/3 134/3 134/17 150/19 156/21 159/3 171/3 175/10 178/24 180/1 181/5 181/5 181/6 183/8 185/13 185/13 185/15 188/2 190/1 191/20 192/15 196/15 197/11 200/4	200/17 201/8 201/15 201/21 204/12 224/12 225/11 227/23 230/6 236/12 240/8 240/15 ambitions [1] 194/7 ambulance [1] 7/10 amended [1] 87/4 Amendment [1] 17/20 Amendment 1990 [1] 17/20 amidst [1] 138/7 amongst [12] 23/23 75/9 91/6 92/7 94/16 94/20 110/20 111/4 142/12 149/15 171/19 198/7 amount [2] 66/3 154/8 analysing [1] 154/2 analysis [7] 13/22 103/1 103/6 154/21 186/22 212/20 213/7 analytical [1] 14/10 annual [2] 136/24 176/24 anomalies [1] 202/25 anomalous [1] 170/19 anonymously [1] 81/8 another [27] 4/22 5/23 6/7 7/13 8/7 40/4 65/23 65/25 85/21 86/10 100/25 117/23 139/10 153/10 158/11 159/19 183/2 199/16 200/13 203/5 210/3 216/11 221/15 228/12 230/25 233/10 233/25 answer [15] 27/14 28/6 84/5 127/25 129/24 132/17 133/19 134/12 135/3 136/11 194/25 211/14 213/3 231/2 231/4 answerable [1] 44/21 answered [1] 3/11 answering [4] 119/16 125/3 177/1 178/24 answers [1] 55/21 anticipate [1] 174/24 anticipated [1] 204/19 anxieties [2] 49/17 194/7 any [103] 3/16 4/11 4/25 7/7 7/15 10/21 11/1 12/22 13/25 14/14 17/11 18/11 19/14 21/1 24/16 25/8 28/9 31/2 33/9 39/1 39/9 45/8 45/14 46/19 54/15 57/3 58/19	58/21 63/22 67/6 80/24 81/1 81/9 82/5 83/13 86/2 86/2 88/13 89/9 90/5 92/4 92/6 98/21 99/20 100/2 100/7 107/16 109/9 110/7 115/11 133/22 142/4 154/8 156/16 175/7 176/1 187/23 190/17 192/10 193/20 193/23 193/24 193/24 194/5 195/12 195/18 202/17 207/10 208/6 209/3 209/4 209/5 211/4 211/6 215/17 215/17 216/15 216/22 217/22 218/23 219/12 219/16 220/25 222/9 224/1 224/11 225/24 226/14 226/23 227/1 227/11 230/1 231/19 232/10 233/14 233/21 234/5 235/4 235/7 235/13 237/17 239/14 239/23 anybody [6] 72/11 104/17 104/25 193/18 204/22 226/24 anyone [2] 171/23 176/6 anything [9] 11/2 27/13 58/4 72/12 204/22 207/6 222/23 232/13 236/2 apologise [4] 69/2 73/24 74/2 127/3 apology [2] 46/13 46/14 apparent [6] 12/4 18/16 54/10 82/12 88/15 88/22 apparently [1] 70/15 appear [4] 60/11 183/25 210/24 228/21 appeared [1] 30/19 appears [14] 26/16 82/8 83/11 83/18 84/19 96/7 130/21 131/9 141/16 146/2 158/11 162/22 167/17 188/16 appendix [4] 108/22 110/24 111/17 119/14 appendix 2 [1] 111/17 appendix 4 [1] 108/22 application [1] 238/15 applied [5] 46/2 76/15 81/16 129/14 173/13 apply [8] 61/15 129/23 173/16 173/17	182/13 182/19 182/20 238/10 applying [4] 16/17 56/17 226/14 238/18 appointment [2] 143/17 161/1 appreciate [7] 10/25 16/9 16/22 90/16 116/13 178/3 237/22 appreciation [1] 184/17 approach [16] 13/5 13/12 29/7 45/16 62/12 81/14 82/4 147/1 176/2 180/13 180/18 180/19 180/22 180/23 187/2 221/6 approached [1] 29/16 approaches [3] 131/7 197/9 199/4 appropriate [37] 6/3 6/11 10/1 14/21 20/12 23/9 28/15 33/12 44/4 52/6 53/6 63/6 67/18 81/10 81/14 85/19 90/24 92/13 92/13 99/9 100/21 109/7 113/12 116/18 135/13 135/19 136/2 136/6 136/7 153/6 162/15 164/12 181/4 181/5 193/25 215/21 238/16 appropriately [2] 100/25 179/12 appropriateness [2] 96/14 98/25 approximately [1] 1/25 April [2] 65/15 206/12 April/May [1] 65/15 are [521] area [4] 23/5 51/23 112/20 238/21 areas [7] 2/22 14/6 38/11 48/5 132/11 159/25 238/6 aren't [5] 18/16 137/6 137/22 137/23 224/11 arena [1] 144/10 argue [1] 185/12 arise [12] 6/21 10/12 10/13 11/6 11/12 70/20 70/20 80/21 81/17 82/5 84/20 141/15 arisen [3] 18/8 19/5 69/11 arises [3] 83/19 83/20 173/7 arising [6] 12/21 13/8 17/11 72/12 108/8 118/19
----------	---	--	---	--

A	159/13 160/4 169/21 197/23	66/4	29/2 29/9 30/24 31/19 44/16 70/14 155/20 162/4 162/9 162/9 162/12 162/12 179/19 180/2 184/8 185/20 187/8 187/14 191/19 191/22 191/23 195/15 197/2 199/18 199/19 200/15 202/1 202/1 202/6 202/7 202/14	became [4] 13/10 38/5 54/9 122/15 because [142] 9/18 10/12 14/5 14/18 14/24 15/15 16/7 18/22 19/23 21/19 22/11 24/1 25/10 28/10 28/18 29/23 30/12 30/16 32/23 34/19 35/5 36/10 37/25 38/3 38/9 39/23 40/18 41/11 41/14 43/20 43/22 44/6 45/12 47/11 49/8 49/12 50/4 50/18 51/6 52/5 53/3 54/3 54/8 55/11 55/18 57/25 61/9 61/18 63/6 63/15 63/21 64/8 65/15 67/4 71/4 71/21 76/23 79/14 83/23 90/1 96/17 106/24 107/23 108/3 114/10 118/24 127/9 129/3 130/3 131/20 134/16 137/7 141/17 142/18 142/22 143/12 148/4 150/13 150/19 150/21 151/9 151/22 152/9 152/18 152/21 153/15 153/21 154/14 156/24 157/3 157/11 157/18 162/4 163/9 164/7 166/25 168/1 168/7 170/12 171/1 172/21 173/22 175/10 180/9 183/2 185/12 185/12 190/3 191/4 191/21 192/3 193/15 193/17 194/5 194/8 196/25 197/7 209/19 214/6 215/24 216/7 216/9 216/13 217/1 218/4 218/20 220/9 221/20 222/3 225/7 225/18 225/23 226/24 227/7 227/21 232/5 234/24 235/18 236/7 236/8 237/23 239/10	
arm's [1] 42/16	assesses [1] 77/19	August [5] 76/17 230/14 231/4 233/3 235/15	back [27] 10/21 12/25 16/14 31/11 32/15 40/7 46/7 65/7 72/25 79/18 114/8 125/20 138/13 164/18 165/8 165/13 179/6 184/3 186/19 190/21 191/3 197/13 218/2 223/4 236/4 237/18 238/3	became [4] 13/10 38/5 54/9 122/15 because [142] 9/18 10/12 14/5 14/18 14/24 15/15 16/7 18/22 19/23 21/19 22/11 24/1 25/10 28/10 28/18 29/23 30/12 30/16 32/23 34/19 35/5 36/10 37/25 38/3 38/9 39/23 40/18 41/11 41/14 43/20 43/22 44/6 45/12 47/11 49/8 49/12 50/4 50/18 51/6 52/5 53/3 54/3 54/8 55/11 55/18 57/25 61/9 61/18 63/6 63/15 63/21 64/8 65/15 67/4 71/4 71/21 76/23 79/14 83/23 90/1 96/17 106/24 107/23 108/3 114/10 118/24 127/9 129/3 130/3 131/20 134/16 137/7 141/17 142/18 142/22 143/12 148/4 150/13 150/19 150/21 151/9 151/22 152/9 152/18 152/21 153/15 153/21 154/14 156/24 157/3 157/11 157/18 162/4 163/9 164/7 166/25 168/1 168/7 170/12 171/1 172/21 173/22 175/10 180/9 183/2 185/12 185/12 190/3 191/4 191/21 192/3 193/15 193/17 194/5 194/8 196/25 197/7 209/19 214/6 215/24 216/7 216/9 216/13 217/1 218/4 218/20 220/9 221/20 222/3 225/7 225/18 225/23 226/24 227/7 227/21 232/5 234/24 235/18 236/7 236/8 237/23 239/10	
arm's-length [1] 42/16	assessing [5] 102/23 145/8 146/23 148/15 159/4	authored [1] 17/4	backlog [1] 138/18	become [5] 52/14 76/5 153/23 185/17 211/11	
arose [3] 43/8 86/17 105/5	assessment [5] 16/4 55/17 89/11 148/1 148/22	authorise [1] 85/18	bad [2] 57/17 129/3	becomes [5] 37/9 42/24 82/11 148/1 148/3	
around [25] 65/14 126/13 127/13 128/10 141/19 147/12 147/16 150/6 152/21 155/6 159/21 162/2 163/17 165/6 170/16 175/8 175/9 183/17 190/23 191/16 192/8 194/18 214/12 230/19 231/19	assigned [1] 238/6	authorised [2] 86/4 100/4	Badger [1] 151/4	becomes [5] 37/9 42/24 82/11 148/1 148/3	
arrangement [1] 78/6	assist [2] 122/9 160/15	authority [15] 7/11 30/6 68/13 71/23 82/20 83/17 83/24 84/22 85/20 99/15 116/13 171/11 171/16 172/5 172/9	BadgerNet [5] 149/22 150/21 150/23 151/13 152/13	been [145] 1/21 7/19 8/5 8/13 8/23 12/25 13/3 18/4 20/6 23/2 23/13 28/14 30/4 30/14 30/17 30/20 30/21 32/10 34/14	
arrangements [1] 9/21	associated [2] 140/15 189/8	authors [2] 67/13 130/22	bank [3] 221/15 221/23 233/25		
arrest [3] 62/1 238/14 238/17	associates [1] 69/12	automatically [2] 18/14 180/9	BAPM [6] 49/23 50/4 160/25 194/24 195/2 195/4		
arrive [2] 83/12 96/22	association [11] 19/23 19/23 49/14 49/21 65/17 68/4 91/10 158/8 158/21 194/6 195/6	available [10] 72/14 153/5 189/12 194/17 208/24 212/24 226/16 226/19 227/22 232/7	Baroness [1] 181/19		
arrived [1] 83/6	assumed [1] 205/14	average [2] 203/3 211/10	barriers [3] 157/20 157/22 157/25		
arriving [1] 92/5	assuming [5] 53/1 200/18 201/8 201/16 202/2	averages [1] 211/23	base [2] 62/13 226/21		
articulated [1] 57/5	assurance [3] 67/6 67/22 69/1	avoid [6] 82/19 83/16 84/17 84/21 84/24 95/23	based [7] 37/9 40/2 64/9 75/23 173/23 208/1 228/2		
articulating [2] 58/24 164/6	at [301]	avoiding [1] 43/1	baselines [1] 13/21		
as [309]	at 6.1 [1] 80/23	aware [26] 15/13 18/7 19/4 19/11 25/17 37/3 51/23 51/25 52/12 55/6 91/25 103/13 109/22 110/8 116/17 144/10 160/19 185/8 209/20 210/1 224/8 224/11 227/5 227/6 230/6 235/10	basic [1] 207/16		
ask [45] 13/23 15/21 18/15 21/1 22/23 24/12 31/2 45/11 47/4 50/15 55/24 56/4 58/18 59/11 60/15 61/10 62/15 65/10 66/16 72/11 78/8 97/21 122/6 177/7 177/8 177/12 184/18 185/23 188/14 195/17 195/23 199/2 203/19 204/22 211/13 211/14 221/19 228/8 234/6 234/7 235/15 235/25 237/4 237/20 239/23	at 6.2 [1] 81/6	awareness [3] 25/3 55/9 160/21	basically [2] 147/5 215/15		
asked [22] 6/13 28/13 56/12 58/17 60/4 60/5 65/20 65/20 66/10 68/16 68/18 103/17 183/21 190/15 199/3 203/17 211/6 211/8 211/16 211/21 211/22 235/17	attach [1] 60/24	away [10] 46/5 86/19 86/20 114/13 147/19 151/22 171/3 173/2 192/23 215/25	basis [5] 2/11 6/8 129/10 135/17 183/23		
asking [13] 58/3 58/16 62/18 62/21 67/10 71/18 71/24 74/24 84/4 131/25 155/21 155/23 209/19	attaching [1] 60/23	awful [1] 237/14	battle [1] 192/7		
asks [2] 60/2 127/10	attempt [2] 16/8 194/17		Bay [3] 25/24 59/8 133/11		
aspect [4] 22/1 72/1 113/4 178/1	attend [2] 174/16 234/10		be [445]		
aspects [10] 12/9 17/1 18/6 21/23 36/1 76/9 80/20 190/18 208/9 222/19	attending [10] 20/2 20/10 30/22 38/16 41/5 45/1 45/4 55/24 58/6 71/10		beacons [1] 53/4		
assess [5] 148/19	attention [12] 17/15 38/20 58/13 126/7 126/13 136/1 160/1 191/6 191/9 192/9 194/22 194/23		beaming [1] 1/6		
	attract [1] 17/15		bear [1] 52/24		
	attracted [1] 34/23		bearing [2] 53/17 61/4		
	attributed [1] 102/8		beautifully [1] 37/3		
	attuned [1] 59/10				
	audit [14] 149/3 149/4 149/8 149/17 149/17 149/24 150/10 151/8 152/1 152/16 152/25 153/12 153/13 153/23				
	auditing [1] 154/14				
	augmentation [1]				
		B			
		babies [44] 16/20 18/9 21/8 40/25 97/21 101/19 121/15 121/18 153/15 153/18 153/18 163/10 164/3 164/7 178/25 179/4 179/21 186/17 187/4 187/5 187/24 190/24 191/10 191/12 191/12 192/6 194/8 200/21 201/16 201/23 201/24 202/3 202/23 203/1 203/2 203/4 211/1 214/3 218/1 218/10 218/17 221/2 221/9 226/11			
		babies' [1] 154/6			
		baby [33] 6/2 8/4			

B	behaved [1] 116/4	206/3 210/10 232/25	136/11 152/24 153/17	BROWN [7] 1/4 1/7
been... [126] 34/15	behavioural [1] 81/23	better [4] 28/11	155/21 155/22 177/12	26/8 53/18 56/4 58/16
34/16 45/12 47/11	behaviours [2] 131/3	132/2 190/6 194/2	178/15 178/15 181/18	241/4
49/9 54/4 59/4 59/17	131/21	between [30] 3/24	192/22 196/23 216/9	budget [2] 176/23
60/6 63/17 64/3 66/2	being [61] 2/1 8/5 8/6	8/7 33/15 35/14 53/23	219/24 229/25 236/10	176/24
66/3 70/1 74/6 83/7	8/17 12/20 18/10 19/3	57/5 63/19 87/1 89/11	bottom [12] 98/1	bullet [5] 88/10
83/9 90/12 90/13	19/10 21/9 21/24	91/23 94/4 112/2	111/5 116/25 117/1	210/23 213/19 213/21
90/22 90/23 90/25	25/11 26/19 39/11	117/22 118/2 122/23	117/10 138/14 145/21	218/25
91/18 92/19 93/1 93/6	46/2 48/4 48/11 48/15	127/25 138/15 153/1	177/25 178/4 178/6	bullying [2] 81/24
95/13 96/2 96/4 96/15	50/9 55/25 59/11	153/2 153/6 154/1	178/7 229/4	157/25
98/23 99/2 100/9	65/16 72/17 80/4 87/3	159/10 163/10 174/22	bought [1] 152/11	burden [1] 223/19
100/11 100/19 100/20	88/3 96/20 98/9 98/14	174/25 175/4 175/17	bound [1] 225/8	bureaucratic [2]
100/21 100/22 101/1	106/9 108/8 109/23	199/15 203/3 213/4	boundaries [8] 62/25	64/10 68/11
101/2 101/12 102/4	117/13 118/20 128/2	Beverley [2] 25/3	84/16 84/23 95/23	burner [1] 191/3
102/19 103/2 103/21	132/19 138/20 142/10	57/12	96/3 96/11 102/19	busy [4] 20/21 47/12
103/25 104/4 104/11	143/4 152/10 153/1	Beverley Allitt [2]	102/22	126/16 183/12
104/22 105/24 106/2	153/5 154/3 157/12	25/3 57/12	boundary [1] 96/3	but [227] 2/18 2/20
106/18 107/3 109/9	157/18 164/18 179/2	bewildering [2]	box [5] 111/5 111/5	2/23 3/3 3/20 4/9 4/13
110/18 110/21 113/5	181/4 187/21 187/24	125/1 167/23	111/18 132/14 166/19	6/9 6/14 7/23 8/1
113/15 116/5 116/22	190/19 197/10 199/2	beyond [3] 89/14	boxes [1] 104/10	10/16 11/1 12/18
119/10 119/22 121/13	199/18 199/19 213/24	148/17 162/20	braces [1] 180/10	13/15 14/8 14/14
122/12 128/10 133/5	217/22 218/12 218/14	big [2] 98/9 98/24	brakes [1] 46/2	14/21 15/1 18/9 22/5
136/5 144/1 151/12	221/22 222/3 235/4	binary [1] 45/15	branch [1] 168/3	22/24 23/24 24/11
151/23 156/18 162/6	beings [3] 57/15	Birmingham [2]	brave [1] 194/7	24/20 27/5 29/11
162/9 167/10 167/24	61/19 192/9	180/5 181/1	break [7] 11/3 26/1	32/20 33/9 34/15
171/25 172/24 173/5	belief [4] 1/13 73/18	birth [2] 155/1 191/5	73/2 94/15 204/25	35/19 35/23 36/12
173/22 173/24 177/18	122/1 206/3	bit [14] 17/6 52/8	205/3 240/12	36/18 37/19 40/4 41/9
187/10 190/15 192/17	believe [14] 1/24	58/15 59/6 65/7 79/21	Brearey [9] 93/23	43/5 45/5 45/20 48/22
193/23 194/14 194/16	46/25 54/13 54/23	97/8 134/1 155/24	95/6 115/5 116/22	50/20 52/7 52/21
194/23 194/23 195/24	72/6 91/2 106/7 112/6	177/9 177/21 206/5	117/11 117/16 117/22	53/17 55/2 56/23 57/2
197/13 198/6 200/19	113/8 140/20 156/25	213/20 239/3	118/19 180/16	57/4 57/19 57/22
200/22 201/22 204/9	157/2 158/16 227/3	black [1] 104/5	Brearey's [2] 116/25	58/21 59/3 59/20
204/19 208/25 211/18	believes [1] 70/16	Bliss [1] 191/19	117/18	59/23 60/2 60/19
212/7 212/17 212/21	bell [1] 41/17	blood [4] 17/13 18/25	breastfeeding [1]	63/22 64/24 66/23
214/6 215/2 216/22	bells [1] 218/18	179/6 187/9	150/8	67/25 68/11 69/10
218/9 220/10 220/22	below [1] 59/20	blue [1] 39/24	Bridget [1] 19/8	70/15 71/3 71/25 72/9
227/6 228/14 229/3	belt [1] 180/10	BMJ [1] 166/6	Bridget Bock [1]	76/17 80/19 84/8
229/4 229/6 229/23	benchmarking [8]	board [26] 84/11	19/8	87/19 87/22 91/13
231/15 232/2 232/8	148/20 216/11 229/12	85/17 95/18 107/12	brief [2] 75/3 97/22	91/24 94/24 95/7
232/8 233/4 233/8	229/20 229/24 230/2	107/15 107/21 108/9	briefing [1] 107/16	95/10 96/11 96/21
234/22 236/15 237/12	230/16 230/24	108/12 131/19 131/22	briefings [1] 47/10	97/14 98/1 99/21
238/12 238/14 238/17	benefit [3] 80/9 96/21	144/5 144/6 144/13	briefly [7] 2/6 37/20	103/18 103/24 104/1
before [26] 2/12 8/16	114/9	144/19 162/15 162/21	44/7 44/12 56/5	104/13 105/2 105/13
36/24 41/15 66/9 66/9	benefits [5] 4/24	163/5 163/6 163/8	112/10 206/25	108/19 110/5 110/8
66/24 73/20 76/8 78/8	113/20 114/3 156/17	164/2 165/3 169/14	bring [2] 14/5 50/1	113/19 114/17 119/1
84/16 109/4 120/12	182/14	189/24 191/17 198/12	brings [3] 42/20	122/8 124/13 125/17
121/10 122/10 129/3	bereaved [17] 14/12	231/10	130/20 202/13	126/19 127/1 128/11
141/23 151/16 220/2	15/1 15/12 28/18 29/6	boards [2] 131/3	Bristol [1] 133/8	128/18 128/20 129/13
224/23 226/10 227/20	29/14 30/6 32/3 32/7	161/16	British [8] 19/23	129/25 134/13 135/4
228/9 230/20 238/18	32/20 32/22 34/4 35/7	Bock [1] 19/8	49/21 65/17 68/4	135/6 136/18 138/18
238/19	36/6 36/12 46/10	bodies [12] 42/16	158/8 158/21 194/6	141/13 143/1 145/14
beg [2] 134/13	46/10	100/3 106/10 106/11	195/6	146/2 148/7 148/11
189/15	bereavement [4]	107/22 111/23 124/14	British Association	148/22 149/9 149/21
begin [2] 86/21	30/1 33/17 35/15	124/17 124/22 125/15	[6] 19/23 49/21	151/5 151/21 152/7
149/16	35/16	166/17 168/17	65/17 68/4 158/8	152/9 152/16 152/19
beginning [4] 69/15	Bershadski [7] 205/5	body [5] 81/14 90/24	158/21	152/25 153/3 153/18
69/18 95/14 114/18	205/11 205/18 205/19	115/17 125/14 168/5	broad [5] 77/14	154/11 154/20 154/23
begs [1] 148/11	240/2 241/15 241/16	book [1] 17/6	124/2 149/13 167/8	155/3 155/22 155/24
behalf [10] 12/12	bespoke [1] 174/4	born [1] 162/9	204/8	156/2 157/10 157/23
47/4 73/24 123/13	best [15] 1/13 4/4	borne [1] 85/8	broader [1] 77/14	158/10 158/14 158/15
134/17 138/23 164/3	32/5 34/2 36/20 39/16	both [27] 25/18 39/17	broadly [4] 76/18	158/17 159/2 162/8
165/1 177/7 238/13	44/11 73/18 96/4	50/5 68/3 78/17 79/8	113/19 140/24 207/24	162/18 163/20 164/5
behave [1] 74/3	122/1 189/25 194/18	98/20 104/25 111/13	brought [2] 40/22	166/23 167/22 169/20
		122/7 124/21 129/6	113/5	170/5 170/5 170/19

B	36/17 92/25 calls [7] 40/16 209/13 214/19 215/4 236/12 236/14 237/15 came [6] 32/16 38/3 105/8 105/12 157/11 238/3 CAMILLA [3] 121/4 121/9 241/9 can [169] 3/22 7/4 7/24 8/10 12/11 12/24 20/3 22/23 23/1 23/20 23/20 26/1 27/11 28/10 28/17 30/18 31/11 31/18 32/5 32/6 32/7 35/12 35/23 37/21 38/17 39/24 41/8 42/2 44/5 50/11 51/14 51/16 52/9 52/20 55/14 56/2 56/4 56/14 58/3 59/4 60/15 65/7 65/10 67/3 68/14 68/24 69/11 71/20 73/5 73/11 75/3 76/7 76/13 78/1 80/21 82/23 85/22 86/11 86/19 86/25 87/13 88/7 91/3 91/3 91/5 93/25 97/3 97/14 97/19 98/11 101/6 101/25 102/1 104/9 107/11 108/16 110/12 110/23 111/17 111/25 115/1 117/7 119/25 121/2 121/7 121/25 122/10 124/25 125/12 126/21 128/8 128/11 128/11 128/25 130/6 130/14 130/17 132/8 135/20 138/4 139/8 140/5 140/22 141/9 143/18 145/7 145/19 145/24 148/18 148/23 149/13 150/14 150/17 152/5 154/7 155/24 157/6 157/14 158/10 158/18 160/15 163/1 165/17 166/9 166/10 166/18 166/24 167/6 169/1 169/8 173/6 177/8 177/12 177/22 178/1 178/3 178/12 179/4 179/14 179/23 180/7 180/13 182/24 183/2 184/5 184/6 184/7 188/2 189/9 195/17 195/23 196/2 197/18 197/20 198/4 199/1 202/7 208/17 211/17 212/10 216/4 221/5 222/17 223/18 228/8 231/2 234/11 234/14 236/25 can't [19] 12/16	12/18 65/13 143/24 151/5 185/9 186/9 186/10 187/3 193/17 194/8 196/25 200/9 210/2 217/16 227/1 228/1 228/10 235/4 cancer [1] 137/15 candour [4] 109/11 109/16 110/3 196/1 cannot [5] 5/25 37/4 62/7 68/25 127/15 capability [1] 103/5 capacities [1] 142/1 capacity [4] 23/25 74/7 81/11 141/21 capital [4] 192/18 193/19 193/24 194/14 capture [1] 235/8 cardiac [3] 62/1 202/24 203/8 cardiology [2] 185/3 185/14 care [63] 5/13 7/10 7/11 8/12 8/13 8/14 8/15 20/6 21/22 22/2 24/24 41/21 54/20 75/10 77/5 124/12 125/7 126/4 133/3 134/19 135/14 137/15 137/17 139/24 140/7 141/24 142/2 142/4 144/24 145/1 153/17 154/3 154/20 156/22 156/24 157/9 158/24 162/2 162/3 163/6 163/8 163/18 163/19 191/10 191/14 191/24 191/25 191/25 192/2 194/18 194/20 195/9 195/15 196/8 196/9 196/10 196/21 197/1 197/17 197/19 197/21 201/13 203/11 cared [1] 121/15 career [1] 214/20 careful [1] 49/14 carefully [3] 18/20 116/7 171/2 caring [3] 25/4 57/15 234/23 Carr [9] 73/9 73/10 119/21 119/25 120/9 121/6 192/18 241/8 241/10 carried [4] 56/12 74/22 76/23 114/15 carry [4] 89/10 168/10 208/21 212/15 carrying [1] 103/5 case [90] 3/14 4/6 4/10 4/20 5/3 7/14 8/11 10/17 16/18 17/10 18/8 19/6 19/8 19/8 20/17 20/20	20/23 21/7 22/9 22/12 24/16 25/8 25/10 26/11 28/2 28/5 28/16 29/5 30/12 30/14 31/3 33/7 34/11 36/23 38/23 40/4 40/25 42/11 43/8 43/12 45/1 45/17 55/11 55/19 55/19 55/25 56/6 57/10 57/10 57/20 57/21 58/1 58/5 58/18 59/9 61/8 63/4 68/4 70/1 70/10 71/4 71/12 72/1 72/5 76/11 79/3 79/13 82/10 82/12 91/2 98/3 107/4 107/6 108/3 110/4 110/6 111/7 141/9 153/9 167/22 172/3 172/7 172/13 179/9 184/14 186/16 188/13 204/23 212/17 223/1 cases [36] 9/4 9/6 11/17 16/7 16/19 16/19 21/18 21/23 21/23 23/17 24/8 30/20 31/16 31/19 32/7 34/19 35/8 37/8 38/4 38/7 38/18 38/19 38/21 39/23 42/6 52/4 52/7 55/6 56/21 57/1 57/2 62/16 63/12 71/7 81/21 89/1 catastrophic [1] 184/6 categories [2] 82/12 146/9 category [5] 81/20 82/10 111/9 148/5 148/7 cater [1] 37/4 causative [1] 89/8 cause [19] 3/12 16/15 17/9 20/12 20/24 20/25 21/14 22/16 25/5 70/22 71/6 71/8 90/18 118/18 183/3 186/10 186/18 187/7 212/7 caused [13] 7/22 8/23 18/10 26/20 89/2 179/12 212/13 215/6 217/24 217/25 218/23 220/5 220/8 causes [4] 2/15 30/25 155/6 181/14 causing [2] 213/17 226/6 cautious [1] 18/21 caveat [1] 194/3 caveating [1] 150/19 CDOP [6] 43/7 52/22 155/17 156/7 156/24 181/22	CDOPs [3] 156/3 157/8 157/12 ceased [1] 94/8 celebrate [1] 14/4 cement [2] 54/24 56/2 central [3] 133/1 137/13 162/12 centre [2] 8/15 30/25 centred [2] 131/11 131/12 certain [5] 23/20 55/6 104/10 129/11 223/21 certainly [14] 57/4 79/19 126/12 126/19 154/7 168/7 170/25 174/12 186/25 188/5 189/22 190/7 195/8 196/24 certificate [4] 20/11 22/19 30/20 45/10 certification [2] 2/10 64/8 certifications [1] 64/21 certified [1] 3/25 cetera [6] 51/22 51/22 69/10 97/22 190/9 223/1 chain [1] 115/3 Chairs [1] 169/14 challenge [3] 22/25 24/14 57/9 challenging [3] 71/19 71/23 229/16 Champion [8] 143/18 143/21 143/22 144/3 144/9 161/1 161/24 163/23 champions [8] 144/1 161/2 161/5 161/6 161/11 161/13 161/25 191/17 chance [1] 54/21 change [4] 63/15 131/8 190/20 237/3 changed [8] 94/6 112/11 156/20 172/23 172/25 173/17 181/9 236/24 changes [4] 110/18 110/22 140/17 190/16 changing [1] 163/19 channel [1] 144/8 channels [1] 125/18 characteristically [1] 34/1 charged [1] 238/12 charity [2] 75/4 191/19 chart [1] 166/9 Charter [1] 75/7 charts [1] 16/25 chase [1] 230/13
----------	---	---	--	--

<p>C</p> <p>chased [1] 230/20 check [1] 55/18 checked [3] 66/12 110/11 110/12 checklist [1] 26/22 cheese [1] 45/22 Cheshire [1] 38/1 Chester [32] 37/15 40/16 74/3 76/9 76/24 77/12 79/3 79/6 86/22 87/2 87/12 92/1 92/1 93/9 105/8 106/4 107/9 107/25 110/20 111/8 111/21 112/5 113/17 114/20 117/23 121/18 173/18 180/17 192/21 195/2 198/14 209/18 Chief [4] 74/18 86/4 161/9 183/19 child [66] 8/12 8/16 12/5 18/5 19/19 34/9 36/1 37/16 38/2 38/8 42/10 42/11 42/21 45/18 46/21 48/4 48/15 48/23 49/10 49/15 49/25 52/8 52/22 53/25 54/22 55/2 55/23 56/22 59/4 60/6 60/21 60/23 70/1 71/8 75/13 75/19 123/5 138/7 138/16 139/5 153/21 155/13 155/16 156/4 156/15 156/18 157/3 171/24 172/13 172/14 172/15 178/1 178/17 180/9 180/11 181/22 184/21 185/25 186/23 187/21 190/23 191/2 196/4 196/16 197/8 197/23 child's [3] 51/7 59/2 183/10 childhood [3] 173/10 173/21 183/17 children [50] 25/4 27/18 48/10 52/11 61/1 61/3 61/17 61/18 62/4 63/10 64/17 74/1 75/10 75/14 108/24 124/4 137/23 138/6 138/20 139/1 139/23 140/1 147/17 157/4 163/7 163/10 163/12 163/14 163/18 163/21 163/25 164/3 164/7 165/4 165/7 171/10 171/23 172/23 173/9 178/17 179/10 181/11 181/23 183/24 185/16 187/22 190/24 191/9 198/3 234/23</p>	<p>children's [18] 74/12 136/20 137/6 137/21 138/18 139/5 139/13 139/25 143/14 157/6 162/23 165/5 171/22 181/2 191/24 195/21 197/4 197/10 choosing [1] 29/8 chunks [1] 117/4 circulated [2] 117/13 224/23 circumstance [2] 100/20 238/18 circumstances [21] 2/15 3/7 9/21 10/5 11/8 11/21 22/9 33/5 33/9 36/14 36/23 41/16 71/17 84/14 85/5 93/5 99/8 105/17 125/12 136/19 137/20 cite [2] 145/9 166/5 cited [5] 12/4 130/11 158/25 159/14 166/12 citing [1] 169/23 Claire [2] 97/17 98/20 Clare [1] 121/9 clarify [1] 54/25 clarifying [1] 70/2 clarity [8] 124/23 125/11 162/19 163/2 164/13 164/19 165/6 168/6 clear [39] 2/19 6/12 6/13 6/15 14/9 23/7 33/14 38/15 60/3 69/14 69/17 72/14 82/10 84/16 95/23 96/2 96/3 96/10 96/17 102/18 102/22 104/1 105/21 113/7 113/10 123/20 126/25 144/8 144/12 163/22 164/5 170/20 172/21 179/14 180/20 181/23 190/8 215/20 222/21 clearer [1] 170/22 clearly [12] 15/11 16/15 25/12 32/4 38/1 49/6 78/12 96/8 144/19 165/3 220/8 220/13 client [7] 78/11 81/3 81/13 86/5 109/3 110/2 110/7 clients [5] 80/25 109/10 113/21 114/15 114/16 clinical [68] 1/25 3/16 6/25 7/1 7/3 7/20 8/21 9/1 9/13 9/20 12/25 13/25 14/7 14/11 14/13 14/15 16/18 18/4 25/6 27/23</p>	<p>57/3 61/25 78/3 78/11 78/16 78/19 78/24 79/8 79/25 80/10 80/11 88/5 90/23 92/20 107/17 112/13 122/17 127/10 128/25 129/5 131/25 132/6 132/6 132/18 140/17 141/19 144/10 154/3 158/4 161/9 175/9 175/15 186/8 186/15 187/13 196/14 197/2 200/14 212/17 226/4 230/1 230/5 231/12 231/15 231/20 233/4 233/15 233/19 clinically [1] 141/6 clinician [12] 30/14 41/5 59/6 70/16 78/17 88/4 125/1 144/16 150/11 168/11 170/18 183/2 clinicians [32] 24/23 33/22 58/23 59/19 78/23 92/20 93/2 112/15 140/12 150/2 168/12 175/23 183/5 183/11 212/22 213/13 213/22 214/2 216/24 217/14 217/15 219/6 219/14 220/10 227/2 227/12 227/15 230/1 231/11 233/5 234/19 235/10 clippings [1] 117/15 closely [4] 52/15 154/7 157/10 161/25 closer [1] 146/14 Clothier [1] 25/2 clue [1] 104/18 cluster [1] 12/5 clusters [1] 13/6 co [3] 161/10 193/5 193/7 co-located [2] 193/5 193/7 co-National [1] 161/10 coding [1] 237/1 coherence [1] 124/23 cohesive [1] 153/22 coincided [1] 65/16 Colin [1] 19/6 collaborate [1] 65/19 collaborative [1] 35/24 collaboratively [1] 65/23 collapse [3] 17/13 184/6 187/7 collapsed [3] 180/2 184/8 187/14 collapses [4] 94/6</p>	<p>94/8 94/10 179/11 colleague [7] 5/3 6/5 23/9 65/18 65/21 215/12 216/2 colleagues [15] 5/4 6/20 11/23 13/19 19/20 23/21 35/3 47/10 49/15 49/24 59/15 59/18 66/5 67/13 117/20 collecting [1] 152/20 collection [4] 145/3 151/8 151/25 153/22 collective [1] 182/9 collectively [1] 58/11 collects [1] 155/12 college [44] 1/17 1/17 25/19 25/20 51/4 68/5 73/24 74/4 75/4 76/3 78/3 78/5 81/7 81/10 81/13 81/21 82/10 85/14 86/1 87/2 106/25 112/25 113/21 115/9 115/15 116/2 116/16 117/14 117/22 123/5 149/9 152/19 153/20 173/3 174/3 177/14 181/20 181/20 188/21 189/11 190/2 190/22 195/25 203/21 College's [2] 105/5 196/2 Colleges [4] 166/20 182/3 189/13 190/5 combination [3] 226/7 236/10 236/22 come [38] 4/15 8/8 8/19 14/3 14/25 24/6 31/11 47/24 56/17 66/24 68/22 72/25 82/22 83/13 84/6 112/17 114/1 121/3 125/20 134/18 135/10 175/6 191/18 191/18 192/20 194/12 196/17 197/1 198/7 199/22 200/1 200/6 201/16 205/8 209/12 212/4 215/20 234/11 comes [8] 106/9 179/6 190/21 191/1 202/1 202/1 223/11 239/19 comfortable [4] 17/24 60/14 63/12 68/23 coming [7] 40/12 66/10 119/22 125/2 200/24 204/24 239/25 commence [1] 17/8 commencement [1] 49/7 commences [1] 85/12</p>	<p>comment [4] 42/21 46/1 68/5 77/2 commented [1] 122/11 commenting [1] 160/24 comments [2] 87/9 120/23 Commission [1] 86/7 commissioned [3] 19/20 65/9 235/1 Commissioner [1] 198/1 commissioning [2] 85/20 112/12 committed [1] 25/23 Committee [1] 68/6 common [8] 21/23 53/5 88/13 90/5 98/10 147/10 192/25 198/12 commonality [1] 89/11 commonest [1] 147/11 communicate [1] 174/8 communicated [4] 91/1 93/9 160/20 165/13 communicating [1] 174/10 communication [5] 35/24 117/21 144/8 159/8 164/17 communications [2] 174/6 175/17 community [1] 173/14 compared [2] 150/4 237/18 competence [3] 59/15 212/19 213/25 compiled [2] 87/12 90/4 complaint [1] 7/25 complement [1] 142/7 complementary [1] 42/25 complete [2] 104/19 147/4 completed [8] 30/21 50/12 82/17 83/1 83/14 100/5 146/3 146/22 completely [5] 53/15 104/15 105/20 117/5 212/8 completeness [2] 113/11 160/5 completing [4] 20/11 45/10 151/7 176/6 completion [1] 174/17</p>
---	--	--	--	---

C	concerning [2] 40/3 132/11	conduit [1] 35/20	considers [2] 7/8 139/22	contrary [10] 82/18 82/21 82/25 83/2 83/2 83/5 83/15 84/5 106/23 222/15
complex [8] 15/10 22/7 38/11 135/4 170/13 185/4 202/24 202/24	concerns [131] 3/17 6/25 7/2 7/3 7/20 7/22 8/9 8/17 9/1 9/5 9/24 10/13 10/17 10/23 11/6 11/17 12/11 20/4 21/1 26/13 27/21 31/2 31/5 31/11 31/11 32/21 34/8 38/24 45/14 49/18 57/3 57/23 58/19 59/17 61/24 80/20 80/23 81/2 81/17 81/25 84/20 85/5 85/6 85/15 85/17 85/22 86/6 86/17 88/12 91/9 91/13 91/25 92/4 92/6 92/14 93/8 93/10 93/19 94/1 95/13 96/8 99/12 99/20 100/6 100/12 101/1 102/9 102/21 104/14 106/4 107/3 107/25 108/8 111/1 111/2 111/3 111/3 111/6 111/7 111/10 113/8 114/20 115/8 115/9 115/12 115/14 116/1 116/7 118/5 118/6 119/7 119/9 126/1 126/17 136/9 136/13 140/12 143/5 157/17 162/18 164/6 164/11 164/14 164/20 164/23 165/7 165/11 171/12 171/19 171/20 174/9 175/16 182/21 188/15 189/2 189/7 189/19 196/17 207/10 212/4 216/25 224/23 225/2 227/13 227/16 227/17 233/5 234/20 235/11 235/11 236/18	confident [3] 43/23 72/5 162/17	consistent [2] 11/12 135/17	contribute [4] 131/7 149/10 224/24 225/6
complexion [1] 23/17	conclude [1] 160/24	confidence [3] 56/7 71/5 165/18	constructed [1] 67/18	contributed [2] 7/23 89/2
complexities [1] 185/21	concluded [1] 223/12	confidential [11] 102/3 102/3 102/7 102/14 103/15 108/3 109/17 155/19 189/21 189/21 236/20	consultant [12] 1/18 9/6 20/14 21/9 21/14 22/10 74/11 115/17 122/15 150/9 176/7 177/13	contributing [2] 89/6 170/7
complexity [8] 137/17 139/23 140/2 163/19 185/15 191/13 203/7 203/8	concludes [1] 240/3	confidentiality [3] 85/25 108/7 225/9	constant [1] 11/9	contributory [1] 89/9
compliance [1] 133/25	conclusion [8] 31/13 56/18 96/22 167/6 199/22 199/25 207/17 239/13	confirm [3] 74/15 121/25 205/20	constantly [1] 168/4	controversial [1] 204/14
complicated [2] 36/13 125/10	conclusions [2] 130/17 130/21	confirmed [2] 216/1 216/9	constraints [3] 13/17 141/11 197/16	convention [1] 37/16
complication [2] 9/2 179/22	concordant [1] 53/13	conflict [2] 4/19 5/2	consult [5] 49/14 170/6 170/25 203/23 204/2	conversation [19] 15/9 21/3 30/16 41/5 41/10 58/9 72/4 147/22 175/8 183/8 186/11 186/14 197/21 199/15 214/5 215/12 234/9 234/17 237/23
complications [1] 7/17	conditions [3] 130/23 131/1 191/13	conflicted [1] 225/7	consultants [11] 51/22 57/5 102/9 102/15 176/22 216/25 217/3 217/4 217/8 217/17 235/16	conversations [3] 186/3 197/25 237/2
complied [3] 110/2 134/6 134/7	condolences [1] 73/23	conflicts [1] 6/20	consultation [5] 49/14 170/6 170/25 203/23 204/2	conveyed [1] 38/14
complies [1] 77/20	conduct [5] 11/16 81/25 83/20 107/22 227/22	confronted [1] 24/16	consulted [1] 70/4	Cooper [2] 97/25 98/12
comply [1] 27/16	conduct [5] 11/16 81/25 83/20 107/22 227/22	confusion [5] 15/16 69/11 168/15 168/18 173/12	contact [18] 7/10 14/25 15/2 29/25 33/14 35/17 36/2 65/16 80/14 87/1 109/15 109/17 189/7 209/25 210/7 218/20 218/22 232/22	coordinated [2] 25/19 52/10
complying [1] 133/14	conduct [5] 11/16 81/25 83/20 107/22 227/22	congenital [2] 202/24 202/25	contacted [1] 32/8	copy [1] 104/3
component [2] 52/20 54/7	conduct [5] 11/16 81/25 83/20 107/22 227/22	connection [1] 213/4	contained [2] 226/13 235/5	core [5] 64/11 69/21 69/21 171/21 176/5
components [1] 2/9	conducted [2] 39/11 233/6	conscience [1] 6/14	contemplated [1] 102/19	corner [1] 104/9
comprehensive [3] 105/4 159/7 162/1		consent [5] 17/23 17/25 109/3 109/4 200/10	contemporaneous [1] 94/24	Coroner [55] 2/17 2/23 3/14 6/24 7/21 10/9 10/9 10/15 15/17 17/10 18/6 23/18 28/5 30/15 33/10 36/22 36/23 37/10 37/17 37/19 37/20 38/1 38/8 38/11 38/15 38/17 38/22 39/20 39/22 40/1 44/25 45/17 46/7 48/14 48/16 55/7 56/25 58/8 62/20 71/11 71/12 71/18 174/19 175/2 175/8 182/19 184/12 186/1 186/4 186/7 186/12 186/13 188/4 199/16 200/11
comprehensively [1] 107/16		consequences [4] 139/10 139/19 189/1 208/13	content [3] 67/12 67/12 68/7	Coroner's [8] 14/8 15/14 15/15 69/16 184/13 199/7 199/11 200/12
comprise [1] 146/3		consider [42] 11/16 18/6 23/2 25/8 40/13 40/24 43/3 44/3 51/3 60/13 60/16 62/15 70/9 81/3 84/12 86/22 88/7 88/12 88/20 89/1 89/5 92/12 106/3 107/21 113/20 125/25 130/4 131/14 134/4 134/8 139/18 146/22 156/11 166/21 208/9 216/16 219/14 220/2 222/17 223/22 223/24 226/19	contents [2] 73/17 121/25	Coroner's Officers [3] 14/8 15/14 15/15
compromise [1] 141/24		considerable [3] 108/22 115/13 138/17	context [11] 59/1 112/21 116/21 130/3 145/9 180/21 187/16 187/19 200/24 235/21 237/6	Coroners [10] 30/18 31/17 37/11 38/1 72/1 174/7 174/9 174/9 188/10 199/5
computer [1] 150/23		consideration [9] 79/15 95/22 96/2 100/4 100/7 108/22 145/7 168/22 204/7	continued [2] 25/18 95/21	corporate [1] 231/12
conceivable [1] 168/13		considerations [3] 80/4 85/7 87/25	continues [2] 138/19 208/21	correct [66] 2/2 2/22
concentrated [1] 23/19		considered [17] 7/15 10/14 13/19 18/20 23/2 25/9 48/11 48/13 89/8 92/17 95/9 105/18 105/19 135/16 182/2 233/1 238/24	continuing [2] 221/1 233/5	
concern [54] 8/2 8/4 8/21 8/22 8/22 9/7 9/9 9/13 10/5 10/20 11/2 17/14 18/2 19/2 19/7 19/13 28/2 32/1 32/15 32/24 33/2 33/6 33/10 39/14 41/16 44/19 46/5 49/2 56/9 59/4 59/23 60/6 60/6 69/13 71/7 111/13 113/8 117/12 118/18 132/4 140/16 168/15 168/17 196/3 208/6 212/14 213/2 214/19 217/19 218/10 232/4 233/7 236/1 237/6		considering [6] 14/24 95/16 104/25 187/6 219/8 220/11	contract [1] 110/1	
concerned [18] 9/12 39/10 51/24 76/22 106/11 108/17 138/25 139/15 142/23 166/25 181/3 186/5 196/12 212/23 213/13 213/22 219/6 225/17			contracting [1] 114/16	
			contractual [1] 110/6	

C			D	
correct... [64] 4/12 38/8 38/20 42/21 43/11 43/20 48/9 55/8 74/20 75/24 76/6 77/16 77/18 77/23 78/18 79/2 79/10 79/12 82/8 82/14 90/3 90/7 93/16 94/23 95/1 96/1 99/14 99/17 99/23 102/25 103/3 103/7 104/7 104/20 104/23 110/21 123/11 135/24 135/25 136/22 137/9 138/1 146/5 161/20 166/22 172/12 180/24 206/1 206/13 206/14 206/19 206/20 206/21 207/21 207/22 208/23 208/25 209/1 209/6 209/7 210/14 214/17 226/2 234/13 corrected [2] 217/13 217/15 corrections [4] 210/17 210/18 210/20 219/1 correctly [4] 33/6 41/2 58/12 199/15 correctness [1] 216/1 correlation [3] 91/23 94/3 94/4 correspondence [2] 99/11 235/15 cost [5] 140/21 141/8 142/14 142/18 142/19 cot [2] 193/21 193/22 cots [4] 194/4 194/5 194/8 201/11 could [77] 1/8 5/8 9/24 10/12 18/22 19/22 20/13 20/14 20/15 21/12 21/16 28/25 35/25 36/8 36/21 48/21 56/18 58/24 59/16 63/4 66/24 68/9 68/9 68/11 70/10 70/20 70/20 80/8 84/11 86/16 98/10 100/17 104/4 109/25 110/4 110/11 116/5 116/6 129/23 132/2 153/14 160/18 173/4 182/10 183/9 184/1 189/7 189/10 192/5 197/6 204/7 205/6 205/20 206/5 206/25 208/20 208/21 209/15 210/10 212/7 212/8 212/12 213/17 215/2 218/5 218/16 218/22 219/9 220/4	220/5 220/8 220/14 227/9 228/1 233/9 234/6 238/14 couldn't [6] 56/22 68/10 68/12 90/19 190/2 225/9 Council [2] 125/9 222/20 counsel [2] 200/3 222/12 counterarguments [1] 185/1 counterparts [1] 11/25 Countess [32] 37/15 40/15 74/3 76/9 76/24 77/12 79/3 79/6 86/21 87/2 87/12 91/25 92/1 93/8 105/8 106/3 107/9 107/25 110/19 111/8 111/21 112/4 113/17 114/20 117/23 121/18 173/18 180/17 192/21 195/2 198/14 209/18 country [6] 141/19 149/19 149/23 150/5 163/19 197/18 couple [4] 47/19 192/16 199/2 232/24 courage [1] 32/24 course [37] 8/24 10/12 19/15 23/10 24/1 25/9 28/16 40/10 42/22 47/13 47/22 56/11 56/15 61/1 64/5 68/15 103/23 121/1 129/12 134/7 142/24 151/22 152/19 152/20 154/21 155/22 156/19 174/4 177/15 181/17 192/5 195/1 202/10 202/20 202/22 205/17 239/11 courses [3] 176/17 176/18 176/23 court [1] 72/25 cover [6] 2/19 103/9 106/16 124/2 128/4 209/15 covered [7] 2/18 40/6 71/14 80/12 112/20 112/21 118/8 covers [3] 2/20 2/22 63/7 CPD [1] 25/19 CQC [3] 124/17 125/7 168/4 cracks [2] 163/11 168/19 crafted [1] 37/3 create [8] 50/3 127/10 132/9 132/11 152/8 152/9 168/6	174/2 created [1] 167/10 creates [2] 64/10 187/20 creating [4] 126/2 128/9 140/24 143/1 creation [1] 118/8 criminal [5] 19/9 39/11 40/4 81/25 83/20 criminality [3] 99/12 99/20 102/24 crisis [1] 138/7 Crisp [1] 112/6 criteria [9] 37/2 37/14 49/12 178/21 178/22 179/16 186/19 188/6 207/24 critical [5] 8/13 147/18 196/21 197/1 197/19 critically [3] 59/3 191/23 192/5 criticism [1] 225/3 crops [1] 17/12 cross [2] 50/20 117/19 cross-refers [1] 50/20 crossed [1] 214/21 crowded [2] 42/15 42/15 crucial [1] 175/7 crystal [1] 69/17 cultural [2] 31/20 235/23 culture [31] 126/3 126/13 126/21 126/22 127/5 127/6 127/10 128/1 129/19 130/1 130/4 130/6 130/15 131/18 132/11 136/7 143/1 146/16 157/15 157/19 157/20 158/24 159/4 159/7 159/13 159/21 160/1 160/4 179/6 235/22 237/8 curiosity [1] 126/14 curious [3] 25/13 126/23 155/22 current [8] 1/16 74/8 77/2 118/10 139/1 139/22 183/14 193/20 currently [7] 1/18 19/16 110/5 110/6 182/12 186/25 197/9 curriculum [7] 171/25 173/20 173/23 174/13 176/4 176/6 176/8 cut [1] 67/25 cuts [1] 50/5 cuttings [1] 117/13	Dame [2] 40/10 41/12 danger [2] 42/9 53/18 data [29] 13/13 125/17 125/17 125/20 136/6 144/20 145/1 145/3 145/5 145/7 146/23 148/15 149/1 149/18 149/21 149/24 150/25 151/1 151/2 151/25 152/20 153/1 153/4 153/22 153/25 155/9 156/4 190/16 237/1 database [4] 149/18 150/3 155/19 156/5 databases [1] 151/20 date [4] 65/9 113/9 116/10 182/5 dated [9] 1/11 1/12 73/15 76/17 101/8 115/6 121/22 205/24 205/25 dated August 2016 [1] 76/17 Datix [1] 128/17 daughter [2] 46/18 72/17 David [7] 78/20 89/22 91/20 91/21 95/8 107/17 120/17 day [23] 41/14 60/7 89/19 93/21 94/6 94/7 94/21 95/8 95/14 96/8 97/4 97/18 158/3 158/3 184/23 189/13 197/2 210/11 229/9 230/15 239/18 240/7 240/11 days [7] 28/22 31/8 46/21 154/25 155/2 155/3 210/17 deadline [2] 67/2 204/2 deal [16] 2/25 6/16 42/8 43/21 61/1 61/2 61/9 80/20 102/1 108/16 118/17 149/11 165/12 165/23 169/2 202/17 dealing [15] 1/15 3/20 7/1 18/13 21/7 24/4 27/13 43/7 99/3 102/4 104/14 137/21 149/1 183/11 197/15 deals [5] 82/4 85/24 115/24 165/21 174/14 dealt [7] 31/12 102/7 118/14 119/8 165/13 189/25 215/9 death [97] 2/10 2/15 3/8 3/12 3/24 3/25 5/6	6/2 6/13 6/24 7/23 8/1 17/10 18/5 18/13 20/12 20/24 20/25 21/14 22/16 24/7 24/17 28/22 28/23 29/5 30/24 30/25 34/9 36/1 36/10 37/2 37/23 42/11 42/12 42/22 44/8 44/15 45/18 48/10 48/14 49/10 49/15 51/19 52/22 53/25 55/22 56/25 59/2 64/21 70/1 70/22 71/6 71/8 79/16 80/5 89/3 154/19 154/21 155/13 155/15 155/16 155/19 155/22 156/4 156/15 156/18 173/10 173/21 174/14 174/18 178/1 179/7 179/8 179/24 180/9 181/1 181/14 181/22 182/20 183/3 183/10 183/17 183/17 184/4 184/10 184/19 185/25 186/10 186/18 186/20 186/20 197/8 202/18 203/13 212/17 217/25 220/5 deaths [61] 2/16 3/10 4/5 5/18 12/5 12/24 16/1 16/10 19/19 22/20 23/3 23/12 23/15 23/19 24/4 34/22 37/16 38/2 38/9 40/21 42/10 43/9 43/12 44/9 48/4 48/13 48/23 50/1 52/9 54/22 63/7 63/10 64/17 65/10 80/5 88/25 89/6 89/9 89/24 90/6 90/18 91/10 91/24 94/4 94/10 94/17 98/7 98/15 101/19 155/11 169/7 173/13 183/12 202/19 203/3 211/19 212/1 213/4 219/6 220/9 220/10 debated [1] 61/14 decade [1] 52/8 deceased [2] 17/21 55/2 December [3] 1/1 1/12 73/15 decide [2] 129/10 219/3 decided [1] 102/20 decides [2] 15/25 16/16 decision [24] 5/12 12/22 30/3 37/10 37/11 38/18 39/13 61/14 78/25 79/8 92/21 96/9 96/11 103/8 112/13 137/13

D	department [9] 5/12 7/12 7/12 41/21 63/20 125/6 162/20 163/3 165/18	59/14	differ [1] 189/15	disabilities [1] 62/8
decision... [8] 209/8 219/18 225/10 225/13 225/14 225/21 226/22 239/1	departments [3] 162/18 164/8 235/22	detection [1] 42/2	difference [7] 13/16 46/19 127/25 143/20 174/22 174/25 175/4	disadvantage [1] 28/10
decision-making [1] 137/13	depend [3] 13/2 212/6 212/10	deteriorate [2] 179/1 179/4	differences [3] 7/24 112/2 183/24	disappeared [1] 98/1
decisions [3] 170/15 170/17 209/7	dependency [2] 201/13 201/14	deteriorated [1] 178/18	different [68] 6/7 7/12 7/12 8/25 9/1 10/18 10/20 11/6 14/6 21/19 21/20 22/21 28/17 29/7 35/6 35/12 36/14 42/17 42/18 42/19 42/19 43/9 55/3 60/19 60/20 60/22 61/7 61/18 71/3 72/10 88/17 94/16 97/13 99/6 112/23 112/24 115/22 125/17 125/18 125/19 126/21 129/14 129/14 131/6 135/21 140/23 143/5 149/2 154/23 155/11 155/23 155/25 156/7 156/13 158/14 158/15 159/18 160/19 161/12 163/22 164/7 166/1 197/9 224/6 224/11 225/12 237/17 237/21	disaster [1] 152/6
decline [1] 139/13	dependent [1] 64/9	determine [1] 88/21	discharge [1] 110/2	discharging [1] 109/10
declined [2] 71/20 112/19	depending [4] 32/15 43/9 81/12 193/1	determined [1] 74/5	disciplinary [1] 235/23	disclose [3] 86/1 106/25 225/9
declines [1] 71/12	depends [9] 9/20 33/7 33/7 38/12 71/5 186/13 195/8 199/11 201/25	determining [1] 93/2	discuss [12] 5/2 29/9 30/24 31/5 41/21 46/6 80/11 81/1 81/8 179/25 188/13 210/8	discussed [9] 61/14 64/12 92/7 94/16 225/18 229/7 234/16 235/9 235/14
deems [1] 85/15	deprioritisation [2] 139/1 143/13	deterrence [1] 42/5	discussing [6] 15/12 21/13 32/22 35/2 78/15 175/13	discussion [21] 15/8 27/24 28/1 56/2 65/18 70/23 90/22 92/11 94/20 94/25 98/21 98/22 108/19 113/6 129/3 175/7 199/24 207/10 210/24 218/5 231/10
deeply [2] 138/25 142/23	deprioritised [3] 137/25 139/6 163/13	develop [2] 148/23 207/5	discussions [1] 198/6	disease [1] 202/24
default [1] 14/22	derived [1] 147/8	developed [6] 158/22 169/22 170/13 171/25 204/9 208/5	diseases [1] 185/16	diseases [1] 185/16
defending [1] 60/11	derives [2] 149/18 149/24	developing [2] 148/2 204/18	dismiss [1] 32/2	disparity [1] 21/16
deficiencies [1] 172/4	dermatologist [1] 21/13	development [6] 14/9 34/21 50/9 176/12 176/13 234/5	dispute [1] 98/20	disseminate [1] 109/18
deficiency [2] 172/18 172/24	describe [9] 17/4 17/5 137/25 138/2 158/19 160/17 164/15 164/18 206/25	developments [1] 63/13	disseminated [1] 105/1	dissemination [14] 102/2 103/25 104/3 104/13 104/17 104/25 105/3 105/9 105/14 105/22 105/23 106/6 106/12 117/4
defied [1] 58/7	described [11] 15/11 98/16 102/9 103/21 130/23 146/11 146/14 160/14 161/13 167/3 199/14	deviations [1] 13/21	disseminates [1] 127/5	distractions [1] 64/11
define [2] 2/6 78/12	describes [3] 96/19 102/14 160/9	devise [1] 152/12	distribute [1] 106/21	district [2] 8/14 8/16
defined [4] 14/18 14/18 77/10 144/19	describing [5] 53/8 78/2 128/10 199/4 199/8	devoted [1] 2/1	diverge [1] 155/25	divided [2] 111/2 132/15
definitely [6] 14/2 62/4 164/1 183/1 209/11 215/3	description [1] 14/10	devotion [1] 54/20	do [139] 6/4 9/19 12/16 14/3 14/16 14/17 14/22 15/23 16/21 17/4 17/4 19/21 20/12 22/5 23/2 23/9 24/2 25/13 28/3 28/6 28/7 28/7 31/2 32/5	
definition [2] 76/25 181/12	deserve [1] 163/21	DHSC [1] 61/15		
definitions [1] 76/21	design [4] 2/13 67/15 67/19 167/10	diagnoses [1] 61/20		
degree [11] 42/5 55/9 56/7 58/22 61/8 125/13 182/17 183/6 184/17 187/13 191/8	designated [7] 52/10 99/16 171/11 171/16 172/5 172/9 172/15	did [38] 6/23 22/25 56/19 65/11 79/4 79/4 79/5 91/12 95/3 100/18 100/23 103/5 108/6 108/11 108/18 115/11 116/15 117/24 121/24 149/20 169/5 171/16 195/18 211/4 211/13 211/14 215/11 223/11 224/15 227/11 230/18 230/19 232/10 234/20 235/13 235/15 237/10 237/16		
delay [2] 38/24 61/22	designed [1] 58/20	didn't [32] 4/10 8/5 31/4 72/2 74/3 82/23 97/21 117/22 119/7 172/10 179/11 180/17 180/19 195/2 203/6 211/9 216/6 222/8 222/9 224/24 225/6 225/23 226/1 226/3 227/3 231/19 231/25 232/16 234/7 235/25 238/10 239/12		
delayed [1] 73/25	desperately [1] 46/9	die [10] 6/23 56/19 179/2 181/11 181/24 181/25 185/4 186/17 187/4 203/2		
delegated [2] 14/20 30/5	despite [1] 45/21	died [11] 3/8 16/15 18/9 21/8 52/11 56/22 186/24 187/14 199/18 199/19 200/15		
deliberate [14] 8/24 58/25 94/17 99/13 101/18 171/12 212/13 213/17 216/17 217/24 218/24 219/10 220/2 226/6	destination [1] 9/22	dies [3] 70/14 155/20 186/6		
deliberately [2] 218/17 227/4	detail [12] 50/16 89/23 119/7 154/8 184/11 211/25 234/16 234/17 235/5 235/8 236/11 237/4			
deliver [9] 90/24 114/11 135/23 165/6 191/14 196/23 197/2 198/3 202/10	detailed [2] 55/13 183/8			
delivered [3] 90/19 194/18 197/18	details [6] 86/2 103/14 109/15 109/17 197/12 229/15			
delivering [7] 131/7 135/20 163/18 196/20 197/3 202/12 203/12	detect [5] 9/17 11/18 41/6 57/10 132/10			
delivery [3] 68/25 162/3 194/10	detected [2] 7/19			
demand [1] 12/18				
demands [2] 139/22 139/25				
denominator [1] 53/5				

D	130/19 131/16 132/21 132/25 138/3 138/22 158/10 158/18 158/25 159/15 159/16 160/2 160/9 166/10 169/10 224/9 224/13 224/18 224/22 226/14 231/3 234/10	195/12 197/12 200/13 203/1 204/11 209/5 221/3 222/3 223/6 229/1 232/18 232/18 234/3 239/23	46/24 47/4 50/14 63/17 65/8 72/13 178/9 183/19 185/2	early [20] 12/9 23/13 31/16 41/6 42/2 47/13 66/16 78/4 105/8 126/14 126/23 127/12 128/10 132/11 143/2 155/8 162/9 202/2 208/18 215/9
do... [115] 32/6 32/9 37/13 42/23 45/3 45/11 45/20 49/22 51/16 51/25 52/14 53/20 54/17 55/17 55/19 57/7 58/19 59/1 59/3 61/4 62/22 66/8 67/9 68/14 69/16 73/8 76/8 80/8 80/20 87/21 88/18 95/3 96/22 99/22 100/5 100/23 101/24 107/1 113/19 115/8 116/13 116/17 118/23 118/24 119/4 120/15 121/3 121/5 122/10 124/16 126/6 127/5 127/6 129/7 131/14 134/8 134/19 134/24 143/7 144/21 145/17 146/10 146/13 146/22 147/19 147/20 149/14 151/6 152/16 153/18 154/17 154/17 154/18 157/2 161/21 162/5 163/1 163/16 166/3 167/20 171/1 180/10 181/15 181/17 182/12 185/10 186/1 187/5 188/23 189/6 189/15 189/15 189/20 190/5 195/11 195/12 198/9 202/3 205/8 205/12 206/24 207/5 207/6 211/20 215/8 222/7 222/21 224/1 227/18 227/23 228/3 232/5 232/23 233/16 236/4	documented [3] 61/25 99/22 118/20	done [24] 11/2 13/14 30/12 33/1 34/15 51/14 63/21 68/1 68/9 70/10 74/4 91/14 100/18 113/13 126/19 127/13 152/14 173/5 214/6 214/14 214/16 222/23 229/2 236/5	Dr Garstang [5] 51/19 53/11 180/4 180/22 180/25	East Kent [1] 59/8
doctor [19] 3/25 5/7 5/24 6/7 9/12 14/16 20/2 20/4 20/5 20/16 52/10 81/9 117/23 125/8 142/23 172/13 172/15 190/4 199/16	documents [5] 3/6 91/24 108/20 115/1 201/6	doomed [1] 90/9	Dr Garstang's [1] 48/8	East [1] 59/8
doctor concerned [1] 9/12	does [50] 5/16 6/23 9/13 13/2 17/10 28/12 33/17 35/19 35/20 37/20 37/20 41/9 54/17 56/24 59/5 60/5 67/8 87/22 90/4 90/5 100/10 101/21 106/2 114/9 134/13 141/24 142/16 143/6 145/17 152/16 154/17 156/11 161/4 170/8 170/18 171/16 174/10 175/25 188/4 193/1 202/11 209/2 212/6 215/18 218/11 223/8 226/18 233/22 237/3 240/4	door [1] 200/24	Dr Jayaram [1] 95/6	easy [3] 137/24 144/18 173/23
doctor's [1] 81/4	doesn't [33] 24/18 34/11 50/21 60/23 78/23 87/22 102/14 103/4 142/6 150/22 151/1 154/17 162/4 175/12 181/2 181/23 182/13 182/19 186/23 187/1 188/6 200/11 202/11 207/13 209/3 209/14 220/25 221/6 224/20 228/21 233/17 233/21 237/2	doors [1] 193/17	Dr Joanna [1] 47/14	echoing [1] 167/18
doctors [16] 4/5 4/14 5/22 14/12 34/2 76/4 118/2 127/11 170/11 170/15 170/20 175/3 189/4 189/18 193/12 235/23	doing [14] 3/2 3/4 48/17 60/11 114/9 132/2 143/20 150/18 198/11 214/6 227/4 229/3 233/9 233/10	double [1] 151/2	Dr Kingdon [6] 120/15 177/1 177/7 192/15 199/1 204/23	ecosystem [1] 170/13
document [48] 49/25 67/17 76/14 76/18 76/21 77/25 79/24 85/4 97/6 101/9 104/6 104/11 111/16 116/9 116/24 117/8 117/9 117/25 118/3 118/10 118/11 118/12 119/8 119/11 130/11 130/12	dominated [1] 93/20	double-enter [1] 151/2	Dr Subhedar [1] 180/18	editor [1] 68/7
	don't [68] 14/14 14/16 15/13 23/24 33/1 33/2 36/11 36/17 36/18 45/24 45/25 46/19 47/6 49/3 51/25 53/25 54/2 59/2 61/11 66/9 68/10 83/4 84/7 84/9 94/24 96/21 97/7 99/21 108/10 108/13 109/13 111/1 129/2 129/25 151/21 152/17 153/15 159/22 163/15 163/25 164/4 170/3 170/23 178/8 179/5 180/1 180/25 183/24 184/24 187/1 189/13 189/14 191/22 193/14	down [31] 11/3 32/8 32/9 32/16 33/11 63/13 73/8 86/19 87/9 91/3 98/11 101/25 111/25 117/7 117/21 120/15 121/5 127/8 130/22 131/20 139/8 139/21 140/9 169/1 177/25 178/1 187/1 187/2 205/12 223/19 234/11	Dr Jayaram [1] 95/6 Dr Joanna [1] 47/14 Dr Kingdon [6] 120/15 177/1 177/7 192/15 199/1 204/23	editorial [2] 67/6 67/23
	downgraded [1] 234/22	downside [1] 38/5	Dr Subhedar [1] 180/18	educate [1] 51/12
	DR [51] 1/3 1/6 1/9 1/10 18/7 26/4 26/9 27/5 27/12 42/7 44/5 46/24 47/4 47/14 48/8 50/14 51/19 53/11 63/17 65/8 72/13 78/20 95/6 95/6 107/17 116/22 116/25 117/11 117/16 117/18 117/22 118/19 120/10 120/15 121/2 121/4 177/1 177/7 178/9 180/4 180/16 180/18 180/22 180/25 183/19 185/2 192/15 199/1 204/23 241/3 241/9	DR [51] 1/3 1/6 1/9 1/10 18/7 26/4 26/9 27/5 27/12 42/7 44/5 46/24 47/4 47/14 48/8 50/14 51/19 53/11 63/17 65/8 72/13 78/20 95/6 95/6 107/17 116/22 116/25 117/11 117/16 117/18 117/22 118/19 120/10 120/15 121/2 121/4 177/1 177/7 178/9 180/4 180/16 180/18 180/22 180/25 183/19 185/2 192/15 199/1 204/23 241/3 241/9	Dr Garstang [5] 51/19 53/11 180/4 180/22 180/25	educating [1] 175/22
	Dr Alan Keith Fletcher [1] 1/9	DR CAMILLA KINGDON [2] 121/4 241/9	Dr Garstang's [1] 48/8	education [5] 54/24 67/19 75/12 76/1 114/6
	Dr Brearey [7] 95/6 116/22 117/11 117/16 117/22 118/19 180/16	Dr David [2] 78/20 107/17	Dr Jayaram [1] 95/6 Dr Joanna [1] 47/14 Dr Kingdon [6] 120/15 177/1 177/7 192/15 199/1 204/23	effect [5] 51/2 74/14 92/3 192/20 214/2
	Dr Brearey's [2] 116/25 117/18	Dr Fletcher [18] 1/6 1/10 18/7 26/4 26/9 27/5 27/12 42/7 44/5	Dr Subhedar [1] 180/18	effective [3] 21/15 127/20 197/14
			Dr Jayaram [1] 95/6 Dr Joanna [1] 47/14 Dr Kingdon [6] 120/15 177/1 177/7 192/15 199/1 204/23	effectively [6] 98/23 131/4 146/2 157/18 189/19 190/9
			Dr Subhedar [1] 180/18	effectiveness [3] 35/10 64/20 167/16
			draft [1] 87/13	efficacy [1] 42/21
			drag [1] 141/23	efficiency [2] 77/8 168/23
			draw [1] 148/19	efficient [1] 156/1
			drawing [1] 123/24	effort [1] 41/25
			drawn [2] 21/11 135/18	eight [8] 66/19 140/8 185/17 214/5 214/12 214/15 229/2 236/13
			drew [1] 219/20	eight months [1] 66/19
			drop [2] 17/13 18/25	either [18] 8/5 9/11 30/10 39/17 48/15 78/23 80/10 83/21 92/20 101/3 175/8 181/23 183/15 195/19 196/24 227/1 229/15 235/19
			dual [1] 156/10	elaborate [2] 124/24 163/1
			due [5] 23/10 79/23 120/25 218/11 219/2	elderly [3] 19/8 184/19 191/7
			duplicating [1] 28/11	eldest [1] 46/17
			duplication [3] 43/1 125/13 164/4	elective [1] 137/17
			uplicative [1] 34/10	electronic [11] 149/18 150/20 150/22 151/7 151/21 151/23 152/5 152/10 152/12 154/5 154/10
			during [22] 7/18 47/7 52/7 82/5 83/14 85/14 86/17 93/17 94/15 96/8 100/9 105/5 107/18 108/13 118/14 118/20 195/1 214/8 219/12 229/23 229/25 231/24	element [8] 77/4 144/25 157/14 162/14 164/9 164/10 164/11 164/15
			duties [5] 231/12 231/16 231/20 233/4 233/19	
			duty [5] 109/10 109/16 110/2 174/8 233/15	
			dying [1] 203/1	
			E	
			e-learning [7] 25/16 25/18 25/21 50/3 67/4 67/6 174/1	
			each [11] 11/14 29/5 36/14 71/4 114/10 124/7 146/8 151/3 156/23 190/25 212/16	
			Eardley [6] 91/6 93/9 94/14 102/6 107/17 109/24	
			Eardley's [1] 102/11	
			earlier [16] 31/15 40/15 40/22 41/18 53/17 55/21 65/13 72/15 97/18 115/20 120/1 126/22 145/11 146/14 161/13 229/2	

E	encouraging [1] 147/3 end [19] 16/16 44/5 46/8 54/17 63/3 64/1 66/24 66/25 69/1 95/8 157/16 171/4 176/25 186/14 199/18 202/12 204/4 204/5 212/3 endeavour [1] 143/5 endlessly [1] 190/22 engage [2] 49/11 188/6 engaged [2] 49/15 171/17 engagement [2] 119/5 159/8 England [19] 1/22 2/16 2/23 3/8 48/5 63/8 64/17 67/19 81/5 124/17 125/6 128/5 137/14 143/23 159/6 193/24 194/11 198/2 209/24 England's [1] 136/23 enhanced [1] 195/19 enlarged [1] 97/8 enormous [1] 66/3 enormously [2] 36/7 66/23 enough [7] 10/14 59/2 59/9 59/9 173/22 173/25 216/19 enquiry [3] 118/25 211/4 218/3 ensure [21] 3/6 3/10 3/11 3/12 3/14 3/23 5/1 42/23 49/11 55/23 109/10 109/21 110/7 119/6 126/4 127/20 130/24 133/22 134/4 134/9 208/15 ensures [2] 4/24 53/5 ensuring [6] 10/3 10/8 38/7 53/8 109/3 109/11 entailed [1] 108/1 enter [2] 151/2 151/3 entered [1] 103/6 entering [1] 149/24 entire [6] 113/3 113/4 131/21 134/18 197/18 214/11 entirely [6] 2/19 143/5 156/7 192/1 222/1 222/15 entity [1] 153/19 entries [1] 99/4 entry [5] 20/22 97/14 97/14 98/4 98/4 environment [9] 39/12 39/19 43/18 140/17 140/24 141/10 142/2 142/5 168/13 environments [1]	158/5 envisage [1] 179/15 envisaged [3] 40/18 82/9 84/19 envisages [1] 78/22 equally [1] 227/24 equip [2] 62/13 129/5 equipment [2] 194/2 237/7 equipped [2] 222/5 223/6 equivalent [2] 81/5 148/20 era [1] 64/9 errors [2] 147/11 147/13 escalate [10] 5/2 10/10 11/23 85/22 99/8 99/12 99/15 140/12 162/17 189/19 escalated [3] 12/6 45/15 100/6 escalation [25] 9/25 11/21 58/14 80/16 80/17 85/3 86/14 99/4 99/5 99/8 110/16 110/17 110/22 110/23 111/22 111/23 112/1 112/10 112/21 118/10 118/11 144/12 165/6 186/1 186/4 escalatory [1] 86/10 escape [1] 58/13 especially [4] 33/24 50/2 57/15 62/10 essence [3] 218/9 224/10 225/21 essential [1] 69/5 essentially [19] 110/25 131/18 137/4 144/8 146/3 147/6 149/21 154/24 158/1 158/5 158/11 159/17 163/10 196/11 196/18 196/20 197/15 210/23 226/8 establish [4] 3/16 64/18 81/10 214/7 established [9] 42/25 49/10 54/4 54/11 136/7 157/15 170/3 207/2 207/23 establishing [2] 34/23 150/8 establishment [1] 42/16 et [6] 51/22 51/22 69/10 97/22 190/9 223/1 et cetera [6] 51/22 51/22 69/10 97/22 190/9 223/1 evaluate [2] 64/20 158/23	evaluation [8] 145/23 146/3 146/21 148/4 148/8 148/17 158/11 159/13 Evelina [1] 201/5 even [30] 7/13 23/4 24/12 26/12 26/14 32/9 33/11 38/24 44/20 45/21 46/12 52/22 57/5 63/8 66/25 80/19 96/5 105/17 119/6 167/11 171/13 181/12 200/18 203/13 215/2 217/25 218/19 223/11 225/24 235/9 evening [1] 97/4 event [2] 36/13 57/13 events [13] 7/16 13/7 22/1 23/17 25/6 25/10 29/12 40/15 40/19 58/6 61/5 61/25 173/18 ever [9] 5/21 191/7 200/22 214/9 214/15 214/24 215/4 227/10 229/2 ever-increasing [1] 191/7 every [36] 3/7 3/7 20/13 22/1 29/5 29/5 29/6 30/12 36/13 37/5 37/5 41/17 48/10 48/14 48/15 48/15 60/7 62/1 63/3 149/19 149/23 149/25 150/13 161/17 162/23 163/5 163/6 163/7 172/1 172/2 180/10 180/11 189/17 195/15 209/24 228/2 everybody [3] 53/9 93/10 172/22 everyone [3] 27/9 27/19 68/18 everything [10] 29/8 30/19 46/1 53/6 63/16 128/24 146/13 150/7 185/19 235/9 everywhere [2] 35/6 53/2 evidence [91] 37/9 41/2 41/12 47/7 47/13 48/8 64/1 64/13 65/8 73/5 74/7 74/25 78/19 80/18 91/7 91/8 91/17 91/20 91/22 92/2 93/19 94/14 94/19 95/21 98/12 100/1 102/6 102/12 102/16 102/24 103/23 107/15 109/25 119/22 120/11 120/12 120/13 120/20 122/23 123/12 123/24 125/21 130/12 136/19	145/4 145/11 146/15 158/8 171/8 178/9 180/4 192/20 198/8 203/21 205/15 212/19 212/24 213/24 215/17 216/14 216/17 216/20 217/1 218/6 218/19 219/16 219/20 219/20 219/25 220/1 220/4 220/7 220/18 220/21 222/21 222/24 223/15 224/14 225/23 226/2 226/3 226/4 226/8 226/10 226/13 226/18 227/20 227/21 228/3 237/9 240/3 evidential [1] 237/17 evolution [2] 4/3 63/14 evolved [1] 167/9 evolving [1] 168/4 ex [1] 230/3 ex-NMC [1] 230/3 exactly [9] 9/3 65/14 98/16 105/22 107/4 136/4 193/14 214/7 215/15 exam [1] 76/3 examination [1] 20/1 examine [1] 160/11 examined [1] 137/3 examiner [139] 1/22 1/25 2/2 2/5 2/7 2/9 2/14 2/20 3/1 3/4 3/22 4/20 5/5 5/8 5/20 5/23 7/6 9/11 9/16 10/16 10/22 11/9 11/13 11/14 11/15 11/22 12/6 12/10 12/14 12/23 13/20 14/2 14/21 15/7 15/20 16/17 17/18 20/9 21/11 22/3 22/6 22/23 24/1 24/5 24/15 25/12 29/24 29/24 30/5 30/5 30/8 30/9 30/10 30/11 31/9 31/23 32/8 32/14 32/25 33/15 34/6 34/21 35/1 35/17 35/18 35/22 36/17 37/1 37/21 37/22 38/6 38/13 39/5 39/15 40/8 40/14 41/3 41/17 42/24 43/19 43/19 44/10 44/21 45/7 45/19 48/4 48/17 48/21 50/7 50/23 51/8 51/17 52/5 52/18 53/13 53/16 53/21 54/1 54/4 54/12 55/6 55/10 55/16 56/8 58/17 59/21 60/2 60/8 63/5 64/12 64/20 65/21 65/24 68/6 69/7
----------	---	---	--	---

E	169/16 219/2	55/21 66/20 92/6	89/2 89/8 89/9 89/12	felt [3] 54/15 180/21
examiner... [24]	exemplary [1] 8/15	103/9 114/17	90/5 129/18 236/22	181/8
69/14 69/15 69/21	exercise [4] 65/12	explaining [2] 31/1	facts [2] 26/11	fenced [2] 143/10
70/2 70/4 70/18 70/21	89/14 100/21 147/6	70/3	213/18	143/12
71/10 72/8 174/18	exert [1] 167/2	explanation [7] 56/23	Faculty [1] 176/15	few [8] 12/19 42/7
177/23 178/12 179/25	exerting [1] 166/13	58/7 70/16 178/20	fail [1] 41/6	78/14 122/11 135/11
183/14 183/19 183/23	exhausted [1] 29/13	179/5 186/21 186/23	failings [7] 88/14	195/5 235/20 237/20
184/2 184/16 184/22	exhaustive [1] 18/23	explicit [1] 69/25	89/6 89/10 89/12 90/5	fewer [1] 203/13
185/7 185/23 185/24	exist [1] 129/6	exploration [1] 90/1	133/6 207/4	fierce [1] 54/20
188/4 188/12	existence [1] 156/19	explore [10] 89/23	failure [3] 90/9 95/17	fifth [4] 87/16 164/9
Examiner's [10]	existing [4] 162/17	92/25 119/7 200/14	95/20	164/14 213/21
14/23 22/19 26/22	181/18 182/20 188/3	208/3 235/21 235/24	fair [8] 22/5 23/14	fifthly [1] 212/22
28/20 28/21 31/15	exists [2] 112/3	237/4 237/6 237/14	55/12 60/9 92/18	fighting [1] 127/7
38/14 43/14 53/19	144/4	explored [1] 228/6	135/7 212/2 222/8	fill [3] 141/17 146/6
54/6	expand [2] 177/21	explores [2] 112/16	faith [1] 31/20	155/18
examiners [57] 4/25	193/25	130/13	fall [2] 111/9 168/19	filled [1] 127/16
5/13 6/1 6/6 10/18	expanded [1] 177/21	exponentially [1]	falling [3] 53/23	filters [1] 131/20
10/20 11/7 17/24	expanding [1] 193/21	191/14	119/9 179/15	final [13] 22/22 26/9
18/12 19/4 19/11	expansion [1] 191/2	express [3] 31/10	familiar [5] 25/1	70/8 106/18 115/7
19/21 21/21 23/5	expect [21] 12/1 13/9	56/7 138/23	46/16 51/18 136/18	115/24 117/25 124/20
23/11 23/24 24/3 25/8	16/13 19/12 24/15	expressed [1] 169/4	174/16	133/9 138/23 160/8
25/21 26/18 27/16	27/22 39/13 39/14	expressly [1] 72/5	familiarise [1] 78/5	160/10 175/20
28/1 32/19 33/12	44/17 55/23 66/22	extensive [1] 16/21	families [15] 15/1	finally [5] 33/13 58/9
33/15 33/23 35/2 37/5	127/15 142/4 174/21	extent [9] 3/3 16/5	31/4 33/5 34/3 41/6	85/9 131/11 154/16
39/1 43/12 43/21	183/6 196/25 205/14	20/6 25/13 57/4 57/11	57/19 73/24 73/25	financial [5] 136/15
46/14 48/11 48/13	220/1 221/11 221/23	211/5 211/9 223/21	108/17 109/4 109/18	136/20 140/14 141/11
48/22 49/3 49/19	233/23	external [12] 100/2	109/21 121/15 200/3	142/10
50/13 52/14 55/13	expected [6] 18/3	100/6 105/14 106/10	200/6	financing [1] 63/21
55/23 59/9 59/14	36/19 45/13 81/23	106/10 111/23 112/5	family [20] 15/16	find [4] 56/23 58/12
59/18 61/8 61/15	179/2 179/10	113/25 124/14 124/17	28/18 29/2 29/6 31/6	152/8 190/10
62/12 62/22 62/24	expecting [5] 45/13	124/22 167/2	33/8 41/10 41/13	finding [1] 74/1
63/10 65/10 67/5	54/16 69/3 183/10	externally [1] 182/18	43/10 45/11 45/12	findings [3] 85/19
183/1 183/5 183/15	201/23	extreme [1] 82/1	45/23 47/5 55/2 58/9	100/2 170/4
183/16 188/9	expense [1] 138/16	extremely [8] 10/2	62/9 72/16 177/8	finds [1] 188/22
example [44] 6/7 7/9	expensive [2] 176/16	18/1 41/3 44/25 142/1	196/12 196/13	fine [1] 46/1
7/11 8/1 8/3 8/10 9/2	176/18	196/23 198/3 203/4	far [12] 51/23 66/20	fire [1] 127/7
10/1 12/4 13/7 14/8	experience [15]	eye [1] 220/16	68/24 74/10 92/17	fire-fighting [1] 127/7
16/25 20/5 20/21	23/13 23/15 29/7	eyes [2] 196/18	124/2 139/15 142/21	first [70] 1/15 3/12
20/23 21/25 22/5 24/9	34/12 34/24 34/25	196/22	181/3 186/5 192/23	3/20 10/14 11/4 23/7
31/21 33/17 40/4	35/1 35/7 36/11 37/7	eyewitness [3] 226/3	235/10	25/15 25/20 26/25
41/11 43/21 45/24	46/10 123/25 171/6	226/4 226/9	fear [1] 38/20	27/15 29/4 31/6 31/8
62/24 80/6 81/3 83/5	176/23 236/9	eyewitnesses [1]	feature [1] 171/7	36/24 42/4 44/14 48/2
83/6 85/21 86/6 86/10	experienced [3]	226/8	features [1] 50/18	53/13 56/19 57/10
119/13 129/8 136/23	171/14 215/13 236/13	F	February [7] 66/24	57/14 57/20 67/11
139/4 139/10 140/16	70/17	face [9] 20/18 20/18	66/25 69/2 115/7	69/5 70/12 76/13
145/14 147/12 208/15	expert [3] 22/10 23/6	21/6 21/6 25/18 25/18	116/11 204/4 204/5	86/22 89/19 89/20
211/10 236/25 238/20	70/17	105/22 178/20 228/1	feed [3] 114/8 161/23	89/21 92/22 93/20
examples [10] 9/4	expertise [15] 21/10	Facebook [1] 97/15	174/10	93/21 96/8 112/23
18/21 19/10 62/6	21/11 21/16 22/19	facilities [1] 194/2	feedback [11] 12/7	115/3 118/23 119/4
111/4 140/19 141/1	23/11 23/23 24/9	facing [1] 141/6	12/13 12/17 34/16	124/3 126/9 132/25
141/13 163/9 236/25	24/11 24/12 24/22	fact [27] 8/18 12/3	35/11 95/7 99/19	134/1 136/3 136/10
exceeds [1] 139/24	48/24 62/21 128/12	18/8 18/9 31/4 31/7	101/6 159/19 160/6	138/13 143/10 145/20
excellent [1] 53/4	184/21 184/25	37/9 49/4 51/19 55/12	235/2	148/8 165/24 169/9
except [1] 197/19	experts [3] 35/15	60/4 61/6 70/20 90/23	feedbacks [1] 34/19	171/5 177/5 192/18
exception [1] 23/6	68/1 68/3	110/16 117/3 118/8	feeds [1] 155/18	205/24 206/15 207/14
excess [1] 176/24	explain [21] 3/22 7/5	150/4 164/15 177/18	feel [8] 31/7 31/9	207/18 208/2 209/15
exchange [1] 21/3	20/3 23/1 37/21 52/2	193/9 198/8 200/4	32/24 33/5 34/12	209/25 213/19 215/3
exclude [1] 181/14	56/18 71/21 88/15	215/9 218/13 219/22	117/21 125/1 132/12	215/3 220/13 220/24
Exec [2] 144/6	94/17 123/16 143/18	239/1	feeling [4] 46/22	221/7 225/1 228/17
144/13	165/16 184/1 186/9	factor [4] 98/10	59/12 102/10 219/21	229/13 231/14
Executive [9] 10/7	186/15 187/3 207/14	129/18 131/1 131/10	feels [1] 191/21	firstly [5] 60/21 78/22
74/18 86/4 131/19	211/17 216/4 238/4	factorial [1] 55/13	fell [1] 237/25	140/19 140/23 210/15
131/23 163/5 169/14	explainable [1] 72/6	factors [8] 88/14	fellow [3] 1/16 5/22	fit [1] 6/18
	explained [9] 28/19		171/20	fitness [4] 207/7
	30/18 51/11 51/20			

F	53/6 82/16 88/11 97/16 111/22 160/7 209/2	203/2	Garstang's [1] 48/8	204/7 216/4 234/17 235/4 235/7 236/6 236/25 238/19
fitness... [3] 215/14 229/8 232/20	foremost [1] 208/2	fresh [3] 168/6 196/18 196/22	gave [8] 74/7 91/22 94/14 99/7 106/25 115/13 180/4 215/24	gives [2] 154/22 155/4
fits [2] 148/24 150/4	forensic [7] 16/8 65/24 77/17 174/22 174/23 175/4 175/11	front [12] 18/16 68/9 113/9 124/25 127/10 131/24 132/5 132/7 160/18 160/21 200/24 210/15	general [13] 1/19 23/6 36/8 125/9 137/12 167/13 183/12 201/23 202/19 203/10 217/18 232/3 232/14	giving [7] 60/10 120/11 123/23 202/16 207/25 224/14 232/13
five [8] 12/24 28/22 130/22 135/15 136/5 165/21 194/13 213/1	foreseeable [1] 151/18	front-loaded [1] 68/9	General Medical Council [1] 125/9	glue [1] 11/10
five days [1] 28/22	foreseen [1] 151/19	frozen [1] 141/15	generalisation [1] 126/11	GMC [3] 63/1 81/8 81/14
five elements [3] 135/15 136/5 165/21	forgive [5] 118/11 120/16 143/24 160/9 168/10	frustrating [1] 182/25	generalist [1] 185/7	go [55] 9/14 10/15 10/21 17/15 22/14 33/16 35/20 43/13 50/11 50/25 55/7 65/7 76/12 77/24 79/9 85/9 97/23 100/22 112/8 112/11 112/15 113/12 115/2 115/3 115/18 119/23 124/7 127/18 132/21 141/14 142/21 145/22 148/12 150/17 160/8 166/9 166/11 167/6 168/14 177/20 187/1 187/1 190/22 197/12 204/24 210/8 210/13 210/22 222/23 222/25 223/4 231/2 233/9 234/14 239/25
five have [1] 12/24	forgotten [5] 162/4 162/8 163/12 193/10 204/2	fulfil [2] 37/13 153/14	generally [10] 19/11 24/2 35/15 113/22 129/9 140/10 142/7 152/25 163/14 193/22	goes [11] 37/22 45/14 67/22 115/4 126/7 155/2 176/9 184/3 229/13 229/19 238/25
five lines [1] 130/22	fork [1] 84/4	fulfilled [1] 37/2	generate [1] 44/18	going [58] 3/19 4/15 8/19 11/11 14/25 16/14 19/13 21/15 24/4 28/2 28/4 28/6 40/7 42/6 48/25 50/15 50/22 51/2 53/2 57/7 64/2 64/3 66/8 66/13 74/24 76/8 76/12 84/14 84/20 100/17 108/13 122/6 124/7 126/9 135/10 137/3 138/8 138/13 141/4 142/13 142/18 142/19 147/14 147/19 147/20 148/5 148/6 152/3 152/4 152/14 162/20 186/19 203/21 212/15 221/9 233/6 237/20 240/6
five points [1] 213/1	form [8] 82/1 147/6 159/12 172/10 181/13 188/18 196/14 208/22	full [17] 1/8 23/25 73/12 93/5 103/14 104/19 106/1 106/5 106/8 106/12 106/15 120/1 121/7 174/17 187/11 205/20 216/21 174/8	generative [1] 146/12	gone [7] 55/18 56/16 57/17 58/4 93/14 211/24 216/12
five years [1] 194/13	forma [1] 112/16	fully [3] 29/20 167/11 174/8	generic [2] 21/22 22/1	good [29] 4/16 9/23 19/17 21/17 38/3 43/6 49/7 49/13 49/25 53/24 58/20 59/2 59/19 60/8 62/6 63/2 72/3 81/7 128/1 134/19 146/16 162/7
fixes [1] 152/7	formal [3] 12/7 85/3 176/10	Fulop [1] 130/3	genuinely [4] 127/14 142/22 150/14 227/3	
flag [2] 19/2 142/25	formalised [1] 176/4	function [1] 64/11	geography [3] 43/11 156/23 157/4	
flagged [2] 7/16 126/17	formally [1] 200/13	functioning [2] 41/2 58/12	germane [1] 170/17	
flagging [1] 204/12	formation [1] 78/25	functions [3] 14/20 107/23 207/8	germination [1] 25/22	
FLETCHER [21] 1/3 1/6 1/9 1/10 18/7 26/4 26/9 27/5 27/12 42/7 44/5 46/24 47/4 50/14 63/17 65/8 72/13 178/9 183/19 185/2 241/3	former [1] 14/7	fundamental [4] 134/23 134/25 135/1 237/13	gestation [2] 154/25 185/20	
flow [1] 153/1	forms [2] 94/16 174/7	fundamentally [1] 236/23	get [25] 23/22 31/16 45/21 45/25 46/7 55/4 61/20 61/21 61/21 63/20 95/11 97/3 118/23 127/5 142/12 158/10 158/18 162/4 163/12 179/5 184/12 189/4 192/2 233/11 239/4	
flowcharts [1] 51/4	forthcoming [1] 235/18	fundamentals [1] 152/9	gets [1] 45/15	
flurry [1] 17/14	fortunate [1] 200/5	funeral [1] 31/21	getting [8] 63/11 66/2 66/4 69/4 131/24 159/20 171/4 186/6	
focus [17] 17/1 50/2 66/1 113/15 114/2 114/4 131/4 137/12 139/5 141/4 144/11 158/14 158/15 159/25 162/6 163/15 191/15	forum [1] 92/11	funerals [1] 31/18	give [27] 1/8 28/25 68/25 69/4 80/10 107/5 107/6 107/8 119/22 120/20 128/18 129/6 136/23 140/19 144/18 155/1 173/4 198/7 199/5 203/1 205/15 209/9 227/11 231/19 232/3 232/8 237/3	
focused [8] 8/3 38/21 92/17 126/1 137/15 152/19 182/8 186/19	forward [10] 32/23 33/4 50/11 77/24 85/9 121/3 140/15 143/10 147/20 205/9	funding [8] 23/24 143/10 143/12 182/12 192/19 193/19 193/25 194/13	given [36] 18/12 39/1 39/6 39/21 46/4 47/7 47/13 61/21 79/15 80/3 88/21 91/7 100/8 100/15 105/19 113/9 115/20 115/23 116/17 126/8 154/3 171/6 174/5 189/5 194/23 197/13 198/15 203/21	
focuses [4] 132/17 136/24 145/5 191/6	foul [4] 180/14 181/15 182/21 200/19	fundings [1] 152/9		
focusing [3] 120/11 137/5 138/15	found [2] 209/21 210/5	funerals [1] 31/18		
follow [18] 11/1 12/19 32/13 45/18 47/7 47/16 85/14 100/10 101/15 103/18 115/12 133/18 161/4 211/20 215/6 215/11 228/22 230/17	Foundation [2] 1/20 133/10	further [22] 3/17 23/22 24/22 46/4 46/25 49/17 63/13 84/17 85/18 92/10 97/24 114/10 119/19 140/1 165/23 198/20 212/20 215/17 215/19 216/17 233/6 239/3		
follow-up [4] 11/1 85/14 103/18 211/20	four [2] 29/14 213/19	future [8] 56/3 95/24 139/25 145/8 146/23 148/17 190/15 233/14		
followed [15] 9/14 12/6 47/17 79/6 79/24 82/13 94/5 101/3 101/7 119/10 134/6 147/23 180/16 214/22 230/25	fourth [7] 88/10 131/9 131/10 162/14 164/10 164/11 212/20			
following [11] 40/11 78/10 97/4 99/11 101/2 110/19 112/4 113/6 114/24 231/10 235/2	frail [2] 184/19 191/7			
follows [8] 12/18	frame [1] 165/12			
	framework [10] 10/4 128/7 128/8 128/11 145/10 145/14 145/14 145/15 145/20 158/14			
	frameworks [2] 128/14 129/6			
	Francis [1] 207/3			
	free [5] 72/21 119/23 132/12 204/24 239/25			
	Freedom [2] 189/16 189/23			
	freer [1] 159/23			
	frequent [2] 11/5 11/12			
	frequently [2] 13/8			
		G		
		gain [2] 114/5 239/11		
		gap [3] 141/17 224/3 227/18		
		gaps [2] 141/15 142/6		
		garner [1] 30/16		
		Garstang [6] 47/14 51/19 53/11 180/4 180/22 180/25		

<p>G</p> <p>good... [7] 176/16 223/23 232/6 232/23 233/15 233/17 236/17</p> <p>Good Practice Series [1] 49/13</p> <p>goodness [1] 97/9</p> <p>Gosport [1] 25/24</p> <p>got [40] 9/10 18/2 27/9 34/4 39/23 40/19 41/23 42/11 51/11 62/7 128/12 131/1 141/20 144/10 147/15 149/4 149/7 150/14 151/6 151/10 157/11 175/12 177/4 184/9 184/17 185/18 187/8 191/21 192/16 194/4 197/16 201/12 201/22 207/10 219/5 222/2 222/6 227/24 236/16 236/18</p> <p>governance [33] 3/17 6/25 7/2 7/3 7/20 8/8 8/21 9/1 9/7 9/13 9/20 12/25 18/5 57/3 124/3 124/8 124/13 125/4 125/24 127/21 130/9 130/13 132/23 133/2 135/13 135/19 141/5 165/22 190/9 190/18 216/12 229/19 230/22</p> <p>government [5] 30/4 41/20 64/22 137/14 156/3</p> <p>GP [5] 6/7 20/14 20/21 21/12 22/6</p> <p>Graham [2] 99/18 120/18</p> <p>Graham Stewart [2] 99/18 120/18</p> <p>gram [1] 187/8</p> <p>grappled [1] 12/9</p> <p>grateful [2] 72/13 72/23</p> <p>gravity [1] 217/20</p> <p>great [1] 211/15</p> <p>greatest [1] 185/22</p> <p>grew [2] 34/25 238/5</p> <p>grief [2] 31/6 121/16</p> <p>grievance [1] 98/2</p> <p>gross [1] 217/25</p> <p>ground [2] 3/2 191/20</p> <p>group [6] 13/20 62/2 107/16 114/1 168/3 168/11</p> <p>groups [3] 47/5 168/1 177/8</p> <p>growing [1] 23/11</p> <p>Guardian [2] 189/16 189/18</p>	<p>Guardians [2] 189/16 189/23</p> <p>guess [3] 162/11 167/23 193/14</p> <p>guidance [48] 6/19 9/23 9/24 11/15 11/22 18/11 19/18 38/25 39/1 39/6 49/23 54/9 54/23 56/3 65/9 65/20 66/6 78/22 81/5 81/15 86/20 99/5 99/7 106/23 106/24 125/1 125/10 136/24 158/9 158/22 171/9 171/10 172/21 173/8 174/6 177/16 181/18 181/19 181/21 198/16 223/22 226/14 226/16 227/19 232/6 232/19 232/25 236/8</p> <p>guide [8] 76/12 78/22 80/19 85/9 86/15 95/25 100/16 110/16</p> <p>guideline [3] 19/18 50/21 79/5</p> <p>guidelines [22] 4/17 6/18 33/22 35/9 35/25 36/2 49/1 49/6 49/7 49/12 50/19 51/1 51/3 51/5 60/4 63/2 171/15 173/11 173/13 173/16 182/4 188/10</p> <p>guides [1] 173/9</p> <p>guiding [1] 36/15</p> <p>gut [2] 102/10 179/23</p> <p>Gynaecologists [1] 149/9</p> <p>Gynaecology [1] 152/20</p> <hr/> <p>H</p> <p>had [90] 4/10 7/9 8/5 8/13 12/3 20/6 25/22 28/24 29/6 31/5 31/10 32/10 35/9 36/5 39/19 47/6 47/9 47/9 49/8 49/18 50/22 52/11 56/21 58/1 58/2 71/7 83/7 90/22 90/22 91/23 91/24 92/2 93/13 96/2 96/4 97/17 98/22 98/22 100/9 100/22 101/2 102/4 102/9 104/4 104/22 107/3 112/5 113/6 115/15 116/22 123/16 128/13 129/2 133/17 156/24 165/2 180/2 192/23 198/17 199/18 205/13 205/14 209/16 209/20 210/9 211/11 213/7 214/9 215/12 215/20 215/25 216/24 217/10 218/17 223/12</p>	<p>224/5 225/2 226/16 227/6 227/17 230/4 230/8 231/15 232/18 234/19 234/22 235/1 235/11 235/11 236/13</p> <p>hadn't [2] 204/19 217/11</p> <p>haematological [1] 22/7</p> <p>half [8] 80/22 115/4 116/12 127/16 214/15 229/3 230/19 236/13</p> <p>halted [1] 83/9</p> <p>hampered [1] 107/23</p> <p>hand [2] 42/4 193/13</p> <p>handing [1] 153/9</p> <p>handled [1] 39/16</p> <p>happen [8] 23/1 35/23 61/23 62/1 64/25 65/2 118/22 152/3</p> <p>happened [20] 10/24 40/19 41/18 44/19 44/20 45/2 45/3 45/25 46/11 46/15 57/17 57/23 64/16 70/10 72/9 74/1 93/17 97/1 104/13 183/9</p> <p>happening [7] 11/20 54/21 64/25 65/1 70/11 170/6 233/12</p> <p>happens [5] 9/20 11/19 36/9 57/20 146/22</p> <p>happy [2] 63/13 200/6</p> <p>harassment [1] 81/24</p> <p>hardly [1] 52/6</p> <p>harm [33] 8/23 8/24 18/10 26/14 26/15 26/19 27/21 57/21 58/25 94/17 99/13 101/18 126/3 127/13 127/22 140/15 140/21 145/6 171/12 188/19 201/3 212/13 213/17 216/18 217/24 218/24 219/10 219/15 220/2 220/5 220/8 221/2 226/6</p> <p>harmed [2] 59/4 60/7</p> <p>harming [2] 218/17 221/9</p> <p>harmonisation [1] 168/22</p> <p>Harold [3] 25/23 56/10 57/11</p> <p>Harold Shipman [1] 25/23</p> <p>Harvey [2] 89/20 93/22</p> <p>has [121] 3/7 5/11 9/13 10/9 11/14 13/5</p>	<p>13/25 16/14 17/19 18/8 18/18 23/2 27/9 28/14 28/14 29/6 29/6 30/4 30/14 30/17 30/19 30/20 30/21 40/17 41/20 46/15 49/9 52/18 53/5 54/3 57/17 64/15 66/2 66/3 67/15 67/18 70/1 70/4 74/21 78/3 91/7 101/12 104/10 105/23 106/18 109/3 109/7 110/2 110/18 112/11 112/17 113/5 113/15 113/24 117/4 119/22 120/14 120/16 128/5 132/14 133/5 134/12 135/15 140/5 144/5 144/6 144/7 144/10 145/12 151/3 151/10 151/12 151/23 156/20 157/17 158/21 162/6 162/9 165/19 166/9 167/9 167/24 169/4 170/13 171/7 171/8 172/23 172/23 173/17 173/20 173/22 173/24 176/4 184/8 184/16 186/23 188/15 189/17 191/8 193/20 193/23 194/12 194/14 194/22 194/23 195/24 195/25 197/23 201/22 208/25 211/1 212/17 212/21 212/21 217/1 219/8 220/10 233/4 236/15 237/11 238/17</p> <p>hasn't [9] 27/11 41/18 66/20 172/25 189/3 191/15 220/22 233/8 236/24</p> <p>hat [2] 177/13 177/14</p> <p>hats [1] 177/12</p> <p>have [493]</p> <p>haven't [5] 31/10 102/12 121/22 157/11 194/4</p> <p>having [32] 7/19 13/3 15/18 19/7 28/24 35/16 35/17 46/13 54/10 57/22 61/8 63/4 98/21 102/15 126/8 135/19 136/2 147/3 148/4 150/21 156/12 158/1 168/18 172/3 175/8 184/2 184/20 186/14 194/5 198/8 202/9 216/22</p> <p>Hayley [2] 97/25 98/12</p> <p>Hayley Cooper [2] 97/25 98/12</p> <p>he [13] 65/23 74/18 74/21 87/9 99/19</p>	<p>107/14 117/1 117/12 117/19 117/20 117/20 215/15 215/16</p> <p>head [3] 59/20 122/23 143/6</p> <p>heading [4] 78/1 80/22 101/10 130/9</p> <p>headline [1] 138/5</p> <p>headspace [1] 127/14</p> <p>health [33] 5/12 41/21 61/20 63/20 67/19 75/13 75/19 81/25 105/1 120/20 123/5 125/6 135/7 138/7 139/2 139/23 150/20 150/22 151/7 151/21 152/10 152/12 153/21 154/5 154/10 157/3 157/6 170/12 174/1 184/21 190/23 191/2 207/3</p> <p>healthcare [20] 17/20 39/9 57/16 109/6 109/14 112/25 113/7 113/11 113/23 130/10 130/15 133/14 134/18 156/20 157/1 158/23 160/18 160/22 166/8 172/22</p> <p>healthy [2] 163/14 179/20</p> <p>hear [4] 41/1 57/19 82/24 141/18</p> <p>heard [16] 18/18 32/25 41/12 78/19 83/6 112/7 112/10 114/17 120/13 132/12 171/8 172/8 178/2 189/4 194/25 217/1</p> <p>hears [1] 69/10</p> <p>heart [2] 28/20 133/8</p> <p>hedge [1] 175/10</p> <p>heighten [1] 25/3</p> <p>heightened [2] 44/18 45/6</p> <p>held [2] 12/21 235/20</p> <p>help [17] 39/6 48/21 64/6 68/22 97/20 114/1 127/4 130/23 131/3 135/1 145/19 148/15 163/2 168/14 177/11 190/5 190/12</p> <p>helpful [15] 37/25 44/11 51/10 51/10 51/15 66/24 67/1 67/1 93/1 119/23 128/8 145/8 146/23 203/16 204/1</p> <p>helpline [1] 189/6</p> <p>helps [3] 36/6 48/20 71/21</p> <p>hence [1] 156/9</p> <p>her [24] 47/24 53/11</p>
---	---	--	---	---

H	honestly [1] 236/20	223/18 225/3 232/3	I ask [7] 47/4 56/4	I had [2] 49/18
her... [22] 65/18 91/8	hope [4] 67/1 131/18	how's [1] 31/11	60/15 78/8 177/7	205/14
98/13 102/6 109/25	204/13 240/12	However [3] 17/25	177/12 195/17	I have [57] 11/15
116/12 120/12 120/23	hopes [1] 36/10	37/7 140/13	I asked [5] 65/20	18/20 18/20 19/20
141/6 180/7 210/25	hoping [2] 50/10	HR [4] 101/10 101/21	65/20 66/10 183/21	26/24 32/9 32/10 33/1
213/13 220/11 220/11	66/16	103/15 103/19	211/16	34/8 36/3 39/23 41/18
220/14 220/21 221/1	hospital [79] 4/13 5/7	huge [5] 126/13	I assume [1] 199/7	42/4 46/17 47/9 47/9
227/12 232/10 233/15	5/9 6/9 7/7 7/13 8/14	154/8 184/20 188/25	I authored [1] 17/4	47/17 51/11 52/2 52/7
233/18 234/2	8/16 10/21 13/1 21/24	223/9	I been [1] 227/6	52/13 54/15 61/16
here [31] 15/13 17/18	25/24 28/24 29/17	hugely [2] 209/9	I begin [1] 149/16	61/16 68/18 71/7
22/17 43/4 45/20	39/12 39/18 43/13	222/2	I believe [9] 1/24	77/11 100/16 103/17
51/12 54/10 54/25	46/18 57/13 57/14	human [4] 21/24	46/25 54/13 54/23	112/20 114/12 125/8
63/15 71/9 71/22	60/25 61/3 61/24	57/15 61/19 192/8	72/6 91/2 106/7 112/6	126/19 128/10 146/25
72/17 79/13 79/24	74/12 76/10 86/22	hygiene [1] 193/13	158/16	147/2 147/24 154/4
82/9 83/11 85/6 87/16	87/2 87/12 90/17 91/1	hypoglycaemia [3]	I call [1] 120/12	175/6 175/12 175/20
88/22 110/25 117/12	91/11 92/1 92/1 92/5	18/24 19/12 62/1	I can [21] 7/4 8/10	177/3 177/11 192/16
127/24 130/20 138/4	92/24 93/9 100/11	hyponatraemia [1]	28/10 32/7 39/24 44/5	194/9 198/20 199/14
160/20 162/16 178/8	100/18 100/22 101/3	169/7	50/11 52/9 56/2 65/7	201/22 204/2 214/5
197/12 201/22 222/23	105/2 106/4 106/11	hyponatraemia-relate	67/3 68/14 73/5 97/14	214/14 228/19 229/2
228/11	107/25 113/17 114/20	d [1] 169/7	108/16 121/2 122/10	229/2 229/3 236/13
herself [2] 28/24	114/24 121/19 125/24	hypothesis [1] 60/1	154/7 180/7 189/9	239/23
196/4	127/21 131/19 131/20	I	199/1	I hope [3] 67/1
hesitation [2] 52/13	135/12 136/14 137/3	I -- I don't know [1]	I can't [4] 65/13	204/13 240/12
67/3	140/10 144/16 146/6	109/13	143/24 210/2 217/16	I just [13] 15/21
Hey [1] 180/18	148/12 153/4 173/13	I agree [20] 72/7 88/2	I cannot [2] 5/25	15/24 28/25 45/25
high [6] 113/8 138/6	177/17 178/18 180/9	88/6 89/17 90/13	68/25	56/14 65/10 78/22
139/3 150/11 201/3	181/2 181/11 181/25	92/15 93/7 96/6 96/23	I celebrate [1] 14/4	121/16 177/8 179/14
201/13	182/21 183/12 186/6	97/2 100/24 103/20	I consider [1] 43/3	214/7 228/8 228/10
higher [1] 137/16	187/25 188/19 192/24	103/22 105/6 106/7	I could [3] 35/25	I knew [1] 215/13
highest [2] 162/23	195/2 195/3 200/7	107/2 107/6 108/15	36/21 205/6	I know [8] 52/2 59/17
212/13	200/10 200/22 209/18	116/23 188/8	I couldn't [1] 225/9	71/19 119/18 134/16
highlighted [3]	hospitals [11] 1/20	I also [3] 62/3 74/2	I describe [1] 17/5	144/3 193/20 236/18
106/18 172/3 173/21	5/14 124/21 128/1	195/23	I did [3] 121/24	I like [1] 37/24
highlighting [1]	128/14 128/20 137/6	I am [81] 3/19 8/19	215/11 224/15	I made [1] 65/13
117/2	137/13 157/19 161/15	15/13 17/24 18/10	I didn't [5] 72/2 82/23	I may [19] 3/19 7/4
highly [3] 39/9 96/20	173/17	19/5 19/14 19/14	224/24 225/6 234/7	8/10 11/3 16/19 39/8
96/25	host [1] 14/5	19/21 22/4 24/17 25/1	I do [10] 16/21 51/25	48/25 56/8 58/15 59/7
him [2] 183/21	hosted [1] 5/14	25/6 25/13 26/17 27/4	87/21 115/8 122/10	59/13 65/8 70/13
215/15	hotline [1] 189/12	27/10 28/9 32/2 37/17	162/5 181/17 189/15	71/15 134/13 177/9
hinder [1] 130/25	hour [1] 120/1	39/21 41/25 41/25	189/15 206/24	177/14 224/7 228/22
hinders [1] 167/15	hours [5] 29/14	42/20 43/3 43/20	I don't [30] 15/13	I mean [20] 32/21
hindsight [1] 96/21	51/20 116/11 189/13	48/25 50/10 51/25	36/11 45/24 46/19	46/8 58/2 64/8 79/17
his [7] 87/8 91/21	193/11	53/9 60/10 60/11	47/6 51/25 53/25 54/2	131/22 140/22 141/8
99/18 107/13 107/20	how [68] 2/6 9/14	60/14 63/12 66/16	59/2 66/9 68/10 83/4	151/20 159/16 159/18
117/20 141/6	13/16 16/1 16/4 17/4	68/23 69/15 71/2	84/7 84/9 108/10	175/3 185/17 188/8
historically [1] 19/5	21/15 22/18 29/1	72/23 74/24 76/8 82/9	129/25 163/25 164/4	196/4 212/10 218/13
history [3] 40/7 41/19	32/22 35/5 37/13	84/4 97/10 110/8	170/23 178/8 180/1	219/5 232/19 237/2
102/16	37/20 37/21 42/4 44/9	116/4 121/17 122/6	180/25 189/13 195/12	I might [1] 170/18
hitherto [1] 172/10	51/24 58/3 71/2 77/19	124/1 124/7 134/3	203/1 204/11 229/1	I missed [1] 134/1
hm [2] 82/7 98/18	111/1 118/17 121/17	134/17 150/19 156/21	232/18 232/18 239/23	I moved [1] 238/6
HMG [1] 182/3	127/20 128/13 128/14	159/3 171/3 175/10	I ever [2] 214/24	I need [3] 39/25
Hodkinson [4]	128/20 129/5 129/25	178/24 180/1 181/5	215/4	55/18 98/8
226/25 227/2 227/5	131/6 131/11 140/5	181/6 183/8 185/13	I explained [1] 55/21	I observe [1] 53/1
234/12	142/11 148/19 148/24	185/13 185/15 188/2	I fear [1] 38/20	I pause [1] 82/21
hold [1] 206/22	150/7 150/15 150/16	190/1 191/20 192/15	I feel [1] 34/12	I picked [1] 201/5
holes [1] 45/22	150/18 151/12 157/6	196/15 197/11 200/4	I find [1] 58/12	I prefer [1] 12/17
holistic [1] 62/12	162/19 163/2 174/10	200/17 201/8 201/15	I first [1] 67/11	I presume [1] 69/16
holistically [1]	180/1 182/19 188/2	204/12 225/11 227/23	I focused [1] 186/19	I probably [5] 175/11
153/16	188/10 189/11 197/6	230/6 236/12 240/8	I followed [1] 214/22	211/24 217/8 233/23
home [3] 7/9 31/19	199/17 199/17 201/11	I apologise [3] 69/2	I go [2] 112/11 223/4	235/8
61/24	207/22 211/14 215/8	73/24 127/3	I got [1] 34/4	I provide [1] 19/18
homeless [1] 62/11	218/11 220/20 221/13	I appreciate [3]	I grappled [1] 12/9	I put [2] 217/12
honest [1] 135/3	222/4 223/4 223/6	10/25 178/3 237/22	I guess [3] 162/11	217/18
	223/7 223/7 223/8		167/23 193/14	I ran [1] 215/14

I	230/25 237/24 240/6	187/12 205/13 237/20	implication [2] 140/14 142/10	51/4 64/17 78/14
I recall [2] 67/10 230/11	I took [3] 33/22 214/4 230/16	I'm afraid [5] 68/25 134/1 158/16 178/10 187/12	implications [3] 107/19 196/6 197/24	103/14 108/21 111/22 174/18 181/15 209/8
I recognise [1] 49/17	I turn [1] 107/11	I've [2] 121/13 214/6	importance [3] 130/12 190/24 192/8	incompetence [1] 218/11
I record [1] 228/15	I understand [20] 9/3 22/16 24/14 35/18 59/25 61/13 64/23 64/24 66/5 73/20 121/10 144/3 145/15 149/3 153/3 169/11 187/15 187/18 203/20 223/18	lan [2] 89/20 93/22	important [21] 12/9 13/16 22/24 30/11 31/22 32/18 62/17 64/2 95/11 98/19 113/1 131/15 132/19 134/21 154/23 157/2 159/24 167/21 175/22 208/12 209/10	inconsistency [1] 180/20
I refer [1] 41/10	I understood [1] 224/25	lan Harvey [2] 89/20 93/22	importantly [1] 29/19	incorporated [4] 4/2 19/22 19/22 25/14
I referred [1] 110/15	I visited [2] 210/2 210/3	ICS [1] 157/11	impose [1] 239/1	increase [14] 79/16 80/4 87/25 88/15 88/21 88/22 139/19 140/1 195/21 211/15 211/19 212/1 220/10 234/24
I reiterate [1] 59/10	I want [5] 85/11 86/22 88/9 171/5 199/14	idea [5] 56/21 147/13 203/1 222/6 222/9	impossible [1] 167/12	increased [1] 219/8
I request [1] 13/14	I wanted [1] 13/23	ideal [3] 148/1 156/23 157/8	improve [6] 50/1 51/12 71/2 114/1 153/17 157/6	increasing [3] 23/16 163/20 191/7
I right [1] 201/21	I was [12] 2/12 15/4 50/15 51/2 118/24 122/25 123/6 214/8 224/24 225/8 234/21 235/7	ideally [3] 36/2 65/2 163/24	improvement [2] 22/14 151/11	increasingly [1] 42/24
I said [2] 43/4 232/18	I wasn't [6] 69/3 72/2 178/10 201/23 217/4 227/5	identifiable [1] 88/13	improvements [1] 63/23	incredibly [1] 189/20
I see [2] 42/17 227/24	I will [10] 33/3 33/3 48/20 50/10 50/12 51/11 59/21 109/13 112/8 173/2	identified [17] 91/23 127/25 130/21 133/5 135/15 135/15 136/6 143/13 151/12 151/15 181/15 202/9 212/21 213/3 213/8 231/9 239/15	improves [1] 114/11	incubator [1] 191/22
I settled [1] 34/3	I won't [2] 59/22 68/15	identifies [3] 130/13 165/10 166/12	improving [7] 130/10 130/14 130/15 157/3 160/1 160/15 168/22	incurs [1] 140/21
I should [2] 44/2 52/2	I wonder [6] 48/25 49/2 60/4 188/20 189/5 204/7	identify [8] 90/5 133/1 152/24 164/22 165/16 165/25 169/3 190/19	inaccurate [1] 167/25	indeed [12] 18/17 67/10 68/20 68/23 72/19 103/23 104/8 119/21 128/16 187/25 204/24 240/10
I shouldn't [1] 200/17	I wondered [2] 44/11 48/5	identifying [1] 134/25	inactions [1] 133/2	independence [6] 3/21 3/24 4/2 4/7 4/13 182/17
I speak [1] 134/17	I work [2] 200/5 202/23	if [297]	inadequate [3] 153/2 187/10 192/22	independent [13] 3/6 3/10 3/22 4/6 4/9 4/19 6/9 6/19 24/23 37/10 113/25 235/1 238/25
I start [1] 73/20	I would [42] 12/1 13/9 15/8 15/8 18/3 19/12 24/15 24/15 27/22 39/13 39/14 42/23 44/17 47/20 52/5 55/23 60/10 69/9 73/22 98/9 114/22 118/23 118/23 119/2 119/2 119/4 120/2 129/21 133/20 158/16 188/14 189/11 194/7 196/17 211/6 211/21 227/6 228/15 232/8 235/17 235/18 236/6	ill [3] 191/23 192/5 203/4	inadvertent [1] 8/23	independently [1] 188/16
I stated [1] 9/15	I wouldn't [4] 142/21 175/13 179/17 211/22	illness [1] 17/7	inappropriate [3] 29/15 99/2 101/23	indicate [1] 104/21
I suggested [2] 65/19 65/22	I'll [1] 66/14	illuminate [1] 159/25	inappropriately [1] 8/8	indicated [2] 95/10 96/24
I suppose [9] 28/4 41/8 64/14 69/13 70/19 140/23 184/3 200/16 229/4	I'm [20] 18/7 25/25 29/22 40/24 45/5 45/25 46/13 46/15 60/10 60/10 60/12 63/13 68/23 68/25 134/1 158/16 178/10	imagine [6] 5/25 47/11 66/10 69/9 118/25 189/11	inasmuch [2] 193/5 200/21	indication [1] 81/16
I suspect [1] 15/5		immediate [9] 10/5 103/18 111/3 111/4 111/10 111/18 186/22 226/20 235/3	inasmuch [2] 193/5 200/21	indicators [1] 137/15
I think [118] 3/2 4/14 23/14 23/22 26/23 28/4 30/11 31/22 32/18 34/25 39/5 42/15 44/14 45/6 46/4 48/7 49/5 50/5 50/5 50/14 51/9 51/9 51/10 51/14 52/24 53/24 54/3 54/19 54/22 55/20 55/20 56/10 57/12 58/16 59/7 63/14 64/2 65/14 69/6 71/15 72/10 83/8 97/7 106/14 113/22 116/5 118/22 126/10 129/24 131/17 132/17 133/16 133/19 135/3 135/6 138/14 142/21 142/21 142/22 145/13 147/2 159/16 160/2 161/24 163/13 163/17 167/22 167/25 168/4 168/9 168/10 168/11 170/11 173/19 175/3 177/4 177/16 177/17 177/19 178/6 181/18 182/24 183/4 183/10 183/13 184/17 184/20 185/1 185/18 185/22 185/24 187/2 190/5 190/7 190/21 191/9 191/16 193/11 193/12 195/25 196/5 197/25 199/10 199/13 214/23 215/2 215/11 217/10 222/11 224/8 225/5 228/5 230/15 230/21 230/22		imagine [6] 5/25 47/11 66/10 69/9 118/25 189/11	inasmuch [2] 193/5 200/21	individual [19] 24/5 33/8 33/16 52/4 71/5 81/9 86/2 88/25 89/1 168/11 176/21 190/4 208/4 212/12 213/5 226/5 233/24 237/5 238/17
		immense [2] 58/22 136/15	inasmuch [2] 193/5 200/21	individual's [1] 81/2
		impact [6] 130/6 138/2 139/19 140/6 167/15 170/8	inasmuch [2] 193/5 200/21	individuals [5] 78/6 100/4 113/2 212/11 212/19
		imparted [1] 59/23	inasmuch [2] 193/5 200/21	induction [1] 214/25
		implement [1] 133/25	inasmuch [2] 193/5 200/21	inefficiency [1] 156/12
		implementation [6] 2/13 95/23 134/11 135/25 136/12 196/7	inasmuch [2] 193/5 200/21	inevitably [4] 6/21 14/12 40/16 64/10
		implemented [7] 40/18 102/20 109/9 133/23 134/10 157/18 190/8	inasmuch [2] 193/5 200/21	inexperience [1] 234/7
		implementing [4] 133/14 133/20 134/16 134/20	inasmuch [2] 193/5 200/21	infamously [1] 188/25
			inasmuch [2] 193/5 200/21	Infancy [1] 173/21
			inasmuch [2] 193/5 200/21	Infant [1] 51/19

I	INQ0009591 [1] 88/8	191/1 191/5 197/1	116/19	208/21 220/22 221/4
infection [1] 179/22	INQ0009611 [1]	203/6	intervened [1]	221/8 221/12 221/25
infections [1] 13/8	101/8	instead [2] 28/7 96/7	115/16	222/2 222/4 222/6
inference [3] 135/18	INQ0009620 [1]	instruct [1] 39/24	intervention [2] 25/5	223/3 223/6 223/8
135/22 214/2	103/11	instructing [1]	62/5	223/13 223/14 223/16
Infirmary [1] 133/8	INQ0010214 [1]	109/11	interview [5] 89/18	223/17 223/23 227/23
influenza [7] 131/12	76/13	instructional [2]	93/21 93/22 96/4	228/10 232/24 233/17
166/2 166/13 166/24	INQ0012274 [1]	67/15 67/18	97/17	237/11 239/12 239/14
167/1 167/3 233/17	130/8	insufficient [2] 85/16	interviewed [2] 96/15	investigations [19]
influenced [1] 8/1	INQ00122766 [1]	198/17	96/20	12/6 12/8 16/25 19/4
inform [2] 51/12	145/11	insulin [7] 18/10	interviewees [2] 96/5	82/19 83/16 83/24
232/10	INQ0012282 [1]	18/13 18/25 19/1 19/7	96/12	84/18 84/22 95/24
informal [1] 12/17	158/19	19/10 187/23	interviewers [2]	100/7 133/6 180/10
information [42]	INQ0012287 [1]	integral [1] 146/12	98/13 98/19	187/5 187/11 221/10
13/13 22/15 38/12	169/7	integrated [5] 156/22	interviewing [1]	222/10 232/6 233/19
43/2 52/17 52/20	INQ0012289 [1]	156/24 157/9 163/6	96/14	investigative [1]
79/19 91/5 95/4	166/6	163/7	interviews [2] 93/20	187/24
104/10 104/21 105/20	INQ0012295 [1]	integration [2]	95/5	investigator [1]
105/23 107/11 108/17	138/3	156/25 157/2	into [42] 4/2 40/17	237/11
115/21 115/22 149/14	INQ0012733 [1]	intelligence [1]	50/1 52/13 72/25	investigator/investig
155/4 155/12 155/21	117/8	132/10	90/18 98/7 98/15	ation [1] 237/11
199/5 208/3 212/12	INQ0012734 [1]	intended [1] 77/11	101/22 103/6 105/3	investigators [1]
213/15 215/15 215/17	115/2	intensive [14] 142/2	111/2 112/8 115/5	12/13
216/14 216/17 216/20	INQ0012742 [1]	142/4 191/24 191/24	119/1 132/15 133/6	invitation [1] 77/2
218/7 219/17 220/4	118/1	191/25 192/2 194/20	133/7 138/8 142/7	invite [2] 51/3 113/25
220/6 222/21 223/15	INQ0012813 [1]	195/9 195/15 197/17	147/13 149/19 149/24	invited [49] 74/22
234/25 235/18 236/2	110/24	197/21 201/13 203/11	151/4 155/18 155/25	76/7 76/11 76/15
237/5 237/15 239/11	INQ0016484 [1]	214/25	156/4 157/11 157/12	77/14 78/2 78/13 79/9
informed [2] 38/18	177/11	interacting [4] 14/11	159/20 161/23 169/6	79/15 80/17 81/22
101/1	inquiries [14] 133/5	35/7 46/20 131/24	170/13 174/10 194/8	84/11 85/17 86/15
informs [1] 152/21	133/15 133/17 133/23	interaction [16] 20/2	197/12 202/2 207/3	86/21 87/11 87/24
infrequent [3] 24/7	133/24 134/5 134/6	20/7 20/8 20/16 20/21	211/24 216/12 223/12	89/15 90/2 90/19
24/8 36/12	134/9 134/10 134/22	21/6 28/18 29/1 30/14	239/4	92/12 93/14 95/3
infrequently [1]	143/24 144/2 162/6	30/21 33/20 41/5 45/1	introduced [5] 2/11	95/12 95/18 95/25
184/7	194/16	45/23 58/5 174/18	40/10 110/18 218/4	100/5 100/15 107/12
ingrained [1] 36/25	Inquiry [46] 1/11 8/12	interactions [3] 35/5	232/20	107/18 108/4 108/7
initial [16] 3/25 30/13	18/18 19/15 25/2	36/6 52/9	introduction [4] 15/9	108/14 109/14 110/1
87/1 112/21 116/8	31/22 37/3 44/15 47/7	interacts [1] 155/7	41/20 156/21 195/24	110/19 112/5 112/14
116/9 209/8 209/22	47/25 50/2 50/10	interest [4] 4/19 86/8	introductions [2]	113/1 113/17 113/23
213/7 218/3 224/25	57/19 58/22 61/5	122/19 159/22	36/3 195/24	114/9 114/13 114/15
231/18 231/24 235/2	63/24 67/1 91/7 91/22	interested [3] 134/3	intrusive [1] 34/10	114/25 115/10 118/12
235/19 238/3	94/15 120/14 120/16	150/15 199/17	invariably [1] 193/6	118/14 120/24
initially [6] 37/17	121/11 121/22 133/7	interesting [1]	invented [1] 197/7	inviting [1] 238/4
37/19 206/12 207/23	134/15 136/12 155/19	197/11	invested [1] 153/21	invoked [2] 37/12
208/17 229/17	169/6 169/6 171/8	interim [11] 208/19	investigate [18] 9/18	239/7
initiated [1] 51/21	180/22 187/19 190/19	216/16 221/1 226/20	10/11 18/15 24/19	involve [2] 21/24
initiatives [1] 140/11	195/1 204/8 204/15	237/21 238/10 238/11	39/25 56/23 71/20	44/23
injected [1] 187/22	205/21 205/24 207/3	238/15 238/18 238/24	101/16 207/20 212/11	involved [15] 20/6
injection [1] 194/14	217/1 222/11 224/8	239/1	215/19 219/4 220/23	21/8 24/24 34/9 34/16
injury [1] 62/5	225/1 225/9 240/15	internal [3] 1/19	221/6 221/21 225/14	51/21 52/15 79/15
innocent [1] 212/8	Inquiry's [2] 61/4	190/9 231/8	228/17 229/6	86/2 181/19 181/20
inpatients [2] 21/5	122/4	internally [3] 56/24	investigated [2] 2/17	184/13 186/7 237/23
21/5	inquisition [1] 59/12	187/25 190/11	181/24	239/9
input [7] 79/8 79/25	inside [1] 22/21	interpret [1] 15/5	investigating [2]	involvement [9] 9/6
88/5 123/17 185/8	insight [2] 159/20	interpretation [1]	11/1 92/14	31/15 54/5 78/23 86/3
185/9 237/1	208/6	84/10	investigation [49]	90/23 92/20 93/2
inputs [1] 149/19	Inspectorate [1]	interpreted [1] 84/8	3/9 37/18 51/7 53/20	239/17
inputting [1] 155/20	168/3	interprofessional [1]	54/2 58/14 71/13	involves [4] 180/12
INQ000569 [1] 97/5	instance [20] 10/15	160/11	77/17 90/17 98/7	180/13 182/17 182/18
INQ0002447 [1]	83/20 100/22 129/23	interrogate [2] 150/2	98/15 98/24 101/11	involving [3] 42/19
234/14	133/24 148/20 153/11	154/8	101/13 101/22 115/19	65/25 99/21
INQ0002965 [1]	159/18 164/1 166/18	interrupt [4] 4/9	116/18 117/16 119/1	IR [3] 78/4 83/14
210/13	170/16 174/15 179/6	25/25 27/5 29/22	133/10 181/13 182/20	128/17
	179/21 186/1 189/12	intervene [2] 48/24	185/9 199/7 208/18	IR-1s [1] 128/17

I	36/11 36/13 36/13 36/13 37/25 39/10 43/11 43/22 46/17 50/7 54/19 58/2 63/3 63/6 65/20 67/7 67/16 69/20 70/6 76/12 76/21 77/17 77/19 78/1 84/7 86/13 87/4 87/8 88/3 88/3 88/8 88/22 93/13 96/17 96/24 97/25 98/19 99/9 101/8 107/14 110/5 110/6 110/24 112/13 112/14 113/1 116/8 116/10 117/10 118/1 118/8 124/11 125/16 127/18 129/5 130/19 133/16 135/3 135/6 135/7 135/25 137/5 137/24 142/18 145/21 148/6 149/24 150/15 150/16 154/23 156/7 159/16 160/14 160/19 162/11 167/10 167/12 167/25 168/4 169/11 173/19 174/12 179/7 179/19 183/2 184/17 185/18 190/10 193/4 193/4 200/3 200/3 200/11 200/23 202/2 208/4 211/16 214/11 217/18 218/10 218/13 219/15 219/16 225/18 226/7 226/18 227/7 229/1 230/18 233/15 235/7 235/9 236/10 236/22 237/24 238/16 238/24 240/8 item [1] 234/15 its [21] 44/10 75/6 75/6 76/1 76/17 82/17 83/15 86/3 100/2 103/4 109/5 110/2 115/16 116/3 117/14 149/18 158/23 167/15 191/23 203/22 238/12 itself [7] 42/20 44/17 99/11 100/18 114/9 166/21 219/22	144/21 145/17 214/6 229/3 joined [3] 35/14 206/12 215/12 joining [1] 227/8 joint [14] 19/17 45/17 51/20 52/10 52/19 53/10 54/8 169/7 178/2 178/12 178/22 181/18 182/4 182/14 journey [9] 7/8 7/14 7/18 16/23 17/2 17/16 33/21 45/14 112/18 judge [1] 220/20 judgment [3] 16/18 29/10 180/12 judicial [1] 37/11 July [11] 40/12 87/6 117/11 118/2 209/19 210/9 219/3 231/19 234/17 235/14 236/24 June [2] 87/5 205/24 junior [4] 9/5 20/15 188/17 189/18 jurisdiction [2] 9/19 180/7 just [146] 1/15 2/18 2/18 3/3 3/20 3/22 5/6 6/14 7/1 8/20 12/19 14/24 15/18 15/21 15/24 18/10 19/16 19/16 20/3 20/4 21/20 24/25 25/6 26/2 26/4 26/5 26/9 26/17 27/6 27/12 27/15 28/25 29/2 29/22 31/3 33/13 33/13 36/11 37/17 37/20 40/7 42/7 43/10 44/5 44/7 45/25 46/25 47/20 47/20 47/23 48/20 50/7 53/1 53/14 54/11 55/19 56/10 56/14 58/2 58/10 58/15 58/15 60/8 63/11 65/7 65/10 69/4 69/6 69/7 69/14 69/17 69/22 70/8 71/1 71/21 77/11 78/22 88/1 98/1 103/16 104/15 112/13 116/22 117/4 118/25 121/16 122/11 123/9 124/13 127/16 128/9 136/3 141/22 143/4 148/6 149/20 153/9 158/14 160/2 162/11 177/8 179/14 188/15 190/10 191/21 192/4 192/9 192/16 193/17 199/1 202/25 203/21 204/2 204/12 206/5 206/25 208/24 209/15 210/10 210/22 211/13 211/17 213/3 213/9 213/20 214/7 215/12	215/20 216/4 216/12 216/13 216/21 218/4 218/8 220/16 221/3 223/24 227/9 228/8 228/10 228/22 230/21 232/16 233/1 238/1 238/2 justice [7] 37/12 65/5 143/7 170/4 198/25 241/6 241/13 justifications [1] 184/2 justify [1] 238/14	know [124] 4/21 24/9 25/10 26/11 32/9 33/12 34/2 37/1 37/13 38/23 45/8 46/11 47/6 48/22 50/6 51/8 52/1 52/2 58/21 59/17 60/24 61/10 66/9 68/19 70/9 70/22 71/19 72/2 84/4 84/7 84/9 89/18 93/18 94/13 95/3 98/15 100/5 105/7 108/10 108/13 108/20 109/13 119/18 125/5 127/11 128/12 128/14 129/25 131/25 132/3 134/16 134/22 134/24 142/18 144/3 144/20 147/14 147/16 147/25 150/1 150/7 150/14 156/3 156/10 157/9 157/23 158/2 161/23 163/13 163/16 165/4 168/14 170/11 170/14 170/23 172/2 174/21 175/3 175/4 175/15 176/11 176/16 178/8 178/18 179/21 180/1 180/25 182/9 183/8 183/12 184/4 185/14 185/19 186/14 187/2 187/6 187/8 188/10 188/12 188/16 190/3 190/4 191/1 192/15 193/12 193/20 194/19 194/21 197/15 200/4 200/14 201/3 211/10 212/9 216/21 218/6 222/3 223/6 229/1 231/25 233/3 235/22 236/18 237/6 knowing [8] 22/20 37/7 42/5 62/24 174/24 174/25 218/6 223/13 knowledge [17] 1/13 4/14 14/6 14/13 22/7 22/14 23/10 23/14 61/11 62/13 73/18 122/1 123/25 183/6 185/5 185/11 206/3 known [1] 188/25 knows [3] 53/9 68/18 69/18
ireland [4] 2/20 2/24 169/6 194/12 is [1010] isn't [35] 14/18 26/15 40/3 45/17 53/12 65/1 85/21 87/5 89/16 91/16 92/19 93/14 94/19 96/17 99/9 106/24 110/11 117/17 128/24 138/9 148/5 167/22 182/11 184/15 191/10 196/16 200/20 208/16 214/1 217/20 218/14 219/13 220/14 220/25 221/7 isolated [3] 188/20 190/11 193/16 issue [40] 9/17 10/17 19/2 19/12 26/10 26/12 26/14 27/8 33/13 34/1 36/3 49/2 55/2 56/9 61/16 62/3 62/19 83/19 83/20 86/22 99/3 111/10 117/2 118/18 125/13 125/14 139/16 142/8 142/9 142/24 171/5 171/15 173/7 188/14 190/7 212/1 224/7 230/14 233/8 235/23 issued [3] 49/1 50/19 119/15 issues [59] 7/16 15/13 17/11 17/18 18/8 18/10 19/5 25/23 30/2 32/6 38/14 43/8 59/10 59/14 61/19 78/6 78/12 80/11 80/24 81/9 81/12 82/5 83/13 92/16 92/25 102/4 102/8 103/13 103/15 103/16 103/18 103/19 105/4 105/18 106/11 107/18 111/20 113/16 116/21 118/13 118/19 122/3 122/7 132/3 135/9 140/6 140/7 142/18 143/12 144/11 146/11 152/24 162/11 164/16 168/18 184/1 192/17 197/3 234/16 it [631] it's [145] 6/13 9/17 12/10 14/14 14/22 18/2 19/23 20/25 21/17 21/18 21/19 22/5 22/24 23/11 23/14 24/18 25/12 27/3 28/4 28/11 28/15 30/1 31/22 32/18 32/21 33/11 36/10	J Janet [2] 40/10 41/12 January [5] 115/21 240/8 240/9 240/11 240/16 JAR [6] 48/23 178/2 178/22 180/1 181/24 187/2 JAR/SUDiC [1] 187/2 Jayaram [2] 93/23 95/6 Joanna [1] 47/14 job [9] 3/2 14/10 25/19 134/19 141/3	K keep [5] 11/10 11/10 59/20 66/14 216/8 keeping [2] 124/4 162/12 keeps [1] 11/20 Keith [1] 1/9 Kelly [16] 89/21 93/22 209/16 209/18 210/6 210/9 210/12 210/17 226/24 227/2 227/11 230/13 230/17 231/4 231/19 234/11 Kelly's [3] 210/20 218/6 219/1 Kennedy [2] 181/19 182/4 Kent [1] 59/8 kept [1] 191/15 key [14] 25/13 29/17 30/2 30/18 33/17 35/16 36/2 46/6 134/22 159/2 170/15 207/8 222/12 222/19 kill [1] 187/20 killing [3] 214/3 218/10 226/11 kind [32] 11/10 41/16 51/14 51/14 57/25 71/23 90/25 104/5 126/23 127/17 127/23 128/4 141/12 155/24 159/20 159/24 159/24 162/1 163/15 163/18 165/7 167/23 176/8 183/6 183/8 186/2 189/14 194/21 198/9 198/15 202/6 222/4 kindly [2] 65/22 66/22 kinds [5] 9/1 131/18 158/2 170/17 212/4 Kingdon [11] 120/10 120/15 121/2 121/4 121/9 177/1 177/7 192/15 199/1 204/23 241/9 Kirkup [1] 194/15 knew [4] 98/13 209/20 215/13 234/1	L laboratory [1] 187/9 lack [23] 9/5 9/6 80/16 115/24 125/11 127/16 135/4 135/5 139/4 139/4 139/10 162/19 163/2 164/13 164/19 165/17 212/19 213/25 216/13 218/19	

L	17/3 19/17 22/13 25/16 25/18 25/21 35/4 36/5 50/3 50/9 62/7 63/8 64/4 67/4 67/6 71/21 95/4 147/18 154/22 174/1 174/1 174/2 176/5 learnt [2] 34/12 74/5 least [8] 28/13 40/20 51/20 54/22 173/12 178/21 183/15 188/20 leave [7] 141/14 141/23 176/22 223/19 228/9 231/22 231/25 leaving [1] 221/16 led [7] 8/17 19/9 44/19 117/15 117/21 149/8 184/10 Leeds [1] 19/6 left [10] 129/9 141/23 175/1 177/22 177/25 178/4 187/11 200/12 220/16 221/18 legal [4] 62/19 118/23 118/25 204/13 legitimacy [1] 167/2 length [3] 42/16 64/13 71/14 lengthier [1] 74/16 lens [1] 21/20 lenses [1] 55/1 less [6] 35/8 191/20 191/20 194/13 197/17 203/11 lessons [1] 132/14 let [3] 57/5 117/21 227/10 let's [5] 17/12 118/25 128/18 212/15 224/7 Letby [32] 40/16 56/7 56/9 91/23 92/4 93/20 94/4 94/5 96/4 96/11 96/14 96/15 96/20 97/4 97/16 98/13 98/21 98/22 99/13 100/9 102/5 102/8 104/15 119/1 213/9 217/24 231/12 231/15 231/20 233/3 234/19 238/11 letter [9] 101/7 103/9 103/18 104/8 106/16 106/16 117/19 118/15 238/3 level [58] 8/6 41/16 44/18 107/24 127/8 132/16 132/16 132/16 132/17 132/18 141/13 144/4 150/11 154/11 154/12 162/15 162/21 162/23 163/15 164/2 165/3 171/18 171/24 172/6 172/11 172/14 172/15 173/12 176/7	184/24 189/24 193/2 193/2 193/3 194/20 194/20 194/21 195/9 201/9 201/9 201/10 201/24 201/25 202/4 202/6 202/6 202/12 202/12 202/19 203/5 203/10 209/13 211/25 212/14 213/15 214/19 215/5 216/5 Level 2 [1] 194/20 Level 3 [6] 171/24 172/6 172/11 194/20 201/10 203/5 levels [1] 237/7 lever [1] 151/10 liaise [1] 49/21 liaising [2] 29/17 29/18 life [5] 16/16 141/7 154/25 155/8 202/3 lifetime [1] 36/11 lifetime's [1] 16/9 light [8] 18/17 46/5 50/2 83/13 90/8 100/8 107/3 170/4 like [50] 17/5 17/6 17/12 22/4 24/16 24/18 24/19 28/25 32/23 37/24 42/23 46/1 47/20 59/12 61/25 63/24 69/22 71/24 73/21 73/22 91/17 104/5 109/19 110/5 114/22 127/24 131/25 132/5 146/21 152/11 153/23 159/12 176/14 180/14 182/7 182/18 188/14 190/19 191/21 196/17 202/11 203/19 207/11 218/2 222/24 224/5 227/21 237/8 237/8 237/18 likely [9] 45/9 90/23 93/13 97/25 135/13 139/19 139/25 152/3 152/4 limited [1] 137/21 limits [1] 62/25 line [21] 25/15 25/20 32/9 32/16 33/11 41/24 63/14 85/13 124/25 127/10 131/24 132/5 132/7 133/11 160/18 160/21 209/12 214/24 215/1 234/16 236/14 lines [9] 20/16 87/9 130/22 136/7 139/21 140/8 162/15 164/12 165/3 link [8] 10/7 206/17 206/18 207/1 207/2 212/5 214/12 224/9	linked [6] 7/24 8/12 49/12 154/7 157/9 194/15 links [3] 77/7 143/25 153/6 list [6] 18/22 81/20 96/12 138/18 139/3 212/16 listed [4] 54/7 82/1 83/13 96/5 listen [3] 32/20 33/1 119/2 listened [1] 116/6 listening [1] 196/16 lists [1] 28/10 literally [4] 35/20 157/9 190/4 192/22 little [13] 7/6 11/4 35/6 36/14 48/23 58/15 65/7 117/9 177/9 192/4 193/16 213/20 239/3 live [3] 17/22 27/6 155/1 lived [1] 43/10 Liverpool [1] 180/18 lives [1] 121/18 loaded [1] 68/9 local [36] 7/7 7/10 9/21 10/2 10/2 99/15 137/24 152/1 156/3 171/11 171/15 172/5 172/9 173/9 194/21 197/20 207/12 221/4 221/10 221/14 221/25 221/25 222/2 222/4 222/5 222/9 223/5 223/16 223/16 223/23 228/10 232/6 232/21 232/23 233/17 237/9 localities [1] 53/18 locality [1] 195/4 locally [14] 24/20 35/5 35/12 52/4 190/1 207/20 215/19 215/22 221/7 221/21 225/14 228/17 229/6 233/25 located [2] 193/5 193/7 location [2] 20/13 233/22 locked [1] 193/17 logical [3] 17/7 34/24 39/25 London [2] 122/24 201/18 long [6] 7/25 16/16 40/17 97/24 130/19 238/19 longer [3] 16/22 205/13 237/25 look [60] 3/17 18/22 21/21 21/22 29/4 42/18 46/4 51/1 61/17	63/13 73/4 76/7 76/8 76/10 77/25 78/8 80/18 81/19 86/21 88/9 98/2 101/6 104/3 104/8 104/8 110/23 110/24 114/22 115/1 116/8 117/25 118/3 127/24 128/14 129/3 130/17 132/13 133/16 136/10 142/3 144/12 145/20 146/1 146/8 153/19 158/16 162/14 168/6 184/11 186/16 187/10 192/5 200/21 202/7 204/13 218/25 220/7 222/25 237/9 238/23 looked [14] 16/5 42/17 83/19 89/15 99/4 99/6 106/24 106/25 111/20 147/7 187/25 201/6 224/13 233/13 looking [28] 8/15 16/1 21/20 42/6 55/1 70/9 79/18 80/19 83/12 85/9 87/16 92/16 97/10 106/16 110/15 114/4 138/13 143/2 154/20 159/4 172/5 184/19 191/11 193/2 218/2 229/15 236/4 236/20 looks [5] 97/23 154/19 154/24 159/12 234/21 lose [1] 221/20 loss [1] 29/9 lost [5] 29/2 31/7 72/4 121/15 121/18 lot [25] 50/15 64/7 66/13 154/22 156/20 174/14 178/3 183/11 187/4 190/15 194/25 200/23 202/17 202/23 212/9 221/24 223/21 227/25 232/21 236/11 236/12 237/4 237/5 237/14 237/15 lots [4] 4/1 35/11 51/13 185/2 loved [1] 109/22 low [6] 44/25 137/16 147/3 200/8 201/14 209/13 low-level [1] 209/13 lower [2] 203/5 203/9 Lucy [15] 56/7 56/9 96/14 96/15 96/20 100/9 119/1 213/9 217/24 231/12 231/15 231/20 233/3 234/19 238/11 Lucy Letby [15] 56/7
----------	---	--	---	---

L	126/5 131/23 137/13 140/17 141/8 170/15 203/22	material [1] 69/5 materials [1] 26/16 maternity [23] 133/11 141/14 141/22 143/25 143/25 144/1 144/14 149/7 152/15 152/19 153/1 153/4 154/1 155/19 159/9 161/10 161/25 162/2 162/5 168/2 193/6 194/16 235/22	maybe [7] 10/15 24/6 120/3 150/16 184/13 203/13 218/3 MBRRACE [3] 155/12 155/18 156/5 McLaughlan [3] 92/2 97/17 98/20 me [32] 5/5 5/20 12/1 23/1 39/21 39/23 45/19 53/8 55/17 63/25 68/7 68/14 69/5 71/21 82/8 98/6 118/11 120/16 143/24 147/24 159/2 160/9 168/10 183/7 184/4 186/11 215/6 218/16 219/17 227/10 232/15 236/19 mean [38] 5/16 9/3 32/21 36/11 46/8 58/2 59/2 64/8 79/17 131/22 134/14 140/22 141/8 142/16 146/1 151/20 152/17 159/16 159/18 167/21 175/3 175/12 185/17 188/8 191/10 196/4 209/11 211/20 212/10 218/13 219/5 219/23 220/25 221/7 226/2 232/19 232/23 237/2 meaning [2] 4/10 15/6 meaningfully [1] 129/7 means [9] 35/6 54/20 62/14 92/13 162/3 168/18 191/6 193/10 200/13 meant [5] 4/4 7/2 191/8 211/21 211/23 measure [1] 142/13 measurements [1] 19/1 measures [8] 26/21 130/24 142/11 143/9 145/24 148/14 150/6 160/14 measuring [1] 145/6 mechanism [3] 5/17 10/21 165/8 mechanisms [5] 44/1 124/11 160/8 162/17 188/3 medical [241] 1/22 1/24 2/2 2/4 2/7 2/9 2/14 2/19 3/1 3/3 3/22 4/19 4/25 5/5 5/8 5/13 5/20 5/23 6/1 6/6 7/6 9/10 9/16 10/16 10/18 10/20 10/22 11/6 11/9 11/13 11/14 11/15 11/22 11/25 12/5 12/10 12/14 12/22	12/23 13/20 13/24 13/25 14/2 14/21 14/23 15/2 15/4 15/6 15/7 15/20 15/21 15/24 16/9 16/17 16/24 17/18 17/24 18/12 19/4 19/11 19/21 20/9 20/11 20/22 21/11 21/21 22/3 22/6 22/19 22/22 23/5 23/11 23/23 24/1 24/3 24/5 24/15 25/7 25/12 25/21 26/18 26/22 27/16 28/1 28/20 28/21 29/23 29/24 29/24 30/4 30/5 30/8 30/9 30/10 30/10 30/20 31/9 31/14 31/23 32/8 32/14 32/19 32/25 33/12 33/15 33/15 33/23 34/1 34/6 34/21 35/1 35/2 35/17 35/18 35/21 36/16 37/1 37/5 37/21 37/22 38/6 38/13 38/13 39/1 39/4 39/15 40/8 40/14 41/2 41/17 42/24 43/12 43/14 43/18 43/19 43/21 44/10 44/21 45/7 45/10 45/19 46/13 48/3 48/11 48/13 48/16 48/21 48/22 49/3 49/19 50/6 50/13 50/23 51/8 51/17 52/4 52/14 52/18 53/12 53/19 53/21 54/1 54/4 54/6 54/11 55/5 55/10 55/12 55/16 55/23 56/8 58/17 59/9 59/14 59/18 59/20 60/2 61/8 61/15 62/5 62/12 62/21 62/22 62/24 63/2 63/4 63/9 64/7 64/12 64/20 65/10 65/21 65/23 67/5 68/5 69/7 69/13 69/15 69/21 70/2 70/4 70/18 70/21 71/10 72/8 75/10 75/12 86/4 108/23 109/4 109/22 114/16 125/9 140/2 169/21 174/18 176/15 177/23 178/11 178/20 179/25 183/1 183/5 183/14 183/15 183/16 183/19 183/22 184/2 184/16 184/22 185/2 185/4 185/7 185/23 185/23 186/20 188/3 188/9 188/12 191/10 medically [1] 186/24 medication [2]
M	macro [2] 132/15 154/12 made [52] 4/21 11/4 12/22 16/4 38/16 65/13 65/16 69/17 70/12 70/13 74/6 80/15 85/25 96/11 100/9 101/13 105/21 107/13 109/24 109/25 112/8 119/9 121/21 133/15 133/23 134/5 134/10 138/17 138/24 143/8 153/5 157/21 160/19 166/23 167/8 191/4 193/20 194/17 205/23 209/3 209/25 210/7 210/17 210/18 218/12 218/14 218/15 219/22 222/3 227/5 235/19 238/17 main [3] 2/5 78/1 112/20 mainly [2] 136/25 195/1 maintains [1] 81/7 major [4] 131/7 133/6 197/3 197/23 majority [4] 15/5 75/22 106/14 198/9 make [47] 15/2 23/7 30/6 36/3 37/10 38/17 38/17 39/10 41/3 53/8 55/3 63/4 65/20 67/16 69/14 73/21 73/22 113/6 113/10 123/13 124/10 133/22 135/12 136/14 137/2 138/15 143/20 153/2 153/3 162/16 165/1 167/20 170/18 176/2 181/23 198/4 199/14 207/18 207/19 208/13 210/1 211/4 216/7 219/18 221/3 226/10 238/25 make contact [1] 15/2 makes [7] 46/19 48/3 48/19 59/25 112/13 172/21 209/8 making [11] 29/11 29/23 29/25 72/14	managed [1] 162/20 management [16] 39/18 124/3 124/8 124/13 125/24 127/21 130/5 140/11 140/14 140/20 142/9 142/12 142/20 165/22 176/15 206/10 manager [6] 10/2 78/10 88/4 91/7 91/17 206/15 managers [10] 77/6 124/5 169/2 169/5 169/22 170/2 170/9 170/14 203/18 217/18 managing [2] 146/12 163/3 Manchester [4] 145/10 145/13 145/16 158/13 Mancini [3] 91/22 97/18 98/20 Mancini's [1] 91/20 mandate [9] 48/12 50/11 50/12 127/20 127/23 128/3 129/22 130/1 144/22 mandated [1] 172/1 mandatory [6] 26/25 27/3 27/16 49/11 54/7 76/4 manner [2] 67/19 164/25 manually [1] 151/4 many [21] 25/10 48/22 57/1 60/19 60/19 63/18 126/16 126/16 141/13 142/6 150/20 151/5 151/20 152/14 156/12 162/5 163/9 178/17 191/16 194/8 201/11 mapping [1] 166/7 March [4] 1/11 1/21 121/22 123/7 marked [1] 142/19 marks [2] 104/5 210/25 Martha [1] 196/4 Martha's [6] 195/24 196/3 196/7 196/11 196/20 197/4 Martha's Rule [5] 195/24 196/3 196/7 196/11 196/20 Masters [1] 206/9	maternal [1] 69/5 maternal [1] 26/16 maternity [23] 133/11 141/14 141/22 143/25 143/25 144/1 144/14 149/7 152/15 152/19 153/1 153/4 154/1 155/19 159/9 161/10 161/25 162/2 162/5 168/2 193/6 194/16 235/22 maternity-focused [1] 152/19 MatNeoSIP [1] 159/6 matrix [2] 111/1 136/6 matter [18] 4/22 6/14 18/20 22/10 25/9 27/22 38/6 44/17 45/16 46/9 57/14 63/1 68/1 68/3 69/6 70/17 180/11 180/11 matters [11] 7/19 18/22 19/15 32/23 38/25 39/2 48/7 141/21 199/2 222/7 236/20 mature [5] 42/25 147/1 147/21 147/25 153/23 maturer [1] 153/13 maturing [2] 23/13 63/8 maximum [1] 141/21 may [93] 3/19 7/4 7/21 7/25 8/10 8/23 9/25 10/19 11/3 16/19 19/22 22/6 22/18 24/5 24/6 26/19 27/21 31/20 32/3 33/6 35/5 36/9 38/20 39/8 43/21 44/21 45/5 46/12 48/23 48/25 49/3 50/18 56/8 56/19 56/22 57/19 58/15 59/4 59/7 59/13 59/19 60/6 61/9 61/23 62/23 65/8 65/15 68/22 70/13 70/18 70/18 71/15 77/3 78/4 81/3 81/8 81/13 85/5 85/18 89/23 115/23 122/8 123/7 131/12 134/13 138/4 141/3 147/12 157/24 157/24 164/7 168/12 177/9 177/14 177/18 179/5 179/7 180/21 181/1 181/8 181/10 187/10 188/16 188/25 200/19 206/20 212/23 213/4 213/23 214/3 224/7 228/22 230/4 May 2021 [1] 123/7	

M	method [1] 43/15	misconduct [1] 81/24	194/5 194/8 194/16	Mr Carr [7] 73/9
medication... [2] 147/11 147/13	metrics [6] 144/21	misguided [1] 53/3	194/23 195/23 201/24	119/21 119/25 120/9
medicine [14] 1/18	145/2 145/7 148/18	misled [2] 105/3	203/12 203/12 203/13	121/6 192/18 241/10
1/19 1/19 4/21 19/24	149/2 155/9	105/21	212/9 221/2 221/9	Mr Newman [7]
41/9 43/6 49/22 60/17	MHPS [1] 81/5	misplaced [1] 222/1	223/22 234/17 235/4	205/7 205/8 205/12
65/17 68/4 158/9	Michael [1] 205/22	missed [6] 61/20	235/7 235/21 236/11	205/23 206/6 239/21
158/21 195/6	micro [3] 132/16	83/9 90/16 134/1	236/12 237/1 237/1	239/24
medicines [3] 61/21	132/18 154/11	151/9 228/19	237/4 237/5 237/9	Mr Okunnu [5] 75/1
140/2 147/16	Mid [2] 133/9 207/3	140/25	237/14 237/15	87/8 87/19 107/13
meet [9] 113/8	Mid Staffs [1] 207/3	misses [2] 128/16	Morecambe [3]	108/2
135/17 143/10 178/21	middle [3] 29/12	140/25	25/23 59/8 133/11	Mr Okunnu's [4]
195/6 207/13 209/14	88/10 166/19	missing [1] 117/5	Morecambe Bay [2]	80/15 95/2 96/18
219/2 222/25	Midlands [1] 238/7	mistakes [1] 74/5	59/8 133/11	99/24
meeting [15] 13/3	midnight [1] 151/3	mitigate [1] 85/16	morning [4] 1/6	Mr Shortland [1]
13/11 77/5 89/20	midwife [2] 161/9	Mm [2] 82/7 98/18	29/14 178/9 183/21	103/10
117/22 118/1 147/7	208/4	Mm-hm [2] 82/7	mortality [18] 7/7	Mr Skelton [10] 47/2
210/5 216/10 229/20	midwifery [6] 161/3	98/18	88/1 88/15 88/21	47/3 65/6 177/5 177/6
230/16 234/10 234/15	161/5 161/6 222/20	Mmm [2] 82/2 87/15	88/23 108/23 149/11	192/12 192/18 199/3
235/20 238/4	230/10 230/12	mode [1] 148/21	150/7 154/16 154/20	241/5 241/11
meetings [4] 11/16	midwives [1] 235/24	models [2] 169/20	155/5 156/5 211/1	Mr Stewart [1] 92/2
12/20 108/23 229/25	might [61] 6/6 20/21	197/11	211/5 211/11 211/11	MR TONY [2] 205/10
member [13] 8/24	33/10 45/9 47/11	modern [1] 64/9	219/7 234/24	241/14
15/3 15/11 45/23 59/6	55/16 55/19 66/10	Modi [3] 115/6	most [17] 8/18 14/6	MRCPCH [1] 76/3
91/10 141/14 144/4	66/11 66/22 69/13	116/10 120/22	16/19 29/18 36/5 45/9	MS [16] 1/4 1/7 26/8
163/6 165/3 189/17	71/2 81/17 83/23	modified [1] 115/11	46/3 105/13 116/20	53/18 56/4 58/16 92/2
196/12 196/13	88/14 94/17 99/9	module [2] 50/3 50/9	172/7 176/13 176/23	94/14 102/6 102/11
members [38] 9/4	105/18 105/19 107/5	modules [2] 69/21	176/24 183/4 216/6	109/24 192/13 192/14
10/7 15/16 39/12	107/6 107/6 110/8	69/21	221/10 226/8	198/23 241/4 241/12
41/10 41/13 58/10	110/9 111/17 112/16	moment [9] 14/25	mother [6] 28/23	MS BROWN [7] 1/4
62/9 68/6 74/2 75/17	112/17 112/19 115/19	25/1 46/18 132/1	162/6 162/12 202/8	1/7 26/8 53/18 56/4
75/19 91/13 92/3	118/24 128/22 129/3	132/4 146/1 170/6	202/10 202/11	58/16 241/4
97/20 112/15 114/19	129/18 130/23 131/3	182/25 215/17	mother's [1] 154/9	Ms Eardley [3] 94/14
114/21 114/23 115/17	135/2 141/14 148/8	moments [2] 122/11	mothers [2] 153/15	102/6 109/24
116/3 119/2 119/3	158/3 159/25 160/3	135/11	154/6	Ms Eardley's [1]
119/5 120/13 123/14	170/18 177/11 180/24	money [3] 141/18	motivations [1]	102/11
133/13 134/17 140/10	180/24 183/14 184/10	142/14 142/18	227/12	Ms McLaughlan [1]
140/20 142/17 144/5	184/10 184/12 187/6	monitor [2] 133/25	move [10] 28/17	92/2
162/16 169/14 171/20	188/8 188/24 199/5	134/11	86/19 86/20 144/25	Ms Scolding [4]
189/6 192/10 227/25	200/14 200/15 202/20	monitoring [1] 35/9	148/5 148/7 151/22	192/13 192/14 198/23
membership [5]	203/19 204/6 204/14	month [4] 203/3	151/22 157/14 178/1	241/12
75/16 114/18 117/14	227/22 238/19	203/13 214/25 230/19	moved [3] 48/7 94/5	much [31] 1/5 28/20
142/12 189/9	mileage [1] 184/20	monthly [1] 147/7	238/6	46/24 55/13 72/19
Memorial [1] 25/24	Milligan [5] 89/22	months [13] 47/8	moving [5] 19/25	72/20 74/15 91/4
mental [1] 81/24	91/20 91/21 95/8	52/23 58/4 64/4 66/19	19/25 38/22 114/13	97/21 113/15 119/20
mention [2] 159/18	120/17	67/7 67/9 98/10	171/3	119/21 119/24 126/7
219/12	million [3] 4/5 21/17	141/17 141/23 149/25	Mr [46] 47/2 47/3	126/22 146/19 152/18
mentioned [10]	35/8	150/13 235/20	65/6 73/9 73/10 75/1	152/18 155/6 155/7
17/17 147/2 153/12	mind [13] 17/9 26/4	Morbidity [1] 108/23	80/15 87/8 87/19 92/2	156/1 156/6 159/23
181/6 186/4 194/24	28/12 52/24 53/17	more [74] 12/17	95/2 96/18 99/24	162/6 198/22 203/5
202/17 217/16 228/9	60/13 61/4 85/8	23/19 28/12 42/7 50/1	103/10 107/13 108/2	204/23 237/9 239/24
229/7	116/15 124/16 192/22	55/13 59/5 59/6 68/12	119/21 119/25 120/9	240/10 240/13
meso [2] 132/16	193/18 214/21	78/14 81/14 87/12	121/6 177/5 177/6	multi [4] 39/13 55/13
132/17	mindful [2] 19/5	97/22 106/21 113/19	192/12 192/18 192/18	180/13 235/23
meso level [1]	39/21	114/12 115/25 116/5	199/3 205/5 205/7	multi-factoral [1]
132/17	mindset [1] 142/16	116/6 116/16 118/12	205/8 205/10 205/11	55/13
message [5] 27/10	mine [1] 97/14	125/25 127/7 128/2	205/12 205/18 205/19	multiple [1] 60/17
34/4 97/15 97/15	minimum [1] 98/5	131/4 134/22 134/25	205/23 206/6 239/21	mum [1] 41/14
162/13	minor [1] 210/18	136/1 140/1 140/13	239/24 240/2 241/5	murder [1] 101/22
messages [2] 97/3	minute [2] 3/20 26/1	140/23 146/19 149/14	241/8 241/10 241/11	murders [2] 25/22
98/16	120/3	152/18 152/25 155/4	241/14 241/15 241/16	40/11
met [4] 45/23 195/4	mirror [1] 2/22	155/6 155/7 156/1	Mr Bershadski [7]	must [15] 4/17 4/18
200/11 220/13	misbehaviour [1]	156/6 160/19 162/1	205/5 205/11 205/18	6/19 11/16 20/10
	83/8	170/22 177/9 184/11	205/19 240/2 241/15	27/16 32/20 48/13
		191/11 191/11 194/4	241/16	50/12 51/21 55/7

M	149/7 149/16 151/22 152/15 156/4 161/1 161/6 161/9 161/10 161/19 161/22 164/22 165/10 181/21 185/22 191/5 nationally [2] 13/20 148/25 natural [6] 16/15 16/15 57/14 72/6 112/18 233/18 nature [9] 80/3 80/11 101/14 108/3 202/10 232/3 234/18 237/3 238/23 navigate [1] 167/13 navigating [1] 72/24 NCAS [3] 81/5 81/8 81/13 near [2] 128/16 140/25 nearly [5] 152/18 212/22 213/12 219/6 220/9 necessarily [9] 5/16 7/24 10/16 37/18 45/4 61/10 159/22 164/4 189/3 necessary [16] 3/15 5/3 5/4 6/6 10/10 10/11 12/11 16/8 24/21 28/12 31/1 31/17 57/22 88/20 119/12 158/10 NED [1] 144/13 need [65] 3/17 6/24 17/10 30/15 37/8 39/15 39/25 45/9 46/4 50/6 51/5 52/14 52/24 54/13 55/3 55/18 56/25 59/5 60/5 64/4 66/2 84/23 85/7 85/8 87/22 89/1 89/5 89/10 96/21 98/2 98/8 111/17 115/18 125/13 141/2 141/2 141/3 145/20 146/10 147/22 153/18 156/10 159/25 163/15 180/10 181/13 182/7 183/22 185/8 185/10 186/1 188/6 188/9 190/12 190/19 191/22 191/23 194/1 195/2 202/7 222/21 223/24 226/19 228/3 233/11 needed [3] 90/17 189/4 208/7 needs [27] 3/14 28/5 29/11 39/5 51/8 55/16 60/7 69/14 101/13 125/14 136/1 139/23 143/11 152/7 152/8 152/12 162/10 164/5	180/15 182/2 185/25 188/23 191/9 193/21 207/12 208/10 222/24 Neena [1] 120/22 negligence [3] 213/18 217/25 226/7 negligent [1] 8/23 neither [3] 9/18 63/6 120/19 neonatal [86] 5/7 8/4 16/1 16/3 16/19 18/13 19/18 19/20 23/3 23/15 23/18 23/25 24/6 28/23 29/3 34/18 36/12 38/8 40/3 44/9 44/16 49/25 54/22 65/10 70/19 80/5 88/12 122/20 139/14 142/2 143/11 143/17 143/21 143/22 144/2 144/7 144/9 144/14 144/24 147/10 149/4 149/17 149/19 149/23 150/3 150/4 152/17 153/1 153/23 154/1 155/2 158/24 159/9 161/1 161/12 161/24 163/23 168/2 174/12 174/20 175/5 175/23 178/25 179/3 179/8 179/20 180/3 180/25 181/2 183/15 183/22 184/5 192/2 192/19 192/21 193/1 193/5 193/12 194/9 194/21 195/20 196/9 196/10 196/24 211/2 234/22 neonate [7] 19/3 24/17 27/21 48/15 60/22 70/14 186/6 neonates [13] 7/14 35/3 35/8 46/17 48/10 52/11 61/9 63/11 64/18 77/4 153/5 181/12 181/25 neonatologist [15] 20/15 22/11 55/25 62/23 65/21 72/5 120/18 121/13 121/14 154/7 175/17 178/24 180/17 183/7 185/10 neonatologists [4] 49/20 50/5 174/21 174/24 neonatology [6] 6/1 21/10 122/17 174/13 177/13 183/4 net [2] 42/20 48/22 nets [1] 44/4 network [1] 23/25 networks [3] 194/10 194/18 194/22 neuro [1] 22/8 neurology [1] 185/3	never [13] 8/15 41/8 41/8 41/9 90/11 90/13 192/2 194/5 213/16 214/6 218/16 218/23 219/11 nevertheless [3] 8/1 37/22 190/11 new [9] 34/15 36/15 49/9 112/17 169/20 176/4 232/20 234/24 240/13 New Year [1] 240/13 newborn [7] 152/21 162/2 183/18 184/6 191/11 192/6 197/5 Newman [10] 205/7 205/8 205/10 205/12 205/22 205/23 206/6 239/21 239/24 241/14 next [16] 11/19 20/1 30/17 57/22 64/2 98/4 115/5 115/18 117/7 120/10 131/2 131/5 132/13 138/8 234/9 240/6 NHS [27] 1/20 5/15 27/20 124/17 125/6 127/2 127/2 128/5 133/10 136/23 137/14 143/23 150/20 152/11 162/23 166/7 166/14 167/9 169/5 170/2 174/2 190/25 193/24 195/17 198/2 209/24 223/19 NHS England [7] 124/17 125/6 128/5 137/14 143/23 193/24 198/2 NHS England's [1] 136/23 nice [1] 97/21 nicest [3] 46/3 46/20 48/9 night [4] 29/13 94/6 94/7 151/3 NMC [19] 206/12 207/18 208/14 208/15 209/3 209/8 217/20 222/12 222/13 222/16 223/12 225/1 225/19 225/25 230/3 230/4 238/10 238/13 239/5 NMC's [2] 224/3 227/19 NMPA [5] 149/8 152/15 153/11 153/19 153/21 NNAP [10] 149/5 149/16 149/21 151/5 151/8 151/9 152/3 154/17 154/19 155/2 no [73] 4/10 4/18 12/7 12/16 14/17	15/16 26/13 28/6 30/15 36/3 37/24 52/18 62/9 65/3 69/3 72/13 80/1 85/3 95/21 96/10 99/15 100/1 102/15 104/18 107/15 119/18 119/18 127/19 151/14 164/22 178/10 179/17 180/11 180/11 195/3 195/15 195/16 195/21 197/18 198/20 200/18 204/22 209/2 211/12 211/12 212/18 212/24 213/24 214/10 218/12 218/15 219/24 219/25 222/6 222/8 222/8 227/14 228/21 228/21 232/1 232/15 232/16 233/23 234/4 234/21 235/3 235/25 236/2 237/4 237/19 237/25 239/22 239/23 no one [2] 26/13 239/22 nobody [2] 54/17 196/16 Nods [9] 70/24 93/12 94/2 164/21 167/5 199/20 203/24 215/23 222/14 non [10] 2/13 4/3 88/4 144/6 144/13 163/5 169/14 174/23 231/12 233/4 non-clinical [2] 231/12 233/4 Non-Exec [2] 144/6 144/13 Non-Executive [2] 163/5 169/14 non-statutory [2] 2/13 4/3 none [2] 10/13 195/11 nor [2] 9/19 63/6 normal [3] 179/20 211/10 211/23 normally [2] 27/22 33/14 Norris [1] 19/6 Northern [4] 2/20 2/24 169/6 194/12 Northern Ireland [3] 2/24 169/6 194/12 not [231] 2/17 2/20 2/23 3/8 5/8 5/10 5/16 6/3 6/4 6/14 6/16 6/18 7/24 7/25 8/11 8/11 9/17 10/25 12/15 13/15 14/14 14/17 14/18 14/22 15/13 16/7 18/8 22/5 22/6 22/23 23/18 24/11 25/11 26/12 28/14
N	naive [3] 22/24 45/7 58/3 name [9] 1/8 1/9 73/12 121/8 121/9 138/11 205/20 210/2 224/18 named [7] 144/7 144/14 163/4 163/6 163/7 165/3 172/12 names [1] 128/18 narrative [1] 130/20 nasty [1] 179/22 national [35] 1/21 1/24 2/2 2/4 2/7 2/8 5/5 5/20 67/4 127/20 128/3 129/22 135/7 137/4 137/7 137/23 143/15 149/3 149/4			

<p>N not... [196] 29/19 30/12 31/8 31/23 31/23 32/2 32/2 32/4 32/19 32/19 34/11 37/5 38/10 38/20 42/20 44/21 45/5 45/19 48/4 48/10 48/23 50/7 51/3 52/14 52/16 52/16 52/16 52/20 52/21 54/7 54/18 55/17 57/16 57/21 57/24 58/13 60/3 60/8 60/11 60/11 61/9 62/4 63/15 69/12 70/18 70/18 77/15 77/17 79/4 79/5 79/5 80/2 81/21 82/10 83/23 84/12 84/20 84/21 86/1 86/2 89/23 90/4 91/12 91/25 94/21 95/3 95/3 95/20 96/4 96/5 96/10 96/15 96/24 96/25 100/5 100/6 100/18 100/23 102/23 103/1 103/2 103/5 103/19 106/6 106/20 107/23 110/5 110/6 110/8 112/8 112/13 112/17 113/10 115/11 116/13 116/18 116/20 118/11 118/20 122/7 124/13 126/7 136/21 137/5 137/7 137/22 137/24 138/20 141/5 141/17 142/9 142/19 143/4 143/14 150/18 152/11 152/22 153/4 153/9 155/10 156/9 157/18 157/19 163/20 166/17 166/21 167/10 167/11 167/22 170/14 170/19 171/10 171/16 171/16 172/6 172/8 173/21 173/25 175/6 175/10 179/3 179/7 179/10 179/14 179/18 179/20 181/3 181/5 181/5 181/6 184/7 184/15 184/24 185/13 186/22 187/11 187/12 187/23 190/1 190/4 191/12 192/1 192/3 193/4 193/6 193/6 196/14 197/14 199/16 201/3 202/25 207/19 208/11 211/9 211/13 211/14 213/1 213/12 217/24 218/10 219/22 220/21 222/1 222/15 222/15 224/10 227/7 227/22 228/18 228/19 228/24 229/1</p>	<p>233/7 233/9 238/21 240/8 note [8] 15/21 95/7 118/1 210/10 210/22 234/15 235/5 235/19 notes [21] 9/11 15/24 16/3 16/3 16/5 18/16 20/1 89/18 89/22 93/18 93/25 94/13 95/22 99/10 99/22 133/4 151/23 154/6 154/9 226/4 227/7 nothing [7] 10/23 43/5 72/4 104/21 204/14 231/8 232/15 nothing's [1] 114/10 noticeable [2] 11/13 13/6 noticed [5] 12/5 13/4 13/10 26/15 128/24 notification [11] 22/20 33/10 37/2 38/15 39/8 39/20 40/5 42/3 44/24 108/17 177/22 notifications [1] 38/9 notified [13] 10/9 12/2 17/10 23/18 28/5 30/15 31/17 37/8 38/2 38/7 38/18 58/8 86/7 notify [2] 39/15 39/16 notifying [1] 44/25 noting [1] 136/13 notion [1] 226/9 notwithstanding [1] 102/21 November [5] 67/11 106/17 205/25 234/12 237/22 now [123] 4/7 4/17 5/10 8/25 36/21 39/21 48/17 59/13 63/16 63/18 64/4 66/6 66/19 72/22 73/4 78/16 79/20 80/3 80/17 82/15 83/18 86/14 86/19 88/17 89/14 90/8 91/3 91/5 92/6 93/13 93/17 95/12 98/15 99/3 101/6 102/6 102/18 103/16 103/23 105/17 106/1 106/16 106/23 107/11 108/16 108/18 109/2 109/24 110/16 112/3 112/12 112/23 116/18 116/20 117/7 118/22 119/23 120/5 121/2 121/21 127/23 130/19 131/14 134/8 135/18 136/5 140/19 144/25 145/9 146/21 149/13 151/6 151/9 153/8 156/19 160/24 161/4</p>	<p>166/16 167/6 167/17 167/25 168/2 170/14 171/4 172/23 173/25 176/4 177/23 178/8 183/4 188/24 191/5 194/11 203/17 203/25 204/25 205/18 210/14 210/22 212/9 213/1 218/2 228/6 229/7 231/18 232/2 232/5 233/3 234/6 234/9 234/11 235/21 235/25 236/6 236/7 236/12 236/24 237/1 237/18 237/20 238/10 239/25 240/6 nowhere [1] 99/10 number [30] 10/13 10/23 23/19 24/3 43/12 74/24 88/17 103/25 105/12 108/24 115/8 120/13 122/6 123/17 124/14 140/23 145/24 147/25 154/21 155/11 159/17 165/25 166/17 168/17 169/8 191/7 198/6 202/19 228/9 234/23 numbers [10] 11/6 34/22 34/23 40/21 193/21 193/22 202/17 203/5 211/12 211/22 numerous [2] 152/10 168/8 nurse [18] 10/2 14/16 19/6 30/1 33/17 35/16 139/14 141/4 142/22 191/23 192/5 197/1 208/4 208/15 218/10 220/2 221/15 233/25 nurse's [1] 228/2 nurses [9] 77/6 127/11 142/2 170/12 170/14 170/20 193/12 195/22 235/24 nursing [14] 11/25 141/25 192/1 192/3 194/6 195/14 195/19 208/4 209/24 210/4 222/19 230/8 230/10 236/18 nutrition [1] 122/20</p>	<p>observation [4] 16/25 51/10 60/9 138/14 observations [4] 18/24 21/25 80/15 156/16 observe [2] 53/1 127/19 observes [1] 137/12 observing [2] 132/2 158/3 obsessed [1] 193/13 obstetric [5] 16/3 17/17 17/22 18/3 152/20 Obstetricians [1] 149/9 obstetrics [4] 35/3 161/2 161/5 161/6 obtain [3] 24/22 185/9 222/24 obtained [7] 35/12 93/19 108/21 109/3 109/12 120/16 223/16 obtaining [2] 35/11 109/2 obvious [9] 13/11 52/3 57/9 57/21 96/3 165/5 179/13 182/14 214/2 obviously [33] 3/1 8/3 16/2 23/4 28/21 29/23 29/25 34/14 49/9 58/20 58/21 60/17 63/18 69/9 81/25 129/11 130/19 171/14 187/21 196/4 197/7 201/25 202/21 204/12 204/17 212/9 214/21 218/6 225/8 234/22 235/18 236/12 239/14 occasions [2] 32/12 235/14 occur [9] 10/19 17/1 22/1 31/18 35/5 49/4 79/4 79/5 175/18 occurred [11] 6/3 6/12 7/17 29/12 39/19 40/15 57/22 93/13 96/7 98/22 105/7 occurrence [1] 44/18 occurring [2] 43/13 85/1 occurs [3] 5/7 53/15 57/13 Ockenden [1] 194/15 October [2] 177/17 177/18 October 24 [1] 177/18 odd [2] 41/14 58/2 ODNs [1] 194/9 off [11] 72/22 98/6</p>	<p>98/21 98/23 99/1 141/22 155/25 177/5 206/5 218/18 234/11 offence [1] 238/12 offer [6] 30/23 31/13 42/2 176/10 189/12 207/9 offering [1] 29/18 office [17] 5/1 11/10 11/13 11/14 12/6 12/14 32/8 33/15 38/3 43/14 43/19 43/19 43/22 44/24 58/13 181/22 206/7 Officer [23] 11/9 12/23 13/24 15/2 15/4 15/7 20/9 29/24 30/9 30/11 34/7 36/17 45/7 69/8 69/14 69/15 70/3 74/18 99/16 171/11 171/16 172/5 172/9 Officer/Medical [1] 12/23 officers [19] 5/14 10/10 11/16 11/22 14/2 14/8 15/14 15/15 30/18 32/19 33/23 35/1 39/24 46/14 50/13 69/16 69/22 123/18 123/20 offices [1] 34/24 often [15] 7/13 34/2 125/10 127/8 159/23 162/4 162/8 163/12 180/1 191/3 191/4 193/10 193/16 233/15 235/22 oh [7] 10/22 19/13 22/15 23/7 181/17 202/5 217/12 okay [21] 21/18 21/19 22/15 30/19 37/24 44/13 46/13 53/9 59/21 72/9 83/12 139/8 195/13 195/17 195/23 198/6 205/16 216/4 217/9 227/18 234/3 Okunnu [6] 74/16 75/1 87/8 87/19 107/13 108/2 Okunnu's [4] 80/15 95/2 96/18 99/24 old [7] 46/21 46/22 46/22 46/22 185/21 194/1 197/2 older [2] 35/8 46/17 omitted [2] 103/16 103/18 omitting [1] 103/15 on [284] once [7] 24/7 28/12 36/11 78/3 89/8 126/17 208/25</p>
---	---	---	--	---

<p>O</p> <p>oncology [1] 22/8</p> <p>one [132] 1/11 4/6 4/21 4/24 5/1 5/22 6/6 12/9 15/20 16/9 17/3 17/6 17/17 18/7 18/9 18/20 20/4 23/5 24/6 26/13 27/10 31/23 33/16 34/13 35/17 36/10 38/19 41/4 41/8 41/8 43/8 43/13 43/21 45/23 46/5 47/5 49/20 49/23 50/8 50/18 52/25 57/22 57/23 59/21 62/20 64/6 65/25 69/6 69/10 70/8 71/1 71/4 75/25 80/15 82/12 84/10 87/24 87/25 94/22 95/14 96/5 96/21 97/4 99/18 100/25 102/22 103/14 103/15 107/13 108/2 109/24 110/18 110/22 111/13 111/14 111/20 112/17 114/12 117/3 118/9 125/14 129/18 130/4 131/1 135/9 141/22 142/3 143/23 143/24 144/1 145/16 148/8 148/18 148/23 152/24 153/10 154/8 155/20 156/24 167/8 174/25 176/5 177/8 178/13 178/21 183/2 184/7 184/22 185/1 186/14 192/1 192/1 192/3 192/3 192/18 192/19 193/2 195/14 195/14 195/23 202/16 203/13 207/8 208/12 211/19 212/21 213/7 213/8 215/3 217/20 219/5 239/22</p> <p>one's [2] 9/10 62/25</p> <p>ones [4] 35/8 67/20 109/23 127/6</p> <p>ongoing [6] 119/1 176/11 192/7 208/19 221/12 233/19</p> <p>online [2] 174/1 174/2</p> <p>only [17] 24/5 27/10 31/24 43/21 95/20 96/10 154/19 163/20 186/22 197/16 200/22 208/24 211/8 212/11 214/11 214/23 230/5</p> <p>onwards [1] 118/4</p> <p>open [13] 19/14 19/14 28/9 58/20 59/1 60/12 132/5 132/6 190/14 194/4 194/7 236/20 239/10</p> <p>opened [1] 60/13</p> <p>opening [2] 222/11 238/13</p> <p>openness [3] 43/2 132/11 196/1</p> <p>operate [2] 44/11 215/1</p> <p>operated [1] 149/5</p> <p>operates [1] 210/3</p> <p>operating [1] 44/10</p> <p>operation [1] 196/3</p> <p>Operational [1] 136/24</p> <p>operative [1] 13/7</p> <p>opinion [5] 31/1 196/14 196/15 227/11 239/8</p> <p>opportunities [10] 5/2 11/18 31/25 32/1 35/4 128/9 141/1 154/22 170/21 221/22</p> <p>opportunity [30] 10/10 23/23 24/21 29/18 29/19 30/23 30/24 31/5 31/7 31/10 34/6 42/2 47/6 47/9 54/14 62/17 80/10 83/10 90/16 92/10 132/7 141/15 141/16 148/2 148/4 151/9 151/10 187/20 196/12 197/13</p> <p>opposed [3] 9/2 21/3 146/24</p> <p>option [3] 100/19 100/21 119/15</p> <p>options [2] 83/21 207/16</p> <p>or [294]</p> <p>order [20] 59/5 82/18 83/16 84/17 88/19 150/3 151/4 181/14 189/4 193/25 208/19 216/16 222/20 226/20 238/10 238/11 238/15 238/19 238/25 239/2</p> <p>orders [1] 237/21</p> <p>organic [1] 13/5</p> <p>organically [1] 13/4</p> <p>organisation [17] 75/16 109/6 112/25 113/7 113/24 114/18 114/21 129/4 131/21 161/18 162/24 165/7 166/20 184/22 189/9 208/13 221/19</p> <p>organisation's [1] 113/12</p> <p>organisational [3] 133/6 159/8 194/10</p> <p>organisations [22] 125/2 125/18 126/12 126/20 127/1 127/2 128/17 128/23 130/25</p>	<p>132/18 135/12 147/1 155/11 166/1 166/1 166/13 166/24 167/4 169/8 176/14 182/18 189/22</p> <p>original [3] 82/18 83/15 83/22</p> <p>originally [1] 17/4</p> <p>origins [1] 40/7</p> <p>orthopaedic [1] 21/13</p> <p>orthopedics [1] 185/3</p> <p>ostensibly [1] 2/14</p> <p>other [56] 10/5 12/13 13/23 19/10 24/2 31/25 33/5 45/8 47/11 51/18 53/14 68/1 69/6 82/19 83/16 83/24 84/18 84/21 91/13 100/3 107/16 107/22 110/20 112/2 125/15 126/19 126/20 128/17 141/5 142/4 143/4 146/18 148/14 148/18 148/20 148/23 150/4 157/1 168/1 175/1 181/6 182/18 190/17 190/17 190/18 192/10 195/3 198/1 198/11 202/24 203/8 203/19 219/10 229/14 233/22 236/1</p> <p>others [13] 18/4 24/19 31/20 46/6 53/20 55/18 56/22 57/12 68/21 70/5 77/6 129/1 186/17</p> <p>otherwise [1] 181/15</p> <p>ought [9] 10/6 82/4 84/12 102/19 106/2 111/19 134/4 170/1 181/8</p> <p>our [45] 9/17 12/15 34/2 35/6 61/19 71/11 74/2 96/5 96/16 101/12 115/9 115/12 116/14 134/17 138/19 141/25 146/10 152/21 155/16 162/5 170/7 170/11 170/14 172/5 173/20 174/15 176/4 183/5 191/5 193/15 196/13 200/8 216/7 216/12 216/21 226/21 228/15 230/3 230/21 231/10 231/11 232/5 238/3 239/10 240/6</p> <p>out [62] 4/7 4/16 6/22 10/16 11/21 15/18 18/22 21/18 22/4 22/21 28/19 35/25 37/14 40/9 40/12 41/18 44/12 53/11</p>	<p>56/13 58/7 63/1 71/14 72/12 74/1 74/22 75/6 76/14 76/24 77/11 81/4 89/10 98/2 101/14 103/5 111/18 114/15 131/6 131/24 140/22 146/6 147/12 149/13 154/6 155/18 164/23 166/11 180/14 182/5 189/2 192/20 192/22 192/22 193/11 193/18 193/18 198/4 202/7 204/6 209/23 224/22 225/1 238/2</p> <p>outcome [6] 150/6 153/14 170/24 176/6 224/2 228/16</p> <p>outcomes [11] 5/18 137/5 138/15 138/16 139/5 150/10 152/21 155/8 157/3 173/23 207/23</p> <p>outlined [3] 118/4 131/3 208/24</p> <p>Outreach [2] 196/21 197/19</p> <p>outset [2] 79/14 90/9</p> <p>outside [4] 57/13 119/10 129/13 198/10</p> <p>outstanding [1] 44/16</p> <p>over [23] 4/4 20/18 41/23 52/7 52/8 63/11 75/16 97/24 115/18 116/14 121/14 122/12 123/2 138/6 138/22 149/20 151/24 153/9 197/20 197/21 199/6 202/20 214/20</p> <p>overall [2] 167/14 201/24</p> <p>overarching [1] 145/15</p> <p>overcrowded [1] 42/10</p> <p>overdue [1] 98/9</p> <p>overlap [1] 168/8</p> <p>overlapping [3] 55/1 124/22 125/10</p> <p>overlooked [1] 61/21</p> <p>overriding [3] 86/6 107/1 107/5</p> <p>overseeing [1] 124/12</p> <p>oversight [7] 13/20 68/6 107/22 108/13 124/21 161/22 198/15</p> <p>Overview [6] 42/11 155/13 155/16 156/15 156/18 181/22</p> <p>overwhelming [1] 18/23</p> <p>own [13] 6/14 27/1 164/1 168/13 182/21</p>	<p>184/1 184/22 189/25 191/23 198/11 215/2 225/7 227/12</p> <hr/> <p>P</p> <p>paediatric [23] 8/13 23/15 34/18 49/20 65/24 77/3 133/8 142/22 144/7 162/18 162/20 163/3 165/18 179/13 183/16 183/22 193/7 195/20 196/7 196/24 197/17 197/19 197/21</p> <p>paediatrician [17] 20/15 21/9 21/9 21/14 22/10 55/25 62/23 70/22 74/11 121/13 122/15 165/14 176/7 184/23 185/10 188/15 188/22</p> <p>paediatricians [35] 50/6 56/21 74/2 75/22 76/5 77/6 106/3 114/19 114/19 114/24 118/9 118/19 123/21 152/23 164/14 164/17 165/11 171/7 171/14 171/19 171/22 171/22 172/8 172/17 174/6 175/22 176/9 185/18 188/5 188/17 188/18 195/19 198/7 198/13 200/23</p> <p>paediatrics [14] 23/4 35/3 60/19 61/6 61/7 122/12 122/13 122/24 123/2 123/5 147/10 153/20 175/23 190/23</p> <p>page [67] 76/13 76/20 76/22 77/24 80/21 80/22 81/19 82/3 85/4 85/10 85/10 85/12 88/11 97/5 97/11 99/25 101/8 103/11 107/14 107/20 110/25 111/5 111/5 111/16 115/3 115/4 115/5 115/7 115/18 116/9 116/24 116/25 117/9 117/11 118/3 124/11 130/18 130/20 132/13 132/13 132/22 132/25 133/9 138/8 138/8 138/13 138/22 138/22 140/8 145/20 146/8 159/3 160/6 160/8 160/9 160/9 160/10 160/10 166/10 167/7 167/8 169/9 169/9 177/20 210/13 231/3 234/14</p> <p>page 1 [1] 231/3</p> <p>page 13 [2] 85/10</p>
--	--	--	--

P	paragraph 10 [1] 125/22	parent [5] 32/16 33/16 34/2 46/21 69/18	18/4	184/21 185/4 190/2 193/15 198/1 203/19 217/1 222/5 230/1 233/16
page 13... [1] 110/25	paragraph 105 [1] 44/6	parents [19] 8/18 9/12 18/1 31/19 33/20 33/24 34/4 34/4 35/7 35/19 36/12 40/25 46/10 109/17 115/20 121/17 150/9 192/6 200/10	past [6] 123/4 145/6 146/24 177/13 205/1 215/15	people's [2] 141/3 172/4
page 14 [1] 111/16	paragraph 11 [1] 127/19	parity [1] 162/12	patch [2] 152/9 152/13	peptide [1] 19/1
page 15 [1] 169/9	paragraph 12 [1] 135/11	part [52] 4/4 9/8 9/23 13/21 15/8 25/7 26/21 26/25 29/10 31/24 35/9 36/25 40/2 43/3 49/12 52/18 60/7 66/17 69/20 69/25 70/6 76/4 78/2 88/14 88/19 98/9 98/24 105/13 108/18 109/16 109/20 110/6 120/11 120/13 120/19 146/12 156/5 159/2 168/15 172/11 172/16 174/7 174/12 174/20 179/13 198/8 209/22 216/11 220/13 229/19 233/8 239/7	pathologist [1] 146/10	per [1] 43/22
page 2 [6] 101/8 116/24 118/3 138/22 145/20 159/3	paragraph 123 [1] 56/6	part C [1] 120/11	pathologist [4] 49/20 65/24 175/9 175/18	perceived [2] 34/13 192/24
page 26 [1] 130/20	paragraph 127.2 [1] 107/14	partial [1] 56/20	pathologists [7] 25/20 51/5 61/1 68/5 174/10 181/21 200/5	perfect [6] 60/1 114/10 168/5 182/8 183/13 202/8
page 27 [1] 132/13	paragraph 127.3 [1] 99/24	participating [1] 170/25	paths [1] 53/7	perfectly [3] 72/6 168/13 190/3
page 3 [5] 116/9 124/11 160/9 160/10 177/20	paragraph 128 [1] 107/20	particular [30] 9/14 13/9 23/4 45/22 56/6 88/18 117/2 118/5 122/19 122/22 129/20 133/7 134/8 136/18 140/6 156/16 166/5 175/16 184/21 187/14 196/10 197/6 197/7 199/3 210/4 213/10 219/20 226/12 226/14 239/5	pathway [1] 76/4	perform [1] 1/24
page 32 [1] 130/18	paragraph 15 [1] 140/8	particular [30] 9/14 13/9 23/4 45/22 56/6 88/18 117/2 118/5 122/19 122/22 129/20 133/7 134/8 136/18 140/6 156/16 166/5 175/16 184/21 187/14 196/10 197/6 197/7 199/3 210/4 213/10 219/20 226/12 226/14 239/5	pathways [2] 144/12 170/21	performance [4] 130/24 137/3 169/15 169/21
page 34 [1] 97/5	paragraph 17 [1] 139/20	Part C [1] 120/11	patient [52] 4/11 6/23 7/9 19/3 22/8 22/12 56/19 62/2 80/24 108/19 114/2 114/4 115/13 124/12 128/7 132/3 133/3 135/14 135/20 135/23 135/23 140/11 140/16 141/1 141/5 141/12 142/3 142/8 142/13 142/17 142/23 145/1 145/10 145/13 146/11 146/12 147/1 147/9 157/17 158/13 164/23 166/7 167/1 169/16 170/9 170/17 196/12 197/25 208/16 223/9 224/4 235/3	performed [1] 113/21
page 34/37 [1] 97/11	paragraph 18 [1] 137/11	partial [1] 56/20	patients [4] 7/8 7/18 17/2 154/9	performing [3] 150/15 150/16 175/14
page 4 [5] 76/20 115/3 117/9 146/8 210/13	paragraph 19 [1] 139/11	participating [1] 170/25	patients [13] 16/11 19/8 34/2 62/2 62/4 114/3 127/14 134/20 142/3 154/3 193/15 209/10 222/13	perhaps [7] 116/20 125/18 159/25 173/4 200/16 204/19 228/5
page 5 [2] 140/8 166/10	paragraph 2.1 [1] 132/22	participating [1] 170/25	patient's [4] 7/8 7/18 17/2 154/9	perinatal [13] 19/24 49/21 65/17 68/4 149/8 149/11 152/15 154/16 158/9 158/21 174/23 194/6 195/6
page 50 [2] 99/25 107/14	paragraph 2.2 [1] 76/22	particular [30] 9/14 13/9 23/4 45/22 56/6 88/18 117/2 118/5 122/19 122/22 129/20 133/7 134/8 136/18 140/6 156/16 166/5 175/16 184/21 187/14 196/10 197/6 197/7 199/3 210/4 213/10 219/20 226/12 226/14 239/5	period [11] 41/24 85/14 87/4 87/17 92/18 97/24 183/18 188/20 221/1 230/18 230/19	
page 51 [1] 107/20	paragraph 21 [1] 145/2	particularly [30] 50/25 56/6 60/22 67/1 79/13 87/24 88/3 100/18 106/10 115/9 121/14 132/6 135/5 135/6 139/13 141/4 141/10 141/25 142/9 144/6 153/18 156/21 162/9 163/17 169/16 171/6 181/25 193/11 197/5 198/14	permission [3] 86/3 106/22 109/12	
page 6 [2] 80/22 234/14	paragraph 24 [1] 149/11	partly [3] 13/5 29/10 157/23	permissions [1] 109/7	
page 7 [3] 80/21 85/4 132/22	paragraph 25 [1] 157/16	partners [1] 35/13	permits [1] 17/20	
page 8 [2] 81/19 167/7	paragraph 26 [2] 158/8 160/18	parts [1] 85/10	persistence [1] 41/25	
page 9 [2] 77/24 82/3	paragraph 3 [1] 2/5	party [1] 109/15	person [35] 3/6 3/7 6/9 7/23 15/12 16/16 17/22 20/11 29/6 29/10 29/25 30/7 32/3 32/22 36/3 42/21 46/21 50/21 131/11 143/19 161/24 164/2 164/5 165/12 175/14 188/13 213/7 213/8 219/9 221/8 221/14 222/17 226/5 227/4 230/6	
pages [2] 16/12 17/8	paragraph 30 [1] 164/16	pass [5] 5/3 6/5 6/16 9/17 73/23	person's [3] 17/6 17/21 32/20	
paid [1] 191/9	paragraph 53 [1] 87/8	passed [3] 5/19 7/20	person-centred [1] 131/11	
pair [2] 196/18 196/22	paragraph 53 [1] 87/8		personal [5] 14/11 58/23 73/23 225/8 239/8	
panel [5] 42/11 155/13 155/17 156/15 238/25	paragraph 7 [2] 2/25 123/12		personally [4] 33/3 41/24 71/7 189/1	
panels [2] 43/9 156/18	paragraph 8 [2] 77/25 123/16		personnel [1] 103/13	
paper [14] 64/9 130/3 130/9 131/17 135/13 135/19 136/2 151/23 166/6 166/12 166/16 166/23 167/7 167/24	Paragraph 85 [1] 95/2			
papers [1] 49/13	paragraph 88 [1] 96/17			
par [1] 163/21	paragraph 9 [2] 124/10 124/20			
paragraph [52] 2/5 2/25 44/6 56/6 76/22 77/25 82/3 82/5 82/15 85/6 85/11 85/12 85/24 87/8 95/2 96/17 99/24 103/11 106/17 106/19 107/14 107/20 111/22 115/7 115/24 117/1 118/4 123/12 123/16 124/10 124/20 125/22 127/19 130/20 132/22 133/9 135/11 137/11 138/23 139/11 139/20 140/8 145/2 149/11 157/16 158/8 159/3 160/7 160/10 160/18 164/16 207/15	paragraphs [6] 47/24 81/20 133/1 166/3 166/5 169/3			
paragraph [52] 2/5 2/25 44/6 56/6 76/22 77/25 82/3 82/5 82/15 85/6 85/11 85/12 85/24 87/8 95/2 96/17 99/24 103/11 106/17 106/19 107/14 107/20 111/22 115/7 115/24 117/1 118/4 123/12 123/16 124/10 124/20 125/22 127/19 130/20 132/22 133/9 135/11 137/11 138/23 139/11 139/20 140/8 145/2 149/11 157/16 158/8 159/3 160/7 160/10 160/18 164/16 207/15	paragraphs 34 [1] 169/3			
parallel [5] 7/21 10/8 155/14 178/12 178/16	parallel [5] 7/21 10/8 155/14 178/12 178/16			
parallels [1] 71/15	parallels [1] 71/15			
parameters [1] 154/21	parameters [1] 154/21			
paramount [2] 35/24 162/11	paramount [2] 35/24 162/11			
parapet [1] 59/20	parapet [1] 59/20			

P	182/22 200/19	239/13 239/17	226/8	preparation [1] 224/14
perspective [9] 4/18 5/11 22/21 41/23 87/10 87/23 119/3 178/23 186/9	played [2] 73/25 133/1	policies [2] 157/18 190/18	powers [4] 208/23 209/5 216/8 239/10	prepare [1] 98/8
perspectives [2] 42/19 55/3	playing [2] 41/15 98/24	policy [15] 5/12 30/3 61/14 80/16 80/18 85/3 86/14 110/22 110/24 112/1 112/10 112/22 118/12 139/2 190/8	practical [7] 5/6 7/2 63/6 68/24 119/5 127/8 153/8	prepared [5] 36/7 36/16 73/14 74/16 74/21
pertain [1] 17/22	plays [2] 71/14 175/21	political [1] 63/21	practically [1] 15/15	preparing [3] 19/16 123/17 123/23
phase [3] 2/14 4/3 64/4	please [40] 1/8 3/4 73/5 73/12 75/3 76/12 76/20 77/24 80/21 81/19 82/3 85/10 86/20 88/8 88/10 97/3 99/3 101/6 101/9 101/25 107/11 110/23 116/17 117/7 118/3 121/7 124/24 130/2 132/22 139/8 140/5 145/20 162/14 166/9 167/7 175/20 205/6 205/16 205/21 210/10	poor [1] 151/3	practice [36] 4/17 9/23 11/11 19/17 29/1 34/11 36/8 49/7 49/13 49/25 53/4 60/8 60/8 63/2 81/3 81/4 114/5 135/16 142/16 152/22 152/23 158/3 158/4 187/1 200/8 208/8 208/17 221/11 221/13 221/24 222/22 225/24 226/21 228/2 232/25 234/2	presence [1] 213/13
phone [7] 62/19 71/18 175/13 197/20 197/20 197/22 210/12	pleased [2] 41/25 42/1	population [3] 185/13 191/8 192/10	practices [2] 33/21 131/21	present [15] 145/8 146/23 148/16 150/9 165/17 212/21 212/23 213/9 213/23 219/5 220/9 221/22 229/23 229/25 230/2
physician [2] 61/17 69/12	plenty [2] 21/22 51/13	pose [1] 215/18	practise [6] 43/6 207/7 215/14 221/2 229/8 232/20	presented [1] 213/19
physicians [2] 1/17 69/12	pm [5] 120/6 120/8 205/2 205/4 240/14	poses [2] 208/15 219/14	practising [2] 208/22 222/18	presently [1] 181/23
physiological [1] 183/24	PMRT [7] 154/16 154/19 154/24 155/3 155/12 155/18 156/5	position [12] 1/23 31/8 62/9 96/13 102/23 109/2 167/18 170/1 170/3 206/16 206/23 220/20	practitioner [7] 20/10 30/22 38/16 45/2 45/4 55/24 71/10	presents [1] 219/7
physiology [1] 60/21	point [50] 3/21 4/11 11/4 19/9 22/22 26/24 26/25 30/22 35/17 35/19 48/2 48/3 48/19 55/22 56/4 62/17 64/18 70/12 72/3 85/25 87/1 87/3 88/10 119/9 124/10 126/5 131/23 135/12 136/14 137/2 137/20 146/23 153/2 153/4 157/21 162/16 166/23 167/17 169/19 212/16 212/18 212/20 213/21 218/25 221/18 223/4 232/22 234/8 234/18 235/13	positively [1] 100/12	practitioners [3] 33/23 58/6 75/13	president [8] 65/18 74/8 115/6 120/22 123/4 123/9 138/24 177/13
pick [3] 2/18 44/1 182/21	pointed [1] 59/5	positives [1] 42/18	pragmatic [1] 5/11	presidential [1] 21/4
picked [9] 26/12 43/15 43/18 56/9 104/3 126/22 187/23 201/5 210/6	points [14] 12/19 42/19 47/19 47/24 78/21 99/6 107/13 122/7 131/17 165/23 167/8 210/23 213/1 213/19	possibilities [1] 45/9	pre [8] 50/14 78/4 80/1 80/6 80/9 80/14 92/24 218/5	pressure [2] 136/15 141/8
pick [3] 2/18 44/1 182/21	pointless [1] 194/4	possibility [6] 25/4 25/9 45/6 72/8 200/18 224/1	pre-empted [1] 50/14	presumably [6] 68/8 69/8 143/11 180/14 203/9 231/24
picking [4] 62/19 71/17 104/17 126/14	points [14] 12/19 42/19 47/19 47/24 78/21 99/6 107/13 122/7 131/17 165/23 167/8 210/23 213/1 213/19	possibly [3] 170/21 188/17 221/2	pre-referral [1] 218/5	presume [2] 69/16 109/6
picks [1] 133/7	police [35] 10/11 12/15 36/22 36/24 38/23 38/25 39/3 39/6 39/8 39/16 40/6 51/21 99/13 99/21 100/3 100/13 100/17 100/23 101/1 115/19 116/18 117/15 182/18 218/20 218/22 219/4 219/9 220/12 228/11 232/11 238/20 239/9 239/11	post [4] 13/7 63/18 141/14 206/7	pre-review [4] 78/4 80/1 80/9 80/14	preterm [7] 153/18 179/4 180/2 185/20 186/17 202/25 203/2
picture [3] 187/11 195/5 195/5	pointless [1] 194/4	post-operative [1] 13/7	precedence [1] 178/14	prevent [7] 108/7 126/3 126/8 127/22 140/15 221/14 233/11
piece [2] 131/15 182/8	pointless [1] 194/4	postgraduate [1] 123/2	precise [1] 187/13	prevented [2] 40/14 40/20
piecemeal [1] 152/14	points [14] 12/19 42/19 47/19 47/24 78/21 99/6 107/13 122/7 131/17 165/23 167/8 210/23 213/1 213/19	postmortem [13] 108/24 174/22 174/23 175/4 175/5 175/7 175/14 199/23 199/23 200/1 200/4 200/10 200/12	precisely [2] 153/14 213/2	preventing [1] 140/21
piloted [1] 197/10	planned [1] 195/22	postmortems [2] 174/16 200/7	predates [1] 54/9	previous [4] 127/25 132/17 213/3 235/14
place [33] 3/23 12/11 17/7 28/21 34/24 38/3 84/17 84/23 92/22 101/14 109/7 109/9 125/25 126/8 126/9 127/22 135/13 135/16 135/19 139/24 157/4 157/11 159/9 159/11 165/2 188/19 191/18 191/18 229/9 230/22 231/11 232/19 236/8	planning [3] 136/24 191/2 191/2	postnatal [1] 196/25	predecessor [1] 76/18	previously [3] 112/7 191/12 225/18
placed [4] 36/2 62/14 126/13 233/4	plans [2] 141/3 159/10	potential [10] 5/1 26/14 26/19 97/23 105/20 127/13 211/19 212/3 213/2 239/14	predominantly [3] 137/16 184/18 207/7	primary [3] 7/10 64/14 207/4
places [2] 9/24 157/24	platform [5] 149/22 150/21 152/13 174/2 174/2	potentially [11] 28/24 64/1 122/22 179/6 197/20 197/22 198/4 209/9 212/6 221/9 221/14	preface [1] 36/20	principal [1] 3/11
plainly [2] 39/8 54/6	play [7] 52/19 98/9 140/22 180/14 181/15	power [5] 17/18 99/7 208/14 209/3 221/1	prefer [1] 12/17	principally [1] 122/3
plan [3] 115/13 182/11 195/18		powerful [2] 34/4	preference [1] 27/25	principles [3] 76/10 76/15 237/13
planned [1] 195/22			pregnancy [3] 155/1 155/7 202/9	prior [3] 92/4 123/9 214/9
planning [3] 136/24 191/2 191/2			prejudice [2] 83/24 84/24	prioritisation [1] 137/14
plans [2] 141/3 159/10			prejudicing [5] 82/19 83/16 84/17 84/21 95/24	prioritise [1] 152/8
platform [5] 149/22 150/21 152/13 174/2 174/2			preliminary [1] 98/6	prioritised [4] 136/21 137/7 138/20 151/24
play [7] 52/19 98/9 140/22 180/14 181/15			premature [4] 199/17 199/18 199/19 199/19	priority [4] 137/7 190/25 192/4 222/12
			prematurity [2] 179/22 186/18	pro [1] 112/16

<p>P</p> <p>proactive [2] 127/6 146/15</p> <p>proactively [1] 126/2</p> <p>probably [33] 28/11 50/14 65/14 68/14 70/18 70/20 129/25 145/16 147/11 148/5 175/11 177/19 177/20 184/18 190/21 205/14 211/16 211/24 212/2 214/23 215/6 217/8 218/19 221/19 230/8 230/25 232/5 233/23 234/1 235/8 235/21 235/24 239/18</p> <p>probe [1] 237/15</p> <p>probity [1] 59/15</p> <p>problem [23] 11/20 12/25 27/6 27/7 31/6 41/6 43/14 43/17 113/24 126/18 133/14 133/20 134/16 134/20 134/23 134/25 135/2 135/4 136/20 147/15 151/15 152/9 197/6</p> <p>problematical [1] 187/6</p> <p>problems [5] 7/17 11/12 134/14 139/18 154/11</p> <p>procedure [2] 13/9 101/2</p> <p>proceed [4] 78/4 78/10 78/25 112/14</p> <p>proceedings [1] 19/9</p> <p>process [87] 4/3 7/6 7/7 7/15 18/5 21/22 31/9 31/16 32/14 34/9 34/15 34/17 35/14 36/15 42/12 42/22 43/7 44/23 45/18 46/6 49/4 49/9 49/10 49/16 50/20 51/6 51/18 52/22 53/10 53/15 53/15 53/21 54/1 54/3 54/8 54/20 55/11 55/12 56/1 63/14 64/8 64/19 67/6 67/16 68/11 68/15 77/15 78/1 78/2 79/23 82/9 82/13 99/6 101/13 101/15 110/17 110/17 112/3 112/3 112/12 113/20 126/3 135/25 156/8 156/8 156/24 177/9 177/22 178/12 180/8 180/15 182/13 182/14 186/21 188/4 189/2 204/18 216/12 217/21 229/12 229/14 229/19 229/24 230/2 236/23 239/4 239/7</p>	<p>processes [10] 2/10 31/24 35/2 35/4 43/1 51/1 67/22 182/20 187/24 224/3</p> <p>produce [2] 103/8 151/4</p> <p>produced [3] 102/2 181/22 212/18</p> <p>professional [17] 4/22 14/9 39/10 58/22 62/25 63/1 74/10 113/25 122/10 124/4 124/17 127/11 165/24 167/11 167/19 176/12 207/6</p> <p>professionally [1] 189/1</p> <p>professionals [5] 57/16 75/20 105/1 158/23 168/16</p> <p>Professor [11] 73/6 73/7 73/9 100/10 115/6 116/10 119/16 119/21 120/22 180/5 241/7</p> <p>Professor Modi [2] 115/6 116/10</p> <p>Professor Neena Modi [1] 120/22</p> <p>Professor Stephen [3] 73/6 73/7 241/7</p> <p>Professor Turner [4] 73/9 100/10 119/16 119/21</p> <p>profile [1] 163/21</p> <p>programme [14] 85/17 143/7 149/4 149/17 149/17 149/25 150/11 150/17 150/23 152/1 153/12 153/13 153/24 159/6</p> <p>programmes [3] 149/2 149/3 176/14</p> <p>progress [1] 138/17</p> <p>progressed [1] 66/20</p> <p>project [1] 206/15</p> <p>promise [1] 193/23</p> <p>promoted [1] 206/16</p> <p>promotes [1] 132/9</p> <p>promoting [2] 43/2 126/13</p> <p>prompt [5] 19/1 19/12 24/18 45/20 66/15</p> <p>prompted [3] 17/14 232/24 233/7</p> <p>proper [1] 101/2</p> <p>properly [3] 38/17 88/19 113/21</p> <p>proportion [1] 141/6</p> <p>proportionate [6] 15/23 15/25 16/7 16/24 41/4 164/25</p> <p>proposal [2] 164/25</p>	<p>168/21</p> <p>proposals [5] 87/10 143/8 167/20 193/20 193/21</p> <p>propose [4] 120/2 145/6 146/2 153/9</p> <p>proposed [3] 20/24 30/25 78/5</p> <p>proposing [2] 71/6 165/9</p> <p>prospect [1] 193/24</p> <p>protect [5] 52/25 222/20 224/3 225/19 233/14</p> <p>protected [1] 53/6</p> <p>protecting [1] 209/10</p> <p>protection [6] 75/13 171/24 172/13 172/14 172/15 222/13</p> <p>protracted [1] 16/21</p> <p>proud [1] 42/1</p> <p>provide [19] 2/8 6/19 19/18 23/25 48/21 52/20 54/24 55/14 68/6 92/10 108/12 139/24 159/24 175/25 186/23 189/21 216/20 223/14 223/21</p> <p>provided [17] 1/10 9/23 26/16 75/10 77/12 82/15 84/8 99/19 103/13 109/5 114/23 115/16 116/2 189/3 189/8 224/8 228/14</p> <p>provider [1] 167/3</p> <p>provides [5] 24/21 38/7 38/13 42/5 54/14</p> <p>providing [7] 18/21 46/14 160/3 162/1 174/3 204/8 208/10</p> <p>provision [2] 76/1 118/13</p> <p>PRUDIC [1] 42/12</p> <p>PSIRF [4] 128/6 145/12 145/12 145/14</p> <p>psychological [1] 158/1</p> <p>public [22] 15/3 15/5 15/11 75/12 82/19 83/17 83/24 84/22 86/1 86/8 133/15 133/17 134/5 136/17 167/13 212/24 213/23 216/8 219/7 222/20 225/19 228/1</p> <p>publication [2] 67/17 138/4</p> <p>publish [1] 105/8</p> <p>published [7] 40/12 49/7 49/14 76/14 128/5 167/25 195/17</p> <p>pulls [1] 149/21</p> <p>purpose [7] 3/9</p>	<p>80/13 113/23 154/1 206/25 207/4 209/22</p> <p>purposes [3] 108/25 110/1 121/22</p> <p>push [1] 64/23</p> <p>put [19] 47/20 59/5 68/2 101/14 143/9 147/12 176/13 185/2 186/18 194/8 210/10 217/8 217/10 217/12 217/18 223/2 223/5 227/11 232/21</p> <p>putting [2] 214/1 232/25</p> <p>Q</p> <p>qualification [3] 14/15 15/6 87/23</p> <p>qualifications [1] 1/15</p> <p>qualified [1] 223/7</p> <p>quality [16] 67/5 67/22 77/8 124/12 126/4 130/10 130/14 132/23 133/3 135/14 140/6 143/11 145/1 154/20 222/9 223/13</p> <p>quarter [4] 12/4 63/9 72/25 204/25</p> <p>quarterly [2] 13/13 13/18</p> <p>queried [1] 98/13</p> <p>queries [1] 67/23</p> <p>question [59] 21/17 22/24 28/13 31/2 37/24 40/17 40/21 41/11 45/7 45/13 49/6 53/24 55/24 57/1 58/1 58/3 59/1 59/11 60/3 60/3 60/9 60/16 61/13 62/18 63/25 66/10 66/15 67/11 68/16 68/18 69/7 71/19 71/24 82/23 83/5 103/17 108/6 109/20 109/20 129/25 133/19 134/2 134/12 134/13 147/18 148/11 175/9 175/10 175/20 186/15 190/14 194/25 202/16 210/25 211/16 221/5 227/9 234/6 235/17</p> <p>questioning [1] 126/23</p> <p>questions [74] 1/4 3/11 6/22 6/23 15/19 17/9 24/13 42/7 44/21 46/25 47/3 47/4 50/15 56/11 56/17 57/7 57/25 58/16 58/17 58/20 60/2 60/12 61/10 62/15 65/5 72/12 73/10 73/20 74/25 78/8 89/16</p>	<p>113/15 119/17 119/17 119/19 121/6 122/6 131/25 132/5 154/24 155/23 171/4 175/13 177/2 177/3 177/5 177/6 177/7 177/12 183/21 192/14 192/16 198/20 198/25 200/14 203/17 204/22 205/11 205/19 211/20 237/20 239/20 239/23 239/24 241/4 241/5 241/6 241/8 241/10 241/11 241/12 241/13 241/15 241/16</p> <p>quickly [5] 13/6 31/17 46/12 87/12 239/19</p> <p>quirk [1] 193/5</p> <p>quite [23] 5/10 47/12 57/18 57/18 59/19 66/1 91/16 115/15 128/24 135/20 147/21 178/4 180/20 182/24 183/10 184/15 184/17 197/11 199/21 204/6 214/25 228/10 233/18</p> <p>quote [2] 48/20 59/23</p> <p>quoted [1] 211/12</p> <p>R</p> <p>racism [1] 157/24</p> <p>raise [11] 10/1 10/20 12/11 12/12 32/24 33/2 33/3 33/6 57/23 125/14 142/17</p> <p>raised [43] 8/17 9/5 9/13 9/25 10/23 11/19 26/13 27/23 27/24 28/1 32/6 32/16 33/10 34/8 56/5 59/18 71/8 80/23 80/24 85/5 85/6 95/13 102/4 102/22 107/4 107/18 111/8 116/2 116/22 118/5 119/7 122/7 122/8 125/14 126/1 136/9 164/11 164/14 164/17 165/11 192/17 217/20 235/11</p> <p>raises [1] 47/19</p> <p>raising [13] 8/20 9/9 27/20 32/1 59/23 75/9 106/4 114/20 117/12 171/18 174/9 189/1 227/13</p> <p>Ramsay [1] 130/3</p> <p>ran [1] 215/14</p> <p>range [5] 7/4 14/3 14/17 21/12 150/10</p> <p>rank [1] 146/8</p> <p>rankings [1] 145/25</p> <p>ranks [1] 146/1</p> <p>rapid [1] 150/1</p>
---	--	---	---	---

R	150/17 221/18	198/2	86/23 86/24 87/3 87/4 87/11 87/14 88/7 88/9 88/13 88/18 90/9 90/11 90/15 90/25 93/3 93/6 95/5 95/10 96/18 97/25 101/17 101/17 112/22 112/24 113/5 113/9 119/10 122/4 124/16 130/2 130/8 138/3 159/4 164/13 228/11	32/14 183/15 193/23 202/13 238/6 regionally [1] 24/21 register [4] 7/18 9/7 32/21 208/20 registrant [7] 212/21 212/23 213/22 219/3 219/5 221/22 230/4 registration [1] 230/5 regret [1] 79/10 regulate [1] 170/21 regulated [3] 42/10 170/12 170/19 regulation [16] 124/5 124/5 125/3 125/21 165/24 166/7 167/19 167/21 169/2 169/5 170/2 170/9 203/18 206/17 206/19 229/14 regulations [11] 4/8 5/15 17/19 22/20 37/4 37/14 48/12 52/25 53/3 169/20 238/2 regulator [12] 82/20 83/17 83/25 84/22 86/7 113/13 125/8 166/21 207/6 207/11 207/13 218/4 regulators [5] 100/3 124/18 166/17 167/12 168/16 regulatory [13] 77/15 85/20 125/19 130/24 166/1 166/2 166/8 166/13 166/24 167/3 167/9 167/15 168/25 reiterate [2] 27/15 59/10 relate [1] 171/20 related [3] 164/9 169/7 173/7 relating [4] 40/16 81/9 93/20 133/3 relation [12] 56/10 69/12 82/17 83/14 83/22 117/12 118/6 169/16 179/23 179/23 192/7 203/22 relations [1] 81/7 relationship [3] 155/24 236/15 236/17 relationships [2] 6/20 207/5 relatively [4] 16/20 23/16 34/15 57/1 relatives [1] 32/7 relevance [1] 122/22 relevant [12] 8/6 8/11 15/24 16/4 24/12 44/14 63/22 78/6 122/4 155/5 190/18 195/4 Reliability [1] 159/8 relinquished [1] 52/3
rapidly [1] 180/13 rare [3] 23/16 32/11 32/12 rarely [1] 164/17 rate [4] 138/19 191/5 211/11 211/11 rates [1] 150/8 rather [12] 13/11 34/13 68/12 130/25 142/3 154/2 173/13 175/1 201/25 205/15 219/21 225/14 rationale [1] 103/9 Ravi [1] 93/23 Ravi Jayaram [1] 93/23 raw [1] 36/13 RCPCH [57] 73/5 74/8 74/19 75/25 76/14 79/7 85/22 90/19 90/24 95/18 96/13 96/19 98/17 99/7 100/1 100/11 100/17 101/4 101/4 101/21 103/4 106/2 108/9 114/18 115/6 118/2 118/17 120/12 120/23 123/14 123/17 125/25 135/15 137/12 138/3 138/23 138/25 139/22 140/10 143/9 149/5 149/10 155/14 156/11 157/1 157/17 160/25 165/1 166/20 166/25 167/19 169/4 170/8 171/13 175/21 175/25 193/20 RCPCH's [8] 87/10 95/12 98/25 107/21 109/2 118/6 124/22 170/1 reach [2] 209/23 238/20 reached [1] 42/1 reaching [1] 238/2 react [1] 184/14 reacted [1] 225/4 reacting [2] 126/1 148/22 reactive [4] 127/7 128/2 143/4 146/19 read [8] 17/8 74/15 77/11 78/22 137/10 152/5 172/22 225/1 reading [5] 9/11 17/5 50/21 104/18 131/17 reads [5] 17/6 17/6 95/2 103/12 219/1 ready [7] 26/7 50/11 66/4 66/8 66/16 69/1 69/5 real [4] 104/24 105/2	real-time [1] 150/17 realistically [1] 148/9 reality [1] 195/3 really [50] 3/5 7/2 10/17 21/17 22/24 32/18 37/25 41/14 41/14 41/19 43/6 45/12 48/2 53/24 128/8 134/19 134/21 136/3 141/21 147/3 147/14 151/10 151/10 153/17 153/17 154/23 156/25 157/2 157/2 157/10 159/19 168/14 170/15 183/9 184/11 185/24 185/24 196/15 199/17 200/15 209/13 212/6 212/10 214/7 216/18 216/23 223/23 225/17 236/17 239/19 reason [18] 7/22 16/6 21/18 37/8 43/3 54/6 67/12 86/6 107/1 143/12 153/20 159/14 187/14 188/24 210/24 211/6 211/8 236/7 reasonable [5] 26/24 49/5 53/5 55/21 62/15 reasons [12] 31/20 52/3 59/19 66/19 107/5 108/2 112/16 120/20 162/7 179/13 185/5 212/7 reassurance [1] 107/9 recall [10] 8/10 32/7 52/9 65/14 67/10 217/6 217/16 227/1 230/11 235/4 receive [11] 3/10 35/21 36/7 36/19 137/24 207/15 209/14 211/14 214/20 231/2 231/4 received [1] 209/17 receiving [3] 91/17 114/6 231/10 recent [3] 34/19 118/12 195/23 recently [5] 50/19 65/9 153/24 173/20 177/19 recipients [1] 105/21 recognise [6] 30/11 48/24 49/17 111/13 170/20 187/3 recognised [3] 39/14 57/21 113/16 recognises [1] 113/24 recognising [1] 52/18 recognition [2] 61/22	recollection [2] 91/12 231/17 recommend [9] 63/24 81/13 148/15 153/6 218/20 218/21 223/11 225/25 239/18 recommendation [10] 25/2 25/7 98/8 133/22 143/23 149/14 164/25 169/12 169/13 169/19 recommendations [19] 19/14 28/9 35/10 40/11 63/22 85/16 100/2 112/8 133/15 133/18 133/21 133/23 134/5 134/10 134/15 134/21 136/12 169/12 176/1 recommended [2] 98/17 162/22 recommending [1] 101/21 record [10] 94/24 98/6 98/21 138/6 139/3 151/7 152/12 214/5 228/15 228/16 recorded [7] 3/13 12/23 20/22 89/21 213/21 227/6 228/11 recording [1] 174/17 records [27] 16/9 16/11 16/14 16/20 16/21 17/6 17/17 17/20 17/21 17/22 18/3 20/22 30/13 44/24 58/7 70/4 109/4 109/22 150/20 151/13 151/21 151/23 152/10 153/10 154/5 154/10 223/1 recovering [1] 46/18 recovery [1] 72/18 recruit [1] 141/4 recruiting [1] 140/17 recurrent [1] 11/5 redacted [5] 104/1 104/2 104/4 104/6 104/11 redaction [1] 105/19 reduced [1] 40/20 redundancy [1] 168/8 refer [18] 39/3 41/10 56/11 139/12 145/11 149/2 202/7 207/25 216/10 216/19 219/18 220/3 221/20 222/16 225/15 225/19 227/21 239/9 reference [43] 18/13 47/23 49/6 49/10 77/7 78/15 79/1 79/11	86/23 86/24 87/3 87/4 87/11 87/14 88/7 88/9 88/13 88/18 90/9 90/11 90/15 90/25 93/3 93/6 95/5 95/10 96/18 97/25 101/17 101/17 112/22 112/24 113/5 113/9 119/10 122/4 124/16 130/2 130/8 138/3 159/4 164/13 228/11 referenced [2] 158/7 158/19 references [2] 103/25 224/18 referral [28] 7/21 26/20 28/11 28/14 36/21 36/22 38/22 38/23 48/16 171/11 171/15 207/13 207/18 207/19 208/14 208/25 209/3 216/7 218/5 218/21 221/3 223/11 225/25 226/10 233/11 239/4 239/12 239/19 referred [19] 3/14 8/5 10/15 12/20 12/25 13/24 36/23 37/16 37/19 39/5 40/8 56/1 110/15 116/16 160/5 172/7 207/12 208/11 208/19 referring [10] 32/14 38/19 38/25 39/2 44/5 81/13 127/24 180/25 219/8 220/11 refers [3] 50/20 133/9 160/11 refine [1] 22/18 refined [1] 38/15 refining [2] 33/21 35/4 reflect [2] 59/22 114/22 reflected [2] 26/24 208/6 reflecting [1] 114/5 reflection [1] 31/25 reflections [1] 116/1 reflects [2] 13/13 146/9 reformed [1] 2/10 reforms [1] 36/16 refreshed [1] 49/9 refusal [1] 52/17 regarding [6] 8/22 26/10 115/8 115/21 232/11 237/1 regardless [1] 19/2 region [2] 159/22 237/25 regional [13] 5/4 5/19 10/16 11/23 11/24 11/24 11/25 13/19	

R	164/2 165/8 174/17 189/24 191/17	resourcing [2] 127/9 139/20	resulted [1] 220/5	114/13 114/21 114/25
reluctant [1] 100/23	reports [16] 102/1	respect [23] 88/25	resulting [1] 101/18	115/10 117/15 118/12
rely [2] 222/1 223/9	102/2 103/8 103/10	103/17 104/15 111/21	results [4] 18/14	118/12 118/14 118/20
remain [1] 237/14	103/14 108/21 108/23	120/12 125/24 145/5	18/15 18/16 109/18	120/14 120/19 120/24
remaining [1] 92/3	108/24 109/5 118/8	152/25 155/15 156/15	resuscitation [3]	149/12 154/17 194/15
remains [1] 106/20	147/5 147/7 148/22	157/21 165/21 167/19	21/8 24/11 179/12	194/15 196/22 197/3
remarkable [1] 44/17	149/25 150/6 150/13	175/21 176/2 185/22	rethink [1] 188/9	212/18 216/11 229/14
remarks [1] 225/2	representative [2]	193/1 193/19 195/17	reticence [2] 58/23	229/17 230/22 231/8
remedied [1] 173/22	86/5 177/20	195/25 196/7 198/13	58/23	235/1 235/2
remember [2] 143/24	representatives [2]	238/11	retired [1] 39/21	reviewed [6] 12/24
210/2	78/5 108/19	respected [1] 29/20	return [1] 151/5	13/18 48/15 52/7 70/1
remind [1] 31/22	representing [1] 34/5	respectful [1] 29/11	returning [1] 231/25	70/4
reminded [1] 25/21	represents [1] 141/8	respecting [1] 33/8	returns [1] 63/9	reviewer [7] 78/12
remit [8] 9/8 12/16	request [8] 12/18	respects [2] 60/20	revalidate [1] 172/2	78/16 78/24 89/22
59/24 82/18 83/15	13/14 14/21 65/13	198/18	review [185] 2/15	92/21 95/8 120/18
83/22 165/4 237/25	79/14 79/22 174/25	respond [4] 13/6	3/17 3/24 6/10 6/13	reviewers [7] 80/25
remote [3] 20/20	196/13	31/8 140/16 179/11	7/7 7/20 11/10 11/16	91/6 99/19 102/20
54/21 200/18	requested [5] 11/15	responded [2] 115/9	13/22 15/21 15/24	109/5 109/23 171/13
remove [5] 208/20	29/20 38/2 49/18 80/4	164/24	16/8 16/13 16/18	reviewing [5] 4/20
231/15 233/16 233/18	requesting [2] 17/24	responding [1]	16/24 17/8 17/20	13/12 42/18 67/24
233/21	39/17	164/20	17/23 18/3 18/5 23/12	67/25
removed [6] 94/7	require [8] 12/13	response [32] 24/10	30/13 31/25 34/9 36/1	reviews [19] 3/6 5/18
104/15 104/22 105/20	33/10 45/19 50/22	44/20 45/17 45/24	41/4 42/22 44/23	34/14 34/15 38/14
105/24 106/5	111/12 143/6 185/5	47/21 48/6 51/21	45/18 46/6 49/10	67/23 76/11 76/15
removing [2] 231/20	188/5	52/19 53/10 54/8	49/15 52/22 54/1	77/14 80/17 86/15
233/15	required [15] 15/23	57/15 85/15 113/12	74/22 74/25 76/8 76/9	108/4 108/7 108/14
renewed [1] 72/16	16/17 17/23 23/8	116/12 116/21 136/8	76/23 76/25 77/10	110/20 114/15 116/15
rep [1] 98/12	55/10 60/14 90/17	143/23 150/1 164/10	77/19 78/1 78/2 78/4	212/18 233/6
repeat [4] 82/23	95/24 101/10 142/13	165/17 169/5 169/8	78/10 78/13 78/25	revisit [1] 66/15
159/11 221/5 227/9	144/25 172/1 188/24	169/12 169/18 178/2	79/9 79/15 79/17 80/1	right [67] 5/10 9/22
repeated [1] 72/16	226/9 226/13	178/13 178/22 182/15	80/3 80/6 80/6 80/9	24/12 29/8 38/7 38/21
repeatedly [1] 133/5	requirement [12]	208/3 215/21 237/6	80/12 80/14 81/12	38/21 50/17 55/4
replaced [2] 141/24	12/7 14/15 20/9 27/2	238/3	81/22 82/11 82/11	57/24 60/2 61/10 66/7
145/12	33/19 36/14 48/17	responses [4] 52/11	82/17 83/1 83/6 83/8	66/18 69/17 85/18
reply [2] 116/8 116/9	49/11 110/7 155/16	53/17 60/10 191/16	83/10 83/14 83/21	86/13 91/16 99/9
report [46] 40/12	155/17 174/15	responsibilities [5]	83/23 84/10 84/11	104/9 106/25 108/5
90/4 98/5 99/11 100/1	requirements [3]	2/23 52/3 53/23 54/25	84/14 85/14 85/17	109/16 117/17 127/6
100/12 102/7 102/14	27/17 30/3 31/14	162/21	86/3 86/17 86/21	128/25 133/11 167/7
103/24 104/1 104/1	requires [8] 14/10	responsibility [8]	87/11 87/24 88/4	169/24 178/6 178/7
104/2 104/17 104/19	14/12 55/11 88/11	4/23 14/23 15/10	88/19 88/20 88/25	178/23 183/1 193/19
104/25 105/4 105/9	127/14 141/3 168/5	27/20 32/3 53/20	89/15 89/19 89/20	195/13 201/2 201/21
105/10 105/12 106/2	227/20	223/19 238/9	90/2 90/20 91/7 91/9	205/23 206/6 206/8
106/9 106/17 106/20	requiring [1] 78/12	responsible [7]	91/16 92/3 92/12	206/11 206/22 208/12
107/1 108/7 109/18	research [2] 156/6	52/21 67/20 90/6	92/18 92/22 92/25	209/17 210/18 210/20
112/6 115/10 115/11	156/7	123/1 164/6 164/20	93/10 93/14 93/18	210/21 211/2 211/3
115/22 117/3 118/15	reserves [1] 85/17	226/6	94/1 94/14 94/15	216/3 216/23 224/16
118/21 119/6 119/8	resident [1] 20/5	responsive [1] 116/6	94/20 94/21 95/3 95/4	225/20 228/20 229/4
119/14 128/15 128/16	resolution [3] 221/25	rest [1] 192/24	95/9 95/12 95/16	229/11 230/13 230/15
128/24 129/2 132/7	232/21 237/10	restart [2] 26/7 27/11	95/18 95/21 95/25	231/5 231/18 231/21
155/16 156/4 156/12	resolved [2] 199/19	restraints [1] 139/12	96/10 96/16 97/5	233/14 234/12 235/6
197/13 228/12	233/8	restrict [6] 193/14	99/10 100/5 100/9	236/23 237/24 238/1
reported [5] 10/3	resource [14] 23/24	208/17 221/24 222/22	100/15 101/2 101/7	rightly [1] 66/1
129/11 150/10 155/12	127/17 135/4 136/6	228/2 234/2	102/5 102/20 102/21	ring [2] 143/10
219/4	139/11 139/16 150/12	restricted [2] 124/13	103/4 107/12 107/18	143/12
reporting [31] 5/17	159/24 170/16 174/3	234/23	107/25 108/8 108/18	ring-fenced [2]
5/18 6/24 10/4 12/3	189/20 189/21 192/9	restricting [1] 222/17	108/20 108/25 109/14	143/10 143/12
13/14 13/18 56/25	197/24	restriction [6] 81/4	110/1 110/19 110/19	rings [1] 207/16
85/19 102/23 125/17	resources [15] 9/18	208/22 221/11 221/13	111/8 111/12 111/20	rise [11] 107/5 107/6
126/2 127/12 128/7	128/3 135/9 136/10	225/24 226/20	112/2 112/3 112/5	120/5 138/19 155/1
128/19 128/21 129/9	137/21 137/25 139/4	result [9] 40/10 53/2	112/6 112/12 112/14	175/24 211/1 211/5
136/13 140/25 145/5	157/22 157/23 176/10	116/14 125/11 139/5	112/18 112/19 113/1	211/7 211/9 211/9
147/4 147/5 155/14	186/2 189/14 190/3	173/17 179/6 213/12	113/17 113/20 113/23	rising [2] 139/23
156/10 160/7 162/21	191/15 194/17	233/4	114/1 114/7 114/8	191/14
			114/9 114/10 114/10	risk [31] 12/14 34/13

R	75/4 87/2 106/25 117/14 123/5 149/9 177/14 188/21 190/22 195/25 Royal College's [2] 105/5 196/2 Royal Colleges [3] 166/20 189/13 190/5 rule [11] 23/6 180/14 195/24 196/3 196/7 196/11 196/20 197/4 197/7 201/23 203/10 rules [1] 202/5 run [3] 16/11 178/12 178/16	164/23 165/5 166/7 167/1 168/3 168/12 169/17 170/10 170/17 191/17 198/1 208/16 212/24 213/23 223/9 224/4 235/3 said [27] 32/9 41/13 41/13 43/4 53/14 58/18 59/21 66/13 66/22 69/11 71/20 72/15 95/8 126/25 180/7 199/10 201/22 215/16 218/16 218/17 218/19 227/15 227/17 229/2 232/18 238/13 239/9 salient [1] 134/21 same [29] 5/17 5/22 15/14 22/3 32/13 43/13 46/23 55/2 67/10 71/13 71/13 116/10 118/18 125/14 125/17 153/3 156/12 210/4 210/11 213/24 215/13 215/15 225/11 225/13 225/22 229/9 231/3 236/6 237/14 sample [1] 145/23 sat [1] 216/13 satisfactory [1] 188/7 satisfied [1] 113/10 saved [1] 141/18 saw [2] 26/13 216/1 say [65] 6/11 6/19 11/7 12/24 15/4 15/8 16/20 17/13 19/16 22/12 22/25 23/14 24/3 28/1 28/7 29/4 33/1 35/18 36/9 39/5 39/8 39/22 40/13 41/8 44/2 44/10 44/14 46/3 54/21 55/10 56/8 56/10 58/18 59/7 59/13 68/16 70/13 70/17 71/16 72/2 72/9 79/21 86/13 99/9 109/13 120/4 121/17 128/23 129/21 130/22 135/7 138/16 139/21 140/7 142/22 154/4 173/19 182/21 194/9 202/18 212/2 225/13 226/1 226/2 232/23 saying [16] 46/14 65/8 71/24 72/5 89/22 129/1 129/13 160/20 181/5 181/6 190/1 222/24 223/18 227/23 227/24 235/16 says [8] 58/10 85/2 87/19 98/1 169/13 212/12 226/25 231/7 scales [1] 160/11	scenario [10] 37/5 40/2 40/6 44/8 70/9 71/14 107/7 179/3 179/9 179/15 scenarios [1] 71/2 scheduled [1] 230/23 scheme [2] 40/17 40/18 School [1] 122/24 Scolding [4] 192/13 192/14 198/23 241/12 scope [10] 9/19 81/23 84/16 89/14 95/23 96/2 96/3 96/10 102/18 102/22 SCORE [2] 158/12 159/7 Scotland [3] 2/21 2/24 194/12 screen [5] 145/21 177/11 210/15 231/3 234/11 screening [10] 216/13 216/21 217/21 226/15 226/17 226/18 227/19 229/21 238/22 238/22 script [3] 69/8 69/23 70/6 scrutinise [3] 6/2 37/22 169/15 scrutinised [1] 4/5 scrutinising [2] 52/4 63/10 scrutiny [4] 3/10 5/19 21/16 100/3 second [32] 3/13 27/18 48/19 49/24 58/1 64/18 70/12 80/22 84/15 95/8 101/11 103/11 112/20 113/4 115/4 116/12 124/4 143/17 144/25 153/12 159/3 159/5 160/10 188/14 196/14 196/15 205/25 207/19 212/16 214/24 215/3 234/15 secondly [2] 60/22 117/1 secret [1] 68/17 section [10] 37/11 81/15 125/22 145/23 146/7 158/7 160/24 166/18 169/23 216/22 section 1 [1] 37/11 sections [4] 78/21 100/15 104/4 104/14 secure [1] 140/13 Security [1] 206/9 see [60] 11/1 12/21 18/12 18/15 27/7 28/10 42/17 47/20 63/24 67/3 71/2 76/13	78/1 80/23 81/22 85/6 93/25 97/14 97/19 99/21 103/1 103/10 104/4 104/5 104/9 111/17 116/24 117/9 118/4 118/7 129/14 132/15 132/19 138/4 141/16 145/21 145/24 146/18 148/8 150/3 153/23 154/18 155/24 160/7 166/18 169/8 177/22 178/3 181/4 189/10 207/11 210/14 210/19 219/19 219/23 227/23 227/24 228/10 234/15 240/13 seeing [3] 132/8 192/8 203/4 seek [5] 5/4 62/18 84/11 95/17 167/1 seeking [2] 31/1 32/2 seem [4] 170/18 171/16 211/18 233/18 seemed [3] 69/5 173/11 218/2 seems [9] 10/23 27/5 52/6 53/12 53/13 159/2 173/11 197/23 199/21 seen [14] 12/15 42/4 85/4 102/11 106/5 106/7 126/19 138/17 141/15 146/25 147/24 163/9 192/4 211/1 self [9] 146/3 146/21 147/5 148/1 148/8 148/17 148/22 158/11 159/13 self-assessment [2] 148/1 148/22 self-evaluation [4] 146/3 148/17 158/11 159/13 self-reporting [1] 147/5 send [3] 66/23 197/22 204/15 senior [15] 10/7 20/14 39/18 39/22 107/16 107/22 124/5 131/19 131/23 169/2 188/17 198/1 203/18 206/15 229/20 Senior Coroner [1] 39/22 seniority [1] 144/4 sense [7] 3/21 44/18 59/25 104/2 148/24 150/23 189/25 sensible [1] 232/14 sensing [1] 191/18 sensitive [8] 15/9 18/1 30/23 46/3 46/9 105/18 109/4 109/22
----------	--	--	---	---

S	sessions [1] 17/3	shorter [1] 120/2	31/18 55/9 61/20	Social [3] 5/13 41/21
sensitivities [1]	set [24] 4/7 4/16 6/22	shorthand [1] 72/23	76/18 118/7 133/18	125/6
71/22	11/21 28/19 35/25	Shortland [3] 78/20	145/17 148/21 148/25	soft [1] 132/10
sent [5] 97/4 97/16	37/14 40/9 41/18	103/10 107/17	152/16 158/13 158/14	solution [1] 151/12
103/10 109/23 187/9	44/12 51/1 63/1 63/16	shortly [2] 28/22	194/11	solved [1] 197/6
sentence [10] 48/20	75/6 81/4 117/17	101/7	similarities [1] 59/13	some [100] 3/3 6/2
84/15 85/12 101/11	129/18 131/6 131/20	should [67] 18/15	similarly [2] 62/7	9/24 14/7 14/13 16/7
106/18 124/20 131/2	149/13 154/24 156/6	18/17 23/5 39/2 44/2	62/24	16/11 16/20 17/1
131/5 131/9 159/5	157/12 218/18	46/2 49/4 52/2 59/3	simple [2] 34/23	19/17 21/10 26/16
separate [6] 51/1	sets [6] 16/11 53/11	74/4 77/22 79/7 79/8	131/25	31/19 37/9 38/1 41/19
118/15 119/8 153/15	76/3 101/14 111/18	79/9 81/1 82/17 83/1	simply [9] 67/16	46/25 47/7 47/9 47/10
178/13 193/10	166/11	83/9 83/14 84/16	96/24 134/24 148/4	47/10 49/1 49/3 51/11
separately [2] 53/16	setting [13] 21/24	86/16 90/11 90/13	192/3 213/18 223/20	53/18 53/18 56/20
156/2	29/17 60/25 61/3	91/14 91/17 91/18	223/25 227/15	56/21 57/2 57/4 60/20
sepsis [3] 61/23	76/14 164/23 186/6	92/6 92/19 94/21	since [12] 1/21 13/14	64/4 69/8 71/22 81/16
187/7 187/10	190/25 196/19 196/25	95/13 96/15 96/25	48/12 49/9 64/16	81/18 118/5 118/7
September [7] 1/23	197/5 197/8 224/22	97/5 97/11 99/20	109/9 167/24 194/14	122/7 126/12 126/25
2/11 48/12 48/14	settled [1] 34/3	100/11 106/5 106/7	201/22 204/17 214/6	127/14 128/13 128/16
89/19 97/12 101/8	seven [3] 87/9	106/12 111/8 116/5	229/3	128/22 132/3 132/14
series [7] 19/18 44/9	139/21 203/3	116/6 118/22 120/1	single [10] 31/24	134/14 141/17 141/17
49/13 49/25 110/21	several [4] 10/19	133/24 134/7 134/9	149/23 152/11 152/12	146/18 147/9 147/22
176/12 210/23	54/5 98/10 188/16	135/18 154/25 160/20	153/19 161/19 161/23	151/2 151/3 152/8
serious [21] 10/6	Shall [1] 120/4	160/21 164/23 165/12	161/23 188/13 209/24	155/23 156/19 159/12
10/14 10/14 80/22	share [3] 91/17	165/13 168/21 169/15	singling [1] 22/4	166/13 168/1 168/6
100/8 111/3 151/9	105/12 106/21	169/22 172/22 173/16	sinister [1] 212/9	168/7 171/14 175/12
209/12 212/23 213/18	shared [9] 91/18 92/7	175/3 175/18 189/5	sit [6] 73/8 120/15	183/21 184/9 186/13
213/23 216/6 218/13	100/1 105/14 106/2	189/10 203/12 217/21	121/5 205/12 216/21	187/21 187/22 188/17
219/7 219/14 222/3	106/9 106/13 108/8	233/6 236/5	217/21	188/18 189/3 189/5
222/16 227/13 227/16	118/9	shouldn't [3] 103/21	site [2] 78/7 210/4	192/17 194/2 194/17
227/18 228/1	sharing [9] 43/2 91/5	105/21 200/17	sitting [2] 72/23	203/17 203/19 208/3
seriously [1] 189/23	91/12 93/8 93/10	showed [1] 63/9	240/7	208/22 209/11 209/13
seriousness [10]	107/11 108/16 149/15	shown [3] 131/11	situation [23] 5/21	209/15 210/16 210/18
107/24 208/1 212/3	153/25	208/5 224/22	6/1 6/12 9/10 10/12	210/24 212/22 213/13
216/5 223/8 226/15	she [43] 41/15 47/19	shrinking [1] 138/18	14/24 26/19 32/13	213/22 214/2 217/14
226/17 227/19 238/22	48/3 48/19 91/7 91/8	shut [1] 31/9	39/4 70/14 70/19 71/3	219/6 220/10 221/11
238/23	91/12 91/13 91/14	sick [2] 141/22	184/8 187/17 188/22	225/2 225/2 231/14
service [48] 76/8	94/5 94/7 97/17 97/19	201/24	190/11 200/12 200/17	232/25 236/25
76/23 76/25 77/3 77/3	98/14 98/24 180/7	sicker [1] 202/3	200/19 216/18 221/21	somebody [25] 16/14
77/7 77/9 77/10 77/20	181/1 184/23 196/4	side [1] 154/4	222/16 227/21	28/12 29/9 29/13 42/5
109/14 112/6 113/19	209/19 209/20 210/5	sideways [1] 16/23	situations [4] 12/21	54/16 54/16 59/16
114/2 114/8 114/11	210/18 213/17 214/3	sight [2] 192/22	16/2 31/18 71/11	97/16 104/2 151/6
114/14 128/25 135/8	215/18 218/16 218/17	193/18	six [4] 4/4 54/10 98/5	152/8 163/11 163/24
136/17 148/19 148/24	218/23 219/7 219/14	sighted [1] 107/24	238/2	168/5 182/22 184/18
150/15 158/9 158/22	220/4 220/8 220/9	signal [1] 57/24	six weeks [1] 98/5	196/17 207/16 207/25
159/23 170/13 202/13	226/25 227/15 227/17	signals [3] 126/15	Skelton [10] 47/2	209/20 222/24 226/10
206/17 206/18 207/1	230/4 231/7 231/7	126/21 126/24	47/3 65/6 177/5 177/6	229/8 230/8
207/2 207/4 207/8	231/22 231/25 233/9	significance [2]	192/12 192/18 199/3	somebody's [1]
207/9 207/22 209/13	231/22 231/25 233/9	154/18 231/9	241/5 241/11	211/18
209/23 210/1 212/5	she'd [1] 238/12	significant [17] 38/24	skills [5] 14/5 14/10	somehow [2] 156/1
214/12 214/20 215/1	sheet [1] 145/23	39/9 75/25 108/11	14/11 14/11 22/14	191/22
218/4 224/9 234/1	Sheffield [1] 1/20	108/24 111/2 111/6	slideshow [1] 67/17	someone [10] 6/17
236/11 237/13 238/4	shift [4] 24/6 43/21	111/9 111/14 112/2	slight [3] 61/16 193/4	12/23 13/24 15/3
services [21] 7/10	94/7 221/15	131/14 135/4 139/12	196/2	35/20 39/3 144/9
78/7 133/12 136/15	shifts [6] 10/19 11/7	141/11 165/25 166/17	slightly [7] 21/19	188/23 227/7 238/9
136/21 137/6 137/22	94/6 94/6 233/10	197/16	55/3 97/13 114/13	someone's [2]
139/6 139/13 139/25	233/10	significantly [3] 8/18	120/2 150/19 189/15	222/22 226/21
143/14 148/21 148/25	Shipman [5] 25/23	236/16 236/24	slip [1] 163/10	something [47] 6/15
153/1 159/10 159/21	40/11 41/11 56/10	signpost [2] 176/14	small [7] 23/19	12/8 17/12 18/14
160/3 193/6 193/7	57/11	190/2	172/17 178/4 181/12	18/17 24/9 46/16 49/2
197/4 197/10	short [6] 73/2 73/14	signposted [1] 33/6	187/3 187/5 191/21	54/17 57/16 57/17
session [1] 95/7	74/14 88/1 88/3 205/3	signs [6] 126/15	smaller [1] 152/1	57/20 60/16 61/6
sessional [2] 6/8	shortcoming [1]	127/13 128/10 143/2	Smith [1] 41/12	62/22 65/1 65/1 69/17
198/10	108/12	184/5 187/10	Smith's [1] 40/10	90/18 100/17 110/10
	shortcomings [2]	similar [14] 12/21	so [361]	110/12 116/15 117/16
	113/16 113/16			

S				
<p>something... [23] 126/7 128/6 129/19 136/17 174/7 174/23 175/18 181/8 182/2 182/10 192/25 193/9 198/12 198/13 200/20 212/7 212/8 226/12 228/8 229/1 232/16 233/1 240/12</p> <p>sometimes [12] 15/2 28/23 32/6 63/19 71/22 72/1 104/5 124/23 125/16 138/15 187/3 200/5</p> <p>somewhat [1] 225/7</p> <p>somewhere [1] 119/9</p> <p>soon [3] 13/10 171/12 173/3</p> <p>sophisticated [1] 147/21</p> <p>sorry [23] 4/9 25/25 26/4 27/4 27/12 29/22 46/15 64/23 67/25 82/23 83/4 84/13 116/4 121/17 134/1 163/7 166/4 168/10 178/7 178/7 205/13 221/5 227/9</p> <p>sort [25] 13/3 17/5 26/21 56/16 60/1 69/8 71/13 77/10 84/24 107/4 132/10 143/3 155/24 193/4 194/19 201/16 201/22 201/25 202/19 212/1 212/3 213/2 221/11 222/6 238/18</p> <p>sorts [6] 59/10 141/18 154/2 185/4 185/4 218/18</p> <p>soul [1] 151/3</p> <p>sound [2] 24/18 66/21</p> <p>sounds [5] 22/4 24/19 110/5 155/4 182/7</p> <p>South [1] 39/22</p> <p>South Yorkshire [1] 39/22</p> <p>space [2] 42/10 143/6</p> <p>spare [1] 151/5</p> <p>speak [26] 15/16 20/5 20/10 26/22 32/16 34/6 36/18 63/9 119/2 132/12 134/17 150/22 150/22 150/23 151/21 152/13 158/2 159/23 183/3 186/13 189/2 189/16 189/22 189/23 190/8 207/15</p> <p>Speak Up [2] 189/22</p>	<p>190/8</p> <p>speaking [12] 9/12 15/17 20/4 35/19 62/20 71/18 163/11 164/3 165/4 174/19 184/4 207/24</p> <p>speaks [1] 163/24</p> <p>special [2] 61/18 122/19</p> <p>specialised [1] 183/4</p> <p>specialism [2] 61/9 183/23</p> <p>specialist [10] 22/7 22/23 60/15 60/18 61/1 61/11 184/2 185/5 185/8 185/11</p> <p>specialists [2] 22/4 61/2</p> <p>speciality [3] 122/17 195/20 238/21</p> <p>specialties [5] 21/12 60/18 60/19 61/15 185/3</p> <p>specialty [10] 8/6 23/4 60/20 62/21 63/4 63/5 135/6 174/13 174/13 185/15</p> <p>specific [22] 18/11 18/21 19/15 25/6 28/10 50/3 63/5 77/4 88/13 116/15 137/23 141/12 144/22 160/11 162/10 169/11 175/12 175/25 183/16 212/11 227/20 227/21</p> <p>specifically [13] 16/1 23/3 29/2 40/3 59/22 68/15 81/9 135/10 175/6 211/22 217/16 236/1 238/6</p> <p>spectrum [2] 146/9 212/3</p> <p>speed [1] 86/25</p> <p>speedy [2] 72/18 196/13</p> <p>spend [1] 232/24</p> <p>split [1] 237/24</p> <p>spoke [2] 25/11 157/10</p> <p>spoken [2] 51/22 209/20</p> <p>spot [1] 59/6</p> <p>spotted [2] 43/24 187/21</p> <p>square [1] 218/11</p> <p>stable [2] 179/10 191/5</p> <p>staff [31] 8/24 9/4 9/6 39/12 59/6 91/10 112/15 114/4 127/10 127/15 128/12 128/15 128/21 128/23 129/2 131/25 132/6 132/12 140/18 141/2 141/14</p>	<p>141/25 144/4 146/4 147/3 148/6 160/18 160/22 171/20 194/4 195/20</p> <p>staffing [6] 8/22 127/9 139/14 142/7 195/7 237/7</p> <p>Staffordshire [1] 133/10</p> <p>Staffs [1] 207/3</p> <p>stage [17] 18/2 23/13 30/17 41/7 42/1 112/19 115/16 126/22 202/1 204/9 208/18 216/13 220/1 220/22 221/3 233/7 238/20</p> <p>stages [4] 31/6 31/16 64/2 202/3</p> <p>stand [2] 58/7 182/12</p> <p>standalone [4] 85/4 86/14 99/5 110/17</p> <p>standard [6] 60/20 75/10 129/23 164/23 165/10 175/5</p> <p>standardised [1] 127/19</p> <p>standards [12] 67/20 77/20 137/4 137/8 137/16 137/24 167/1 194/6 194/24 195/3 195/4 195/7</p> <p>stands [1] 128/6</p> <p>start [20] 17/7 34/24 43/4 65/11 70/3 73/11 73/20 75/3 79/18 80/21 89/15 115/1 120/1 120/5 121/7 132/21 162/1 180/15 204/25 206/5</p> <p>start at [1] 120/5</p> <p>started [5] 66/18 67/11 115/20 122/13 188/18</p> <p>starting [6] 95/9 117/1 124/8 169/19 232/22 240/10</p> <p>starts [1] 147/2</p> <p>state [4] 98/19 123/13 125/23 157/16</p> <p>stated [3] 9/15 31/15 77/1</p> <p>statement [79] 1/12 2/6 2/25 9/15 9/16 25/17 28/19 40/9 40/13 41/19 42/9 44/6 47/24 48/8 48/10 53/11 56/5 60/17 73/14 73/17 73/21 74/14 75/1 80/16 87/8 91/21 95/2 96/18 99/18 99/24 107/14 107/20 120/22 121/10 121/21 122/1 122/3 122/7 122/8 123/13</p>	<p>123/17 123/23 124/2 124/11 125/22 127/18 130/5 135/11 136/14 137/10 138/8 138/9 138/11 138/24 139/11 139/20 140/8 143/9 145/2 145/7 145/9 149/1 155/10 158/20 160/17 165/24 166/12 167/18 169/3 169/24 171/3 203/18 207/14 224/25 225/3 225/6 225/7 225/8 238/13</p> <p>statements [10] 1/10 1/12 74/16 74/21 120/17 120/21 120/25 205/24 206/2 222/11</p> <p>states [6] 84/15 88/11 99/19 106/19 107/14 124/20</p> <p>status [1] 70/3</p> <p>statute [3] 14/19 33/20 54/9</p> <p>statutory [25] 1/23 2/11 2/13 4/3 4/8 4/18 12/16 36/16 48/12 48/17 49/8 50/20 53/15 54/9 54/11 64/4 64/16 66/2 66/4 156/8 171/10 172/21 173/8 209/5 239/10</p> <p>stay [1] 16/21</p> <p>staying [4] 8/20 24/25 26/5 155/9</p> <p>step [11] 20/1 39/9 69/5 86/11 136/3 175/7 183/1 214/9 231/11 231/15 233/18</p> <p>Stephen [6] 73/6 73/7 73/13 93/23 115/5 241/7</p> <p>Stephen Brearey [2] 93/23 115/5</p> <p>stepped [1] 182/22</p> <p>steps [19] 15/19 41/4 51/7 51/11 56/12 56/17 68/11 81/17 85/7 85/21 86/16 109/9 109/21 111/19 111/22 134/4 148/8 209/4 233/14</p> <p>Stewart [3] 92/2 99/18 120/18</p> <p>still [17] 33/11 59/24 118/11 118/13 151/19 177/19 181/13 195/4 206/22 223/20 224/2 225/10 225/22 233/9 235/11 235/12 239/18</p> <p>stipulate [1] 5/16</p> <p>stools [1] 53/23</p> <p>stop [9] 70/10 83/10 83/22 84/20 84/21 95/4 155/3 221/1</p>	<p>221/7</p> <p>stopped [2] 40/15 188/3</p> <p>stopping [2] 232/13 232/15</p> <p>stops [1] 155/1</p> <p>stories [1] 141/18</p> <p>straight [2] 210/13 215/24</p> <p>straightforward [4] 57/1 170/22 170/24 228/3</p> <p>strategy [2] 14/9 232/20</p> <p>streamlining [1] 194/19</p> <p>strength [2] 54/23 232/6</p> <p>strengthen [1] 208/7</p> <p>strengthened [2] 236/11 236/16</p> <p>stresses [1] 136/20</p> <p>stressful [1] 115/14</p> <p>stretched [1] 142/1</p> <p>strict [1] 202/5</p> <p>strike [1] 179/23</p> <p>strikeouts [1] 210/19</p> <p>string [1] 117/21</p> <p>strongly [3] 54/23 169/20 192/20</p> <p>structure [4] 5/19 24/20 76/10 230/21</p> <p>structured [2] 13/16 194/22</p> <p>structures [12] 124/3 124/9 125/2 125/25 127/21 135/22 135/24 136/2 165/2 165/22 168/8 194/11</p> <p>struggle [1] 189/11</p> <p>struggling [1] 128/2</p> <p>study [1] 176/22</p> <p>style [1] 132/9</p> <p>sub [3] 60/19 174/13 176/8</p> <p>sub specialties [1] 60/19</p> <p>sub specialty [1] 174/13</p> <p>sub-curriculum [1] 176/8</p> <p>subconsciously [1] 17/8</p> <p>Subhedar [1] 180/18</p> <p>subject [8] 3/8 22/10 29/9 61/5 68/1 68/3 70/17 212/17</p> <p>subjective [1] 102/15</p> <p>subjectively [1] 84/8</p> <p>submission [1] 203/22</p> <p>submitted [1] 115/10</p> <p>subparagraph [2] 81/20 81/22</p>

S	suggestion [13] 42/8 51/15 88/22 109/24 167/14 217/17 218/12 218/23 219/11 219/15 219/16 226/23 227/1	survey [1] 159/9 surveys [4] 35/11 159/11 159/19 160/6 survivable [1] 191/13 surviving [2] 140/1 191/12 suspect [5] 7/22 15/5 37/8 188/18 218/16 suspected [1] 171/13 suspicion [2] 187/4 226/11 suspicious [2] 91/25 184/9 suspicious [1] 58/25 swift [1] 69/7 swiftly [1] 68/12 Swiss [1] 45/22 switch [1] 72/21 sworn [4] 73/7 205/10 241/7 241/14 sympathies [1] 73/23 system [58] 2/9 2/14 2/20 4/2 4/24 10/4 12/10 12/15 12/22 31/23 32/25 34/21 35/1 35/10 38/6 38/13 40/8 40/14 40/20 41/3 42/4 42/24 44/10 48/4 48/21 49/8 50/7 53/16 55/5 55/13 56/8 56/24 63/7 63/23 64/9 64/12 64/16 64/21 66/2 66/4 124/21 126/3 131/7 148/2 151/4 156/17 156/24 157/10 158/12 165/16 167/9 167/14 167/15 177/23 183/14 188/1 228/15 237/24 systematic [3] 13/2 13/12 13/15 systems [15] 54/16 125/20 126/6 126/8 128/15 128/19 128/21 132/18 136/25 152/14 154/14 155/21 156/22 157/1 188/6	216/15 220/19 230/18 230/19 238/19 takeaways [1] 131/15 taken [30] 5/12 16/2 30/3 30/17 40/17 61/14 68/12 81/1 81/17 82/4 85/7 85/15 86/11 86/16 86/16 100/16 103/14 109/21 111/19 116/14 134/4 164/18 214/9 216/22 217/22 231/11 231/15 232/11 236/12 237/12 takes [8] 5/8 28/21 32/24 51/6 67/7 84/17 147/6 178/13 taking [5] 98/2 140/15 188/19 213/1 233/14 talk [8] 15/19 35/15 44/7 56/5 129/22 191/19 200/6 236/19 talked [3] 112/22 190/16 190/17 talking [11] 9/11 69/18 127/1 140/24 143/1 153/25 181/1 185/13 185/14 185/15 195/9 tall [2] 184/18 185/23 tangible [1] 37/9 targets [3] 130/24 137/22 143/15 teach [1] 51/2 teaching [4] 1/20 171/7 173/16 173/20 team [58] 4/25 27/23 39/18 46/6 62/23 83/6 84/11 88/20 89/1 91/13 91/19 92/3 92/7 92/8 92/11 93/11 94/1 94/15 94/20 95/3 95/14 95/17 96/16 97/20 103/5 111/12 112/14 113/1 113/3 113/4 114/7 114/9 114/21 120/14 120/19 127/11 131/12 131/19 131/23 179/13 197/22 204/13 212/17 212/20 215/13 219/2 224/9 225/2 225/3 226/19 229/8 229/18 229/21 230/3 231/13 235/23 238/5 238/22 team-centred [1] 131/12 teams [5] 129/5 131/13 132/18 196/21 197/19 technical [2] 26/6 27/8 technically [1]	129/24 telephone [6] 15/4 20/19 20/20 21/6 199/6 217/7 tell [12] 20/17 39/23 43/4 50/21 58/18 126/6 129/19 148/6 159/2 196/2 233/24 234/3 tells [2] 148/16 231/7 template [1] 69/22 ten [1] 194/11 tend [4] 133/18 152/18 187/1 193/13 tension [1] 63/19 term [9] 88/18 90/8 90/11 90/15 90/25 93/5 109/25 110/6 153/17 terms [52] 5/6 7/3 12/20 18/9 21/10 21/15 23/3 26/20 28/23 29/7 34/23 35/16 42/10 43/10 43/15 58/16 76/17 77/7 77/11 77/14 78/15 79/1 79/11 86/23 86/23 87/3 87/4 87/11 87/14 88/7 88/9 93/3 93/17 95/10 106/1 112/22 112/24 113/5 113/9 119/4 119/10 122/4 125/3 149/13 153/4 153/8 192/23 204/6 207/11 211/23 214/19 237/10 terrible [2] 40/24 57/17 territory [1] 52/13 tertiary [1] 8/14 test [4] 56/14 198/4 218/3 220/13 testing [3] 27/10 27/10 58/15 text [5] 84/7 97/3 97/15 132/25 160/10 than [26] 13/11 28/12 34/13 35/8 55/14 87/13 126/2 130/25 142/3 154/2 173/14 175/1 194/13 197/17 201/24 201/24 202/3 203/13 203/14 205/13 219/10 219/22 225/15 235/5 236/1 237/15 thank [94] 1/5 2/8 3/5 3/19 4/1 9/15 11/3 16/6 18/19 19/25 20/8 24/14 24/25 25/15 26/8 26/9 26/23 27/15 29/4 37/24 40/23 42/14 44/3 44/13 46/24 47/17 47/18 48/1 48/19 49/5 51/9
	T			
	table [1] 53/11 take [52] 15/20 16/22 26/1 26/2 31/19 32/23 33/3 38/4 46/4 46/5 48/25 59/21 62/3 62/13 67/8 71/12 81/21 82/10 85/11 85/22 86/19 87/13 91/3 98/5 98/10 98/11 101/25 111/25 117/7 119/25 127/12 139/8 141/2 142/6 147/19 169/1 173/2 175/24 176/9 180/17 180/19 184/14 189/22 204/11 204/25 209/4 216/6			

T	their [86] 5/13 5/18 6/3 6/8 6/14 11/24 12/12 14/3 14/18 14/20 15/10 16/17 23/13 24/2 25/14 25/16 25/22 30/16 30/24 31/1 31/10 31/19 34/3 37/7 37/7 37/10 38/2 49/24 59/15 59/16 59/20 59/24 63/5 63/20 66/1 70/2 99/12 102/9 107/22 109/10 109/22 114/1 114/5 114/7 116/7 119/3 120/21 121/15 121/15 121/18 128/23 129/1 134/11 134/20 149/24 150/25 151/2 151/8 156/4 158/3 160/4 167/2 168/12 168/17 174/6 174/8 180/12 185/8 192/6 196/20 198/9 198/10 198/11 203/20 207/6 208/7 208/17 221/20 223/13 225/24 233/5 233/16 236/1 237/5 237/10 239/12	85/9 89/10 93/22 96/3 98/4 112/20 115/19 118/20 125/7 131/9 131/20 132/13 133/11 134/22 143/5 144/12 147/5 147/13 147/18 147/22 148/7 149/7 149/25 155/1 155/9 158/25 160/17 165/5 176/12 176/14 179/11 199/24 200/9 201/16 202/13 203/4 203/9 204/12 206/16 208/2 209/3 210/8 210/16 215/1 215/25 220/16 223/20 228/12 228/15 229/18 230/24 236/2 237/18 238/5 theory [2] 135/24 135/24 there [418] there's [29] 8/22 16/2 33/9 33/9 42/9 58/22 63/18 67/2 88/21 107/1 124/14 125/11 125/12 126/17 127/19 128/18 133/20 134/22 142/19 150/1 150/11 193/9 198/6 211/6 211/18 221/22 232/15 236/11 239/17 therefore [8] 11/12 70/2 101/13 170/18 209/7 221/2 221/9 233/11 these [48] 8/25 10/23 13/3 23/16 31/24 35/5 38/11 39/23 57/25 59/10 62/15 88/8 100/12 101/1 127/17 128/14 134/15 139/18 151/21 152/25 153/2 154/2 154/5 154/10 155/14 157/25 159/11 160/19 161/12 163/20 166/17 168/8 168/16 176/23 177/12 178/25 189/25 192/8 193/16 202/25 212/22 213/9 216/25 218/1 227/2 227/13 230/23 233/5 they [263] thing [15] 5/17 13/23 23/9 29/4 40/24 44/14 70/8 89/21 112/17 112/24 118/23 119/4 152/16 156/12 233/16 things [29] 6/10 13/3 21/20 42/17 42/18 47/11 49/22 49/23 52/25 53/1 56/24 57/24 63/20 64/6 64/24 66/6 68/9 126/8 128/4 130/4 135/21	180/14 182/12 186/25 189/25 190/17 192/19 214/1 223/24 think [166] 3/2 4/14 10/22 23/14 23/22 25/11 26/19 26/23 28/4 30/11 31/22 32/18 34/2 34/25 39/5 42/15 44/14 45/3 45/6 46/4 46/19 48/7 49/5 50/5 50/5 50/14 51/9 51/9 51/10 51/14 52/24 53/19 53/21 53/24 53/25 54/2 54/3 54/19 54/22 55/20 55/20 56/10 57/7 57/12 58/16 59/1 59/3 59/7 61/4 63/14 64/2 65/14 66/8 67/9 69/6 71/15 71/19 72/10 83/8 97/7 98/7 102/18 106/14 113/22 116/5 118/22 126/10 127/12 128/5 128/9 128/25 129/24 131/17 132/17 133/16 133/19 135/3 135/6 138/14 142/21 142/21 142/22 145/13 147/2 148/7 153/16 157/5 159/16 160/2 160/15 161/24 163/13 163/17 163/25 164/4 167/22 167/25 168/4 168/9 168/10 168/11 170/11 170/23 171/1 173/19 175/3 177/4 177/16 177/17 177/19 178/6 181/18 182/24 183/4 183/10 183/13 184/17 184/20 185/1 185/18 185/22 185/24 186/10 187/2 189/13 189/15 190/5 190/7 190/21 191/9 191/16 193/11 193/12 194/17 195/12 195/25 196/5 197/25 199/10 199/13 200/21 200/23 201/2 214/2 214/23 215/2 215/8 215/11 217/10 220/10 222/11 224/1 224/8 225/5 227/18 228/5 230/15 230/21 230/22 230/25 232/17 232/18 236/4 237/24 239/23 240/6 thinking [15] 31/3 32/4 32/10 105/3 155/6 156/21 162/1 163/12 171/1 182/9 190/24 195/8 198/10 198/16 204/18 thinks [1] 98/2 third [17] 3/16 7/1	50/3 57/6 64/19 70/12 81/22 105/2 105/13 111/5 116/25 118/4 124/5 145/23 157/14 207/20 212/18 THIRLWALL [4] 65/5 198/25 241/6 241/13 this [311] this and [1] 51/16 thorough [1] 231/8 thoroughly [1] 144/21 those [115] 1/12 2/16 3/1 3/20 6/6 7/1 7/18 7/22 9/7 11/8 11/19 11/20 11/23 12/1 12/8 15/20 16/22 17/9 17/23 18/6 22/9 24/8 25/4 26/20 30/17 30/19 30/20 31/8 32/11 34/5 34/8 34/16 35/14 37/4 37/4 37/14 38/4 41/4 41/15 42/25 43/15 44/20 57/7 58/20 59/17 59/17 62/9 64/24 68/8 71/17 75/22 82/12 84/23 87/4 89/1 89/12 91/12 92/14 93/5 93/10 95/13 98/16 104/9 106/4 107/5 111/2 113/2 117/14 118/7 118/9 119/17 120/25 123/20 124/7 128/1 128/17 128/21 132/9 135/17 136/10 141/18 146/1 146/8 149/3 149/13 149/15 155/21 166/3 171/19 173/12 175/25 177/3 186/2 187/20 188/6 188/11 190/10 198/18 201/24 201/25 204/21 206/2 207/23 208/9 208/23 209/4 210/19 213/1 214/1 219/13 222/6 235/11 236/22 239/15 239/20 though [6] 8/20 26/13 44/20 62/17 97/23 106/20 thought [4] 50/18 66/11 181/7 233/24 thoughts [5] 20/23 30/16 38/14 58/21 190/15 thousands [2] 16/12 16/12 three [32] 3/11 6/22 15/19 17/9 47/8 49/18 49/19 49/22 56/11 56/12 56/17 56/17 57/25 64/3 67/7 67/9 115/1 123/10 124/2
----------	---	---	--	--

T	214/4 214/11 214/11 214/23 215/6 215/10 215/13 217/5 218/21 222/8 223/24 226/16 230/3 230/5 230/6 230/18 230/20 231/14 232/4 232/7 232/17 233/2 233/13 234/2 234/7 235/25 236/3 237/16 238/1 238/19 239/18 timeline [2] 65/11 112/11 timelines [1] 164/19 timeliness [1] 113/11 timely [5] 3/15 65/15 136/8 164/10 164/24 times [4] 7/25 124/25 137/17 228/9 timing [2] 29/8 204/6 tip [1] 99/1 tip-off [1] 99/1 tipped [1] 98/23 title [2] 15/7 166/6 today [12] 72/14 74/7 118/17 123/24 205/15 206/23 219/2 224/2 224/5 224/10 224/14 225/22 today's [1] 237/15 toes [1] 204/1 together [10] 58/11 65/19 130/21 131/13 171/9 173/8 213/1 214/1 219/9 232/25 told [28] 45/12 45/25 71/25 72/2 91/8 94/1 94/3 94/10 98/6 100/22 119/18 205/14 210/25 211/4 211/18 212/16 213/24 214/8 216/24 216/25 217/2 217/4 218/9 231/9 231/14 231/22 234/21 240/8 tomorrow [1] 98/6 TONY [3] 205/10 205/22 241/14 too [7] 40/17 42/15 61/17 88/1 88/3 141/13 204/14 took [9] 33/22 159/9 214/4 214/24 215/4 229/9 230/16 230/22 238/9 tool [13] 145/10 146/2 146/21 149/12 152/22 154/17 154/23 156/6 156/7 157/3 158/11 158/15 159/13 tools [9] 148/14 149/14 149/15 152/25 153/3 154/2 159/18 160/19 160/20	top [10] 76/22 82/4 85/11 85/13 104/9 132/3 177/21 212/2 214/19 216/5 topic [4] 28/17 114/12 182/8 237/21 topics [1] 124/3 totality [3] 159/17 160/2 197/5 touch [2] 127/1 135/10 touched [4] 136/11 145/3 155/10 202/16 towards [7] 74/4 148/5 148/7 149/10 171/4 224/24 225/6 toxic [1] 158/5 traffic [1] 50/8 tragedies [1] 59/7 tragic [1] 46/9 train [1] 185/17 trained [7] 14/3 21/21 61/16 69/10 169/15 183/5 226/12 trainee [2] 159/19 160/6 trainees [4] 123/2 159/21 174/15 189/18 training [42] 13/25 14/1 24/25 25/7 25/14 25/16 25/18 26/10 26/11 26/18 26/22 27/1 27/2 27/3 27/17 37/1 40/6 54/24 56/3 69/20 71/15 76/4 123/1 128/13 170/20 171/24 172/6 172/11 172/14 172/16 172/17 172/19 174/5 174/8 174/11 174/20 175/21 175/25 176/2 176/6 183/17 198/16 trainings [1] 40/3 trajectory [1] 22/13 transcript [1] 27/6 transcripts [1] 102/11 transferred [4] 8/7 8/13 8/17 153/5 transferring [1] 7/13 translate [1] 142/7 transparency [1] 43/2 Transport [1] 202/13 traumatic [1] 29/12 traumatised [1] 192/6 tread [1] 204/1 treat [1] 4/10 treating [2] 27/23 70/15 treatment [3] 9/2 61/22 138/7 treatments [1] 140/3	trends [2] 11/18 13/21 trespassing [1] 52/13 triangle [2] 71/9 71/9 tried [2] 19/7 235/8 trigger [5] 181/4 186/11 186/21 216/7 221/18 triggered [3] 180/8 180/15 183/10 triggers [2] 188/11 208/14 troubled [1] 183/9 true [15] 1/13 3/24 73/17 122/1 125/16 126/10 126/16 133/16 134/18 135/6 135/7 173/19 193/11 200/7 206/2 truly [1] 24/10 Trust [41] 1/20 6/7 32/15 115/11 115/12 115/21 127/5 129/9 129/10 129/10 129/20 133/10 141/16 163/5 164/1 166/19 169/14 172/1 176/20 189/17 190/25 209/24 210/3 210/3 211/1 217/11 217/12 217/18 221/14 221/16 221/16 221/23 222/5 223/2 223/5 223/12 233/10 233/10 233/13 233/23 233/25 trusted [2] 12/10 150/12 trustees [1] 107/15 Trusts [21] 116/14 126/17 126/20 127/2 129/15 129/23 146/15 146/18 150/20 151/2 151/5 152/11 154/5 161/23 169/22 176/13 196/19 210/6 223/19 223/21 236/15 truth [4] 43/5 43/5 43/5 46/11 Truthfully [2] 175/5 200/20 try [5] 16/8 64/1 165/6 168/6 221/23 trying [6] 56/23 71/2 175/10 188/2 225/5 225/11 Tuesday [1] 240/16 turn [14] 36/21 36/24 73/4 76/7 76/20 91/3 91/5 107/11 111/16 121/10 124/8 140/5 190/5 224/7 turnaround [1] 150/1 Turner [8] 73/6 73/7 73/9 73/13 100/10	119/16 119/21 241/7 turning [3] 2/4 15/18 123/12 turns [1] 21/18 two [37] 1/10 26/1 26/2 30/2 47/23 49/19 49/22 78/21 83/21 85/10 87/5 88/1 93/20 102/2 103/8 103/14 108/19 112/14 112/15 117/2 118/8 141/22 142/3 143/8 143/9 149/2 153/2 153/7 161/8 165/23 167/8 182/3 192/5 205/23 210/17 214/1 230/25 two days [1] 210/17 two reports [4] 102/2 103/8 103/14 118/8 two weeks [2] 87/5 88/1 type [6] 60/3 103/6 176/11 179/14 220/6 232/9 typed [1] 210/16 types [2] 111/1 226/13 typically [1] 200/21
U				
			ubiquitous [1] 198/19 Uh [1] 19/13 Uh-oh [1] 19/13 UK [2] 75/23 193/22 ultimately [4] 14/8 46/16 68/7 90/4 unable [1] 150/25 unacceptable [1] 192/1 unaware [1] 92/4 uncertain [1] 24/20 uncertainty [4] 175/15 187/13 187/19 215/5 uncommon [5] 179/3 179/7 187/12 192/25 193/4 unconscionable [1] 58/12 unconscious [1] 62/5 uncover [1] 237/11 under [13] 17/19 30/5 77/25 80/21 81/12 101/10 123/10 130/9 132/22 136/15 139/20 169/11 181/24 under-resourcing [1] 139/20 underlying [1] 134/14 undermine [1] 165/18	

U	121/16	97/3 103/18 104/3	203/11	181/12 181/12 183/4
undermining [1]	Union [1] 98/12	104/17 113/9 119/11	usually [5] 77/8	184/6 184/6 184/8
157/25	unique [6] 7/6 29/5	126/14 126/22 132/12	114/16 147/6 187/16	185/23 187/16 187/19
underneath [1]	62/4 63/4 71/5 157/5	133/7 147/23 149/20	200/24	188/19 189/2 190/11
166/19	uniquely [1] 61/18	149/22 154/25 156/6	utilised [1] 115/12	192/20 193/15 195/5
understand [44] 9/3	unit [50] 5/7 5/23	157/12 158/2 158/10	utterly [1] 62/6	198/22 199/17 200/5
15/25 22/16 24/14	5/24 6/3 8/4 8/5 8/7	158/18 159/23 162/15		200/7 201/3 202/2
32/5 35/18 45/24 49/4	8/13 10/22 20/16	163/11 163/24 173/19	V	202/2 202/5 203/16
59/25 61/13 64/23	22/23 29/3 43/17	175/24 176/25 182/21	valuable [4] 36/5	204/23 208/18 209/21
64/24 66/5 73/20 83/4	44/16 58/2 59/16	182/22 184/5 185/21	159/20 189/2 189/20	214/18 215/13 218/13
92/24 119/3 121/10	88/12 97/22 133/24	186/14 187/23 189/16	value [5] 29/10	224/6 225/21 232/8
129/8 144/3 144/11	134/9 149/19 149/23	189/22 189/23 190/8	153/22 171/1 200/4	235/7 239/24 240/9
145/15 145/19 147/14	150/4 153/10 178/25	191/15 192/16 199/18	228/1	240/13
149/3 150/18 153/3	179/4 179/8 179/20	201/5 202/12 207/16	variability [2] 48/3	vested [1] 159/22
157/6 158/23 162/5	180/3 181/1 181/2	210/7 210/10 210/16	53/22	via [5] 17/19 33/16
169/11 181/16 185/19	184/5 191/24 191/25	211/20 214/22 215/6	varies [2] 20/13	39/19 39/25 40/1
185/25 185/25 187/15	191/25 192/21 193/2	215/11 228/22 230/17	202/21	Vice [1] 123/9
187/18 188/2 190/6	193/3 193/3 194/21	239/10	variety [1] 176/10	Vice President [1]
200/15 203/20 208/5	199/16 202/6 202/6	update [10] 49/24	various [9] 42/16	123/9
211/13 223/18	202/12 202/12 202/18	50/10 52/17 54/13	51/7 72/24 128/18	view [27] 16/2 38/4
understandably [2]	202/20 203/5 211/2	173/5 173/24 182/11	133/17 134/15 190/17	41/1 42/14 54/19 56/3
34/22 117/18	234/22	182/12 230/14 230/20	193/21 201/5	56/20 70/21 72/9
understanding [11]	units [16] 8/7 16/19	updated [4] 49/23	vary [2] 33/18 193/1	95/12 96/19 98/25
15/1 64/15 101/12	23/20 142/2 143/11	66/14 173/24 236/8	vast [3] 21/16 75/22	102/15 124/23 127/4
157/4 161/7 161/8	150/4 175/23 192/2	updates [1] 47/10	198/9	133/13 133/13 139/3
171/18 172/4 173/15	192/19 193/1 193/5	updating [3] 19/17	vehicle [2] 128/8	142/11 155/13 170/8
178/11 178/15	193/16 193/23 193/25	66/6 182/7	165/6	170/11 175/18 180/21
understood [4]	194/1 197/17	upfront [1] 112/18	verbal [1] 99/19	186/17 215/21 238/16
167/11 199/14 201/4	unknown [1] 223/10	upgrade [1] 194/1	verbally [1] 228/14	viewed [1] 137/6
224/25	unless [9] 82/18 83/1	upload [1] 150/25	verbatim [1] 59/23	viewpoints [1] 170/7
undertake [11] 64/22	83/15 86/5 128/11	uploading [2] 120/21	version [20] 102/2	views [8] 28/25 29/1
65/22 92/22 127/17	129/2 163/11 172/12	120/25	102/3 102/4 103/25	30/16 42/13 45/4
171/23 172/14 186/16	182/22	upon [12] 13/10 77/2	104/13 105/9 105/14	203/20 204/9 231/11
196/22 198/18 222/5	unlikely [4] 54/3	81/12 114/23 122/9	105/22 105/23 106/1	visit [26] 77/2 78/4
223/8	211/16 232/8 235/7	124/24 127/1 135/10	106/5 106/6 106/8	80/1 80/7 80/9 80/12
undertaken [5] 14/20	unnecessary [1] 38/9	145/4 155/10 193/2	106/12 106/13 106/15	80/14 82/6 89/19
27/2 38/10 174/16	unpack [1] 213/20	228/2	117/4 210/14 210/15	89/20 91/9 92/5 92/12
182/10	unprecedented [1]	uptake [1] 200/7	210/25	92/18 92/24 93/18
undertaking [1] 54/2	138/19	urgent [4] 31/19	versions [2] 117/3	93/21 95/14 96/9 96/9
undertook [1] 231/8	unreasonable [1]	31/21 81/1 86/6	195/5	99/10 105/5 107/4
undoubtedly [1] 53/4	16/13	us [33] 20/17 24/18	very [111] 1/5 5/6	108/8 108/18 196/21
unexpected [19]	unsafe [1] 158/2	26/17 54/14 58/18	11/4 16/1 24/7 25/12	visited [2] 210/2
7/16 17/13 18/24	unsatisfactory [1]	64/6 66/23 72/21	26/24 27/4 28/19	210/3
21/25 24/10 24/17	199/22	109/17 115/13 115/14	28/22 31/16 38/24	visiting [1] 193/14
35/21 44/15 55/22	unsuitable [1] 90/1	116/19 127/4 135/1	41/1 41/25 44/7 46/24	voice [1] 32/25
57/13 58/6 61/25	unthinkable [2]	145/19 154/22 173/4	47/13 51/15 62/11	volume [3] 137/16
94/11 173/10 178/1	25/12 58/24	186/2 188/11 196/2	62/14 66/22 66/25	139/23 187/9
179/8 179/24 186/20	until [13] 149/20	202/10 202/14 210/7	70/14 72/13 72/15	vulnerabilities [1]
186/22	149/22 153/24 154/25	210/15 212/14 216/4	72/19 72/20 89/19	60/25
unexpected/unexplai	173/20 179/5 221/4	216/7 220/18 223/14	89/20 91/4 96/3 101/7	vulnerability [3]
ned [1] 94/11	223/12 227/22 238/11	232/22 232/24 233/24	116/4 117/18 118/18	60/23 62/3 184/1
unexpectedly [5]	238/17 240/8 240/15	239/10	119/4 119/20 119/21	vulnerable [6] 62/6
13/8 52/12 70/15	unusual [13] 24/11	use [8] 68/11 69/9	119/22 119/24 121/17	62/8 62/10 62/11
182/1 184/9	58/10 79/14 79/18	128/13 128/21 129/5	121/17 126/16 127/8	191/11 193/15
unexplained [3] 25/5	79/19 79/22 87/24	152/18 168/16 175/11	133/18 133/18 135/3	
80/5 94/11	96/20 96/25 198/14	used [3] 39/22 48/4	141/9 141/9 142/15	
unfathomable [1]	203/12 211/24 227/7	167/13	147/3 147/10 150/11	
121/16	unwell [1] 181/13	useful [7] 22/25	151/9 155/8 155/23	
unfolded [1] 59/8	up [72] 2/18 9/14	45/12 166/9 209/21	159/24 162/6 162/7	
unfortunately [1]	11/1 12/19 17/12 24/4	210/5 229/4 229/6	162/7 162/10 167/12	
79/23	26/12 35/14 43/16	using [5] 152/23	170/13 171/2 173/20	
uniforms [1] 39/24	43/18 44/1 44/19 51/1	162/17 188/3 196/20	173/23 175/12 176/16	
unimaginable [1]	56/9 62/19 65/9 71/17	226/22	176/16 176/16 176/18	
	85/14 87/13 92/18	usual [2] 87/13	179/4 179/23 179/24	

W	way' [1] 116/17	22/11 24/20 25/3	70/13 71/24 71/25	37/7 38/24 39/2 48/24
Wales... [8] 2/19 2/20	ways [12] 35/12	26/13 27/12 27/14	72/15 74/1 76/8 77/22	57/12 58/16 65/11
2/23 3/8 42/12 63/8	42/17 50/5 51/13	31/4 34/8 34/20 34/24	80/20 81/1 82/1 82/8	65/14 66/7 67/11
64/17 194/12	51/15 61/20 131/12	38/10 38/10 38/19	82/15 83/11 83/18	80/20 83/6 94/5 94/7
want [42] 27/13	140/23 148/23 156/13	38/24 40/9 43/9 45/25	84/4 84/19 85/2 87/19	95/13 95/16 103/10
31/19 31/21 33/2	160/3 198/4	47/16 47/19 48/11	89/2 90/16 90/17	106/9 109/11 110/15
36/18 46/11 46/11	we [490]	49/13 49/15 51/24	93/17 93/25 96/7	112/14 113/21 116/15
46/12 64/25 65/2	we'd [1] 218/4	56/23 57/2 57/4 63/10	96/13 97/10 97/19	117/19 126/6 126/25
68/11 68/22 72/11	We've [1] 236/10	65/8 67/2 71/25 76/17	98/1 98/13 98/16	127/15 129/22 134/5
76/5 81/3 85/11 86/22	wealth [1] 123/24	86/15 86/25 87/12	98/25 102/2 104/13	136/8 141/20 143/14
88/9 115/2 115/3	webinar [1] 176/11	88/8 89/5 91/9 91/24	105/7 108/13 108/19	146/21 149/1 149/21
121/11 128/23 129/2	week [7] 10/19 24/6	92/4 93/9 94/1 94/1	109/2 109/13 109/21	153/25 155/20 159/3
143/3 148/7 148/12	43/22 185/20 225/1	94/3 94/5 94/10 94/11	112/1 113/19 114/22	160/17 164/10 164/13
153/15 153/16 153/17	230/23 240/5	95/13 97/20 99/6	116/1 116/14 118/24	164/23 167/23 171/13
156/25 163/24 171/5	weeks [10] 32/9	100/6 100/23 102/1	119/12 126/6 127/4	171/19 173/1 173/5
184/12 185/24 187/20	33/11 52/22 58/4 87/5	103/10 104/15 106/4	127/23 127/24 128/3	173/16 174/25 183/8
197/12 199/14 203/1	87/13 88/1 98/5	107/23 108/20 109/8	130/21 131/9 131/14	184/4 185/25 186/5
204/11 204/14 204/22	154/24 231/1	110/15 111/7 114/4	131/22 132/1 132/1	187/8 191/1 194/1
239/8	weigh [1] 191/20	114/20 114/21 115/20	132/2 132/2 132/7	202/7 207/15 211/4
wanted [9] 13/23	welcome [1] 193/15	117/13 118/5 120/19	134/3 134/21 134/24	222/2 223/6 224/25
15/21 15/24 34/5 38/4	welcomed [1] 195/25	122/23 123/1 123/4	135/1 140/7 142/4	225/13 226/1 228/15
117/17 121/16 164/1	well [110] 4/17 7/14	123/9 138/24 146/19	143/18 143/19 143/20	231/25 234/10 236/20
214/7	8/25 11/4 14/8 16/3	156/2 157/12 159/10	143/20 145/6 145/19	238/5 239/4
wanting [2] 184/11	18/19 19/22 19/24	161/4 170/5 171/12	146/1 146/2 146/14	where [107] 5/21 6/1
203/25	23/16 24/16 24/23	172/12 178/8 179/10	146/18 146/22 147/14	8/11 8/12 9/4 9/10
wants [1] 239/22	25/15 26/25 28/6 28/7	182/22 184/4 187/22	147/19 147/19 148/6	9/13 9/24 10/13 10/22
War [1] 25/24	32/23 33/6 35/23	187/24 188/19 191/12	149/13 152/3 153/8	12/11 12/22 14/21
ward [8] 9/4 10/2	41/13 41/14 43/3 44/1	197/14 198/8 198/11	154/17 154/18 156/23	16/2 18/2 21/8 21/24
13/9 36/8 44/9 150/9	45/5 45/6 45/8 45/16	198/15 199/2 199/4	157/8 157/20 158/19	22/16 23/5 27/14
196/17 196/25	48/7 49/22 50/7 53/2	199/7 203/17 203/20	161/21 161/21 162/22	27/21 32/7 34/3 39/4
warning [5] 126/14	54/4 55/6 57/3 62/14	205/13 206/15 206/16	163/1 164/18 164/18	40/4 42/1 43/10 44/7
126/24 127/12 128/10	66/20 70/13 71/11	211/12 213/13 213/18	164/24 165/9 165/9	44/8 45/18 45/22
143/2	79/25 83/11 84/10	215/8 216/18 216/24	165/24 166/11 167/2	52/14 54/16 66/2
warrant [1] 105/19	89/14 108/11 120/21	216/25 216/25 217/2	167/18 167/19 171/18	70/14 71/7 71/11
was [248]	125/15 128/5 129/13	217/2 217/2 217/4	171/24 173/15 174/5	80/22 81/17 81/23
was October 21 [1]	140/22 144/3 145/22	217/17 224/22 225/5	175/9 175/15 180/11	82/5 82/25 84/5 84/14
177/17	146/25 146/25 147/12	226/12 226/13 226/14	183/9 184/10 186/5	84/19 85/6 86/7 86/16
washing [1] 193/13	148/18 149/19 150/8	227/3 227/13 230/1	186/10 186/15 188/10	88/3 103/12 104/10
wasn't [28] 40/21	150/18 153/11 154/19	231/14 231/22 232/22	188/23 189/6 191/12	105/17 107/1 125/1
69/3 72/2 79/24 86/13	156/9 161/7 161/22	233/6 233/13 234/17	194/19 195/8 196/2	125/12 126/12 126/20
95/17 98/17 99/5	163/6 163/15 163/24	234/23 235/10 235/12	196/6 196/6 199/7	126/20 126/21 126/22
104/2 104/18 104/24	167/21 173/2 173/22	237/7 238/2 238/5	199/13 202/1 202/6	127/16 128/25 129/17
107/8 118/9 118/24	176/22 178/15 180/24	weren't [5] 57/2 57/4	202/6 203/19 204/1	132/12 132/19 136/19
172/10 178/10 201/23	181/10 182/4 184/3	90/24 104/5 237/23	207/11 207/24 209/9	137/2 137/20 139/12
213/16 216/19 217/4	185/7 185/12 186/8	West [1] 39/22	210/1 211/10 211/11	141/10 141/13 142/10
217/23 219/21 223/25	186/17 189/13 196/16	what [233] 3/3 3/12	211/20 211/21 211/23	143/2 143/2 143/19
227/5 232/7 232/13	200/6 204/6 211/20	3/21 4/13 5/15 6/23	211/23 211/24 213/21	144/11 146/25 147/7
233/1 235/18	212/15 213/20 216/21	7/2 8/21 9/3 9/20 11/4	214/8 218/9 219/9	147/24 148/9 148/11
waste [1] 146/10	216/24 217/23 218/25	11/5 11/8 11/19 13/17	219/19 219/23 220/1	148/12 150/3 159/25
waters [1] 218/3	219/13 220/8 220/20	14/5 15/23 15/25	222/4 223/18 223/22	162/19 163/10 164/16
way [40] 3/15 4/6	221/6 221/24 222/4	16/16 17/9 18/18	225/5 225/11 225/17	165/10 168/14 175/16
5/10 13/19 15/14	222/19 222/23 222/24	20/25 25/13 27/7 28/7	226/2 226/18 227/23	184/8 184/9 188/12
16/15 22/3 22/9 29/16	223/6 224/1 224/7	32/11 32/22 35/18	227/24 229/13 229/19	189/19 193/25 194/18
35/23 36/20 38/17	226/22 227/10 230/4	36/9 36/22 38/6 38/11	232/23 236/1 237/7	197/20 200/5 200/13
38/21 43/6 46/3 46/20	230/23 232/10 232/23	38/25 39/6 41/24	237/10 237/11 238/16	202/1 202/23 209/14
48/9 50/8 59/11 62/8	233/8 234/2 235/15	42/13 42/23 43/3 43/4	what's [10] 19/13	210/6 210/19 218/5
62/20 68/2 90/19	well-established [1]	44/8 44/19 44/19	20/6 70/10 132/3	226/11 228/10
91/21 100/25 115/8	54/4	44/19 45/2 45/2 45/3	146/11 147/18 155/13	whereas [5] 51/2
116/4 143/3 148/1	wellbeing [1] 157/7	45/9 45/11 45/11	235/5 237/7 237/8	129/1 154/19 156/5
157/5 159/20 176/24	went [5] 43/9 79/17	45/13 45/24 46/11	whatever [1] 147/16	191/24
185/21 194/22 196/19	171/13 229/11 229/17	47/20 48/5 50/6 53/14	whatsoever [1] 36/4	whereby [3] 112/12
197/18 204/18 213/6	were [143] 2/10 4/5	56/19 56/21 58/17	when [79] 6/11 15/14	128/15 216/19
223/20 227/11	4/5 6/13 10/17 12/5	64/11 64/15 64/15	16/18 18/12 21/16	wherever [3] 36/9
	12/20 12/21 13/7 20/4	65/11 68/14 70/10	24/9 25/8 26/14 37/1	184/13 201/18

W	210/24 213/3 213/8 214/4 214/5 214/12 214/21 215/6 216/6 216/10 216/11 224/9 225/19 226/20 226/25 227/8 228/16 229/14 229/17 229/20 232/20 232/24 236/16 while [5] 187/24 208/18 208/20 221/11 233/19 whilst [13] 27/19 28/10 32/2 43/7 64/8 67/12 85/3 86/13 126/5 135/12 138/24 171/9 221/8 whistleblew [1] 182/23 whistleblower [1] 188/25 white [1] 104/9 who [132] 3/2 3/7 3/25 4/5 5/7 5/23 6/8 7/9 8/12 10/20 11/7 11/10 11/23 13/25 15/25 16/14 16/16 19/6 20/5 20/11 21/8 22/3 22/6 22/8 22/23 23/18 24/15 27/10 29/2 29/13 29/22 30/9 31/4 34/16 35/14 35/15 39/22 39/24 41/13 46/21 46/21 49/15 52/10 52/11 59/10 59/14 59/16 59/18 60/2 62/4 62/6 62/7 62/7 62/9 65/21 65/22 65/24 67/25 68/6 68/21 68/22 69/12 69/18 70/18 76/5 77/6 82/21 91/6 104/2 106/1 106/11 112/13 114/4 114/16 114/20 120/11 120/17 120/18 120/19 120/22 121/15 121/18 125/1 127/5 127/6 128/1 128/1 128/13 141/4 142/23 144/4 144/6 144/6 144/10 144/10 146/15 146/18 159/21 163/24 165/12 168/12 168/16 170/14 175/24 176/9 176/15 178/25 180/4 180/4 181/12 181/25 183/11 184/16 184/23 188/15 188/22 189/7 190/4 190/10 190/11 192/15 196/16 198/7 199/16 207/16 208/15 217/1 219/5 219/14 227/15 230/8 238/25 who's [5] 7/9 96/4	144/13 164/20 184/18 whoever [1] 238/3 whole [14] 7/8 7/14 11/11 43/5 64/21 77/3 88/14 92/7 97/22 127/11 150/5 176/8 214/20 230/24 wholly [3] 16/13 29/15 99/2 whom [6] 10/18 17/23 49/19 83/3 105/1 155/11 whose [2] 3/8 16/11 why [37] 22/25 34/5 40/21 41/18 44/20 67/8 67/10 67/10 71/21 71/24 95/3 100/6 108/2 112/16 140/19 146/10 146/22 147/15 153/20 185/9 185/10 186/23 187/3 187/14 191/22 200/15 211/17 214/4 214/21 216/5 220/23 228/24 230/18 230/19 234/7 234/19 235/16 widely [1] 106/21 wider [3] 23/17 23/23 62/13 widespread [2] 142/11 142/15 will [121] 3/4 3/25 12/12 16/9 16/22 20/3 21/2 21/3 23/12 23/15 23/20 23/22 24/1 25/1 25/17 26/2 26/5 27/6 28/7 28/7 28/23 29/22 30/6 32/4 33/1 33/3 33/3 36/17 36/18 36/19 36/23 37/3 37/13 46/5 46/7 48/20 50/10 50/12 51/11 51/15 53/19 53/21 54/1 54/24 56/2 59/21 63/15 63/15 63/21 64/6 64/6 64/7 64/14 64/19 66/16 66/23 68/14 68/19 69/1 72/1 72/25 77/5 77/7 80/18 80/25 86/1 97/8 98/5 98/7 101/15 106/20 109/13 112/8 112/18 113/12 114/5 114/7 114/8 115/1 115/2 115/3 116/13 117/25 120/5 120/11 120/21 120/25 125/20 128/23 129/1 129/14 140/12 144/1 146/1 152/23 155/3 168/7 170/6 170/25 172/8 172/25 173/2 174/3 175/24 176/13 176/22 177/20 185/7 186/13 186/14	186/16 186/16 190/8 202/10 203/3 204/13 204/25 219/3 220/18 238/25 240/13 William [1] 73/13 wish [4] 60/11 64/14 72/17 176/9 wished [1] 59/19 wishes [1] 33/8 withheld [2] 105/24 218/7 within [35] 5/14 5/15 5/24 8/8 13/16 31/8 43/22 51/20 53/10 59/24 63/23 80/19 81/15 86/14 99/7 111/9 124/21 137/6 144/9 144/24 147/9 159/6 160/21 161/15 161/17 162/18 168/8 175/22 175/23 179/15 181/1 184/21 228/24 229/21 237/25 without [23] 54/4 58/4 59/11 86/3 88/4 106/21 178/20 179/2 180/12 186/20 187/21 199/23 200/1 200/2 202/16 203/25 215/17 216/17 216/22 217/22 219/16 221/21 223/13 witness [8] 73/14 91/21 99/18 119/19 120/10 120/17 130/12 143/9 witnesses [2] 220/6 220/17 woefully [1] 198/17 women's [1] 161/10 won't [6] 59/22 68/15 68/17 142/12 142/17 151/7 wonder [7] 48/25 49/2 57/16 60/4 188/20 189/5 204/7 wondered [2] 44/11 48/5 wonderful [1] 63/25 wondering [4] 18/11 25/6 26/17 37/17 word [6] 16/6 22/18 26/15 166/19 167/13 175/11 words [6] 37/3 51/18 53/14 141/5 143/4 198/11 work [41] 3/20 6/8 11/7 17/5 24/5 49/22 49/23 53/2 59/16 63/23 65/19 65/23 66/3 67/11 67/21 84/17 131/13 131/15 132/19 134/19 143/3 143/7 143/19 146/25	151/12 158/5 161/2 161/15 182/9 184/24 189/19 190/8 191/13 198/5 198/17 200/5 202/11 202/23 204/6 208/16 221/22 worked [1] 206/6 worker [5] 29/17 33/17 35/16 36/2 46/7 workers [1] 30/18 workforce [10] 134/18 135/5 139/12 139/24 141/19 141/20 191/1 191/3 195/18 197/16 working [32] 5/22 5/24 10/19 35/24 60/1 66/5 81/7 122/12 122/13 123/20 127/15 141/6 141/21 141/25 144/16 156/17 160/12 161/24 171/9 171/23 172/22 173/8 173/25 184/14 189/17 189/18 221/8 221/15 221/16 231/12 233/24 236/17 workplace [1] 160/4 works [5] 29/1 50/4 51/24 78/11 180/4 world [10] 4/20 147/11 152/17 168/2 168/5 175/6 183/3 183/13 196/13 202/8 worlds [1] 54/18 worried [4] 132/8 150/16 168/12 196/15 worries [1] 132/1 worry [2] 97/7 198/9 worrying [1] 132/1 worst [1] 54/18 worth [2] 191/20 236/13 worthwhile [1] 46/13 worthy [1] 192/9 would [345] wouldn't [24] 6/11 26/4 37/18 43/14 45/3 93/6 93/14 109/14 109/16 111/12 142/21 168/14 175/11 175/13 179/17 181/7 181/14 211/22 211/24 214/18 216/15 216/16 239/14 239/15 write [1] 137/11 writer [1] 72/23 writes [1] 97/19 writing [4] 117/19 214/7 214/22 215/7 written [1] 108/21 wrong [9] 61/20 79/17 82/9 96/25 101/22 107/8 126/7 126/9 159/3
----------	--	---	---	--

W wrongly [1] 102/8 wrote [2] 210/5 210/11	136/19 137/10 138/9 138/11 139/3 139/11 139/20 140/8 140/20 142/6 142/12 142/16 143/8 145/2 145/4 145/6 145/9 145/11 146/15 148/6 148/19 148/24 149/1 149/14 155/10 157/4 157/4 157/14 157/16 158/7 158/8 158/19 159/20 159/23 160/17 162/14 162/16 164/9 164/9 164/14 164/15 165/21 165/23 166/12 166/20 167/18 169/3 169/23 171/3 171/6 173/15 175/10 175/18 176/24 177/12 177/13 177/13 177/17 178/11 178/23 181/20 182/21 184/1 186/15 189/6 190/15 197/20 199/16 202/18 202/20 203/18 204/8 204/18 205/15 205/20 206/3 207/14 213/3 214/11 214/20 215/2 215/10 218/25 220/13 224/14 228/24 229/11 233/7 234/15 236/9 237/25 238/16 yours [1] 184/15 yourself [3] 51/17 72/14 188/5			
Y year [18] 1/23 2/12 23/12 24/7 65/13 113/14 117/10 139/14 139/14 149/20 149/23 185/21 195/18 202/20 209/25 230/24 232/19 240/13 year-on-year [1] 139/14 years [22] 4/4 41/24 46/22 46/22 46/22 54/5 54/10 63/18 121/14 122/12 123/10 156/19 172/2 185/17 194/13 206/7 214/5 214/13 214/15 229/3 232/25 236/13 yellow [1] 210/19 yes [312] yet [6] 23/25 48/4 157/11 172/25 192/2 220/22 Yorkshire [1] 39/22 you [787] you've [2] 112/7 214/15 young [3] 27/18 70/14 139/1 your [186] 1/8 1/13 1/15 1/16 1/24 1/25 2/1 2/4 2/5 2/6 2/25 3/21 22/12 22/12 27/14 28/19 28/25 28/25 32/24 40/9 40/13 42/9 42/13 44/6 45/3 46/5 47/20 47/23 48/5 49/3 51/3 51/23 53/17 56/5 58/2 60/12 60/16 65/7 68/13 72/16 72/17 73/12 73/18 74/1 74/7 74/10 74/14 75/19 80/18 89/16 97/20 106/20 106/21 109/10 114/18 114/21 114/23 116/1 119/22 121/7 121/10 122/1 122/7 122/8 122/10 122/17 122/22 123/12 123/13 123/23 123/23 124/2 124/10 125/21 125/22 127/4 127/18 127/24 128/21 129/5 130/2 130/4 130/11 131/22 131/22 132/3 132/17 133/13 133/13 133/19 134/2 135/11 136/11 136/14	Z zoom [1] 111/17			